Rural Continuing Professional Development Program (RCPD)

Annual Report

April 01, 2009-March 31, 2010

Submitted by: Dr. Tandi Wilkinson, Dr. Brenna Lynn and Ms. Deirdre Maultsaid

“There are huge advantages to 'learning in situ'."I am excited about the RCPD, which will deliver rurally relevant CME/CPD, right in our own communities."

--- Dr. Rebecca Lindley, a rural British Columbia family physician, a member of the RCPD Medical Advisory Committee, and Co-Principal Investigator on the BC Rural Physicians Continuing Professional Development/Continuing Medical Education Needs Assessment.

Contents

Executive Summary

In the first two years, the Medical Advisory Committee (MAC) has directed Rural Continuing Professional Development (RCPD) to concentrate on the following five deliverables in order of priority:

- Develop and integrate new “Closer to home” programs with the event staff at University of British Columbia Continuing Professional Development (UBC CPD), at low-cost, high-return for rural communities to meet identified Continuing Medical Education/Continuing Professional Development (CME/CPD) needs and as a tool to build awareness and interest in RCPD.
- 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.
- 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 the Rural Education Action Plan (REAP).
- Build relationships with rural practitioners so that they can give ongoing input and direction to RCPD; integrate rural programming for both rural specialists and GP’s so that they can give input and participate in educational programs.
- Develop web communications: develop and design a BC Rural CPD webpage in collaboration with the Rural Coordination Centre of British Columbia (RCCbc) website; develop an up-to-date inventory of rural CPD programs and enable web viewing.

The RCPD team has worked to fulfill these deliverables, while aiming to meet the identified learning needs (REAP needs assessment) of rural physicians via pertinent and accessible educational opportunities including the shock course (the new “Closer To Home” program), rural internet search workshops, and webinars on rural psychiatry and chronic disease management.

I. Introduction

The University of British Columbia, Faculty of Medicine, Division of Continuing Professional Development, with support from the Rural Coordination Centre of BC started the Rural Continuing Professional Development (RCPD) Outreach Program to deliver CME/CPD to the 1,900 rural physicians in BC. The RCPD program works with and on behalf of rural physicians, to build relevant, valuable CME/CPD educational programs for rural physicians.

The Rural Physician Needs Assessment (REAP) helped identify barriers toward participation in rural CME/CPD activities. While urban based conferences impart topical information, provide networking opportunities and a refreshing change of scenery, rural physicians face particular challenges leaving their many responsibilities and busy medical practices in their smaller communities. Rural physicians find it difficult to obtain locum coverage to travel and attend conferences and events that are far from home and delivered outside of the community. These physicians have asked that the RCPD educate them “Closer to Home” and in the context of rural practice (focusing on a team approach) and follow the tenet of the Society of Rural Physicians of Canada, “Education for Rural Physicians, by Rural Physicians”.

The Needs Assessment also helped identify urgent and emergent topics of special learning interest to rural physicians. Most notably, these physicians indicated a priority need to acquire more knowledge and skills in emergency medicine, obstetrics, gynecology, psychiatry and chronic disease management.

The RCPD is integrating with existing rural physician education programs already supporting delivery of education on the above topics; creating new rurally relevant educational programming, as well as work to have content more rurally relevant when presented on these topics in non-rural settings. The program helps rural physicians to build relationships between themselves and other health care professionals based on the “Closer to Home” philosophy, using local specialists, local GPs and other health care professionals with advanced expertise within their region of practice for teaching purposes.

The RCPD program, led by a Medical Director and Project Manager, and with input from UBC CPD senior leadership and its Medical Advisory Committee, acts as an administrative resource, advocate, coordinator, instructional design and educational programming centre.

The purpose of this report is to fully describe the RCPD program for the period of April 1, 2009 to March 31, 2010. The following topics are discussed: administrative progress (particularly changes in staff and the MAC); program development in the five deliverable areas named as priorities by RCPD; assessment of physician learning needs, and evaluations of the programs.

II. Administrative Progress

1. Staff and office

Medical Director

The open position of Medical Director of the RCPD for 2010 on was advertised through the RCPD Medical Advisory Committee (MAC), rural networks, the UBC Department of Family Practice and Faculty Development listserv to clinical faculty, and the BCMA. A number of strong candidates applied for the position. A selection committee was assembled and interviews took place in December, 2009. The previous Medical Director, Dr. Mary Johnston, aided the new Medical Director ease into the role during the transition period, and continues to work on special projects as a member of the RCPD MAC. Dr. Tandi Wilkinson commenced the position of Medical Director of the RCPD on Feb 1, 2010.

Medical Director Biography

Tandi Wilkinson grew up in rural BC and received her MD from UBC Medical School. This was followed by a rotating internship at St Paul's Hospital in Vancouver and then a UBC Family Practice Residency, in the rural program. After graduation she worked for a number of years in Hazelton BC, a primarily First Nations community in northern BC. She provided full spectrum family practice care, including obstetrics, emergency medicine and inpatient care. She was also involved in family medicine resident teaching as a clinical instructor. She worked in the private health care system in Australia and has worked in many rural communities in BC. In 2006 she received her Special Competency in Emergency Medicine (CCFP - EM) designation and switched to full time emergency medicine. She became a certified independent ultrasound practitioner in 2007. She currently practices in Nelson BC. Tandi is very interested in CME and has been active in the provision and planning of rural CME events throughout the province, including sitting on the planning committee for the Society of Rural Physicians conference in Nelson in 2008. She was a co-developer and instructor of the RCPD Shock Course in 2009. She continues to instruct the course and train future instructors, and is now a Clinical Assistant Professor in the UBC Faculty of Medicine.

