THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

PROGRAMS, COURSES AND RESOURCES FOR PRACTICE FACILITATION AND QUALITY IMPROVEMENT

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SUMMARY OF PROGRAMS AND COURSES[1]

INTRODUCTORY
ASPIRE course: 4 days (ENG): Teaching safety and quality in residency training and ASPIRE course: 2.5 days (FRE): Teaching safety and quality in residency training
Canadian Patient Safety Officer Course: in person or online (CPSI)
C-QuIPS Group-Based QI Workshops: 1-day workshop (University of Toronto)
Effective Governance for Quality and Patient safety: 1-day course (CPSI)
IDEAS (HQO) Foundations of Quality Improvement: 2-day course - 3 hours online and 1-day in person workshop (Health Quality Ontario)
Investigating and Managing Patient Safety certificate course: 2.5 days (HQC Alberta)
LILT: 12-18 month program: traditional and flipped classroom (Health Quality Council Saskatchewan)
RQIP: 24 hours (within 12-24 months): flipped classroom (Health Quality Council Saskatchewan)
Practice Improvement Essentials (PIE) part 1: half day workshop (CFPC) – in piloting stage
Departments of Family Medicine – various programs for Quality Improvement in residency

[1] : Advanced courses are not listed in this table but include Masters and PhD degrees related to QI and Systems design

INTERMEDIATE
Certificate in Patient Safety & Quality Management course -7-8 months (HQC Alberta), in-person and online
Clinician Quality Academy – In person: 5 days residency sessions, 9 days of classroom sessions, 8 months to complete a QI project (BC Patient Safety and Quality Council)
C-QuIPS certificate course: 10 months (60 hours) (University of Toronto)
CQIP: 10-month program: Flipped classroom, online modules (Health Quality Council Saskatchewan)
EQUIP: Advanced course: 5 days in person (over 9 months) (University of Toronto)
IDEAS (HQO) Advanced Learning Program (ALP): 5 months (Health Quality Ontario)
Investigating and Managing Patient Safety certificate course – 2.5 days (HQC Alberta)
Practice Improvement Initiative Essentials part 2: half day workshop (CFPC) – in piloting stage

OVERLAPPING
EXTRA Program: Executive Training Program (Canadian Foundation for Healthcare Improvement): 14 months (bilingual)
Faculty Resident Co-Learning Curriculum in QI (University of Toronto): 2 workshops
IHI Open School Online Courses (Institute for Healthcare Improvement) - Offers Certificate programs
Toward Optimised Practice: In person: 4 days (2-day blocks, 2 weeks apart)

PRACTICE FACILITATION PROGRAMS
Agents d'amélioration continue de la qualité (ACQ), Québec
Agency for Healthcare Research and Quality Primary Care Practice Facilitation (AHRQ) • EvidenceNOW • Developing Curriculum and training, • Webinars, • Case studies and lessons learned, QI Practice Facilitators (White paper, Quick-start Guide, Tips)
Alberta Health Services • AIM Alberta • Health Change Methodologies (HCM) • Better Choices Better Health (BCBH) • Collaboration for Change Initiative (CCI)
CoMPAS+ bonification de ateliers [workshop improvement] (Québec) – 3hrs to 1 day
Primary Care Quality Practice Facilitation Program: Champlain Local Health Integration Network Primary Care Section (Ottawa) – 6-24 months
Patient Safety Education Program – Canada (CPSI)
TeamSTEPPS (CPSI) – Also delivered in Alberta in collaboration with Health Quality Council Alberta

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

Name of program or service:	AHRQ has several initiatives underway to support primary care but will describe our EvidenceNOW grant initiative in this brief.
Overall program goal(s):	The Agency for Healthcare Research and Quality (AHRQ) is the lead Federal agency charged with improving the safety and quality of America's health care system. AHRQ develops the knowledge, tools, and data needed to improve the health care system and help Americans, health care professionals, and policymakers make informed health decisions.
Program description: • How many facilitators? • What is their focus- QI, EMR or Research facilitation? • How do they engage physicians/practices? • Outcome measures (how many practices/physicians etc. supported since inception?	EvidenceNOW is an AHRQ grant initiative dedicated to helping small- and medium-sized primary care practices across the U.S. use the latest evidence to improve the heart health of millions of Americans. The overarching goal of EvidenceNOW is to improve the delivery of heart health care at over 1,500 primary care practices across the country. Our first goal is to help practices **implement evidence** to improve health care quality, with a focus on the ABCS of heart disease prevention. Our second goal is to help practices identify ways to **build their capacity** to receive and incorporate other patient-centered outcomes research findings in the future. Our third goal is to study how **external QI support** helps primary care practices improve the way they work and improve the health of their patients. Finally, EvidenceNOW will build and **disseminate a blueprint** of what works to transform primary care.
Program's funding model and sources	AHRQ is a health services research agency that supports intramural and extramural research programs. EvidenceNOW is a $112 million investment over four years. It includes seven grants to establish regional Cooperatives, one grant for an independent, external national evaluation, and a contract to create a Technical Assistance Center.
Who does your program target?	Small- and medium-sized (10 clinicians or fewer) primary care practices
• How many family physicians and/or family medicine and primary care practices does your program support? • Are PF hired by your program or by the primary care organizations?	The initiative has reached over 1500 primary care practices in 12 states. The exact mix of family physicians, internists, physician assistants and nurse practitioners has not been determined at this time. PFs were deployed by the seven Cooperatives. Some were employed by a single institution, others brought together a handful of partners who employed the PFs, and still others worked with large numbers of practice transformation organizations to do the work.

