

Findings: Overall, the findings suggest that the NCMS has a positive effect on annual hours worked on the farm, with a 4–5% decrease in the likelihood of not working and a 5% increase in the likelihood of off-farm labor force participation. When stratified by individual characteristics, the effects on labor supply are similar for males and females, while statistically significantly different for older, those older than 35 years of age, and poorer, those households with per capita income below the median level in China, individuals.

Interpretation: Studies concerning the effects of public health insurance on labor supply in developing countries remain limited. The findings of this study provide important insights into how public health insurance programs, like the NMCS, may affect patterns of labor supply among rural residents, and can help policy-makers improve health policies aimed to reduce the number of uninsured farmers while maintaining high levels of labor supply and productivity as well as health status among the most vulnerable of populations.

Source of Funding: None.

Abstract #: 2.027_HHR

A Qualitative Approach to Evaluating the Global Barriers of International Emergency Medicine Development

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Background: The ACEP International Ambassador Program was developed as a venue for international experts to provide current status and progress of Emergency Medicine (EM) in their assigned countries. An annual one-day conference was created to convene ambassadors and allow for collaboration to reach the common interest of advancing emergency care. Our objective was to analyze the major perceived barriers for the evolution of our specialty.

Methods: Open-ended interviews conducted during the program's annual conference were collated from 2013–2015. Ambassadors (N=75) were divided into focus groups. Interviews were centered on themes: barriers by stage of EM development; local, regional, and international needs for EM development; and barriers and needs of International EM education. Data collection obtained by real-time scribes and grouped into key findings. An inductive approach was used to identify barriers for the evolution of EM abroad.

Findings: Ambassadors represented 83 countries (almost 50% of the world's nations). The definition of EM is very country specific. Identifying local stakeholders that could advocate for EM can be difficult. Even though the motivations of local governments are difficult to recognize at times, the involvement of Ministers of Health, public officials, and local leaders are an essential part in advancing the specialty. Furthermore, international organizations could provide quality control for the development of EM through a process of merit. A heterogeneous curriculum and lack of knowledge of EM as a specialty has been a major challenge for residency

programs. Centralizing educational resources can reduce duplication of efforts and would benefit educational processes for EM residency programs and health personnel.

Interpretation: International Emergency Medicine remains underdeveloped. No clear definition of EM as a specialty exists. The scope of practice of EM abroad is still not widely recognized, which further increases the difficulty of its evolution. The indispensable expansion of EM will be exponential with the support of regional leaders to form a unique identity of the specialty. Leaders play a vital role in standardization and communication, while serving as catalysts in resolving shared concerns. It is important to attempt to professionalize IEM education. With the support from ACEP and IFEM, initial steps to professionalize IEM education would include course maps with milestones and guide for a core curriculum.

Source of Funding: None.

Abstract #: 2.028_HHR

State of Emergency Medicine Residencies in Colombia

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Background: Emergency medicine is in different stages of development around the world. Colombia has made significant strides in the development of emergency medicine in the last two decades and recognized it as a medical specialty in 2005. The country now has seven emergency medicine residency programs, three in the capital city of Bogota, two in Medellin, one in Manizales, and one in Cali. The seven residency programs are in different stages of maturity, with the oldest founded 20 years ago and two founded in the last two years. The goal of this study was to characterize this seven residency programs.

Methods: Semi-structured interviews were conducted with faculty and residents from all the existing programs in 2013 and 2016. Topics included program characteristics and curricula.

Findings: Colombian emergency medicine residency programs last three years, except for one that is four years. Programs accept 3–10 applicants every year. Only one program has free tuition and the rest charge a fee to the resident. The number of emergency medicine faculty ranges from 2–15. Emergency medicine rotation requirements range from 11% to 33% of total clinical time. One program does not have a pediatric rotation. The other programs require one to two months of pediatrics or pediatric emergency medicine. Critical care requirements range from 4 to 7 months. Other common rotations include anesthesia, general surgery, internal medicine, obstetrics, gynecology, orthopedics, ophthalmology, radiology, toxicology, psychiatry, neurology, cardiology, pulmonology, and trauma. All programs offer 4–6 hours of protected didactic time each week. Some programs require ACLS, PALS and ATLS, with some programs providing these trainings in house or subsidizing the cost. A majority of programs require one research project for graduation. Resident evaluations consist of written tests and oral exams several times per year. Point-of-care ultrasound training is provided in four of the seven programs.

