IDC Research Days 2014

Partners for Health: Communities, Families, Researchers, and Care Providers

November 5-7, 2014

Civic Centre, Prince George, BC

CONFERENCE PROGRAM

Prince George, British Columbia

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IDC Research Days Conference would not have been possible without the support and contribution of a number of organizations, universities, individuals and community members. We extend a warm thank you to all for their many hours dedicated to planning this successful event.

Civic Centre Entry
Photo courtesy of NH Communications

Mr. PG, at the junction of Highway 97 and Highway 16

Research Days 2014

Partners for Health: Communities, Families, Researchers and Care Providers

November 5-7, 2014
Civic Centre, Prince George, BC

Welcome to the IDC Research Days Conference

Welcome to the 2014 IDC Research Days Conference. It is a privilege for Northern Health to partner with UNBC in hosting this annual event. A special acknowledgement and thank you goes to the organizing committees for their work over the last year to plan this conference, including the Abstract Review committee and the Conference Planning committee.

The focus for the 2014 conference is "Partners for Health: Communities, Families, Researchers, and Care Providers" with an emphasis on how partnerships contribute to knowledge generation and knowledge mobilization for the purpose of improving health. The conference themes are healthy communities, integrated, accessible health services, and person-centered, family-focused care.

This conference has been designed to profile Northern BC research, evaluation, and quality initiatives and will provide formal learning as well as informal opportunities for participants to learn from each other. I hope the three days provide a forum for exchanging ideas, creating new partnerships and furthering existing partnerships in the interests of fostering health and wellbeing for the people we serve.

Cathy Ulrich
President and CEO,
Northern Health

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innovation and development commons

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Research Days 2014

Partners for Health: Communities, Families, Researchers and Care Providers

November 5-7, 2014

Civic Centre, Prince George, BC

Welcome to the IDC Research Days Conference

On behalf of the Innovation and Development Commons (IDC) and the University of Northern British Columbia Health Research Institute (HRI), we would like to welcome you to the 2014 Research Days Conference, *Partners for Health: Communities, Families, Researchers and Care Providers*. The goal of this year's conference is to bring together different experiences and perspectives regarding knowledge sharing, research and collaboration and we are excited to be connecting our local researchers, practitioners and community groups.

The IDC is an on-going partnership between Northern Health and UNBC which aims to facilitate education, research, and innovation in the North and ultimately improving the quality of life and health outcomes for Northerners. The UNBC HRI works closely with the IDC and NH to fulfill the HRI mission that aims to facilitate the creation and translation of knowledge that will enhance the health and wellbeing of individuals, families and communities. The partnership between UNBC and NH, enhanced by our joint commitment to community engagement, provides a unique environment for the creation of knowledge and its translation into practice.

We are excited to begin Research Days this year with a keynote address by Dr. Gina Browne from McMaster University. Dr. Browne will share with us her innovative way of conducting randomized trials to gather evidence that influences health care planning and decision making. The program offers eight workshops to provide a range of learning opportunities that focus on working in partnerships with patients, communities and organizations. We welcome plenary speakers and panellists on our third and final day to broaden our understanding of engaging patients in research and health planning.

We anticipate connecting with you during the conference and hope you enjoy what we have planned for the 2014 Research Days Programme.

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UNBC UNIVERSITY OF NORTHERN BRITISH COLUMBIA

Fraser Bell
VP, Planning Quality Information Management

Martha MacLeod
Co-Chair, Health Research Institute

PRINCE GEORGE

We are pleased to welcome you to the beautiful and dynamic city of Prince George, British Columbia for the 2014 IDC Research Days Conference **"Partners for Health: Communities, Families, Researchers and Care Providers"**.

Prince George is the place where roads, rails and rivers meet. Located at confluence of the Fraser and Nechako Rivers and at the junction of Highways 16 and 97 (786 kilometers NE of Vancouver), the city is a major transportation hub located in the heart of British Columbia. Our city is never still and seems to constantly have an event, festival or celebration to bring people together. In Prince George you will find top-notch theatre, arts and culture. Visit the beautiful campus of UNBC and discover for yourself why it's been ranked 'the best in the West'. From your hotel enjoy our 11km Heritage River Trail system that follows the rivers and winds through some of Prince George's most scenic and historic sites. Take a short hike through Forests for the World or enjoy the sights of Exploration Place, The Railway and Forestry Museum or Twin Rivers Art Gallery.

Come to Prince George and not only will you find wilderness and wildlife, you will also discover all the modern amenities we can offer. Prince George, a city well worth exploring and a fabulous host for this conference!

Fraser River
Picture Courtesy of
NH Communications

Moose in Prince George
Picture Courtesy of
NH Communications

BC Cancer Agency, Centre for the North

University Hospital of Northern BC

Health Sciences Centre, UNBC

Courtyard, UNBC

Photos courtesy of University of Northern British Columbia Communications

PARTNERS

Northern Health

Northern Health is responsible for the delivery of health care across Northern British Columbia, including acute care, mental health, public health, addictions, and home and community care. The Authority covers almost two-thirds of B.C.'s landscape, which is home to over 300,000 people. www.northernhealth.ca

Innovation and Development Commons

The Innovation and Development Commons (IDC) is a partnership between Northern Health and the University of Northern British Columbia (UNBC). It aims to facilitate education, research, and innovation in the North, ultimately improving the quality of life and health outcomes for Northerners.

Health Research Institute

The mission of the Health Research Institute (HRI) is to facilitate the creation and translation of knowledge that will enhance the health and well-being of individuals, families and communities. The HRI supports UNBC's health researchers to find ways of enhancing the creation of knowledge, the development of research capacity and the exchange of knowledge with research partners: communities, community organizations, practitioners, and most notably, Northern Health.

SPONSORSHIP

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SCHOOL OF NURSING
SCHOOL OF SOCIAL WORK
NORTHERN MEDICAL PROGRAM

BC BRITISH COLUMBIA Nurses' Union

RHSRNbc
Rural Health Services Research Network of BC

GILEAD
Advancing Therapeutics. Improving Lives.

CATIE

BC Cancer Agency
CARE + RESEARCH
An agency of the Provincial Health Services Authority

ACKNOWLEDGMENTS AND APPRECIATION

University of Northern British Columbia
for their support and partnership
with the conference

Workshop Presenters
Dr. Gina Browne, Colleen McGavin, Trevor Hancock,
Jude Kornelsen, James Wilton, Lara Lise Barker, Raquel Miles
Stephanie Powell-Hellyer, Karim Saleh

Keynote Speakers
Dr. Gina Browne

Plenary Speakers and Panels
Bev Holmes, Colleen McGavin, Patricia Howard
Chantelle Wilson, Cindy Hardy, Yaron Butterfield, Chester Hiebert

Traditional Territory of the Lheidli T'enneh

All of the presenters who participated
in this conference

The Scientific Review Committee
for their review of the abstracts
Linda Axen, Emily Ryan, Tanis Hampe, Tamara Checkley
Rachael Wells, Melanie Mogus, Alice Muirhead, Tammy Hoefer

Conference Planning Committee
Linda Axen, Tamara Checkley,
Jayleen Emery, Taylor Fleming, Emily Ryan
Tanis Hampe, Tammy Hoefer, Rachael Wells, Alice Muirhead,
Kim Powley, Elizabeth Whittles, Tricia Kozuki

PROGRAM AT A GLANCE

Wednesday, November 5, 2014		
7:45am – 8:30am 7:45am – 4:00pm	Continental Breakfast Conference Registration	*Civic Center, Room 101* *Civic Center, Foyer*
8:30am – 8:45am	**TRADITIONAL WELCOME** Lheidli T'enneh Band	*Room 101-102*
8:45am – 9:00am	**OPENINGS AND GREETINGS** **Cathy Ulrich**, CEO Northern Health **Daniel Weeks,** President and Vice-Chancellor UNBC	*Room 101- 102*
9:00am – 10:00am	**KEYNOTE SPEAKER – Person-Centred Health Care Works!!... and Saves Money!!** **Gina Browne**, B.ScN, MS, PhD, Hon.LL.D, FCAHS Professor School of Nursing, McMaster University Founder and Director, Health and Social Service Utilization Research Unit	*Room 101- 102*
10:00am – 10:30am	**Refreshment Break & Poster Viewing**	*Civic Center, Foyer*
10:35am – 12:10pm (3)	**CONCURRENT SESSIONS** Session A: Partnerships and Collaboration Session B: Changing Clinical Practice I Session C: Women's Health	*Room 101* *Room 201-203* *Room 204-206*
12:15pm – 1:10pm	**Lunch & Talk by Irene Day, Director of Operations, BC Centre for Excellence in HIV/AIDS**	*Room 101- 102*
1:10pm – 1:15pm	**Transition time**	n/a
1:15pm – 2:30pm	**WORKSHOPS** A) Gina Browne – Inspiring Evaluations of the Impact of Innovations in Health Care B) Trevor Hancock – Holistic Policies for Health Communities C) Lara Lise Barker – Communicating with Your Pharmacist D) Raquel Miles – The Practical Functionality of Process Mapping in System Transformation	*Room 101* *Room 201-203* *Room 204-206* *Room 208*
2:30pm – 3:30pm	**Refreshments available**	*Civic Center, Foyer*
2:40pm – 4:30pm	**WORKSHOPS cont'd:** A) Gina Browne B) Trevor Hancock C) Lara Lise Barker D) Raquel Miles	*Room 101* *Room 201-203* *Room 204-206* *Room 208*
4:30 – 6:30	**Reception & Poster Viewing**	*Room 101- 102*

PROGRAM AT A GLANCE

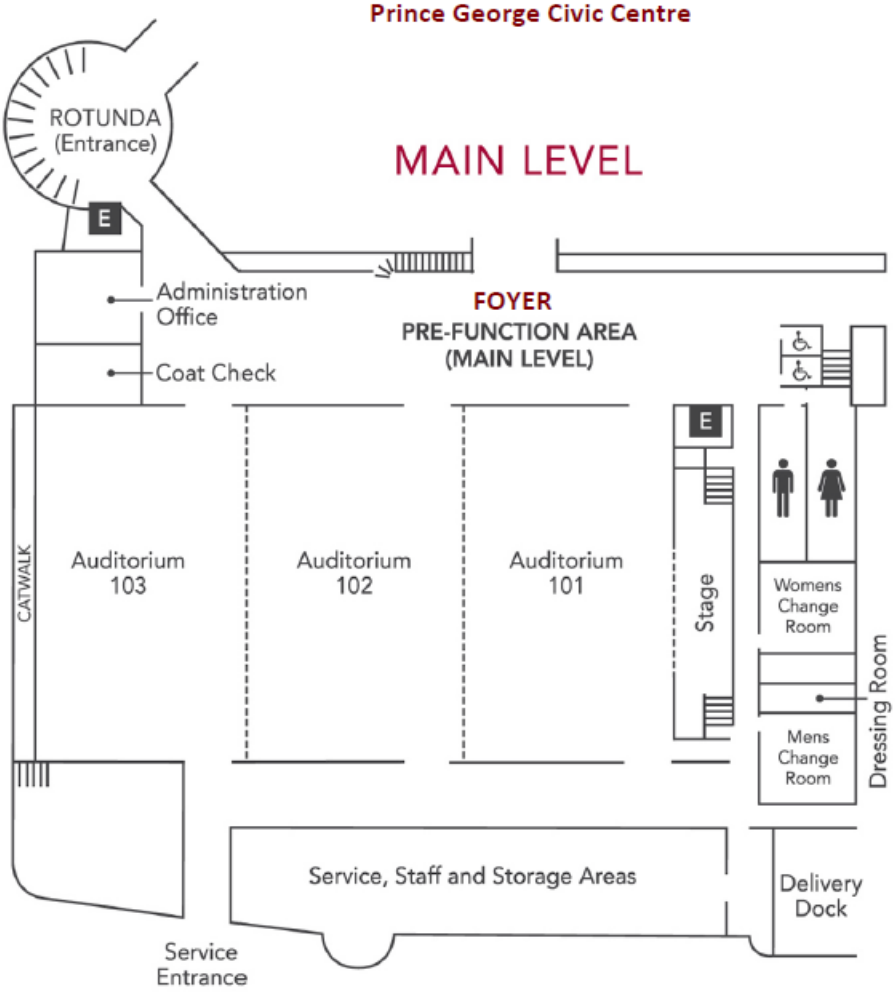
Thursday, November 6, 2014		
7:45am – 10:00am 7:45am – 8:45am	Conference Registration Breakfast Buffet	*Civic Center, Foyer* *Civic Center, Room 101*
8:45am – 10:00am	**WELCOME & PLENARY SESSION:** **Patient Engagement in Health Care: How Can Research Help us Get it Right?** **Bev Holmes,** Vice-President, Research Impact Michael Smith Foundation for Health Research **Colleen McGavin,** Patient Partner	*Room 101- 102*
10:00am – 10:15am	**Refreshment Break & Transition Time**	*Civic Center, Foyer/Room 101*
10:15am – 12:00pm (4)	**CONCURRENT SESSIONS** Session A: Changing Northern Healthcare Session B: Creative Pathways for Person Centered Care Session C: Changing Clinical Practice II Session D: Integrated Health Services	*Room 101* *Room 201-203* *Room 204-206* *Room 208*
12:00pm – 12:45pm	**Lunch – transition to poster rapid fire**	*Civic Center, Foyer/Room 101*
12:45pm – 1:25pm	**Rapid Fire Poster Presentations**	*Room 101- 102*
1:25pm – 1:55pm	**Poster Viewing**	*Room 101- 102*
1:55pm – 2:10pm	**Transition Break/Refreshment Break**	*Civic Center, Foyer*
2:10pm – 5:15pm	**WORKSHOPS** A) Colleen McGavin – Patient Engagement – Sharing a Vision B) Jude Kornelsen – How to Win Friends and Influence Health Planning: Strategies for Collaborative Health Services Research C) James Wilton - Communication HIV Transmission Risk D) Stephanie Powell-Hellyer & Karim Saleh– How to Engage Vulnerable Communities in Health Behaviour Change	*Room 101* *Room 201-203* *Room 204-206* *Room 208*