Working Group and Staff

The RCPD working group, currently consisting of Dr. Tandi Wilkinson, Medical Director, RCPD, Dr. Bob Bluman, Assistant Dean, UBC CPD, Dr. Brenna Lynn, Director, UBC CPD and Ms. Deirdre Maultsaid, Project Manager, RCPD continues to meet to monitor progress of deliverables. Dr. Mary

Johnston was previously involved with the working group and participated in a transitional working group meeting to hand over projects in progress.

The RCPD has engaged a UBC CPD Research Assistant and several UBC students to help with the development and delivery of the program.

2. Medical Advisory Committee (MAC)

The current members of the MAC are:

Member	Role (Community of Practice)
Dr. Granger Avery	Co-chair Joint Standing Committee on Rural Affairs and Executive Director RCCbc, also representing Vancouver Island region (Port McNeil)
Dr. Bob Bluman	UBC CPD Assistant Dean (Vancouver)
Dr. Celina Dunn	UBC Medical Director of Educational Programs (BC)
Dr. Nancy Humber	representing Interior Health region (west) (Lillooet)
Dr. Mary Johnston	representing Interior Health region (rural locums)
Dr. Harry Karlinsky	Medical Director of UBC CPD BC Physician Integration—International Medical Graduate Program (Metro Vancouver)
Dr. Mike Kawerinski	representing Northern Health region (Stewart)
Dr. Neil Leslie	representing Interior Health region (east) (Revelstoke)
Dr. Rebecca Lindley	representing Vancouver Coastal Health region (Pemberton)
Dr. Brenna Lynn	UBC CPD Director
Ms. Deirdre Maultsaid	UBC RCPD Project Manager - co-chair
Dr. Rod McFadyen	representing Vancouver Island Health Authority
Dr. Christie Newton	Director, Continuing Professional Development and Community Partnerships, Department of Family Practice, & Director of Interprofessional Professional Development, College of Health Disciplines, UBC (BC)
Dr. Ian Schokking	representing Northern Health Authority (Prince George)
Dr. John Soles	representing Interior Health region/SRPC – BC President (Clearwater)
Dr. Bob Woollard	Associate Director RCCbc
Dr. Tandi Wilkinson	UBC Medical Director of RCPD– co-chair (Nelson)

The MAC held meetings on June 9, 2009, September 8, 2009, December 9, 2009, and February 26, 2010. The following topics were discussed:

a. Emergency Medicine education programs
b. Obstetrics & Gynecology Education Programs
c. The newly formed Rural Coordination Centre (RCC) committee on Rural Critical Care course development
d. Speakers Inventory
e. Integration with existing programs
f. Recent conferences (for example, the Rural Prince George Health Symposium and Society of Rural Physicians of British Columbia Hazelton)
g. Upcoming conferences such as the RCCbc rural emergency conference in Kelowna
h. concepts and organization of the RCPD Shock course, and the pilot offering of the course
    i. Dr. Mary Johnston (past Medical Director) was at the Shock pilot in Revelstoke and Golden in November, 2009 and reported that the pilot went very well.
    ii. The MAC agreed that instructors should be Ultrasound certified (the educational developers and the RCPD will continue to work on this aspect), skilled in ER and knowledgeable of rurally specific concerns.
    iii. Members of the planning committee are: Dr. Tandi Wilkinson, RCPD Medical Director, chair (CCFP–EM), Dr. Mary Johnston, RCPD MAC member , family physician, Ms. Deirdre Maultsaid, UBC-RCPD Project Manager, Dr. Anna Reid (CCFP–EM), Dr. Jeff Plant (RCPSC-EM) and Dr. Francois Louw (CCFP-Anesthesia)
    iv. UBC CPD is providing intellectual and operational support for this program
i. RCPD/CPD educational events:
    i. Dementia workshops
    ii. Finding Medical Evidence workshops
    iii. Rural Psychiatry Videorounds/Webinars
j. Chronic Disease Management Videorounds/Webinars
    i. The MAC confirmed the five topics for the spring: COPD, Renal Failure, Congested Heart Failure, End stage palliative Care, and Rheumatoid Arthritis.
k. St. Paul's Emergency 2009 Conference and Evaluation
    i. It was noted that the content of the 2009 conference at Whistler was rurally relevant, but not always geared to rural physicians.
    ii. However, this was considered acceptable to the MAC in the context of the St. Paul's conference.

The MAC has been highly engaged in live meetings and teleconferences since the beginning of the program.

III. Program Development

Identified Priorities

From 13 identified program areas for development, five program areas were identified as priorities by the MAC. These deliverables (creating “closer to home” programs, creating a speakers inventory, connecting with existing programs, building relationships with rural practitioners, and developing web communications) are reported on below. For the full list of identified deliverables, please see Appendix A.