Describe the Practice Facilitation role(s) in terms of competencies	The national evaluation team identified nine support strategies to help practices engage in data informed QI. (https://escalates.org/story/pf-hit-paper/) These strategies include addressing workflows, performing chart audits, teaching practices how to validate data, helping practices work with vendors, and connect with external data infrastructures. Stay tuned for more to come.
How do you build and sustain Practice Facilitation competencies? • How do you train facilitators and what continuing professional development do you provide them with or encourage them to undertake?	AHRQ does not train practice facilitators but has created a suite of practice facilitation training materials over the past 10 years. • *Integrating Chronic Care and Business Strategies in the Safety Net* – Toolkit and Practice Coaching Manual, 2009 • Consensus Conference on Practice Facilitation (Coaching), 2010 • *Developing and Running a Primary Care Practice Facilitation Program: A How-to Guide,* 2011 • *The Practice Facilitation Handbook: Training Modules for New Practice Facilitators and Their Trainers*, 2013 • *Primary Care Practice Facilitation Curriculum,* 2015
How is the overall program assessed and evaluated?	The national evaluation team is conducting an independent, overarching cross-cooperative evaluation that includes assessment of ABCS, capacity of practices to perform QI, delivery of the intervention, and internal and external context. Each cooperative is also conducting their own regional evaluation.
List successes:	Over 1500 practices touched, ABCS evidence implemented, Qi support infrastructure created and strengthened, update of lessons by other programs
List challenges:	Shifting landscape of primary care, evolving evidence landscape, limitations of current EHRs
Key contact person:	Bob McNellis, Senior Advisor for Primary Care, at robert.mcnellis@ahrq.hhs.gov
Website and/or key reference material	Useful websites: AHRQ home (www.ahrq.gov), EvidenceNOW (www.ahrq.gov/evidencenow), PCMH resource center (pcmh.ahrq.gov)
Resources	• *Developing and Running a Primary Care Practice Facilitation Program: A How-to Guide*, 2011 • *The Practice Facilitation Handbook: Training Modules for New Practice Facilitators and Their Trainers*, 2013 • *Primary Care Practice Facilitation Curriculum*, 2015 • Monthly practice facilitation newsletter (send me an email to subscribe)

AGENTS D'AMÉLIORATION CONTINUE DE LA QUALITÉ (ACQ), QUÉBEC

Intégration des agents d'amélioration continue de la qualité (ACQ) dans les groupes de médecine de famille universitaires (GMF-U) du Québec

Le 1er avril 2017 a pris effet au Québec le cadre de gestion des GMF-U du ministère de la Santé et des Services Sociaux (MSSS). Ce cadre détermine les balises d'une organisation de services de première ligne modèle et probante, propices à soutenir adéquatement et équitablement les GMF-U. Selon le MSSS, les GMF-U incarnent un puissant levier de maturation des lieux de dispensation de soins et de services de première ligne vers le modèle du centre de médecine de famille du Collège des médecins de famille du Canada, milieu de pratique exemplaire de la prestation et de la coordination en temps opportun de tous les services de santé requis, centré sur les usagers et intégré au réseau.

Ce cadre précise les trois missions interdépendantes des GMF-U :

- Prodiguer, de façon exemplaire et innovatrice, des soins de santé et des services de première ligne intégrés;
- Enseigner à prodiguer des soins de santé et des services de première ligne intégrés;
- Participer au développement et à l'application des connaissances, notamment par la recherche et l'érudition.