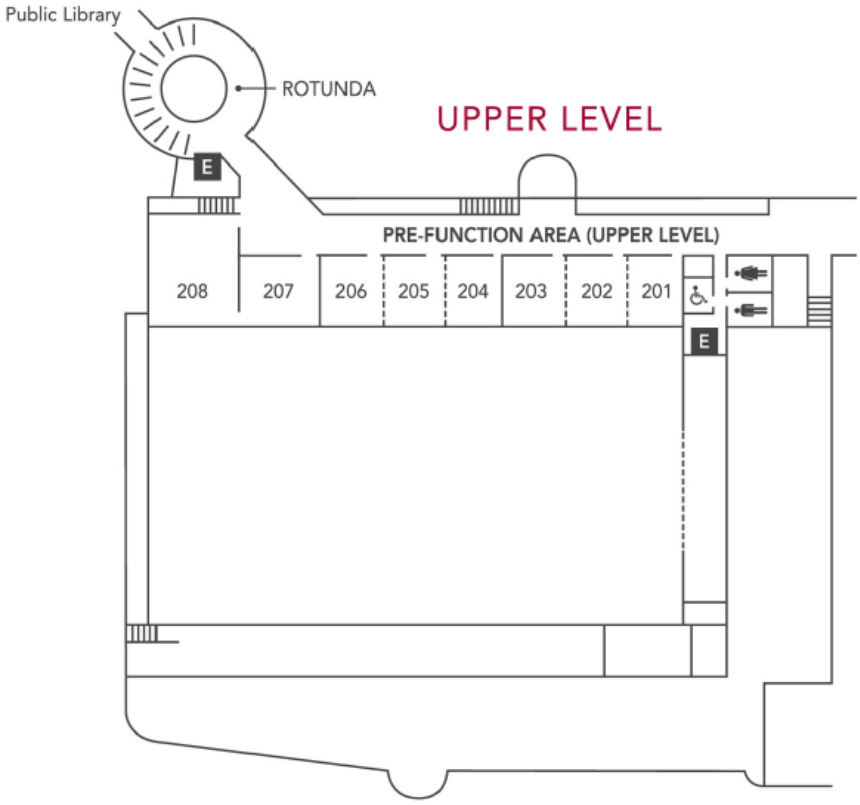
PROGRAM AT A GLANCE

Friday, November 7, 2014		
7:30am – 10:00am 7:30am – 8:30am	Conference Registration Breakfast Buffet/Breakfast Tables	*Civic Center, Foyer* *Civic Center, Room 101*
8:30am – 8:45am	**Welcome and Student Poster Award**	*Room 101- 102*
8:45am – 9:45am	**PANEL SESSION:** **Healthy Communities through Patient Engagement** **Bev Holmes**, VP Research Impact Michal Smith Foundation for Health Research **Patricia Howard**, Regional Aboriginal Coordinator, Blood Borne Pathogens Services **Chantelle Wilson**, M.Sc. Program Manager, Northern Health Assessment Network & Suspected Child Abuse & Neglect Clinic **Cindy Hardy**, Professor and Chair, Department of Psychology, University of Northern BC **Yaron Butterfield**, Bioinformatics Cancer Research and Cancer Survivor **Chester Hiebert**, Patient Partner	*Room 101- 102*
9:45am – 10:00	**Transition Time**	*n/a*
10:00am – 11:45am (4)	**CONCURRENT SESSIONS** Session A: Environmental and Public Health Session B: Considerations for Health Planning Session C: Population Health II	*Room 101* *Room 201-203* *Room 204-206*
11:45am – 11:50am	**Transition time**	*n/a*
11:50am – 12:10pm	**CLOSING REMARKS** **Martha MacLeod,** Co-Lead UNBC Health Research Institute	*Room 101- 102*

Photo courtesy of NH Communications

Prince George Civic Centre





KEYNOTE SPEAKER

Dr. Gina Browne B.ScN, MS, PhD, Hon.LL.D, FCAHS
Wednesday, November 5, 2014
9:00am – 10:00am

Prince George Civic Centre, Room 101

Person-Centred Health Care Works!....and Saves Money!

Dr. Gina Browne
Professor, School of Nursing, McMaster University

Twelve Ontario economic evaluations of interventions for vulnerable populations conducted in randomized trials will be presented. The presentation emphasizes engaging providers/researcher relationships as co-creators of evaluation strategies, study designs and measures of patient and system outcomes. The key message from the presentation is that it takes "passion" to make changes to the health care system that achieves more cost effective patient care.

Dr. Browne teaches and supervises students in both the Health Research Methodology program and the graduate programs of the School of Nursing at McMaster University.

Since 1978, Gina has been in clinical practice as the family therapist for a Halton Health Service Organization. She has a long track record of conducting research in chronic illness and service utilization at McMaster University, in developing others in the conduct of research, linking and coordinating a variety of clinical and research initiatives. She is particularly interested in clientele shared by health and social sectors, the combination of problems that guides simultaneous use of services, factors which explain the variability of client outcomes and the cost of a "life without purpose" to society. It has been said that, "Gina often thinks the unthinkable, says the unsayable and does the undoable!"

PLENARY SESSION

Thursday, November 6, 2014
8:45am – 10:00am

Prince George Civic Centre, Room 101

"Patient Engagement in Health Care: How Can Research Help Us Get It Right?"

Plenary Speakers:

Bev Holmes, VP Research Impact
Michael Smith Foundation for Health Research.

Colleen McGavin, Patient Partner

Plenary Session:
Canada takes pride in its health care system for good reason – but almost everyone has a story to tell that demonstrates there is much room for improvement. Patient engagement - recently called "the blockbuster drug of the century" - has the potential to bring about such improvement at the individual, community and system levels.

But what exactly does "patient engagement" mean and what does it look like? How do we know if it's working, and how can we get better at it? Ultimately, how can we realize the potential?

Through a combination of personal stories, professional insights, and advice and learning from experts, Colleen McGavin and Bev Holmes will address these questions, emphasizing the increasing importance of research in improving patient engagement, and encouraging community involvement in such research.

Colleen McGavin

Colleen McGavin is a retired business educator having taught courses in communication and information technology for nearly 25 years at Camosun College in Victoria. She has extensive experience as a cancer patient and as a caregiver to her elderly parents and, since 2010; she has been an active volunteer with Patient Voices Network, a program that is supported under the banner of Patients as Partners through the Ministry of Health. In this capacity, she has worked with organizations such as the BC Patient Safety and Quality Council, Doctors of BC, the Ministry of Health, Island Health, and the Michael Smith Foundation for Health Research to make positive change in the health care system. Colleen sits on the Interim Governing Council for the Strategy for Patient Oriented Research (SPOR) and she is part of a research collaborative investigating women's values and preferences concerning antibiotics for the treatment of uncomplicated urinary tract infection. She has been regularly invited to speak on subjects such as patient-centered care and patient engagement in health research and she is published in the Journal of Family Nursing on the subject of patient- and family-centered care. In 2014, Colleen completed the training to become a certified member of the International Association of Public Participation (IAP2).

Bev Holmes

Bev is Vice President of Research and Impact at the Michael Smith Foundation for Health Research. Her portfolio at MSFHR includes funding programs, projects, knowledge translation and impact analysis. She and her team run MSFHR's research competitions and undertake projects aimed at strengthening BC's health research enterprise. Through their knowledge translation work, they focus on increasing the use of health research evidence in practice and policy. They are also responsible for measuring the impact of MSFHR's work, and they explore methods and mechanisms to evaluate the impact of health research in BC more broadly. On behalf of MSFHR, Bev facilitated a provincial project to develop a business case for a patient-oriented research support unit in BC. The unit, currently being established, is part of a Canadian Institutes of Health Research Strategy for Patient Oriented Research (SPOR).

PANEL SESSION

"Healthy Communities through Patient Engagement"

Friday, November 7, 2014
8:45am – 9:45am

Prince George Civic Centre, Room 101

Plenary Panelists:

Yaron Butterfield
Bioinformatics Cancer Researcher and Cancer Survivor

Cindy Hardy
Professor and Chair, Department of Psychology, University of Northern BC

Bev Holmes
VP Research Impact
Michael Smith Foundation for Health Research

Chester Hiebert
Patient Partner

Patricia Howard
Regional Aboriginal Coordinator, Blood Borne Pathogens Services

Chantelle Wilson
Program Manager, Northern Health Assessment Network & Suspected Child Abuse & Neglect Clinic

Patient engagement is fast becoming an essential component of care delivery and research. Hear the perspectives from patients, clinicians, and researchers about their challenges and successes with addressing patient engagement. An interactive discussion with the audience will surface how we can use these stories and experiences to improve patient engagement in our own practices thereby fostering a culture of patient-centeredness in all aspects of our work.

WORKSHOPS

"Inspiring Evaluations of the Impact of Innovations in Health Care"

Wednesday, November 5, 2014
1:15pm – 4:30pm
Prince George Civic Centre, Room 101

Current Northern B.C. innovations in health care will be highlighted and the workshop will engage participants in discussing how these existing efforts could be enhanced by crossing service sectors to combine treatments with actual opportunities that engender hope and purpose for vulnerable populations. Basic evaluation designs and common outcome measures across a variety of initiatives will be highlighted.

Dr. Gina Browne
Professor, School of Nursing, McMaster University

Gina Browne teaches and supervises students in both the Health Research Methodology program and the graduate programs of the School of Nursing at McMaster University.

Since 1978, Gina has been in clinical practice as the family therapist for a Halton Health Service Organization. She has a long track record of conducting research in chronic illness and service utilization at McMaster University, in developing others in the conduct of research, linking and coordinating a variety of clinical and research initiatives. She is particularly interested in clientele shared by health and social sectors, the combination of problems that guides simultaneous use of services, factors which explain the variability of client outcomes and the cost of a "life without purpose" to society. It has been said that, "Gina often thinks the unthinkable, says the unsayable and does the undoable!"

WORKSHOPS

"Holistic Policies for Healthy Communities"

Wednesday, November 5, 2014
1:15pm – 4:30pm
Prince George Civic Centre, Room 201-203

Using a model that integrates community, environment and economy and identifies six key qualities of a healthy community, participants are led through a process of considering how various public policy issues need to be addressed in order to create healthier public policy that creates the conditions for better and healthier communities. Policy issues such as housing, food, transportation, parks, public works and other important municipal issues are addressed.

Trevor Hancock, MB, BS, MHSc
Professor and Senior Scholar
School of Public Health and Social Policy,
University of Victoria

Trevor Hancock teaches that cities wanting to improve the health of their citizens need to pay attention to both their physical and their social environments. Think of increasing the amount of green space downtown or introducing community programs that connect citizens with their cities.

Over the past 30 years as an internationally recognized health promotion leader, Dr. Hancock has helped to put health on the agenda of thousands of cities and towns around the world.

He has had a long-standing interest in the relationship between human and environmental health and is one of the founders of the global Healthy Cities and Communities movement.

Dr. Hancock teaches in the School of Public Health and Social Policy at the University of Victoria, where his graduate courses connect students to real on the ground problems facing society.

The challenge now is to increase awareness. As co-chair of a working group studying human and ecosystem health for the Canadian Public Health Association (CPHA), he is searching for new, creative ways to communicate his message.

In Dr. Hancock's words: "We want the three minute viral video, not the academic paper."

WORKSHOPS

"Communicating with Your Pharmacist"

Wednesday, November 5, 2014
1:15pm – 4:30pm
Prince George Civic Centre, Room 204-206

This workshop seeks to enhance the capacity of people living with HIV/Hep C and other related illnesses to better communicate with their pharmacists, an essential part of a strong and effective healthcare team. We will explore the role pharmacists play in supporting good ongoing health in people living with HIV/Hepatitis C. By learning unique communication tools, participants are empowered to increase their understanding of how they can better engage and work to improve their rapport with their pharmacist.

Lara Lise Barker
Regional Health Education Coordinator, CATIE

Lara Lise Barker is a Regional Health Education Coordinator at CATIE working in BC. She has been engaged in work around HIV/AIDS for several years, including in HIV/AIDS policy and advocacy at the European AIDS Treatment Group in Brussels. Lara holds a Hons. B.A. in Political Science, French and Spanish and completed her M.Sc. Public Health in Berlin, Germany with a focus on Body Mapping work with people living with HIV/AIDS.

WORKSHOPS

"The Practical Functionality of Process Mapping in System Transformation"

Wednesday, November 5, 2014

1:15pm – 4:30pm

Prince George Civic Centre, Room 208

Julianna Ireland
Outcomes Analysts, Planning and Performance

Melanie Mogus
Outcomes Analysts, Planning and Performance

Raquel Miles
Community Programs Integration and Implementation

Marna deSousa
Care Process Coach, Community Programs Integration and Implementation

Over the last 18 months these four have come together to form a dynamic process improvement team! They have done extensive process mapping with all community programs in the Omineca area. They look forward to sharing their knowledge, expertise and learning with all of you.

Process mapping is a valuable tool that allows you to ask the questions about a process:

- How is it done?
- Who is responsible?
- What information is received and from where?
- What decisions need to be made?
- What is the output?
- Where are the next steps?

The purpose of process mapping is for *better understanding*. It involves the gathering and organizing of facts about the work and displaying them so that they can be questioned and improved by knowledgeable people. With Northern Health's strategic focus and commitment to 'integrated accessible health services' as goal posts, process mapping has emerged as a practical and functional tool to employ in guiding and capturing system transformation. Process mapping has been used extensively in the Omineca District in Mental Health and Addictions, Home and Community Care, Public Health, the Primary Care home and Acute Care. Drawing on the expertise of front line clinicians and staff, processes for service requests, appointment bookings, finance, charting, team communication and information sharing, assessments, registration and discharge planning have been mapped. These maps serve as a starting point to understand the direct relation and impact to patient care, visually and narratively identify gaps in the system and opportunities for improvement and establish and complete numerous quantitatively measured test cycles. The outcome is the creation of new processes which comprise the new and improved current state.

By linking these new processes to existing functional system maps which depict the organization at a broad level, we have been able to visualize the integration work in the context of the rest of the organization (data, organizational structure, strategies) which gives us the potential to create greater capabilities in analyzing and planning a change – a key component to ensuring the success of Northern Health's strategic pillar of **Integrated Accessible Health Services.**

WORKSHOPS

"Patient Engagement – Sharing a Vision"

Thursday, November 6, 2014
2:10pm – 5:15pm
Prince George Civic Centre, Room 101

More and more, patients are being engaged in health research. A policy framework to guide researchers is being developed as part of the work of the SPOR SUPPORT Unit. What are the benefits and challenges of working in this way? At this workshop, participants who have experience working with or as patient partners will be invited to share their own experiences. Following this, the evidence to support the case for true patient engagement will be presented. By the end of the workshop, participants will have contributed to establishing a baseline of attitudes and perceptions and to moving the discussion beyond the current state.