1. New closer to home programs

The RCPD has commenced creating programming/integrating with other programming in the following areas: emergency medicine, obstetrics & gynecology, psychiatry and chronic disease management, (see specific initiatives below).

Education on Emergency Medicine

An emergency medicine Working Group was formed; there were several rural physicians from the MAC participating, including Dr. Rebecca Lindley and Dr. Mary Johnston.

Additional emergency medicine courses were attended by MAC members and reviewed to inform the RCPD course development (particularly the Shock course). The Simulator-assisted Rural ER course and the, Comprehensive Advanced Life Support course, are reviewed below.

Simulator – assisted (rural ER)

Several members of the RCPD MAC attended the ER Simulator course taught by Dr. Jeff Plant and his team in Interior Health. The course involves practice on the simulator using emergency scenarios. The simulator comes with the instructor (ER physician), ER nurse, and technician in a van. The ER team in the local hospital runs through the scenarios together and discusses them. The benefits of using a simulator are that it presents situations of high acuity in a safe learning environment. The scenario booklet is left behind for the team, which is considered a helpful teaching tool. The team appreciates receiving education in their own community, and this is a model for education that RCPD emulates.

Comprehensive Advanced Life Support (CALS)

Several members of the RCPD MAC attended the Minnesota-developed CALS taught in Smithers in June, 2009. A pre-reading manual, 1481 pages long, was provided.

The participating MAC members created a summary of the workshop evaluation, a condensed version of which appears here.

- Positive aspects of the workshop: diversity of instructors, teacher to student ratio, encouraging, emphasis on practical hands-on training, lots of training tools.
- Less positive: hands on sessions sometimes lacked focus and resulted in lost learning time, not enough hands on practice in real time for difficult situations, manual too long, American slant taken on learning materials.
- Summary: good for a refresher/update but not adequate for a comprehensive "one stop" introduction to acute care.

RCPD Shock Course

Physician Learning Needs

The need for more emergency medicine training has been identified in the REAP/UBC-CPD needs assessment. As well, the Shock development team, including Dr. Tandi Wilkinson and Dr. Anna Reid (in their experience teaching Central Venous Access and Sepsis Workshops for the Society of Rural Physicians of Canada) noted that rural doctors are uncomfortable managing patients with shock. Therefore, the Shock course takes a comprehensive approach to recognizing the various syndromes of shock and how to resuscitate these patients.

The target audience for the course is rural family physicians, rural specialists and rural family practice residents. Emergency room nurses from the community and medical students are invited to audit the course. Please also see below in the section, "Future Plans", for more updates.

Course Description

This is a seven hour accredited course on the treatment of shock, specifically developed by rural physicians for the rural emergency room setting, emphasizing new developments in treatment and use of new technologies, especially ultrasound.

The course focuses on various types of shock. In keeping with the RCPD mandate and what we have learned from other MAC reviewed ER courses, the characteristics of the course are the following:

- Was developed and is taught by rural physicians and committed teachers
- Is adaptable for each community's needs
- Is locally delivered to teams/"closer to home"
- Is worth the time and money, as it counts towards 7 accredited hours for RCPSC and for CFPC
- Is interactive, with small group instruction
- Is partially dedicated to hands on practice of clinical skills and techniques
- Is properly equipped with training equipment (torsos, central venous insertion kits, ultrasound machines)
- Is designed as small group learning with the ratio of instructors to participants at 6 to 1
- Is open to emergency nurses who can audit for free, promoting interprofessionalism, teamwork, and low barriers to attendance

The learning objectives of the course are:

a. To recognize and treat the various types of shock (hypovolemic, distributive-septic and anaphylactic, cardiogenic, obstructive and neurogenic);
b. To provide optimum Early Goal-Directed Sepsis Care (the Golden Hours of Sepsis Treatment);
c. To place central venous catheters and interosseous needles; and
d. To manage various shock cases.

The course format includes both lecture and hands-on practice. There are 6 short lecture discussions. The topics are: Approach to the Shock Patient, Sepsis Management, Cardiogenic and Anaphylactic Shock, Hemorrhagic Shock, and Drug Therapies. The lectures are interspersed with three hours of hands-on skills practice and case management, using clinical experience of the participants, or loosely scripted scenarios.

The hands on practice is conducted on:

- three central venous line torsos (one with ultrasound capacity) with practice on inserting central lines
- practice using an interosseous drill using training bones
- models of participants, using in-hospital and loaned ultrasound machines

Shock Course Evaluation

The pilot was delivered to Revelstoke on November 14 and Golden, November 15, 2009. The course was considered excellent from participant evaluations. Overall, the course was rated highly and appeared to

be very successful. Physicians appeared to think that the course had an appropriate amount of short lectures and hands on practice and that the content was relevant and could be applied to physician practice immediately.
Most physicians had heard about the course from a colleague. See Appendix B.1 for the complete evaluation.