Ce cadre de gestion s'adresse à tous les GMF-U du Québec. Il précise les composantes essentielles d'un milieu de première ligne exemplaire, autant sur le plan clinique que sur ceux de l'enseignement et de la recherche et établit un modèle de gestion et d'allocation équitable des ressources humaines, financières et matérielles en GMF-U. Le nombre d'inscriptions pondérées en GMF-U, qui tient compte de la complexité et du temps requis pour effectuer certains types de pratique, est l'indicateur retenu par le MSSS comme source d'attribution des ressources humaines, financières et matérielles. Cette prise en effet du cadre de gestion des GMF-U a entraîné l'intégration de nouveaux professionnels dans les 46 GMF-U du Québec, soit des agents d'ACQ. Un GMF-U dont le nombre d'inscriptions pondérées est de moins de 12 000 usagers se voit attribuer un agent à temps partiel (17,5 heures par semaine), tandis qu'un GMF-U dont le nombre d'inscriptions pondérées est de 12 000 usagers et plus se voit attribuer un agent à temps plein (35 heures par semaine).

Ces agents agissent à titre de facilitateurs de la pratique dans les différents domaines d'activités des GMF-U. Ils assument des fonctions liées principalement à la mise en place d'une culture d'ACQ au sein des GMF-U et à la coordination de projets d'ACQ qui sont identifiés localement. Ces projets visent à améliorer l'efficacité, l'efficience, l'accessibilité, la continuité, la sécurité, la réactivité, l'équité ou la viabilité du GMF-U. Les agents sont des employés de centres intégrés ou de centres intégrés universitaires de santé et de services sociaux (CISSS et CIUSSS) qui exercent dans les GMF-U. Comme pour les autres ressources allouées en fonction du cadre de gestion, les agents d'ACQ sont sous l'autorité hiérarchique du cadre intermédiaire du GMF-U qui provient également du CISSS ou du CIUSSS. La dyade de cogestion médico-administrative de chaque GMF-U, composée d'un directeur médical et du cadre intermédiaire, convient des priorités d'ACQ du milieu. De plus, chaque CISSS et CIUSSS ont une direction avec une expertise conseil en ACQ à laquelle les agents peuvent se référer au besoin.

Le CIUSSS de la Capitale-Nationale s'est vu confier un mandat provincial de soutien et de coordination des agents d'ACQ dans les GMF-U du Québec, et ce, en collaboration avec les autres CISSS et CIUSSS. Un

conseiller cadre en ACQ de cet établissement est ainsi appelé à coordonner l'action de tous les agents. Celui-ci est responsable de consolider une culture d'ACQ au sein des GMF-U du Québec et de soutenir la réflexion stratégique, l'action et la prise de décisions ayant des impacts concrets dans les milieux. Un comité-conseil a été mis en place afin de guider ce conseiller cadre en ce qui a trait à ses orientations et ses activités prioritaires. Ce comité est composé d'une quinzaine de représentants de parties prenantes des GMF-U (usagers, cliniciens, décideurs, enseignants et chercheurs), qui proviennent de différentes régions du Québec. Suivant les recommandations du comité-conseil, différentes activités de coordination et de soutien ont été réalisées au cours de la dernière année : élaboration et diffusion d'un cadre de référence en lien avec l'ACQ dans les GMF-U du Québec, diffusion de bulletins d'information, soutien à l'intégration des agents d'ACQ, animation d'une communauté virtuelle de pratique pour les agents d'ACQ et visite de l'ensemble des GMF-U pour y rencontrer entre autre les agents d'ACQ et les dyades de cogestion médico-administrative. Pour plus d'informations, vous pouvez consulter cette page sur l'ACQ sur le site Internet de notre partenaire Réseau-1 Québec ou communiquer avec M. Jean-Luc Tremblay, conseiller cadre à l'ACQ pour les GMF-U du Québec.

Integrating QI agents in academic family medicine groups (GMF-Us) in Québec

On April 1st, 2017 the Quebec Ministry of Health and Social Services' (MHSS) management framework for GMF-Us came into effect. This framework sets the requirements for a model, evidence-based organisation for primary care services, capable of adequately et equitably supporting the GMF-Us. According to the MHSS, GMF-Us represent a powerful lever for ensuring the progression of primary points of care toward the patient medical home model proposed by the College of Family Physicians of Canada, an exemplary centre of practice for the coordination and delivery, in a timely manner, of all required health care services, centred on users and integrated into the network.

This framework stipulates three interdependent mandates for the GMF-Us:

- Deliver, in an innovative and exemplary fashion, integrated primary heath care and services;
- Teach how to deliver integrated primary health care and services;
- Participate in knowledge development and application, particularly in research and scholarship.