Colleen McGavin
Patient Partner

Colleen McGavin is a retired business educator having taught courses in communication and information technology for nearly 25 years at Camosun College in Victoria. She has extensive experience as a cancer patient and as a caregiver to her elderly parents and, since 2010; she has been an active volunteer with Patient Voices Network, a program that is supported under the banner of Patients as Partners through the Ministry of Health. In this capacity, she has worked with organizations such as the BC Patient Safety and Quality Council, Doctors of BC, the Ministry of Health, Island Health, and the Michael Smith Foundation for Health Research to make positive change in the health care system. Colleen sits on the Interim Governing Council for the Strategy for Patient Oriented Research (SPOR) and she is part of a research collaborative investigating women's values and preferences concerning antibiotics for the treatment of uncomplicated urinary tract infection. She has been regularly invited to speak on subjects such as patient-centered care and patient engagement in health research and she is published in the Journal of Family Nursing on the subject of patient- and family-centered care. In 2014, Colleen completed the training to become a certified member of the International Association of Public Participation (IAP2).

WORKSHOPS

"How to Win Friends and Influence Health Planning: Strategies for Collaborative Health Services Research"

Thursday, November 6, 2014
2:10pm – 5:15pm
Prince George Civic Centre, Room 201-203

Influencing health services policy through research is a challenge that has besotted researchers – and funders and policy-makers – despite the growing attention to the necessity of this dynamic exchange. Often timelines, misalignment of research and planning priorities and skepticism mar even the best intentions of both constituencies. One thing that is common to the emerging understanding of effective research-to-action noted in the literature is recognition of the importance of relationships. This workshop will consider the opportunities for authentic collaboration throughout the health services research process with three key stakeholder groups: communities, care providers and health service decision makers. Within this framework, we will look at the 'when', 'why' and 'how' of collaboration, the importance of establishing common values and provide examples of tools to facilitate collaboration. We will end by reviewing examples of outputs of collaborative engagement.

Jude Kornelsen
Assistant Professor
Co-Director, Centre for Rural Health Research

Jude Kornelsen, PhD, is a health services researcher and Assistant Professor in the Department of Family Practice at UBC who has a focused program of research on rural maternity care. As co-director of the Centre for Rural Health Research, her primary focus involves rural maternal health issues including the emergence and integration of midwifery in our health care system. In this position Dr. Kornelsen works toward creating productive research environments and coordinates and oversees student positions. She has undertaken numerous funded studies on rural women's experiences of care and additionally directs a program of research into the emerging social phenomenon of elective cesarean section. Dr. Kornelsen is a former CIHR New Investigator, a Michael Smith Foundation for Health Research Scholar and an Honorary Associate Professor at the University of Sydney.

WORKSHOPS

"Communicating HIV Transmission Risk"

Thursday, November 6, 2014
2:10pm – 5:15pm
Prince George Civic Centre, Room 204-206

Accurate assessment and communication of HIV risk is important to help clients understand their risk and make informed risk-taking/health-seeking decisions, such as the adoption of risk-reduction strategies and the decision to get tested for HIV. However, assessing and communicating HIV transmission risks is challenging and has become even more complex in recent years, particularly as we have learned more about the range of biological factors that can influence HIV risk and as new partially protective HIV prevention strategies have emerged.

Front-line service providers working with people at risk of HIV infection need to have a solid understanding of the approaches and challenges to HIV risk communication. This interactive session will review technical concepts related to communicating risk information and explore the traditional models for assessing HIV risk. Workshop participants will be encouraged to think critically and constructively about the limitations of these models and how they could be improved. Integrated within this presentation will be activities and case studies to practically explore and demonstrate these concepts and challenges. Activities will include small group work in which participants will be asked to develop their own HIV risk model. The workshop will also review some of the innovative risk communication models being adopted by organizations within Canada and abroad.

James Wilton
Biomedical Science of HIV
Prevention Coordinator, CATIE

James is the Biomedical Science of HIV Prevention Coordinator at CATIE where his knowledge exchange work focuses on the biology of HIV transmission and new HIV prevention technologies. He is currently involved in research projects related to the implementation of HIV pre-exposure prophylaxis and understanding how gay men and other MSM in Canada understand and use biomedical HIV information to make safer sex decisions. He has a Bachelor's Degree in Microbiology and Immunology from the University of British Columbia and is currently completing a Master's of Public Health Degree in Epidemiology at the University of Toronto. James is also a trained HIV counselor and tester in Kenya and prior to working in HIV/AIDS field he spent several years as a basic science researcher at the British Columbia Cancer Research Center.

WORKSHOPS

"How to Engage Vulnerable Communities in Health Behaviour Change"

Thursday, November 6, 2014
2:10pm – 5:15pm
Prince George Civic Centre, Room 208

Our research project was approached with the question: How do we empower Mental Health Service Users (MHSU) as individuals and as a community to affect change? Working with a research team consisting of health professionals, UNBC research associates and community partners, this project aims to empower clients *Activity Centre for Empowerment (ACE)* to take action. This project will provide new research data on effective methods to overcome barriers such as stigma, as well as barriers specific to vulnerable populations to improve health behaviours for clients. These important research questions led researchers to examine both *Self-Determination Theory* and *Community Based Participatory Research Theory,* after which it was found that this project is a combination of both theories.

Learning Objectives:

- Define Community Engagement Research
- Explain Community Based Participation Research and Self-Determination Theory
- Identify how research can help advance work in community (+ why this approach is better than other methods)
- Describe the unique roles of academia and community partners in community based research
- Outline key steps in developing and sustaining community research partnerships

Stephanie Powell-Hellyer
Research Associate, UNBC, NMP
Instructor, Northern Studies

Karim Saleh
Psychiatry Resident & Researcher, UHNBC

Stephanie Powell-Hellyer
Is a research Associate at UNBC in the Northern Medical Program and an Instructor in Northern Studies. Stephanie's current research is focused on identifying barriers and facilitators to healthy lifestyles for mental health service users in Prince George. Her research background includes health in the circumpolar north, Arctic food security, northern contaminants, international environmental policy, health risk communication, tobacco reduction, community action including advocacy. Currently, Stephanie is working with a research team alongside Dr. Candida Graham and Dr. Karim Salem engaged with mental health service users, peer leads, and community partners to develop physical activity interventions using a joint methodological approach.

Karim Saleh
Is Psychiatry resident and researcher currently working at UHNBC who is involved in community based participatory and mental health service user engagement research. His research background includes extensive Neuroimaging research in Major Depressive Disorder. Whilst working under his mentor Dr. Thomas Frodl at Trinity College Dublin (Dublin, Ireland), Karim has published papers in major Psychiatric journals in North America and Europe. Currently, Karim is working to develop strategies for improving wellbeing within the Northern mental health service user population alongside the research team which includes his mentor Dr. Candida Graham and research partner Stephanie Powell.

BREAKFAST TABLES

Friday, November 7, 2014
7:30am – 8:30am
Prince George Civic Centre, Room 101

Purpose of Breakfast Table:

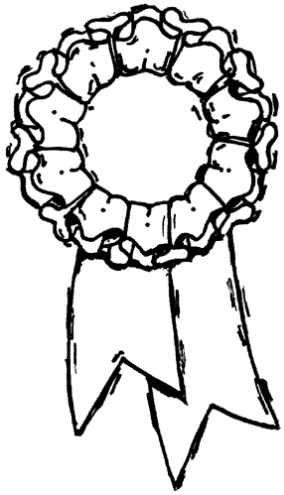
- Allow for informal conversation regarding your program's goals in relation to knowledge, research, and collaborative action
- Provide an opportunity for focused networking between program leads and participants from across Canada with similar interests and ideas

Breakfast Table Hosts & Titles:

- **Jude Kornelsen/Emily Ryan, Rural Health Services Research Network -** What is the Rural Health Services Research Network of British Columbia (RHSRN*bc*) all about?
- **John Giannisis, Community Coordinator, Van Bien Elementary School & Marnie Alexander-** Community School Coordinators - Pulling the Puzzle Pieces Together
- **Leo Hebert, Executive Director, PG Metis Housing Society -** Your Home, Your Health: Holistic People-Centred Approach to Housing
- **Luke Harris, UNBC -** Novel Non-Invasive Research and Diagnostic Technologies
- **Sabrina Dosanjh-Gantner -** Health is Everyone's Business: How do we work better together to promote the health and well-being of our communities"
- **Lindsay Vine -** Student perspective on working with communities
- **Heloise Dixon-Warren -** Exploring The Culture of Local Food and Well-being: Linking Agri-*culture* and Community Health
- **Kendra Mitchell-Foster -** Current efforts and growing momentum in Aboriginal Health in Northern BC.

We encourage you to sign up for a Breakfast Table at the Registration Desk

STUDENT POSTER COMPETITION



The IDC Research Days is featuring a Student Poster Competition. Students that have designated their poster for consideration in the competition will be judged by ballot voting by your peers for Quality, Evidence, Illustrations, and Overall Appearance. There will be one award of $150 as contributed by the University of Northern British Columbia Health Research Institute that will be given to the top student poster presentation. The winner will be announced Friday, November 7, 2014 in the morning.

Aerial View of
UNBC Campus
and Prince George

Photo courtesy of UNBC Communications

CONCURRENT SESSIONS

Wednesday, November 5, 2014			
Time	**Room 101 – Session A** **Chair: Alice Muirhead** Theme: **Partnerships & Collaboration**	**Room 201-203 – Session B** **Chair: Emily Ryan** Theme: **Changing Clinical Practice I**	**Room 204-206 – Session C** **Chair: Rachael Wells** Theme: **Women's Health**
10:35 – 11:00	**#118 - Kerensa Medhurst** Collaborating for Cancer Prevention in Northern British Columbia: Building Multi-Organizational Collaboration Using a Harmonized Approach	**#100 – Aleisha Thornhill** Time to Antimicrobial Therapy in Septic Shock: Post-Implementation of an Adult Sepsis Protocol	**#103 – Helen Bourque** Vaginal Pessaries in Primary Health Care
11:00 – 11:25	**#122 – Martha MacLeod** Partnering for Change: Engaging Municipal Leaders in Primary Health Care Transformation	**#110 – Kwamena Beecham** Neoadjuvant Systemic Therapy Utilization in Breast Cancer: Potential Impact on Nodal Radiotherapy	**#115 – Caitlin Frame** Outcomes of Remote Midwifery Care in Fort Smith, Northwest Territories
11:25 – 11:45	**#132 – Sabrina Dosanjh-Gantner** Partnering for Healthier Communities – Northern Health's Approach to Partnering with Local Governments	**#121 – Mikolaj Piekarski** Anthracyclines – Still Effective in Cancer Therapy?	**#149 – Lindsay Van der Meer** Nutrition-Related Characteristics of Women with Breast Cancer Admitted to the BCCA Centre for the North
11:45 – 12:10	**#158 – Meghann Brinoni** Research and First Nations Health: The Way Forward	**#131 – Nancy Viney** The SurgiNet system now supports health care providers to alert patients who use tobacco to "Stop Smoking Before Surgery"	**#163 – Jude Kornelsen** The Safety of Rural Midwifery-Led Midwifery Services in BC: Findings from a Pilot Study

CONCURRENT SESSIONS

Thursday, November 6, 2014				
Time	**Room 101-Session A** **Chair: Tamara Checkley** Theme: **Changing Northern Healthcare**	**Room 201-203-Session B** **Chair: Tammy Hoefer** Theme: **Creative Pathways for Person Centred Care**	**Room 204-206 Session C** **Chair: Tanis Hampe** Theme: **Changing Clinical Practice II**	**Room 208 – Session D** **Chair: Alice Muirhead** Theme: **Integrated Health Services**
10:15 – 10:40	**#161 – Theresa Healy** Healthy Community Development - Northern Health's Approach to Building Collaboration Between NH and Community	**#135 – Victoria Carter** Partnering to Create Culturally Safe Organizations	**#111 – Kelsey Roden** Use of Single Fraction Radiotherapy in Complicated Versus Uncomplicated Bone Metastases Cases	**#102 – Helen Bourque** Innovation regarding treatment of anxiety/depression in a fee for service office utilizing a collaborative model.
10:40 – 11:05	**#120 – Marcia Leiva** Prince George Primary Care Teams – Experiences from the field	**#123 – Jessie King** Decolonizing First Nations Status and Impacts on Health	**#108 – Dan Horvat** Improvement of Radiation Oncology Therapy Completion Note: Qualitative Survey Analysis Through Physician Reports	**#143 - Jennifer Tkachuk** Community Evaluation: Developmental Screenings with Children 18 Months to 4 Years
11:05 – 11:30	**#128 – Raquel Miles** The Practical Functionality of Process Mapping in System Transformation	**#125 – Patricia Howard** Scanning for Silos: Creative Pathways to Partnerships and Wellness	**#126 – Robert Pammett** Evaluation of a Screening Questionnaire to Identify Patients at Risk of Drug Therapy Problems in Community Pharmacies	**#116 – Erin Wilson** Interpretive Practices Towards Understanding Relational Continuity
11:30 – 11:55	**#157 – Janice Paterson** The Rapid Mobilization Process: Partnering to deliver in-home rapid access to care	**#156 – Si Transken** Creativity for Social Justice and Healing: Some empowering examples!	**#124 – Robert Olson** Impact of a multi-pronged intervention to improve the use of single fraction radiotherapy for bone metastases across six centres	**#162 – Robin Roots** The Northern and Rural Cohort: A Partnership to Increase Physiotherapists and Physiotherapy Services in Northern and Rural BC

CONCURRENT SESSIONS

Friday, November 7, 2014			
Time	**Room 101 – Session A** **Chair: Tamara Checkley** Theme: **Environmental and Public Health**	**Room 201-203 - Session B** **Chair: Tanis Hampe** Theme: **Considerations for Health Planning**	**Room 204-206 – Session C** **Chair: Rachael Wells** Theme: **Population Health II**
10:00 – 10:25	**#114 - Angela Wheeler** Northern Health Survey on Private Water Systems	**#112 - Yaron Sidney Butterfield** Personalized medicine includes patient engagement and empowerment	**#113 - Sue MacDonald** Kids Helping Kids-Healthy is Happy
10:25 – 10:50	**#129 - Davina Banner-Lukaris** Engaging Family Doctors in Upstream Public Health Initiatives in Northeast British Columbia: Opportunities and Challenges	**#117 - Julius Okpodi** Where do we locate ourselves: Aging and Concerns for Lesbian, Gay, Bisexual and Transgender (LGBT) Seniors	**#133 - Paul Sharp** Healthy Eating and Active Living in the North: Examining the Man's Perspective
10:50 – 11:15	**#130 - James Haggerstone** Community Health Information Portal 2014	**#127 - Rohitha Fernando** Can the concept of "locally grown" help food insecurity in Northern British Columbia?	**#136 - Alice Muirhead** How behaviours and expectations shape experience: Youth, parents and competitive sport
11:15 – 11:40	**#134 - Dr. Charl Badenhorst** The Importance of Including Socio-Economical Health Impact Assessments as Part of Current Environmental Impact Studies in BC	**#147 - Daman Kandola** Inter-hospital transfer for cardiac revascularization: the experience at a rural-urban teaching hospital in northern British Columbia	**#106 – Kendra Mitchell-Foster** Arts of Immersion: Promoting Understanding about First Nations' Health and Well-Being in Northern Medical Education