Some significant comments are highlighted here:

In response to the question what the physician will do differently, several said they would take a "*more aggressive approach to shock; use of central lines and ultrasound."*

In response to the question what was the most helpful aspect of the course, many physicians said the *"hands on", "interactive"* aspects. One physician summed it up: "*practical aspects - case discussion, central line and u/s practice, how to choose pressors."*

One physician stated: "*excellent program, rural focus ++"*
Another stated: "*This is much more helpful and empowering than any course so far."*

Future Plans

Negotiations are under way to deliver the course in two adjoining communities around BC on weekends, at the rate of four-six times a year, as well as at the RCCbc Rural Emergency Continuum of Care Conference in June, 2010. The course is operating on a cost recovery basis, considerably cheaper than other programs (i.e. $500 vs. an Alberta based urban course of $900+). RCPD is delivering the course in Invermere and Fernie in May, 2010 and negotiating to deliver the course in other communities such as Lillooet, and 100 Mile. The RCPD is aiming to reach each small community hospital in BC over the next two – three years. See Appendix B.2 for a sample flyer.

Since the plan is to reach many rural communities, more instructors are being identified and trained. The instructors need to be ultrasound certified or working on their certification and have rural ER experience. Instructors are first attending the course in order to be mentored to partner-teach subsequent sessions. We are considering adding a nursing module to this course. Currently, nurses can audit; however we want to make a specific module that addresses nursing issues, with the flexibility to tailor this module to the community. This is under discussion.

It should be noted that the companies Sonosite and Vidacare generously agreed to loan equipment for the pilot, with a technician to accompany the ultrasound machines from Sonosite.

Education on Obstetrics

The highest learning need identified for rural family physicians in the 2005/06 REAP needs assessment is regular hands-on practice with possible emergency scenarios for obstetrics. A literature review has been conducted on Obstetrical Emergencies to further understand rural physician learning needs, as a start to developing this program.

Future Plans

At our recent all day Medical Advisory Committee in April 2010, plans became more defined to develop a rural OB course. This would be a small group outreach course designed for the rural OB team (doctors, nurses and midwives), delivered by rural practitioners and a regional OB specialist. The course would consist of optional modules of care, each module being tailored to best support the various models of rural OB care: 1) “no OB service”, 2) “OB but no Caesarean section backup”, and 3) “OB care with surgical back up”. The goals of the course would be to review the known standards of best care, and to support the learning and confidence of the entire OB team. We have a plan and a project lead, but need to secure more funding to develop and offer this course to rural physicians.

The team will continue to identify opportunities to develop and offer education on gynaecological issues.

Education on Psychiatry

Because webinars can be viewed from home or office and are thus easily accessible at a low cost for rural physicians, the RCPD MAC considers this a valuable learning format. Since there is no hands-on training required for psychiatry, it is an area of medicine that is ideally suited to a distance education format such as a webinar/videoconference. As agreed with the Medical Advisory Committee, the CPD Fall 2009 morning series of six videorounds/webinars were on rural psychiatry (for information on the evening series, please see the section entitled, “Evening Webinars and Videorounds”). The videorounds were delivered in the hospital videoconferencing room and physicians signed up as a group for the series.

Speakers and Topics

Both rural psychiatrists and psychiatrists who do outreach were approached to participate as speakers. This has allowed the RCPD to connect with this group of rural specialists. It was suggested to the speakers that they focus on cases and leave plenty of time for questions and answers.

Table 1 shows the speakers and topics for each webinar on rural psychiatry.

Table 1: Speakers and Topics

Date	Topic	Speaker	Community/Health Authority
Oct. 1, 2009	Depression - Current Approaches	Dr. Fiona McGregor	Vernon, IH
Oct. 15, 2009	Anxiety - Panic & General Anxiety Disorders, Phobias & OCD	Dr. Richard Magee	Nelson, IH
Oct. 29, 2009	Psychoses - Emergency Treatment, Stabilization and Monitoring	Dr. Barbara Kane	Prince George, NH
Nov. 12, 2009	Concurrent Disorders: Psychoses and Drug Abuse	Dr. Laura Chapman	Victoria, VIHA
Nov. 12, 2009	Depression in the Elderly	Dr. Michael Wilkins-Ho	Vancouver, VCH/Outreach, NH
Dec. 10, 2009	Coping with the Adolescent Whose Behaviour is Out of Control	Dr. Jake Locke	Vancouver, VCH

Rural Psychiatry Webinars Evaluation

The program commenced on October 1st, 2009, with registrations by 8 rural hospitals (videoconferencing) and 24 registrations for at home/office webinars. With hospital participation at approximately 5 physicians per site, there were approximately 50-60 participants from across BC for each educational event. The webinars are archived and available indefinitely on the CPD RCPD webpage for asynchronous viewing after the webinar.

Of the participants that filled out an evaluation form, 53% practice in a rural community either exclusively, or in addition to an urban location. The webinars were evaluated highly and considered useful to practice by physicians. The accessibility of the webinar contributed to the overall positive attitude toward the event. One physician commented, “I always say this, but I’ll say it again: MORE, PLEASE! It is such a treat not to have to take time off from work and not to have to travel to the big city for CME purposes”. See Appendix C for the complete evaluation summary of the fall 2009 webinars.