This framework applies to all GMF-Us in Québec. It defines the essential components of an exemplary primary care setting, for clinical, teaching and research activities, and establishes a model for the management and equitable allocation of human, material and financial resources in the GMF-Us. The weighted panel size in the GMF-Us, that take into consideration the complexity and the time required to perform certain types of follow-ups, is the indicator used by the MHSS for the allocation of human, material and financial resources. This application of the management framework for the GMF-Us resulted in the integration of new professionals into the 46 GMF-Us in Québec, namely the QI agents. A GMF-U with a weighted panel size of less than 12,000 users has one part-time QI agent (17.5 hours per week), while a GMF-U with a weighted panel size of more than 12,000 users will have a full-time agent (35 hours per week).

These agents act as practice facilitators in the various domains of activities in the GMF-Us. Their primary role pertains to the implementation of a QI culture within the GMF-Us and the coordination of locally defined QI projects. These projects aim to improve the efficiency, effectiveness, access, continuity of care, security, responsiveness, equity or viability of the GMF-Us. QI agents are employees of the Integrated

Health and Social Services Centres and Integrated University Health and Social Services Centres (CISSS and CIUSSS) and practice in the GMF-Us. As with other resources allocated according to the management framework, QI agents report to the GMF-U`s middle manager, also from the CISSS or the CIUSSS. The medico-administrative co-management dyad in each GMF-U, composed of a medical director and the middle manager, agrees on the QI priorities for that establishment. In addition, each CISSS and CIUSSS has an executive with QI expertise whom QI agents can consult as required.

The CIUSSS de la Capitale-Nationale was mandated by the province to provide support and coordination for the QI agents in the GMF-Us in Québec, in collaboration with the other CISSS and CIUSSS. A QI executive advisor in this establishment is responsible for coordinating the activities of all agents. This person is also responsible for consolidating the QI culture in the Quebec GMF-Us and supporting the strategic thinking, action and decisions that have a concrete impact in these settings. An advisory committee has been created to guide the executive advisor with regard to their strategic orientations and priorities. This committee is composed of approximately fifteen of the GMF-U`s stakeholder representatives (users, clinicians, decision-makers, teachers and researchers), from different regions in Québec. According to the advisory committee's recommendations, different support and coordinating activities have been rolled out during the past year: creation and distribution of a general framework pertaining to QI in GMF-Us, distribution of information bulletins, support for the integration of QI agents, facilitation of a virtual community of practice for the QI agents and visits to all GMF-Us to meet other QI agents as well as the medico-administrative co-management dyads. For more information, visit our partner, Réseau-1 Québec's QI Web page or contact Jean-Luc Tremblay, QI executive advisor for Québec, GMF-U.

ALBERTA HEALTH SERVICES

Name of program or service:	**Quality & Education – Primary Health Care** Our team aims to build capacity for improvement in three different ways: 1) focused programs; 2) building the general capacity of facilitators across the system; and more recently 3) bringing components and principles from our specific program areas into system-wide initiatives. *This synopsis focuses on the specific programs and general capacity building.* **Our Team has multiple programs available to Primary Health Care organizations: Access. Improvement. Measures or AIM Alberta (Access improvement); Health Change Methodology® (patient centred care and care planning); Better Choices Better Health® (patient self-management); Collaboration for Change Initiative (patient centred design); Team Strengthening (foundational)**
Overall program goal(s):	We accelerate health system improvement in Alberta. We spread innovation, we bring teams together to work on common improvement priorities, we build capacity for improvement and sustainability in providers, teams and leadership across the province
Program description: • How many facilitators? • What is their focus- QI, EMR or Research facilitation? • How do they engage physicians/practices? • Outcome measures (how many practices/physicians etc. supported since inception?	<u>AIM Alberta</u> AIM Alberta is an access improvement program that supports day of choice access improvement for primary health care organizations. • Six improvement facilitators across the province, 12 contracted faculty • Since inception have had 31 collaboratives (#30 and 31 currently underway) which have involved 29 PCNs, 217 primary care practices, 139 AHS program teams and specialist practices. <u>Health Change Methodology® (HCM) & Choices and Changes</u> We have two programs that support behaviour change skills in providers to help patients make the best health decisions for them. Choices and Changes offers specific, brief and efficient communication strategies to help providers facilitate patient/client behaviour change and adherence to a treatment plan within the constraints of a typical office visit. HCM is a behaviour change approach that supports health care providers to embed person-centred care into clinical consultations, care planning, discharge planning, disease management, health promotion, rehabilitation, return to work and other health services. Since inception we 41 physicians and their teams have been trained in primary care, and within two years all of community rehabilitation in the province. HCM: Two master trainers, 22 current trainers and 8 trainer candidates (will be trainers by end of Oct) <u>Better Choices Better Health® (BCBH)</u> Better Choices Better Health is a patient self-management program that teaches patients how to put health knowledge into practice. BCBH Facilitators: In person sessions: 218 (57% are volunteers)