POSTER PRESENTATIONS

Prince George Civic Centre Room 102 and Foyer

101 **Barnes –** *Radiotherapy Fractionation Schedules Prescribed are Dependent on the Distance a Patient Travels to Receive Treatment*

104 **Vine -** *A NEW IDEAKIT: Partnering for Healthier Communities Toolkit Evaluation and Quality Improvement Project*

105 **Tiwana/**Barnes/Kiraly/Miller/Hoegler/Olivotto/Olson - *Palliative Radiotherapy for Bone Metastases: Population-based Utilization Near End of Life in a Canadian Province*

107 **Gentles**/Woodbeck/Tiwana/Beecham/Olson/SmithWozeny/Olson **-** *Navigating Lung Cancer in the North: A comparison of patient timelines across Northern BC.*

109 **Dosanjh-Gantner** - *Engaging local governments and community partners: Learning events on building healthier northern communities*

119 **Aldiabat/Axen -** *What Do Nursing Students Need to know about Health Education for Older Adults who live in Canadian Rural Areas?*

137 **Muirhead -** *Miles Between Us: Advancing First Nations, Inuit and Métis Cancer Control in Canada*

138 **Pousette -** *Summer science camps: An opportunity to educate, experiment and be active*

139 **Johnson -** *Voices in Thread: Women's Childhood Experiences of a Primary Caregiver that Remained in a Relationship with an Alleged or Known Sex Offender, an Arts-based Inquiry*

140 **Matthews** - *Exploring the connections between nature connectedness, outdoor recreation, and human well-being in Vanderhoof, British Columbia*

141 **Johal** - *Subthreshold Diode MicroPulse laser photocoagulation for Central Serous Chorioretinopathy in a rural setting*

142 **Lidstone/LeBlond/Horrock** - *Screening for Dysphagia in Residential Care: Burden or Benefit?*

144 **Turnbull**/Cozac/Swanson/Monk/Agoston - *The Birth of an Integrated Model of Primary Care*

145 **Pammett -** *A Primary Care Pharmacist in the North!*

146 **Lively**/Amlani/Buxton **-** *Drug use in Northern Health, results of a provincial harm reduction client survey*

148 **Paterson/**Turnbull **-** *Reflections on patient and provider experience results in Northern Health's efforts to integrate primary and community care*

150 **Bennett**/Koehn/Hardy **-** *Daily Experiences of Parenting a Child with Suspected FASD*

151 **Pyke -** *What Promotes Inter-professional Collaboration between Primary Care and Public Health?*

152 **Powell-Hellyer**/Graham/Saleh - *Palliative Radiotherapy for Bone Metastases: Population-based Utilization Near End of Life in a Canadian Province*

153 **Glennie-Visser**/Yarmish/Dosanjh-Ganter/Healy **–** *An Integrated Approach to Community Grants*

154 **Griffith -** *Improving Patient Care CT Dose Reduction through a Collaborative Approach*

155 **Lively -** *Take Home Naloxone*

159 **Fernando** - *One Danger, Two Systems*

160 **Fernando -** *Role of Hazard Analysis Critical Control Points (HACCP) in traditional food systems for Northern, Rural and Aboriginal populations.*

ABSTRACTS – ORAL PRESENTATIONS

Abstracts appear as submitted and have not been edited except for formatting.

Wednesday, November 5, 2014	
Session A: Partnerships and Collaboration **Room 101**	10:35am – 12:10

118

Collaborating for Cancer Prevention in Northern British Columbia: Building Multi-Organizational Collaboration Using a Harmonized Approach

Kerensa Medhurst, Nikolai Holm, and Sherri Tillotson

Cancer prevention in northern British Columbia occurs within a larger context of dispersed rural and remote communities. The drivers of obesity, nutrition and physical activity are recognized to be multiple, diverse and complex including both personal behaviours and aspects of the physical, economic, socio-cultural and political environments that shape them. These realities were the impetus for senior management from three health organizations, Canadian Cancer Society (CCS), BC Cancer Agency (BCCA) and Northern Health (NH), to explore opportunities for harmonization of their respective cancer prevention services, and to study the nature of collaboration itself.

Despite increasing focus on collaboration there is still need for better understanding of collaborative processes and for conceptual tools to help organizations develop effective collaborations in complex systems. By designing, implementing, and evaluating of two interventions; Stop Smoking Before Surgery (SBSS) and Men's Healthy Eating and Active Living (MHEAL) we are taking an active learning approach in explore collaborative practices.

Through the use of ongoing critical reflection in the form of focus groups, partner surveys, and regularly scheduled reflective questions, the project has not only sought to iteratively isolate best practices for collaborative approaches in population health, but has to demonstrate that collaborative endeavors can create sustainable spaces for further innovation in health programming. We will highlight our findings to date which include how the knowledge and experiences from the SBSS and MHEAL interventions can be distilled into key learnings for other potential collaborative partnerships.

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Partnering for Change: Engaging Municipal Leaders in Primary Health Care Transformation

Martha MacLeod[1], Cathy Ulrich[2], Neil Hanlon[1], Joanna Paterson[1]
(1-University of Northern BC, 2-Northern Health)

Background

The Northern Health Authority (NH) has undertaken a process of whole system transformation centering on the integration of Primary Health Care (PHC). PHC transformation is situated in communities, allowing NH staff, physicians, community organizations and municipal leaders to take hold of and develop opportunities for innovation that improve the health of the population. This presentation will describe the processes by which municipal leaders are engaged as partners in health system changes.

Methods

A multiple case study approach is used to examine how health system change takes place at the NH regional level and within seven northern British Columbia communities over a four-year period (2011-2015). Three years of interviews with community leaders, physicians and health authority staff, as well as NH developmental evaluation documents provide data for analysis. Research findings, which are brought back to the communities and the municipal leaders each year, contribute to ongoing PHC transformation and partnership development within communities.

Findings
Themes arising from the analysis of the municipal leaders' interviews include recognizing and taking hold of opportunities to work together differently; appreciating the value in aligning goals and working together strategically for mutual benefit; understanding that 'health' is not limited to hospitals and doctors' offices; and that communities play an important roles in supporting the health of their populations.
Discussion
Municipal leaders are vital to the engagement of communities in partnerships for community-based health system changes. Through their involvement as partners, municipal leaders contribute substantively to the co-alignment of health services and structures with community initiatives in ways that serve the needs of northern populations.

132
Partnering for Healthier Communities – Northern Health's Approach to Partnering with Local Governments
Sabrina Dosanjh-Gantner, Lead, Healthy Community Development – Local Governments

Northern Health has developed the Partnering for Healthier Communities (P4HC) approach in order to reduce the health inequities that exist in the north. This approach recognizes that improving the health of northern communities requires the coordinated effort of many sectors and aims to build healthier communities to reduce the incidence of chronic disease and injury through effective partnerships between Northern Health, local governments, and other key stakeholders.
Northern Health is moving towards partnering with local governments and other key stakeholders to further strengthen our relationships and work collaboratively towards building healthier communities through three main objectives:

- Increase communication and partnerships between Northern Health, local governments, and other key stakeholders to support building healthier communities.
- Build the capacity of Northern Health and local government staff and key stakeholders to effectively support building healthier communities.
- Develop and enhance tools and resources to support local governments in the assessment, planning, implementation and evaluation of healthier community strategies.

Action strategies to address these objectives include the establishment of P4HC Committees, where committees are co-chaired by local government and Northern Health and have a multi-sectoral membership. Committees have a shared agenda to develop action oriented strategies to enhance community health based on locally identified risk factors. Currently, Northern Health has developed partnerships and P4HC Committees with 20 local governments. Additional action strategies include, but are not limited to, ongoing educational opportunities for staff and external partners, such as facilitation training, workshops and webinar opportunities, the development of tools and resources, student engagement in project development and community granting opportunities.
By the end of the presentation, delegates will have a better understanding of Northern Health's P4HC approach, as well as the action strategies developed and implemented to meet the objectives of this approach.

158
Research and First Nations Health: The Way Forward
Meghann Brinoni, First Nations Health Authority

October 1st, 2014 marks one year since Health Canada officially transferred its First Nations Inuit Health (FNIH) Branch BC Region health services, programs, employees, and resources over to the First Nations Health Authority (FNHA), with the goal to improve the health and well-being of First Nation in BC. This is an unprecedented shift in First Nations health governance, based around community-driven decision-making and control. The FNHA is also in a unique position to inform and facilitate transformative change within First Nations research and knowledge gathering. Over the past year, the FNHA has encountered challenges and lessons learned that the organization is eager to share in this session.
In this session, the FNHA will offer its perspective on the conduct of health research within BC's First Nations communities. The FNHA will provide updates on its research activities over the past year and describe what the future of research could look like, at the FNHA and in partnership with communities. This session will also involve

active discussions around culturally appropriate ways of approaching research in First Nations communities, applying the principles OCAP™, and addressing Intellectual Property rights.
By the end of the session, participants will:

- Gain up-to-date news from the FNHA on its research activities, priorities, and plans;
- Learn how the FNHA is engaging with communities to design FNHA's research strategy, protocols, and agenda;
- Hear from the FNHA's research team on its activities related to research ethics, data governance, and supporting community-driven research;
- Share their experiences with research in First Nations communities and discuss best practices for respectfully engaging communities; and
- Engage in dialogue on current research and information needs within the region and the potential for strengthening partnerships between researchers and communities.

Wednesday, November 5, 2014	
Session B: Changing Clinical Practice I **Room 201-203**	10:35am – 12:10

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Time to Antimicrobial Therapy in Septic Shock: Post-Implementation of an Adult Sepsis Protocol

Aleisha Thornhill BSc, BSc(Pharm), ACPR, Katie Shovar, BSc(Pharm), ACPR, Dr. Abuobeida A. Hamour, MBBS, MSc, DTM & H, MRCP(UK), CCST(UK), FRCP(Edin), FRCPC

Background: Septic shock is sepsis-induced hypotension despite adequate fluid resuscitation and has been associated with a mortality rate of approximately 50%. The Surviving Sepsis Campaign suggests antimicrobial therapy be administered within one hour of recognition of septic shock. Evidence suggests current recommendations of receiving antimicrobial therapy within the one hour are not being met. A 2008 study completed at UHNBC found mean and median times to antimicrobial therapy to be 4.8 hours and 3.5 hours, respectively. In December 2010, UHNBC implemented the "Initial management of severe sepsis for adults" protocol.
Objectives: The primary objective of this study was to describe time to antimicrobial therapy in patients presenting with septic shock post-implementation of the "Initial management of severe sepsis for adults" protocol at UHNBC. The secondary outcome was survival to hospital discharge or 28 days.
Methods: This was a retrospective observational medical chart review of patients admitted to UHNBC between January 1st, 2011 and December 31st, 2012 for the treatment of septic shock. Patients were included if they met the diagnostic criteria for septic shock. For all included patients time from onset of sepsis-induced hypotension and the administration of antimicrobial therapy was collected. Descriptive analysis was completed for the primary outcome and odds ratios were calculated to analyze secondary outcomes.
Results: Forty-three patients met the inclusion criteria for septic shock. Mean time to administration of antimicrobial therapy was 2.4 hours with twelve patients receiving antimicrobials within the recommended one hour. The protocol was used in 17 patients and the mean time to antimicrobial therapy for these patients was 1.3 hours. Sixteen, 37%, of patients did not survive.
Conclusion: At UHNBC, time to antimicrobial administration in patients with septic shock is greater than the goal time of one hour. Since the 2008 UHNBC study, there were improvements in time to antimicrobial therapy and the proportion of patients receiving therapy within one hour. Compliance to the protocol was low, however when the protocol was used it appeared to reduce time to antimicrobial therapy.

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Neoadjuvant Systemic Therapy Utilization in Breast Cancer: Potential Impact on Nodal Radiotherapy

Kwamena Beecham[1], Scott Tyldesley[2], Caroline Speers[2], Christine Simmons[2], Rona Cheifitz[2], Michelle Sutter[3], David Voduc[2], and Robert Olson[1]

1. BC Cancer Agency, Centre for the North, Prince George
2. BC Cancer Agency, Vancouver Centre
3. University Hospital of Northern British Columbia

PURPOSE

Neoadjuvant systemic therapy (NAST) in breast cancer potentially down-stages disease, thereby posing challenges to the standard indications for nodal irradiation. We assessed the pattern of NAST utilization in our province and its effect on the recommendation for nodal radiotherapy (RT).

MATERIALS/METHODS

Of the 11,628 patients with stages I to III breast cancer from 2007-2012, 603 patients (5.2%) were treated with NAST. Data from our provincial database were obtained to determine relationships between NAST use and nodal irradiation.

RESULTS

The median age of patients who received NAST was 52 years (range 25 - 91 years). 90% received chemotherapy, 64% were assessed with clinical and/or imaging studies, 34% had FNAs, and 2% had preoperative sentinel lymph node biopsies. All patients who had sentinel lymph node biopsies had clinically negative nodes. 91% of patients had nodal irradiation after NAST. On logistic regression analysis, NAST utilization was lower in 3 out of 5 centres compared with the largest centre ($p < 0.05$). Increasing tumour and nodal stage were the main predictors for NAST use (p-value <0.001). There was a decreased use of NAST with time compared to 2007, but this was not statistically significant (p-value 0.34).

CONCLUSION

Contrary to our initial hypothesis, there has not been a significant increase in NAST over time. Nodal irradiation is used in the majority of patients who received NAST. Clinical nodal status did predict for subsequent nodal irradiation

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Anthracyclines – Still Effective in Cancer Therapy?