Some highlights of the evaluations are:

- 100% of participants would attend future CPD webinars
- Participants stated that webinars are useful to their practice
- The participants wished for more time for questions
- Participant physicians found it useful to understand psychiatric treatment even if they don’t work directly with psychiatry

- The talk on Psychoses & Drug Abuse was appreciated for presenting screening tools and resources
- The talk on Depression in the Elderly was extremely helpful and relevant for possible diagnosis for various somatic complaints from the elderly
- Webinar participants requested more talks on adolescent and youth issues

Education on Chronic Disease Management

CDM was the fourth top identified learning need for rural physicians in the REAP rural physician needs assessment. The complexity of the management of patients with chronic diseases (particularly in rural communities that may be without specialist support), confirms the MAC recommendation on the compelling necessity for education on chronic disease management. Consequently, the spring 2010 Videorounds/Webinars are occurring on Chronic Disease Management topics. See Appendix D for a sample flyer and an evaluation report of the January 21, 2010 webinar on Renal Failure. (The evaluation of the March 18th, 2010 session on Chronic Obstructive Pulmonary Disease will be available soon.)

Confirmed topics for the January 2010–May 2010 sessions are (speaker in brackets):

1. Renal Failure (Dr. Malcolm Ogborn)
2. Chronic Obstructive Pulmonary Disease (Dr. Mark Fitzgerald)
3. End Stage Palliative Care (Dr. Romayne Gallagher)
4. Congestive Heart Failure, including management of acute pulmonary edema (Dr. John Bosomworth)
5. Rheumatoid Arthritis (Dr. John Watterson)

2. Inventory of speakers and topics

The Speakers Inventory is being developed to help enable BC rural physicians to organize educational events in their own communities with the following principles in mind:

- rural accessibility
- rural relevance
- self-directed use (with monitoring)
- usability/sustainability
- Availability of complementary evaluation tools

279 possible rural speakers have been gathered from many source lists, including from UBC CPD and SRPC past educational events, and the REAP survey. The list is comprehensive (from all data mining

sources). Current contact information has been obtained for all participants and the inventory is being updated.

The list was sent to the RCPD MAC to collect their assessment of speakers they know or have heard speak. The MAC "highly recommended" 83 of the speakers on the list. The MAC will be approached again to follow up with physicians that they might know.

The RCPD MAC has discussed the issues of privacy (for speakers of their contact information), faculty development (including discussion of including the most effective speakers and educators), use, and functionalities of the Speakers Inventory, and how this will be kept up to date. The MAC has also discussed the portrayal of information, particularly whether MAC recommendations and general evaluations should be publicly viewable. The topic of how and whether to distinguish between highly recommended and previously unevaluated speakers was also discussed. These decisions are in process.

The identified rural physician speakers have been sent a formal invitation and profile form, stating that their contributions are valued and asking them to participate in the Speakers Inventory and confirm/update their profile. They have been asked to consent to having their name and topic choices publicly displayed on the RCCbc website. Profiles are currently being submitted to the RCPD. Thus far, we have received 65 responses from speakers, including 26 MAC "highly recommended" speakers. 54 speakers in total have agreed to be on the list, of which 24 are "highly recommended". See Table 2 for the list of communities represented.

Below is a table of the communities and regional centres from which speakers have submitted profiles, accurate as of February 26, 2010.

Table 2: Speakers willing to be on the RCCbc website:

Community	#	**Community**	#
Campbell River	1	Powell River	2
Castlegar	1	Prince George	8
Courtenay	1	Qualicum Beach	2
Creston	1	Rossland	2
Dawson Creek	1	Salmon Arm	5
Fort St John	1	Saturna Island	1
Fraser Lake	1	Sechelt	1
Kelowna	7	Smithers	1
Lillooet	1	Trail	2
McBride	1	Victoria	6
Nelson	3	Whistler	1
Oliver	1	Williams Lake	1
Pemberton	1		
Penticton	1	**Total**	**54**

The inventory will be launched in summer, 2010, on the Rural Coordination Centre website in coordination with other web communications. This web design mock up has been created by the RCCbc web development team in consultation with RCPD.

3. Connect with existing programs

Through the Medical Director, the MAC, REAP and the RCCbc, the RCPD program staff have been apprised of CME/CPD programs around BC; linkages, and working partnerships are being formed. The RCPD is focusing on identifying instructors to assist with RCPD educational delivery, or whom the RCPD can assist to facilitate the programs that they have already created. With help and input from the RCPD MAC, the RCPD program has connected with several ongoing CME/CPD committees/offerings, including, most notably in this period, the Rural Coordination Centre Rural Critical Care Course Development committee and the RCCbc Rural Emergency Continuum of Care Conference. For the RCCbc conference, we are developing plans to promote the RCPD at the conference. We will have a booth with information and use the opportunity to collect contacts and ideas from rural physicians. We are considering having our Shock mannequin available for central line insertion practice.

Other CPD conferences/Workshops

The RCPD has participated in previous events and is apprised of upcoming events that may involve rural physicians, in particular:

i. The UBC CPD Obstetrics Update Conference
ii. The BC Physician Integration Program (BC-PIP)
iii. St. Paul's Emergency Medicine conference
iv. The Dementia Education Strategy
v. The Finding Medical Evidence workshops
vi. The evening Webinars and Videorounds program
vii. The Simulator-Assisted Emergency Medical Procedures (SEMP) course, in partnership with the Centre for Excellence for Surgical Education and Innovation (CESEI)

The RCPD has promoted rural participation and rural outreach for rurally-relevant programs as appropriate. A more detailed update on the above events follows.

i. Obstetrics Update

The 22nd Obstetrics Update for Family Physicians Conference took place in November, 2009. Dr. Andrew Sear of Quesnel sat on the planning committee and provided a rural perspective. The conference went well. There were 56 rural physicians in attendance (44% of total). The rural evaluation of this conference is briefly reported on below; see Appendix E for the complete rural evaluation summary of the conference.