Interpretation: As emergency medicine continues to develop in Colombia, more residency programs are expected to emerge with a focus on standardization of training across the country. Faculty development and sustainability of academic pursuits will be critically important. In the long-term, the specialty will need to move towards certifying board exams and professional development through a national EM organization.

Source of Funding: None.

Abstract #: 2.029_HHR

The PIERS on the Move mobile health application

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Program/Project Purpose: To develop a simple decision aid for triage and treatment of women with hypertensive disorders of pregnancy (HDP) in low-resourced settings that can be sustainably implemented through public/private partnership.

Structure/Method/Design: The PIERS on the Move app uses a simple graphical user interface to assist the health care worker user with triage and treatment decisions based on validated clinical risk assessment models that identify women with a suspected hypertensive disorder of pregnancy at greatest risk of developing severe adverse maternal complications, such as eclamptic seizures or antepartum haemorrhage, within 48 hours.

Outcome & Evaluation: From 2012 - present, this app has been evaluated for usability and feasibility for large-scale implementation at primary health care level in a large multicounty cluster RCT, the Community Level Interventions for Pre-eclampsia trial (NCT01911494). During the pilot trial phase 8370 women were cared for using the app and 302 triage or treatment decisions were made. The definitive trial phase is expected to conclude in December 2017 and will establish impact of task-shifting antenatal care to community based health workers using the PIERS on the Move app on combined maternal and perinatal mortality or severe morbidity.

Going Forward: As the CLIP trial concludes, significant additional work will be required to ensure sustainability of the program through integrate into a health system. In order to transition from the context of a clinical trial to a sustainable scale-up, we have established an industry partner to design a commercial product based on our app. Through the CLIP trial process evaluation, we will identify the policy maker and end-user needs and requirements for designing a sustainable product. This will likely include expansion of the scope of the app beyond the HDP, depending on the local health system needs. A quick and effective method of iteratively testing and refining updates to the application in response to these policymaker and end-user needs will be required to maintain certainty of effectiveness as we transition from health services research to scale.

Source of Funding: Saving Lives at Birth (Grand Challenges Canada); Bill and Melinda Gates Foundation.

Abstract #: 2.030_HHR

Assessing the Impact of Standardized Educational Curriculum Modules on Medical Interns' Preparedness for Independent Practice in Botswana

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Program/Project Purpose: Currently, there is no standardized internship educational curriculum in Botswana. Medical school graduates participate in one year of internship training, after which they are assigned to practice independently as medical doctors. Challenges to training in this setting include variability in medical school backgrounds of interns and in clinical resources and supervision across eight internship sites. This project seeks to address these issues through the implementation of standardized educational curriculum modules at internship sites across Botswana.

Structure/Method/Design: Following a needs assessment using structured interviews of 14 medical interns, we developed a process for generating over 100 content-hours of curriculum materials in internal medicine. The curriculum content was developed by physicians with experience working in the Botswana healthcare context and peer-reviewed by five "lead editors." An implementation pilot currently underway is nested within a national prospective cohort study of medical interns, using pilot-site interns as the intervention group and interns at other sites as the control group.

Outcome & Evaluation: Evaluation of the curriculum is being conducted using the W.K. Kellogg Foundation Outcomes Logic Model. Basic outputs include the curriculum format/content and intern satisfaction, as assessed by questionnaire at the completion of training. Outcome and impact assessment will utilize paired questionnaires before and after the internship year to measure the degree of change within individuals at intervention and control sites with regard to the following: medical reasoning domain scores on a structured knowledge assessment, self-assessed preparedness scores across 32 clinical practice domains, self-rated confidence scores across 14 clinical skills domains. Baseline data for 53 participants (98% of incoming interns) were collected in August 2016 and paired follow-up data will be collected in August 2017. Interim data regarding outputs (curriculum details) and outcomes (baseline knowledge and skills scores) will be reported.

Going Forward: The internal medicine curriculum package is being piloted from August 2016 through August 2017. After a final editorial revision, the curriculum will be disseminated nationally in August 2017. If successful, curriculum initiatives in obstetrics and gynecology, surgery, and pediatrics will follow and will lead to the