Mikolaj Piekarski, PhD, PharmD, BC Cancer Agency, Center for the North, Pharmacy
Department of Medicinal Chemistry, Karol Marcinkowski University of Medical Sciences, Poznan, Poland

Present-day is developing in many fields. Many pathological processes are better understood, including carcinogenesis. Consequently, the failure of pharmacotherapy aimed at cancerous diseases is becoming explainable. At the same time, new anticancer drugs continue to be introduced. Anthracycline antibiotics are a well-known and widely used group of anticancer drugs. However, in addition to their efficiency they demonstrate severe side effects compounded by the appearance of resistant cells. Therefore, the search for new anthracycline derivatives with improved pharmacodynamics properties and fewer adverse effects is in progress, delivering promising results. The aim of this presentation is to:

1. Present currently used anthracyclines and their mechanisms of activity
2. Describe the biggest limitations of their use in therapy
3. Present some of the new and promising developments in that group of medicines

Based on that, author will try to answer the question posted in the presentation title – is there future for anthracycline antibiotics in cancer treatment?

131

The SurgiNet system now supports health care providers to alert patients who use tobacco to "Stop Smoking Before Surgery"

Nancy Viney (presenting author), Northern Health, El Taylor (presenting author), BC Cancer Agency, Cherisse Seaton, UBC Okanagan , Kerensa Medhurst, Canadian Cancer Society, & Joan Bottorff, UBC Okanagan

Tobacco specific questions have been added to the SurgiNet system for UHNBC as part of the Stop Smoking Before Surgery Initiative, a joint collaborative effort between the Canadian Cancer Society, the BC Cancer Agency and Northern Health with researchers from the University of British Columbia (http://harmonization.ok.ubc.ca/). Electronic medical records and health records systems have the potential to improve the quality of care and improve health outcomes. The new SurgiNet questions will ensure that all patients are screened for tobacco use, and all smokers are informed of the benefits of quitting and linked to the provincial cessation services prior to their surgery.

A recent survey of Northern Health surgical patients revealed that only half were aware of the increased surgical risks of their smoking – despite the now substantial literature indicating that patients who stop smoking prior to their surgery experience better health outcomes. Patients who are advised of the benefits of quitting smoking prior to surgery are more likely to be motivated to quit in order optimizing their surgical outcomes.

The new tobacco-specific questions will be presented as well as information about how the questions will be used by health care providers at booking, preadmission, and admission to day surgery along with plans for evaluating the introduction of these questions. In addition, an overview of training and resources to support health care providers asking the new tobacco-specific questions will be provided. Patients can be referred to the provincial smoking cessation resources, such as QuitNow.ca, which now includes surgery-specific cessation resources, as well as HealthLink BC for free NRT.

The inclusion of tobacco-specific questions represents the unique role of Northern Health information systems in providing a systematic approach to support surgical patients to improve their outcomes and in the ongoing evaluation of tobacco reduction efforts.

Wednesday, November 5, 2014	
Session C: Women's Health **Room 204-206**	10:35am – 12:10

103

Vaginal Pessaries in Primary Health Care

Helen Bourque, Nurse Practitioner, Northern Health Authority, Aurora Health Clinic

In 2012, this Fee for Service office realized the need for non-surgical approaches in assisting women who were experiencing pelvic organ prolapse. In order to respond to patient's needs and symptoms, research regarding non-surgical measures was instituted.

A pessary sizing kit was purchased by the office for use in the office, and over the past 2 years, we have over 10 patients utilizing vaginal pessaries for pelvic organ prolapse. This initiative was multifaceted in that research occurred, collaborative, collegial discussions ensued in the office, and a process was created in order to assist patients with their symptoms. Two years later, lessons have been learned, and this group of providers is pleased to offer a non-surgical approach to pelvic organ prolapse in the office setting that was not previously available to this group of patients in this particular practice setting. This initiative was a result of patient's needs that were expressed in the office setting, a 12 month or longer waiting time of seeing a specialist, and the results of research, willingness of collaborative colleagues to support the initiative in the form of purchasing a sizing kit, and allowing providers the ability to explore this non-surgical option with patients.

115

Outcomes of Remote Midwifery Care in Fort Smith, Northwest Territories

Caitlin Frame, MSc, Bachelor of Midwifery (Candidate)
Dr. Patricia Janssen, PhD, Lesley Paulette, RM, Gisela Becker, RM, MA, Vicki Van Wagner, RM, PhD (candidate), Saraswathi Vedam, RM, FACNM, MSC, SciD(hc),Dr. Patricia Spittal, PhD

Objectives: This project examines the outcomes of primary maternity care in Fort Smith, where midwives have provided the only maternity care service since 2005. The objective is to compare perinatal outcomes at Fort Smith

(2005-2012) (n=300) with outcomes from 1) the Inuulitsivik Midwifery Program in northern Quebec (n=1388), and 2) the community of Hay River where women evacuate at 37 weeks to receive intrapartum care elsewhere (n=143). Approach: Using a retrospective cohort design, outcomes from Fort Smith that were compared to the two comparison groups include: transfer rates outside of the community for childbirth; maternal outcomes such as postpartum haemorrhage and severe perineal trauma; rates of intervention including induction and Caesarean sections; neonatal outcomes such as morbidity, mortality, Apgar scores, and admissions to NICU; and breastfeeding rates. Focus groups were held with women from Fort Smith who had used the midwifery program to understand their experiences of using the midwifery service and what it means to have access to community birth. Results: Forty five percent of women from Fort Smith delivered in the community with midwives. There were no statistically significant differences in the odds of 5-minute APGAR scores less than 7. The odds of 1-minute APGAR scores below 7 in Fort Smith were increased compared to the Hudson coast communities; however the rate was similar to those of newborns of women who reside in Hay River and delivered in Yellowknife. Two themes emerged from the focus groups: 1) the midwifery model of care in the community leads to positive experiences of maternity care, and 2) the benefits of and reasons for giving birth in the community. Discussion: These results support the return of childbirth to remote northern communities. This is the first study to look at maternal and newborn outcomes from a midwifery clinic in the Northwest Territories.

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Nutrition-Related Characteristics of Women with Breast Cancer Admitted to the BCCA Centre for the North

Lindsay Van der Meer, RD[1], Emilia Moulechkova, RD(t)[2,3], Laura Ledas, RD(t)[2], Courtenay Hopson, RD[3]
[1] BC Cancer Agency Centre for the North, [2]UBC Dietetics Program, Faculty of Land and Food Systems, [3]Northern Health

Purpose: to describe the nutrition parameters with implications for cancer survivorship of women with breast cancer (WBC) admitted to the BC Cancer Agency Centre for the North (BCCA CN).
Methods: a retrospective chart review of all (N = 92) WBC admitted to the BCCA CN during the 2013 calendar year was performed. The following information was collected from electronic and paper charts: age, height, weight (initial, most recent), Nutrition Screening Tool (NST) score, treatment (intention, type), and referral to a Registered Dietitian (RD).
Results: the majority of WBC referred to the BCCA CN was above 50 years of age (89.2%). Nearly all received treatment (98.9%) including surgery (93.5%), hormone therapy (70.7%), radiation therapy (53.3%), chemotherapy (35.9%), and/or targeted therapy (6.5%). Most women (91.3%) were treated adjuvantly. The majority (82.9%) of WBC were at low risk of malnutrition, whereas very few were at medium (15.9%) or high (1.2%) risk as identified by the NST. A minority (15.2%) of WBC were referred to see a RD. The majority of WBC were overweight (33.3%) or obese (40.9%) at the time of their new patient appointment. On average, WBC gained 0.1kg (SD=0.4) or 0.4% bodyweight (SD=0.5). At the time of their most recent weight there was an overall increase (4.9%) in the number of WBC above the healthy BMI range (38.2% overweight, 38.2% obese, total 76.4%).
Implications: consistent with the literature, the results of this study demonstrate that WBC are often above a healthy BMI range at diagnosis and gain weight post diagnosis. A minority of WBC are referred to a RD despite evidence that lifestyle and weight management interventions involving RDs can assist with weight loss and may improve breast cancer outcomes/reduce risk of chronic disease.

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The Safety of Rural Midwifery-Led Midwifery Services in BC: Findings from a Pilot Study

Dr. Jude Kornelsen

Background: There have been dramatic shifts in the provision of maternity services in small rural communities across British Columbia in the past ten years, coinciding with but not limited to the regulation of midwives. In BC we have two rural midwifery-led communities that provide care without local caesarean, the nearest caesarean section service in both instances being a ferry ride away. Although there is evidence to support highly functioning models of midwifery care with positive outcomes from the far north, the efficacy of models serving more heterogeneous communities that are less isolated has not been evaluated.

Methods: This population based outcomes study used catchment methodology to compare the outcomes of all women residents in midwifery-led service models to the outcomes of other service models in BC. The data was provided by Perinatal Services British Columbia for 2003 – 2012.
Results: Findings show that the midwifery-served populations have good outcomes (perinatal mortality was 4.6 per 1000 vs 8 per 1000 for rural services with generalist caesarean section backup), a lower rate of gestational age <37 weeks (43 per 1000 versus 68 per 1000 for rural services with generalist caesarean section backup) and low intervention rates (caesarean section rate was 22.9 versus 23.4 for rural services with generalist caesarean section back-up).
Conclusion: Emerging data supports further expansion of a midwifery-led model for rural communities in British Columbia with diverse population characteristics.

Thursday, November 6, 2014	
Session A: Changing Northern Healthcare **Room 101**	10:15am – 12:00

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Healthy Community Development – Northern Health's approach to building collaboration between the NH and community
Theresa Healy, Healthy Community Development – Aboriginal Communities, Northern Health

Northern Health's Healthy Community Development program has been working for several years to introduce a more upstream approach to health care service delivery by focusing on the capacity of community to identify, organize and impact local health priorities and work in partnership with Northern Health.
In many ways, this work has been supported by the fact NH's practitioners in addition to their professional associations, also play many different and valuable roles outside of their workplace in their home communities. This means they are well placed to act as a bridge, bringing the Health Authority's available resources and knowledge into the heart of the communities they call home with finely tuned understanding of how and where those resources will be best directed. As a result, concepts of community health, a population health approach and prevention / promotion ideas are accessible and achievable at the local community level.
In this presentation, participants will be introduced to a brief overview of the healthier community development principles and processes that are foundational to the work. However, the bulk of the presentation will be a "re-enactment" of a typical agenda designed to bring professionals, politicians, business, community activists and other stakeholders together in a space that enables collaborative and effective action. The presentation will provide an introduction to the useful exercises and tools designed to support the best of community knowledge to be married to professional skills and expertise. These exercises are readily replicable and can be adapted to local circumstances.
By the end of the presentation, delegates will have a better understanding of Northern Health's P4HC approach, as well as the action strategies developed and implemented to meet the objectives of this approach. The agenda resource package distributed to participants will also give them a "takeaway" to support planning their own interactive community sessions.

120
Prince George Primary Care Teams – Experiences from the field
Marcia Leiva, Lead Primary Health Care, Community Programs Integration, Northern Health

The first pillar of the NH Strategic Plan 2009-2015 is "Integrated Accessible health Services – Northern people will have access to integrated health services, built on a foundation of primary health care." Prince George is one of three Integrated Health Services prototype communities working towards this aim.
Establishing multidisciplinary teams working in collaboration with Primary Care Homes in the service of the patient is one of the key objectives of Integrated Accessible Health Services. In Prince George, Northern Health is

collaborating with the PG Divisions of Family Practice to test this new model of delivering services. Prince George is one of three communities testing new ways of delivering services.
In Prince George, eleven primary care homes (fee for service- family physician practices) have agreed to participate in testing this model with two Northern Health primary care teams. With the patient at the center, the teams include primary care providers, medical office assistants/primary care assistant, nurses, social workers, mental health clinicians, occupational therapist, physiotherapist and life skill support worker.
In this presentation you will have the opportunity to learn about the workflow and care pathways that are currently being tested in this new model, what the experience has been for the providers and clinical team in working in this new way, as well as what we have gleaned so far from the patient experience.

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THE PRACTICAL FUNCTIONALITY OF PROCESS MAPPING IN SYSTEM TRANFORMATION

Raquel Miles, Northern Health (PRIMARY CONTACT), Melanie Mogus, Northern Health, Julianna Ireland, Northern Health, Marna deSousa, Northern Health

Process mapping is a valuable tool that allows you to ask the questions about a process:

- How is it done?
- Who is responsible?
- What information is received and from where?
- What decisions need to be made?
- What is the output?
- Where are the next steps?

The purpose of process mapping is for *better understanding*. It involves the gathering and organizing of facts about the work and displaying them so that they can be questioned and improved by knowledgeable people. With Northern Health's strategic focus and commitment to 'integrated accessible health services' as goal posts, process mapping has emerged as a practical and functional tool to employ in guiding and capturing system transformation. Process mapping has been used extensively in the Omineca District in Mental Health and Addictions, Home and Community Care, Public Health, the Primary Care home and Acute Care. Drawing on the expertise of front line clinicians and staff, processes for service requests, appointment bookings, finance, charting, team communication and information sharing, assessments, registration and discharge planning have been mapped. These maps serve as a starting point to understand the direct relation and impact to patient care, visually and narratively identify gaps in the system and opportunities for improvement and establish and complete numerous quantitatively measured test cycles. The outcome is the creation of new processes which comprise the new and improved current state.
By linking these new processes to existing functional system maps which depict the organization at a broad level, we have been able to visualize the integration work in the context of the rest of the organization (data, organizational structure, strategies) which gives us the potential to create greater capabilities in analyzing and planning a change – a key component to ensuring the success of Northern Health's strategic pillar of **Integrated Accessible Health Services.**

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The Rapid Mobilization Process: Partnering to deliver in-home rapid access to care

Janice Paterson; Stella Ndunda

The Rapid Mobilization (RM) is a process that provides rapid access to assessment and clinical support to manage acute episodes for individuals identified in the Primary Care Home, Acute care and Community care services at patients/clients homes. RM is one initiative among many enabling Northern Health to achieve its mission of providing integrated accessible health services for northerners.
In this presentation, we share data collated from provider and program delivery sources to demonstrate how the program is progressing in achieving its goals of providing quick access to the right level of care in the right place, as well as the challenges experienced in implementing the new approach.