The overwhelming majority of those who completed the conference evaluation responded positively to the workshop. 55, (or 24% of the total conference participants) were identified as rural physicians, while 56, or 43% of those who completed the conference evaluation identified themselves as rural physicians. It appears that not only might all the pre-identified rural physicians have completed the conference evaluation, an additional person self-identified as a rural physician. Overall, comments from rural physicians were positive. One respondent said, “Great update and overviews; comprehensive and current”. Both the comments and the overall ratings of the knowledge learned in this conference suggest that rural physicians found this information to be pertinent, informative, and applicable for future use in their practice.

With the support of the Obstetrics Update Conference Planning Committee, a free evening webinar on Obstetrics was offered in November, 2009 for the benefit of rural physicians who were unable to attend the conference in person. Please the section entitled “Evenings Webinars and Videorounds” below.

ii. The BC Physician Integration Program (BC-PIP)

The purpose of the BC Physician Integration Program has been to provide International Medical Graduates (IMGS) on the *College of Physicians and Surgeons of BC’s Provisional Register* with a comprehensive orientation to the British Columbia medical system. IMGs are required to practice in underserviced areas, and many IMGs who are family physicians practice in rural areas.

The BC-PIP offers education to IMGs and to their supervisors. Annual conferences are held in October and April. The next conferences are confirmed for April 23 & 24th, 2010, and October 15 & 16th, 2010. In October, 2009, there were approximately 30 rural IMGs in attendance, wherein they were able to network with other rural colleagues as well as be oriented to practice in BC.

The Physician Integration Program continues to administrate an electronic community of practice. It is an online resource meant to provide practice and exam-related resources and support for IMGs. In addition, the first offering of the MCCQE Part I exam preparation course will be on April 25th while the first offering of the MCCQE Part II exam preparation course will be on September 11th at BC Children’s Hospital. The BC-PIP also organizes a Faculty Development Workshop for incoming physician supervisors of IMGs. The next date for this workshop is October 16th, 2010.

iii. St. Paul’s Emergency Medicine conference, 2009

The Medical Director and several members of the RCPD MAC attended the St. Paul’s Emergency Medicine Update, Sept 24-Sept 27, 2009 on behalf of the RCPD and evaluated the conference for rural

relevance (See Appendix F for the rural evaluation summary). The evaluators of the conference commented that the needs and situation of rural physicians were taken into consideration more frequently than in past conferences. This enfranchising of rural physicians allowed them to state their opinions at the conference and be considered part of the emergency room workforce in BC. The evaluators commented that the rural programming could be increased even more, with rural medical professionals presenting on rurally-relevant topics. The written reports have been delivered to the St. Paul's planning committee for 2010, which now has a rural physician member (Dr. Tandi Wilkinson).

At the Rural Emergency Workshop entitled "The Day in the ER You Never Want to Have", physicians stated that they learned a lot about toxicity and shoulder, hip and ankle reduction methods, all very appropriate in rural practice. One physician commented, "Relevant topics targeted to a rural MD audience – excellent!"

iv. Dementia Education Strategy

The CPD Dementia Education Strategy is supported by the Alzheimer's Drug Therapy Initiative of the BC Ministry of Health. A rural family physician and RCPD MAC member is now part of the Dementia Education Strategy planning committee. The RCPD has dovetailed with the Dementia Education Strategy wherever rural outreach has been possible.

The Strategy aims to improve family physician confidence and skill in diagnosing, treating and managing dementia in their patients. The barriers for physicians in BC to perform proper Dementia Management consist of the following factors (lack of): time, rural resources, specialist access, pharmacological knowledge, full knowledge of guidelines and assessment tools, full knowledge about Dementia and Driving, information about the ADTI, adequate (perceived) financial compensation. Additionally, complexity of care and "health care team" have been mentioned as barriers to dementia management.

To address some of these issues, a special effort has been made throughout the education strategy to reach rural areas with regional conferences (Cranbrook, Nelson, and Prince George) and workshops. Workshop locations have been chosen based on geographic reach, the number of seniors in the area and the possibility of gathering enough physicians to make a viable discussion group. Thirty-nine workshops have been delivered around BC, 17 in rural communities and several in regional centres (e.g., Kamloops and Penticton) at which some rural physicians participated. See Appendix G for an evaluation summary of the program as well as a sample flyer.