Thursday, November 6, 2014	
Session B: Creative Pathways for Person Centered Care	**Room 201-203** 10:15am – 12:00

135
Partnering to Create Culturally Safe Organizations
Victoria Carter, Lead, Aboriginal Health Engagement and Integration, Aboriginal Health, Northern Health

A team will share with you the work that has been done to improve person centered care by building cultural safety in the north. It will discuss the importance of commitment to cultural competency at all levels in the organization and how partnerships are essential. The key strategies in this work: the creation of new Vice President of Aboriginal Health position, partnerships with the First Nations Health Authority, the Northern Health (NH) uptake of the Provincial Health Services Authority Online Indigenous Cultural competency training, collaborations at the local level such as healthy community workshops, Aboriginal Health Improvement Committees, the Aboriginal Patient Liaison positions, knowledge translation, and using Aboriginal patient experience data to motivate change will be presented. A facilitated tabletop discussion will follow supporting identification of and actions on, your opportunities for building cultural safety within your sphere of influence.

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Decolonizing First Nations Status and Impacts on Health
Jessie King, PhD Candidate

First Nations Status identity and impacts on health are considered in this presentation. As a community, First Nations have their identity controlled by the Federal government through the Indian Act. This can have numerous implications for their health and well-being as a People. This research, currently in the data collection phase, will use Indigenized Grounded Theory to pinpoint First Nations definitions of identity and health to create theory on the link between the two. Identity and health are intricately linked and are defined differently within Western frameworks. What identity means and is to a First Nations person is different from the way in which mainstream society and the Government of Canada define it. This is due to the legal framework of eligibility that restricts who is and who is not an “Indian”. Health also holds a very different definition; whether it is the medical model’s absence of illness or a holistic model that is based upon maintaining balance between mental, physical, spiritual and emotional health. Primarily this research will be focused upon theorizing impacts on health for First Nations who are faced with Indian Act eligibility criteria to obtain (or maintain) Status identity. This presentation will reveal the struggle around eligibility criteria in obtaining Status and the potential impacts on health using a eudaimonic lens. Eudaimonia is a philosophy that states that happiness and health is based on an individual’s freedom to be who they were meant to be and live to their fullest potentials.

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Scanning for Silos: Creative Pathways to Partnerships and Wellness
Patricia Howard, Regional Aboriginal Coordinator, Blood Borne Pathogens Services, Northern Health

The purpose of this presentation is to provide insights into how environmental scans can be used to identify community needs and develop systems pathways. Northern Health’s Blood Borne Pathogens Team has implemented the use of pre-visit environmental scans to gain insight into the broader context of how HIV program integration occurs at the community level. Environmental scans are completed in each community with stakeholders, community members, health care staff, First Nations organizations and peers. Environmental scans are then coded for common themes that identify existing services and supports, identify gaps and challenges, and suggestions for potential solutions. This information is then wrapped in a quality improvement workshop presented in each community with the intended outcome of community led and driven partnerships that work towards integrated sustainable health solutions. This quality improvement initiative highlights the

interconnectedness between health care services and the community agencies that foster social cohesion and good health as healthy community partnerships are developed.
The primary objectives of the environmental scans are to:

1. Examine existing services and supports
2. Map existing services in communities
3. Identify gaps and challenges
4. Implement potential solutions

To date the results provide a review system of HIV care and care pathways to ensure all healthcare providers and community partners are supported and have a clearly articulated process as they access services for those living with and affected by HIV. In particular, key trends, such as stigma and the relationship between environmental factors that impact the community, the clients and their families have been identified along the pathway.
By the end of the presentation, participants will:

1. Understand how environmental scans are an effective quality improvement tool;
2. Recognize community engagement and relationship building are essential to program integration and partnerships;

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Creativity for Social Justice and Healing: Some empowering examples!
Si Transken, Phd, RSW, Associate Professor, School of Social Work / Gender Studies

For thirty years I have been utilizing various types of creativity (poetry, storytelling, art, and impromptu performance) to collect information and distribute information to grassroots community groups. Most recently I have been using ARTivsim to collect, share, translate and inspire knowledge from/ with vulnerable populations as part of the Vancouver Art Therapy Certification Program. For the purposes of this session I would like to speak to the following themes: Why use art based research? In which contexts does this mode of data collection work best? Which scholarly voices are most applicable to contexts here in the north? I will provide a hand out with a substantive bibliography. Examples I will discuss include my recent experiences of working/ learning with two First Nations community healing circles and with vulnerable groups of women (survival sex trade workers, homeless women, addicted women). A small 'art show' will be part of the backdrop of this presentation.

Thursday, November 6, 2014	
Session C: Changing Clinical Practice II **Room 204-206**	10:15am – 12:00

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Use of Single Fraction Radiotherapy in Complicated Versus Uncomplicated Bone Metastases Cases in BC for 2013
Kelsey Roden[1], Emily Yurkowski[1]
[1]BC Cancer Agency Centre for the North

Objectives
Evidence shows that the use of single fraction radiotherapy (SFRT) is as effective for treating uncomplicated bone metastases in a palliative setting as multiple fraction radiotherapy (MFRT). We sought to determine the rates of SFRT use treating uncomplicated versus complicated bone metastases in BC for three complication types.
Methods
All patients treated with radiation therapy for bone metastases in 2013 were reviewed. A total of 3200 treatments were analyzed according to presence of complication, complication type and fractions used. Complications were defined as pathological fracture, soft tissue involvement, and neurological compromise.
Results
A total of 3200 treatment courses were delivered to 1880 patients, of which 59.7% were SFRT. SFRT was used significantly more often in uncomplicated (79.4%) versus complicated (40.4%) cases ($p < 0.001$). SFRT was used

significantly less often ($p < 0.001$) in patients with pathological fractures (50.6%) versus those without (61.8%). SFRT was used significantly less often ($p < 0.001$) in patients with soft tissue (33.6%) versus those without (67.0%). SFRT was used significantly less often ($p < 0.001$) in patients with neurological compromise (25.9%) versus those without (68.5%).
Implications
SFRT use was more common in uncomplicated cases compared to complicated cases. The use of SFRT was lowest in bone metastases complicated by a soft tissue mass or a neurological compromise.

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Improvement of Radiation Oncology Therapy Completion Note: Qualitative Survey Analysis through Physician Reports

Dan Horvat, Collins R, Olson R., Klassen, T, Northern Partners in Care

Objectives
Northern Partners in Care (NPiC) and the BC Cancer Agency are working in collaboration to establish the effectiveness of a therapy completion note (TCN) within the clinical area of oncology. Through a multi-phase evaluation, NPiC aims at determining which aspects of the current TCN are ineffective, and through another phase establish a standardized TCN that can be used across disciplines.
Methods
A qualitative survey analysis was conducted with approximately 180 physicians. During phase one of the radiation oncology project data was collected from the BCCA CAIS system. A RT Completion Note (TCN) was printed for each patient that had completed some form of cancer treatment in the past 2 years. Each TCN was sent out with an evaluation and sessional form to the General Practitioner of the patient. To date we have received 110 completed evaluations. We are in the process of synthesizing that feedback with feedback we are obtaining from specialist physicians (oncology and non-oncology), GPs involved with developing electronic care plans for patients, the BC Cancer Agency more broadly, other Shared Care projects and a literature review. Once completed we will develop a revised TCN and re-evaluate it from the receiving GPs perspectives.
Results
Approximately half of the evaluations have been received and shown promising findings. Most physicians reported that within the current TCN responsibility of the physician was clearly indicated, along with a clear follow-up schedule. However in regards to potential side effects described in the TCN, about half suggested they were provided while the other half suggested they were not. In regards to contacting the oncologist similar results were found where about half of physicians stated it was provided while the other half disagreed. In regards to the transition of patient care most physicians stated that the current TCN was meeting those needs. Preliminary findings indicate the specific should be included in the standardized TCN. Around 50% stated that cancer treatment technique could be included within the new TCN. In regards to treatment dose 81 % stated it was not necessary to be included in the new TCN. 90 % of GP's stated that the common side effects to treatment should be stated within the TCN. 61 % also stated that the rare side effects should be addressed in the TCN as well. In regards to contact information for the oncologist 64 % reported it should be included in the new TCN. When asked about any additional information, some GP's responded with providing more follow up information.
Implications
The analysis conducted has revealed important findings in relation to establishing and completing a new TCN to maintain physician and specialist relations and improve patient care.

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Evaluation of a Screening Questionnaire to Identify Patients at Risk of Drug Therapy Problems in Community Pharmacies

Robert Pammett (Primary Investigator; Northern Health, University of British Columbia), David Blackburn (University of Saskatchewan), Kerry Mansell (University of Saskatchewan), Jeff Taylor (University of Saskatchewan), Derek Jorgenson (University of Saskatchewan)

Introduction: Suboptimal drug use is a major contributor to adverse patient outcomes in primary care. Considering their accessibility and frequent interactions with patients, community pharmacists may be well suited

to identifying patients who are at high risk of drug therapy problems (DTPs) and who may benefit from a comprehensive medication assessment.
Objective: To determine if a short screening tool can identify patients at risk for DTPs in a community pharmacy setting.
Methods: A 5 question self-administered screening tool was identified in the literature and adapted to reflect current practice in community pharmacy. Adults requesting a refill prescription from 3 different community pharmacies over 12 weeks completed the screening tool, and had a comprehensive medication assessment with a pharmacist. Information from the assessment was used to: (1) determine the ability of patients to correctly answer the screening tool questions and to classify themselves into the appropriate risk category (high or low risk); and (2) compare the number and severity of DTPs identified in each risk category.
Results: 49 patients completed the study. Most patients were able to answer the questions on the screening tool correctly. The level of agreement was very good (Kappa 0.91, $p<0.01$) between the overall patient determined risk category and pharmacist determined risk category. Patients identified as high risk (n=18) had a mean of 3.72 ($p<0.01$) more DTPs than low risk patients (n=31). All but one (94.4%) of the high risk patients had at least one Moderate or Severe DTP, while less than half (48.4%) of low risk patients had at least one Moderate or Severe DTP.
Conclusions: This screening tool is a reliable method for identifying patients in community pharmacies who have a large number of DTPs. Patients identified as high risk using this screening tool may be optimal targets for community pharmacy based medication assessments.

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Impact of a multi-pronged intervention to improve the use of single fraction radiotherapy for bone metastases across six centres

Robert Olson, Manpreet Tiwana, Helena Daudt, Kelsey Roden, Emily Yurkowski, Vince Lapointe, Wayne Beckham, Ross Halperin, Ivo Olivotto

Background: Extensive level 1 evidence demonstrates that single fraction (SF) radiotherapy (RT) for bone metastases is equally efficacious to more inconvenient and costly multiple fraction courses. Previous work had shown that the use of SFRT for bone metastases varied from 26% to 73% ($p<0.001$) between five cancer centres in BC, which provides 100% of the RT to the population.
Methods: Several province-wide interventions were implemented in 2012 to improve use of SFRT, including meeting with Radiation Oncology practice leaders, and province-wide presentations describing the practice variation by centre and physician. The utilization of SFRT for bone metastases from 2007-2011 was compared to utilization of SFRT in 2013, to assess the impact of the intervention.
Results: 16,898 courses of RT for bone metastases were delivered from 2007–2011 and 3,200 courses were delivered in 2013.The rates of SFRT use in 2007, 2008, 2009, 2010, 2011, and 2013 were 50.5%, 50.9%, 48.3%, 48.5%, 48.0%, and 59.7%, respectively ($p<0.001$). The individual centres' increased utilizations were: Centres A 26% to 32%, B 36% to 56%, C 39% to 57%, D 49% to 56%, and E 73% to 85.0%, but the variation in use of SFRT between centres persisted (range 32%-85%). Centre B, with the largest SFRT increase (20%) had additional rounds presentations on SFRT evidence, in addition to the program-wide interventions.
Discussion: This study demonstrated an increased utilization of SFRT for bone metastases, after a province-wide intervention on to increase the use of SFRT including dissemination of actual practice by centre and physician. The intervention appeared to reverse a trend to decreasing use of SFRT, and saved approximately half a million dollars in BC for 2013. This suggests that programmatic comparison and dissemination of quality indicators can lead to increased uptake of evidence-based practice.

Thursday, November 6, 2014	
Session D: Integrated Health Services **Room 208**	10:15am – 12:00

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Innovation regarding treatment of anxiety/depression in a fee for service office utilizing a collaborative model

Helen Bourque, Nurse Practitioner, Northern Health Authority, Aurora Health Clinic

This fee for service office which hosts 6 primary care providers has developed an innovative approach in assisting patients who are suffering with anxiety and/or depression. Once a diagnosis has been made, either the GP or the NP may initiate pharmacological treatment, but the patient will also be offered counselling services at the office utilizing the skills of the NP who has full access to the CBIS manual through the Ministry of Health. The NP provider has also had additional training in CBT techniques through CBT Canada. Over the course of 6 specific mental health appointments usually of 30 min in duration, the patient is taught various cognitive behavioral therapies in order to deal with their problems, and /or to support their goals. Patients are pleased to stay within the 'fee for service' home, and continue to receive treatment and are able to observe the collaborative model in the clinic setting. This integration of primary care providers has provided flexibility and responsiveness to patient needs in a timely fashion. At any time, if the provider (GP/NP) sees fit, a further psychiatric consult will be initiated, and/or further mental health services will be utilized. Patients have the opportunity to receive care that is seamless, timely, and appropriate.

A retrospective chart review of patients with diagnoses of anxiety/depression who have engaged in 'in house' counselling has resulted in an overall reduction of PHQ9/GAD7 scores and reduction in return visits for mental health reasons.

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"Community Evaluation: Developmental Screenings with Children 18 Months to 4 Years"

Joanna Pierce (UNBC), **Jenn Tkachuk (Northern Health, Children First),** Melanie Martin (Northern Health, Public Health Nursing), Lynn Barager (Northern Health, Dental Health program), Gail Mason (YMCA of Northern BC, Child Care Resource & Referral), Lianne Matsuo (Northern Health, Speech & Language Program)

The purpose of this research was to explore the use of developmental screenings with the 18 month to 4 year old population in Prince George, BC. To date there isn't a standardized process in British Columbia for screening child development after the age of 18 months, which is a concern due to the rising numbers of vulnerable children entering our school systems. In Prince George there are a number of children's services implementing screening for this age group, but at this time there is no consistency. A community evaluation was conducted using a semi-structured interview design to address the question "How are early childhood developmental screenings facilitated in Prince George, British Columbia, for children ages 18 months to 4 years?" Service providers were asked a number of questions related to their experiences using developmental screening tools. A thematic analysis was conducted revealing a broad inconsistency in how screenings are facilitated in Prince George. Recommendations included: developing consistent language around screenings; developing a standardized process for screenings; ensuring individuals have appropriate training to implement screening. Currently the Child, Youth and Family Network, a community table in Prince George made up of stakeholders involved with children, youth and families, is utilizing the recommendations of the evaluation as a tool to improve implementation of developmental screening in Prince George.