Table 3: List of the workshop communities, spring 2009 and Fall/Winter 2009/2010

Spring 2009	Health Authority	Fall/Winter 2009/2010	Health Authority
1. Clearwater	IHA	1. Vanderhoof	NH
2. Vancouver	VCHA	2. Williams Lake	IH
3. Abbotsford	FHA	3. Invermere	IH
4. Comox	VIHA	4. Squamish	VCH
5. Duncan	VIHA	5. Cranbrook	IH
6. Fort St. John	NHA	6. Victoria	VIHA
7. New Westminster	FHA	7. Salmon Arm	IH
8. North Vancouver	VCHA	8. Port Alberni	VIHA
9. Penticton	IHA	9. Powell River	VCH
10. Port Hardy	VIHA	10. Langley	FH
11. Prince George	NHA	11. Vancouver	VCH
12. Queen Charlottes	NHA	12. Kamloops	IH
13. Revelstoke	IHA	13. Richmond	VCH
14. Sechelt	NHA	14. Parksville	VIHA
15. Smithers	NHA	15. Chilliwack	FH
16. Trail	IHA	16. Nelson	IH
17. Vancouver	VCHA	17. Dawson Creek	NH
18. Vernon	IHA	18. Quesnel	NH
		19. White Rock	FH
		20. Kamloops (2)	IH
		21. Kelowna	IH

An analysis of statements from facilitator and participant interviews about the workshops seems to indicate that among other findings, physicians may be more likely to attend accessible local community based education. In addition, physicians enjoyed the small-group, interactive case-based discussion format of the workshop. The process of organizing the workshops has fostered connections with many rural CME Coordinators.

Finding Medical Evidence – Supporting Patient Care (Using the Internet to Your Advantage) Workshops

In fall 2009, BC College of Physicians and Surgeons librarians went on a series of road trips to rural areas. There were four rural workshops: Pemberton, Trail, Cranbrook, and Nelson, with a total of 32 participants. To ensure program success, RCPD worked together with the Interior Health education and IT teams.

Some highlights of the program and evaluation are listed here (see Appendix H for a flyer and a detailed evaluation of all four workshops):

- Considered excellent by the majority – many felt the small-group, hands-on interactive approach was the most effective part of the workshop
- Considered a great opportunity for interaction
- Appreciated the hands on experience
- After the workshop, participants planned on more frequently using the BC College website, Medline, and Google Scholar, and less of “Dr. Google”.

Comments from participants include: “Kept me awake after a night shift, impressive!!”, “It was great to have such a small group”, and “Thanks for coming to Cranbrook. It saves me some travel!!”

Evening webinars and videorounds

For more information on the morning webinars and videorounds, please see the section entitled “Psychiatry”. As the RCPD assumed leadership of this project on July 1, 2009, this report will only cover events occurring after this date.

On Oct 22, 2009, the RCPD helped to create a free evening webinar with “highlights” of the St. Paul’s conference. The topics chosen were considered rurally relevant. Dr. Devin Harris spoke on Acute Stroke, Dr. Peter Skippen spoke on Pediatric Head Injury and Dr. Chris DeWitt spoke on Pill Street Blues.

On November 19, 2009, a free evening webinar on the topic of Obstetrics was offered to physicians, and marketed to rural physicians since Obstetrics and Gynecology continue to be topics on which rural

physicians seek and need CME/CPD. Dr. Paul Thiessen spoke on the Effects of Maternal Drugs and Dr. Ellen Giesbrecht spoke on Post Partum Hemorrhage.

The RCPD worked on a rural physician evaluation report to share with the RCPD Medical Advisory Committee and to provide feedback to the conference planning committee for future conferences on this topic (see Appendix I for this report).

Some highlights of this report are as follows:

- All respondents rated the program satisfactory or above
- Overall, comments from rural physicians were quite positive
- Rural physician respondents felt that the conference was relevant to their practice
- Rural physicians appreciated the small-group size and wanted even smaller groups
- Rural physicians also requested longer lectures and more time for questions
- One physician commented, “Drugs in pregnancy always an issue and not just for doctors doing OB but also in ER and rural practices. PPH always a need to know when you need it now and a good review”.

The RCPD helped organize the Dec 3, 2009 free webinar on Physicians’ Well-Being by Dr. Nancy Craven, and helped her to orient her talk to rural physicians, although this talk was also relevant for participating urban physicians.

Rural physicians appreciated this webinar. One physician stated, “Always helps to get more awareness of the pitfalls of working in a rural medicine. The importance of looking after oneself and each other.”

Future Plans

In the fall, the RCPD will offer the videoconference program in the mornings, for the rural hospitals, without the web-based learning at the same time. The RCPD conducted a mini-survey of videoconference participants around BC. The RCPD team suggested that we would be switching to a web-based system and solicited the thoughts of a random sample of past videoconference participants. Videoconfererence participants consistently stated that they valued the videoconferences highly for the following reasons: 1) having the session as a group in the hospital boardroom lends itself to collegiality and more learning; 2) having it as a group means that the group can talk about local practice issues that arise from the videoconference; 3) having it as a group in the hospital formalizes the CME routine (it is more convenient); 4) uptake will be higher and other healthcare professions will also attend on a drop-in basis, which is good for the community. The RCPD are seeking suggestions on possible themes for the

fall 2010 series but are considering continuing to focus on the same themes: emergency medicine, psychiatry and chronic disease management, since there will always be many topics to cover

For the evening distance education program, we will change to another web-based format, to allow the rural speakers to participate from their homes, rather than having to travel to Vancouver. This should improve the rural relevancy of the series. We will offer them as free evening sessions to improve participation and raise awareness of RCPD.