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Interpretive Practices towards Understanding Relational Continuity

Erin Wilson, UNBC

Continuity is a core value of primary care. With ongoing primary care reforms that emphasize access and inter-professional teams, the traditional mode of providing continuity, namely the physician-patient dyad, has been altered. Current research in the area of continuity has predominantly focused on research methods that isolate interrelated variables, or rely on anonymous units of aggregated data. Further, as clinicians, policy makers, researchers and the public increasingly realize the pendulum has swung too far towards protocol-driven and condition-focused care, there is a need for increased emphasis and attention on the role of expert clinical judgment to provide personalized medicine.

This presentation will review a research method of interpretive practices with a hermeneutic lens to examine the patient-provider relationship in a way that reflects the influence of context and the complexity of patient

circumstances. Patient-provider encounters that promote continuity can be viewed as practices that providers and patients undertake to form, negotiate and make sense of relationships with one another in a primary care setting. Interpreting everyday practices that patients and different types of providers engage in to negotiate care will provide a significant contribution towards understanding how patients feel "known", and how therapeutic relationships are established, maintained and nurtured over time in the context of team-based care.

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The Northern and Rural Cohort: A Partnership to Increase Physiotherapists and Physiotherapy Services in Northern and Rural BC

*__Robin K Roots__[1], Susan Murphy [1], Anne Worthington[2]
[1]Dep't of Physical Therapy, University of British Columbia (UBC), [2]Evaluation Studies Unit, Faculty of Medicine, UBC. *presenting author robin.roots@ubc.ca

Background: It is well known that health care providers who train in rural locations are more likely to work in a rural community in the future. As one strategy to address recruitment and retention of physiotherapists in northern and rural BC, the provincial government funded a clinical education program to provide physiotherapy students clinical placement opportunities in northern and rural communities.
Intervention: In partnership with UNBC, and with the support of Northern Health (NH), the UBC Masters of Physical Therapy Program established a Northern and Rural Cohort (NRC) in September 2012 and admitted 16 students in its first year. Building on lessons learned from the UBC Northern Medical Program, our admissions process uses the Rural and Remote Suitability Score and essay questions to select students with attributes for rural practice. NRC students complete four (out of 6) placements in northern or rural communities, and one academic course at UNBC as a pilot of academic distribution.
Results: An evaluation of the first cohort has shown that NRC students have unique characteristics: they are more likely to have a rural background, be married or common-law, and have higher levels of financial stress. NRC students performed equally well compared to non-NRC students on performance assessments, and ratings of clinical placement experiences were comparable across urban, rural, and northern locations. Collaborating with NH we developed 10 new clinical education sites including programs in primary health care and aboriginal health, thereby increasing access to physiotherapy services.
Outcome: The first NRC will graduate in November 2014 so it is premature to speculate on the influence the NRC program has on career choice/location; however two students have accepted positions in remote locations where long-standing vacancies existed. The program evaluation will study the first four cohorts and monitor effects on recruitment and retention of physiotherapists to northern BC.

Friday, November 7, 2014	
Session A: Environmental and Public Health **Room 101**	10:00am – 11:45

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Northern Health Survey on Private Water Systems

Angela Wheeler, Northern Health

Current legislation and service delivery models ensure the provision of protection services (monitoring, auditing, training and education) from Health Authorities to community drinking water systems and the people they serve. People who obtain their drinking water from private single connection sources receive little in way of support around safe drinking water. Yet, drinking water is a vital component to the environments we all live in. Northern Health, Environmental Health Officers are trying to close some of the service gaps as we move upstream to reduce preventable illnesses. One such initiative is advocating regular bacteriological sampling of private water systems. Since we have limited interaction with private water systems and their users, we conducted a survey to gain insight into this sector of rural Northern Health communities.

A telephone-based survey was conducted in the fall of 2013 in rural locations throughout Northern Health. Questions were designed to obtain information on demographics, knowledge of systems, source, treatment (if any), and to learn current sampling behaviours and what the perceived barriers to sampling are. Respondents were identified based on area codes and selected randomly from phone directories. 166 responses were obtained.
The data obtained will be used to identify knowledge gaps in rural areas and the barriers to private water sampling. This in turn will be used to craft an effective marketing campaign as we advocate for private water sampling. Our research will serve to foster the development of services as we work towards our goal of building confidence and safety in rural private drinking water systems.

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Engaging family doctors in upstream public health initiatives in northeast British Columbia: Opportunities and challenges

Davina Banner, Charl Badenhorst, Horvat, D., Chapman, R., Kandola, D.,
Klassen, T. & Manahan, C.

Context: Growing chronic disease, persistent health disparities and a rapidly ageing population are creating significant challenges for Canadian healthcare services. Such challenges are heightened in rural and northern communities across Canada where health services across sparse geographical regions struggle to cope with serious health human resource challenges, highest levels of chronic disease, and poorest population health. Engaging physicians in public health initiatives provides an important opportunity to develop new models of care that can strengthen the provision of primary health care and improve health outcomes.
Objectives: To understand the opportunities and challenges of engaging physicians in upstream public health initiatives further, we undertook a qualitative study guided by the question 'How can family doctors be engaged in upstream public health initiatives?'
Design/sample: A qualitative descriptive study was undertaken with a purposive sample of 10 family physicians from northeast British Columbia, a rural region that has significant industrial growth and health human resource challenges. Sampling was undertaken to ensure sufficient variation in key community, physician and practice variables.
Findings: The analysis of the data informed the development of three major themes, these including the challenges of working in a stressed health care system, identifying community priorities, and fostering connectivity. The participants highlighted the challenges of working in a stressed healthcare system, where workforce challenges make it difficult for physicians to focus on upstream preventative practices. Further integration of public health and primary care services was seen as an important mechanism to help meet the health needs of the region. These included opportunities for greater sharing of information, collaboration to support the development of targeted preventative services, as well as developing processes that foster connectivity, including shared education and information exchange
Conclusion: The study has highlighted some important challenges to delivering upstream public health services, as well as opportunities for collaboration.

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Community Health Information Portal 2014

James Haggerstone, Health Information Analysis, Northern Health

We want to work with communities and other partners to identify and act on key issues and we want to support northerners to live well and to be free from injury and illness.
To do this we must first have a respectful understanding of the northern BC landscape: the communities; the places; the industries; the people; the diversity; the challenges; the opportunities for partnerships and innovation; and, most importantly, the underlying Determinants of Health.
With a focus on rurality and the diversity of northern communities, this presentation will feature the publicly available Community Health Information Portal (CHIP) as a tool for students, researchers and decision makers.
chip.northernhealth.ca

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The Importance of Including Socio-Economical Health Impact Assessments as Part of Current Environmental Impact Studies in BC

Badenhorst CJ, Mulroy P, Thibault G, Healy T.

Background

Socio-economic impacts (SEI) of industrial 'Boom and Bust' cycles were recognized in the mid 1800's, yet the lessons learned from the past have had limited impact when it comes to preparing communities for significant industrial development(s). In British Columbia (BC), legislation and policies ensure comprehensive environmental assessments (EA). However, comprehensive SEI assessments don't form part of standard EA methodologies.

Motivation

BC has experienced significant industrial development, particularly in the oil and gas industry with 30,000 wells drilled in the northeast (NE), within a relatively small geographic area. New technologies have resulted in another 10,000 proposed wells. BC investments for Liquefied Natural Gas (LNG) processing plants, ports and pipeline development are estimated as billions of dollars resulting in significant growth in many BC communities. In light of this, Northern Health and the Health Officers Council of BC (HOC) hosted a workshop on October 9, 2013: "Socio-economic impacts of 'Boom and Bust' cycles on Communities: Can these cycles be better managed in our current economy?"

Aim

Discuss future public health (PH) strategies, legislation and policies for development and implementation of comprehensive SEI assessments in addition to EAs.

Objectives

Bring together health, government, academic, industry, and community representatives to discuss phases of industry development, planning and assessment processes, and impacts in order to strategize about how to maximize the benefits and limit adverse SEI impacts of industrial development.

Results

The themes and outcomes focused on how impacts can be better managed through improving collaboration and planning between all partners focusing on community sustainability, applying 'upstream' thinking, and PH philosophies to improve population health and economic sustainability.

Recommendations

That HOC develop and implement strategies, legislation, and policies to 'trigger' comprehensive SEI assessment along with EA.

Friday, November 7, 2014	
Session B: Considerations for Health Planning **Room 201-203**	10:00am – 11:45

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Personalized medicine includes patient engagement and empowerment

Yaron Sidney Butterfield

At the BC Cancer Agency's Genome Sciences Centre, we are analyzing the tumour and normal DNA make up of selected patients in order to determine treatment modalities specific to that patient. This is the genomic aspect of doing what we can to cure cancer or help in extending survivorship and limiting unnecessary negative drug interactions. As a long term survivor of GBM, one of the most devastating forms of brain cancer, I have experienced firsthand the negative and positive side effects of treatment, both biologically and psychologically. As a co-chair of the Patient and Family Advisory Committee (PFAC, for brain tumour patients/families), we discuss programs and initiatives for the benefit of the brain tumour community. One such program we initiated was the Patient Navigator where newly diagnosed brain cancer patients can meet long term survivors. I and another survivor meet the GBM patients undergoing treatment, answer questions that they might have and provide

knowledge through learning about our experiences and how we tackled the cancer experience. I have continued in this volunteer role for two years now and seek to empower the patient to take control of their healing. As a researcher, I often summarize recent discoveries that hold promise. This program brings another tool per se to the patient's recovery kit. One of the biggest benefits of this program for patients is the sense of hope and positivity, often difficult to obtain without meeting a person that has survived.
I am a strong believer that in order for us to make impacts in the lives of people diagnosed with devastating diseases, we need to consider the wholeness of the patient- physical, emotional and spiritual and empower the patient to feel as having a role in treatment. In order to open up the Patient Navigator program to a larger range, i.e. for patients that are farther away, potentially a live web based approached could work. There are many avenues yet to be explored.

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Where do we locate ourselves: Aging and Concerns for Lesbian, Gay, Bisexual and Transgender (LGBT) Seniors

Julius Okpodi (PhD Candidate)
Affiliations: University of Northern British Columbia

Background: The world is aging, many researchers and practitioners have become interested in the aged, the aging process, and the concerns of seniors. However, there is a heterosexual assumption in all these studies that neglects to consider the identity and belongingness of homosexual senior population. LGBT seniors share with all seniors the same goal of living with comfort and dignity in their last stages of life. As they face changes in health, capability and social circumstances, the need for social and healthcare services, community and institutional care, and senior housing will grow. The objective of my research is to give voice to the subjective experiences of LGBT seniors by gaining rich and deep understanding of the challenges faced in accessing housing services.
Methodology: A qualitative approach of hermeneutic phenomenology was used to collect and document the findings.Based on this review, hermeneutic phenomenology will be appropriate in facil*it*ating an in-depth exploration into the essences and meanings attributed to housing services for LGBT seniors. The approach also provides way of understanding a phenomenological question of *being-in-the-world* of the text, and in this case, *being-in-the-world* of LGBT seniors who are challenged by housing services.
Implication for Policy and Practice: The findings developed for this study will allow the understanding of sexual minority seniors and the need for the field of gerontology to increase research on this population. Furthermore, the findings from my research will be used to generate evidence for stakeholders and academics on the relative contribution to the aging process. Moreover, this research is expected to help seniors across Canada to get the required support—from professionals.

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Can the concept of "locally grown" help food insecurity in Northern British Columbia?

Rohitha Fernando, MPH FIH CNM, Support Services Manager North West HSDA East Cluster Northern Health Authority. PhD Student, College of Health Sciences, Trident University, CA USA

Objective
To find documented evidence for locally grown food as a solution to food insecurity for Northern, Rural and Aboriginal population in Northern British Columbia.
Study design and method
Literature review with recent, relevant and peer reviewed work published in professional journals.
Discussion
The concept of buying local revolves around perceptions, availability, nutrition and quality.
Northern, Rural and Aboriginal people consider food that is harvested from local areas and prepared using procedures that have been passed down through generations as country traditional food for both spiritual and physical health.
Consumers' attitudes towards a product could be heavily influenced by communication. While private sector manipulates credence attributed to locally grown products for a firm's marketing communication strategies, public agencies and non-profit organizations can learn from the distinction between direct and indirect effects of such credence attributes.

Dubbed as Canadian "bible" of nutrition, with some 24 million copies distributed nationwide, Canada Food Guide provides nutritional advice to age and gender, while providing more specificity on suitable serving sizes. Evolved with evidence based knowledge for nutrient standards and prevention of chronic disease, Canada Food Guide encourages intake of wide variety of food. Both business and social interest were vested in Canada Food Guide. Food insecurity is an important public health issue for Northern, Rural and Aboriginal populations.
Concerns about nutritional quality, food safety, environmental impact, and local economic loss associated with buying food from far-flung places have prompted the consideration of locally grown food. Such policies should be amply supported by global food quality assurance systems such as HACCP. Unfortunately HACCP has been developed in non-Aboriginal contexts.
Conclusion
None of the attributes; credence perceptions, nutritional aspect or the perceived quality of locally grown food is too far from providing sustainable solution to food insecurity in Northern, Rural and Aboriginal populations.

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Inter-hospital transfer for cardiac revascularization: the experience at a rural-urban teaching hospital in northern British Columbia

Daman Kandola, BHSc., MSc., Shubair, M.M., BSc., MSc., Ph.D, Hadi, H. MBChB MRCP CESR, Banner-Lukaris, D., RN, Ph.D , Harris R.L. BSc., Ph.D

Context: Canada's vast geography makes it challenging to deliver healthcare services on a uniform basis. Larger, urban centres are often equipped with advanced technology and specialized services in stark contrast to Canada's rural regions where healthcare services are limited and patients are often faced with having to travel for care.
Aims: To explore access to percutaneous coronary intervention (PCI) in a cohort of cardiac patients at a rural-urban teaching hospital in northern British Columbia without an on-site cardiac catheterization facility. Specifically; 1) whether time delay to PCI is associated with higher adverse outcomes (death, re-infarction, heart failure, stroke) in unstable angina (UA), non-ST Elevation Myocardial Infarction (NSTEMI) and ST Elevation Myocardial Infarction (STEMI) groups within 30-days and 1-year of hospital admission and 2) whether higher risk patients, according to the Global Registry of Acute Coronary Events (GRACE) score, receive diagnostic catherization and/or PCI faster in all three groups.
Methods and Results: Retrospective reviews of 265 medical charts, of patients presenting to the University Hospital of Northern BC with a diagnosis of UA, NSTEMI and STEMI, revealed high prevalence of cardiovascular risk factors such as hypertension and dyslipidemia. On average, STEMI patients were ~2.5 years younger than NSTEMI or UA patients. Furthermore, males comprised >50% of patients in each diagnostic category. Average times-to-PCI across the three categories was 5.9 days, greater than both the recommended treatment and provincial guidelines. Quantitative analysis of the apparent association between adverse outcomes and times-to-PCI was not performed due to inadequate sample size. Pain to needle time was not examined as it was beyond the scope of this study.
Conclusion: Results indicate, currently, a 'risk averse' strategy for patient transfer is being employed. Our data provide valuable feedback for cardiac services in this region and offer a basis for further longitudinal investigation of this topic.