The SEMP Course, in partnership with *CESEI*

The Simulator-assisted Emergency Medical Procedures (SEMP) course has already been created by CPD in partnership with the Centre for Excellence for Surgical Education and Innovation (CESEI).The SEMP course runs over one full day and involves 6-10 educational modules, such as “Needle Cricothyrotomy and transtracheal jet ventilation” and “Chest Tube insertion”. Physicians study the online modules ahead of the practice day. Simulator-assisted training provides training for high acuity situations, in a safe environment. The CESEI training triangle places emphasis on the following components: 1) e-learning is at the bottom (reaches the most people, happens over the longest time; 2) practice on simulators; 3) practice specialized surgical skills (only those who need customized courses)
The most recent course was on October 16, 2009; three more courses over 2009-2010 will run as part of the initial pilot. The percentage of rural physicians attending the course was 54% in January 2009, 67% in May 2009, and 32% in October 2009. The pre-learning modules are considered very worthwhile and will be a model of education that the RCPD will be using (more than just pre-reading).

4. Build relationships with rural physicians

In addition to the educational events mentioned above, the RCPD continues to work on RCCbc website content. The RCPD inventory of speakers and web calendar will be launched on the RCCbc website.

The CPD evaluation form for conferences has been modified by location of practice (see Appendix J for a sample evaluation form). Rural physician input on all educational programming will be available to the RCPD, and we can adapt our content and delivery accordingly, as well as communicate directly with these participants. We can convey evaluation reports back to the MAC for future educational programming ideas.

The RCPD has attended several events during this period, including the SRPBC—Annual BC conference, and the RCC Rural Health Symposium, and will be attending the RCCbc Rural Emergency Continuum of Care Conference as noted above.

The RCPD has published several profiles of the program, which highlight the focus of the program and invite input. See Appendix K for samples of each of the following:

- BC Medical Journal – Pulsimeter, July, 2009
- Rural Health Symposium- syllabus
- SRPBC-Hazelton-postcard

5. Develop web communications

Work on shared web communications is ongoing with CPD and the RCCbc. The counterpart Project Managers (PMs) from these centres have met to discuss web design, marketing and organizational needs. The PMs are working on a set of criteria for inclusion of events and programs on their respective website calendars, creating a list of desired features, and working on a method for managing the calendar in consultation with web developers.

The RCPD has provided content for the RCCbc website. Four pages are currently online: “About UBC-CPD”; “About CPD/CME accreditation”; “Point of Care and Evidence Based Medicine Tools”, divided into sections entitled additional resources, workshops, open access tools, partial open access tools, subscription only tools, and institutional subscription only tools; and “RCPD Input Form”, where website viewers can provide input on future events and the website (see Appendix L for screenshots of each page). These pages on the CPD and RCC sites were launched in the last week of March, 2010. The “Speaker’s Inventory” and “Educational Calendar” pages remain under construction. The “Rural Links” page, with links to resources on rurally-relevant CME, health authorities and initiatives, general rural information, provincial resources, and both open- and restricted-access journals, are still in the design process with the RCCbc.

IV. Learning Needs Assessment and Evaluation Strategy

For education programs to be effective and accredited, they must meet identified learning needs and be continuously evaluated. The RCPD is currently conducting a thorough literature search on Continuing Medical Education/Continuing Professional Development (CME/CPD) effectiveness in rural areas, to determine the best methods and approaches. Results of this literature search will be written and can be posted on the RCCbc website. The literature search will also inform future RCPD educational plans. The team is also conducting an environmental scan of other rurally oriented CME/CPD programs in Canada, the US and Australia. The purposes of the environmental scan are to confirm our approaches, compare

with other approaches for cross-fertilization and development, and to grow possible partnerships or sharing where appropriate.

The RCPD Program is committed to robust research and evaluations of educational activities so that the perceptions and learning requests of rural physician are heard and addressed. For RCPD-designed educational programs, the team is creating comprehensive and tailored evaluation forms to use both as a method of ongoing appraisals of physician's needs and ongoing input into course development. The shock course evaluation form is one such example. See Appendix M for a sample of this form.

Where rural physician participation has been significant in CPD educational events, evaluations from previous UBC CPD programs have been examined, including conferences on emergency medicine (25% rural physicians) and obstetrics (35% rural physicians). As stated above, CPD has modified our standard conference evaluation form to include location of practice. CPD is using evaluations from courses and workshops to inform the outreach and accessibility success of the RCPD. The following conferences are now being tracked and evaluated:

- Obstetrics Update
- St. Paul's Emergency Medicine Conference
- The Diabetes conference

V. Conclusion

2009-2010 has been an active and productive year for the RCPD program. The team has taken many opportunities to hear input from rural physicians and stakeholders on the directions the program should take. With the support of the MAC, the RCCbc and the UBC CPD senior leadership, the team has been resourceful in implementing excellent educational programs, including the shock course, webinars, and internet search workshops. These programs are evolving with the active and consistent input from participants and the MAC. The RCPD will continue to strive to also meet the unperceived and expressed learning needs of the 1,900 rural physicians in BC, working in consultation and partnership with rural physicians, and other rural organizations and programs.