Friday, November 7, 2014	
Session C: Population Health II **Room 204-206**	10:00am – 11:45

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Kids Helping Kids-Healthy is Happy

Sue MacDonald[1,2] Donncha O'Callaghan[,3], Cindy Smith[2], Sarah Brown[4] and Glenda Newsted[4].
[1] Action Schools! BC, [2]School District 57, Prince George, BC [3]Immaculate Conception School, Prince George. BC. [4] City of Prince George, BC

Objective: To increase levels of physical activity, food knowledge and sense of community in high schools and elementary schools while utilizing a student led tri-mentorship model.
Methods: High school leadership students are trained in active living and healthy eating using a "train the trainer" model. The high school students then facilitate a day of training for elementary leadership students with active team building opportunities interspersed. Elementary students are encouraged to reflect how they can best share ideas in their individual schools. A former Olympian assists in the development of an individual school pledge and with the support of Action Schools! BC, each school is presented with materials that they can begin using immediately. At a celebration event several months later, students network to gain ideas while sharing their own school's success.
Results: Teachers acknowledged a markedly higher level of activity in their schools while all leadership students discovered how valuable and exciting it was to be a central factor in the visible changes.
Conclusion: Healthy is Happy has led to increased physical activity and healthier choices in all schools while maximizing opportunities for student engagement. While all schools received identical training, personalizing for their own schools led to greater student involvement and program success. Healthy is Happy!

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Healthy Eating and Active Living in the North: Examining the Man's Perspective

Steven T. Johnson[1], **Paul Sharp**[2] (Presenting author), Kerensa Medhurst[3], Theresa Healy[4], Cherisse Seaton[2], Margaret Jones-Bricker[3,] Sonia Lamont[5], Joan Bottoroff[2]

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2. Institute for Healthy Living and Chronic Disease Prevention, University of British Columbia Okanagan, Kelowna, British Columbia, Canada
3. Canadian Cancer Society, Prince George, British Columbia, Canada
4. Northern Health, Department of Population Health, Prince George, British Columbia, Canada
5. British Columbia Cancer Agency, Vancouver, British Columbia, Canada

Background: Little is known about best practices for the promotion of healthy eating and active living among men living in northern British Columbia.
Aim: To determine barriers and facilitators for being physically active and eating healthy and strategies for supporting these lifestyle behaviours.
Methods: Using purposeful sampling, men were recruited through advertisements in Prince George and surrounding communities. An honorarium was provided. Two focus groups were held where structured questions were used to guide the consultation process. All sessions were recorded and transcribed. Thematic analysis was employed to organize and describe emerging themes.
Findings: Twenty-one men from northern workplaces participated (age range 23-73; 80% Caucasian; 52% income below $80,000/year; 52% with trade certification or university degree; range of hours worked in previous 7 days 0-126). Barriers for healthy eating included lack of choice/limited availability and cost. Lack of time, bad weather, poor access and lack of energy were main barriers for physical activity. Facilitators for healthy eating included planning, social support and awareness of healthy choices through education. Time management, social support and openness towards new type of activities were viewed as facilitators to being active. Participants also offered insights into how the workplace could be used to facilitate healthy living. Overall, living a healthy lifestyle was viewed as important for maintaining work related health, as a means to keep up with the kids and for relieving stress.
Interpretation: For these preliminary results, men described that maintaining a healthy lifestyle while living in the North poses numerous challenges but can be accomplished through specific lifestyle related strategies. Supporting healthy eating and active living for men must consider challenges posed due to the amount of time spent in the workplace. The workplace is viewed as an important conduit to support healthy eating and active living behaviours.

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How behaviours and expectations shape experience: Youth, parents and competitive sport

Alice Muirhead, MSc. (cand.) and Dr. Shannon Wagner (MSc. supervisor)

Sport is an important part of growing up -- physically, mentally, and emotionally -- for many children and adolescents, and parents have an important influence on their children's sport experiences. The objective of this research is to explore how the expectations, goals, and behaviours of parents influence the experience of competitive sport for athletes aged 13 to 17. The major hypothesis is that parents who set process, rather than outcome expectations and goals, and who demonstrate supportive behaviours will have children who are more likely to enjoy and plan to continue participating in sport. The sample for this study will be selected using a convenience sampling method, found through personal sport contacts. The sample will consist of 100 female and male parents and 100 athletes from each alpine ski racing and hockey. Data collection for this study consists of four online surveys, one for each parent of skiers or hockey players, and one for each hockey player or alpine ski racer. The surveys are designed to measure the following parent variables: directive behaviour, praise and understanding behaviour, active involvement behaviour, expectations, verbal encouragement, unconditional praise, high goals, lack of goals, effort goals, and the impact they have on adolescent sport experience and intention to continue with sport. The athlete surveys will explore the same variables by asking athletes what they perceive their parent's expectations, goals, and behaviours to be, and what they would prefer their parents to expect or do. It is hoped that the results of this project will guide coaches, parents, and sport organizations to create sport experiences that encourage children to view sport as a lifelong endeavour, regardless of the actual or potential performance outcomes.

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Arts of Immersion: Promoting Understanding about First Nations' Health and Well-Being in Northern Medical Education

Kendra Mitchell-Foster, S de Leeuw, C Law, JN Reid

Introduction: First Nations peoples in British Columbia, as globally, bear disproportionate burdens of ill-health. Few Indigenous people enter medical education, and integrating understandings about Indigenous peoples, communities, and cultures into medical education remains a challenge.
Methods: Second-year medical students co-facilitated with researchers a creative arts-focused immersion education experience called Art Days where Indigenous community members from the Nak'adzli First Nation first created art and then reflected on the connections between creative expression and health. Themes were identified through participant survey data and reflections, as well as student reflections.
Results: Indigenous participants identified connections between creative expression and healing: arts as rooted to place, culture and cultural revival, emotional and spiritual healing, community-building and preserving Indigenous ways of knowing and being. Undergraduate medical student reflections revealed the themes of *cultural safety*, *theoretical-experiential knowledge gaps*, and *othering*.
Discussion: Challenging assumptions held by medical students about First Nations and Indigenous peoples and communities related to conceptions of health and well-being, stereotyping, applicability/transferability of clinical practice, and ways of being, knowing, and goal-setting.
Conclusions: Medical humanities and creative arts have good potential to broaden medical education. Art production in community especially holds potential to integrate student critical self-reflection and a focus on empathy and cultural safety.

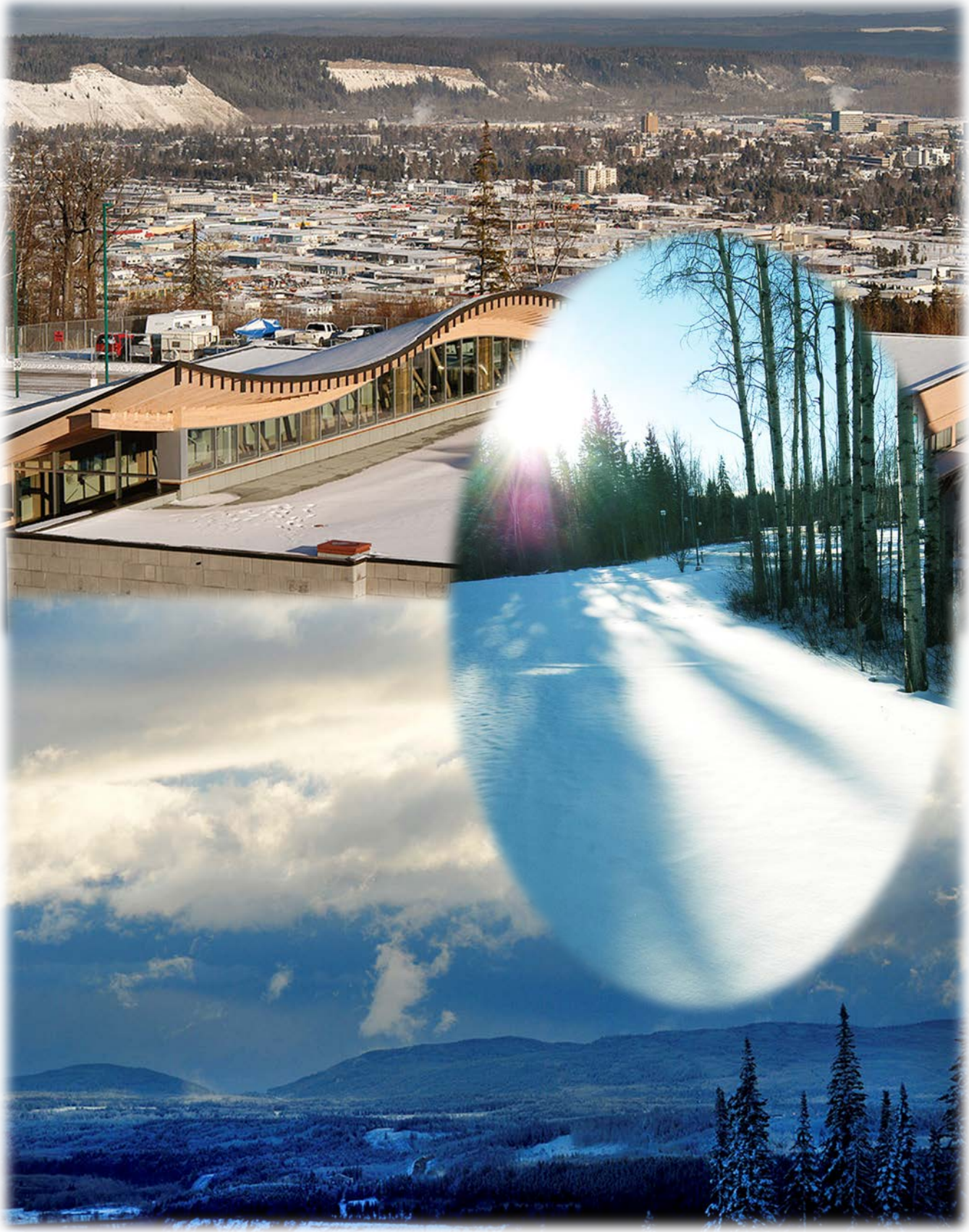

Photo courtesy of UNBC Communications

Conference Evaluation

Conference Objectives

- Showcase Northern BC research, evaluation and quality improvement projects;
- Profile advances in how partnerships contribute to knowledge generation which can improve health;
- Support purposeful networking for established and emerging partnerships;
- Enhance attendees' research, evaluation and quality improvement knowledge and skills.

Please rate the conference overall on the following scale (*circle the appropriate response)*:

Poor	Fair	Good	Very Good	Excellent
1	2	3	4	5

General Conference

Please circle the number that reflects your level of agreement with each statement below:

	Strongly disagree	Disagree	Undecided	Agree	Strongly agree
The conference learning/objectives were met	1	2	3	4	5
I learned about a research/ evaluation/quality improvement project that could inform my work	1	2	3	4	5
The conference was a valuable opportunity to network, make or strengthen existing contacts	1	2	3	4	5
I have gained new knowledge to build or enhance health policy, research or quality improvement partnerships	1	2	3	4	5
I have a better understanding of the resources that exist to support research in Northern BC	1	2	3	4	5
I believe that I gained high value for my time spent at this conference	1	2	3	4	5
Overall the conference was well organized	1	2	3	4	5

What could have been done to improve the conference?

Conference Sessions

Please rate the conference sessions on the following scale (*circle the appropriate response)*:

	Poor	Below Average	Average	Above Average	Excellent
Keynote Speaker: Gina Browne, *Person-Centred Health Care Works!.... and Saves Money!*	1	2	3	4	5
November 5 Concurrent Sessions *(Themes: Partnerships and Collaboration, Changing Clinical Practice I, Women's Health)* **(Circle the session you attended)**	1	2	3	4	5
November 6 Concurrent Sessions *(Themes: Changing Northern Healthcare, Creative Pathways for Person Centred Care, Changing Clinical Practice II, Integrated Health Services)* **(Circle the session you attended)**	1	2	3	4	5
November 7 Concurrent Sessions *(Themes: Environmental and Public Health, Considerations for Health Planning, Population Health II)* **(Circle the session you attended)**	1	2	3	4	5
Plenary Session: *Bev Holmes & Colleen McGavin, "Patient Engagement in Health Care: How can Research Help us Get It Right?"*	1	2	3	4	5
Rapid Fire Poster Presentation	1	2	3	4	5
Poster Viewing/Reception	1	2	3	4	5
Breakfast Tables	1	2	3	4	5
November 5 Workshop *(Gina Browne, Trevor Hancock, Lara Lise Barker, Raquel Miles)* **(Circle the workshop you attended)**	1	2	3	4	5
November 6 Workshop *(Colleen McGavin, Jude Kornelsen, James Wilton, Stephanie Powell-Hellyer & Karim Saleh)* **(Circle the workshop you attended)**	1	2	3	4	5
Panel Session: November 7 – *"Healthy Communities through Patient Engagement"*	1	2	3	4	5
COMMENTS about any of the sessions above:					
Is there anything you plan to do differently because of having attended this conference?					
What was the most valuable part of the conference for you? **(List the sessions, discussions, presentations etc. that were especially beneficial to you)**					
Do you have any suggestions for future conference topics:					
Do you feel there was <u>any</u> industry bias in any of the presentations? **Yes No**					

If you would be interested in participating on an Advisory Group or Planning Committee for Research Days 2013, let us know! Please contact idc@northernhealth.ca

THANK YOU FOR YOUR FEEDBACK

Please drop off your evaluation form at the registration table.