	Online: 14 (57% volunteers). We offer twelve online sessions per year. Total: 232. <u>Collaboration for Change Initiative (CCI)</u> CCI is a coalition of organizations and patient citizens in Alberta that have a commitment to improving primary care through dialogue, mutual exploration, and citizen-centered action. The Coalition has been guided by the vision of the Patient's Medical Home* where health care is orientated and centred around the patient and his or her journey through the health care system. The coalition is organizing, facilitating, and implementing innovative ways to enhance citizen- and patient-engagement in primary care practices. The goals of the CCI are to: • Test and learn innovative and different ways to have primary care and patients truly work together • Create the tools and supports to replicate the process • Build capacity and capability in primary care organizations to work with patients and citizens in an ongoing way (i.e. sustain the change) • Use the capacity and capability of one organization to build the capacity in other primary care organizations (i.e. spread strategy) The group has been working with three large primary care organizations (Family Care Clinics and Primary Care Networks) to test and learn how to best support teams to engage with patients. Training is in the process of being developed for a train the trainer approach of spread in the spring/fall of 2019. <u>Team Strengthening</u> Our team strengthening program is foundational to much of the work we do, and is embedded into other initiatives. There are several one hour workshops we offer: • Creating a Team Charter • Establishing Norms • Leveraging Team Diversity • Building Trust (in development) • Managing Tension and Conflict (in development)
Program's funding model and sources	All funding is within the global budget of AHS. There is funding both within the provincial PHC team that supports all of the zones, and some operational dollars in each of the zones where clinical operations run out of.
Who does your program target?	We have three specific target audiences: 1) primary health care providers and their clinical teams; 2) improvement advisors in primary care organizations; 3) improvement advisors within other settings (i.e. primary health care and within Alberta Health Services).

• How many family physicians and/or family medicine and primary care practices does your program support? • Are PF hired by your program or by the primary care organizations?	Our programs are open to all primary care practices in the province. In our model of delivery, we have improvement advisors who have expertise in improvement approaches as well as the specific program areas we offer and how to implement the principles of access, patient centred clinical consultations, self-management, patient co-design and team strengthening into clinical practice. Most of the primary care organizations have their own improvement facilitators that work with our facilitators to support implementation within the clinical setting.
Describe the Practice Facilitation role(s) in terms of competencies	This section speaks to how we support general improvement/practice facilitation skills as opposed to the programs we have for delivery. It should be noted that for our self-management programs and behaviour change programs we have a separate group of competencies that can be shared upon request. We have built our approach to developing facilitation skills on the following premises: 1) In order to have people who want to change the system, we need to train people as system oriented across all levels of the system; 2) People learn 10% didactically, 20% through mentorship and relationships and 70% on the job; 3) The system needs to be designed to support those who need the system the most (those with chronic disease). As such, we have designed our competencies based on a system orientation, with person-centred principles and aligned to the Wagner Expanded Chronic Care Model. We deliver and build learning and skill acquisition using open-source and multi-modal approaches. We have not yet fully defined the knowledge, attitudes and skills, but at this time we use these themes to help us categorize and consider how we find and offer training opportunities for practice facilitators. Our competencies fall into six themes: <u>Patient Safety, Access and Patient Centred Care</u> Patient-centered care requires the elimination of duplication and delay of services. Emphasis is on the system of care delivery that prevents errors; learns from the errors that do occur; and is built on a culture of safety that involves health care professionals, organizations, and patients. Patient and provider co-produce health outcomes that the patient values. <u>Change Management</u> *PROSCI, ADKAR, Behavioural Change, Current models and frameworks, specific to the context such as Medical Home* Change management is a combination of processes, tools and techniques to help move a project or initiative forward. It involves managing the

	people side of change to achieve a required business outcome resulting in the adoption and realization of change. Coaching and Facilitation Coaching and facilitation are core competencies for anyone who leads a team, project, committee or meeting. The role is to empower people by bringing out ideas, enabling participation, get buy-in, and manage resistance. Innovation *Human Factors, Design Thinking, Liberating Structures, Complexity Theory* Innovation has the potential to improve design and systems. The methodology is used to solve complex problems, and find desirable solutions for clients in ways that align to how people behave and act. Innovation draws upon logic, imagination, intuition, and systemic reasoning, to explore possibilities of what could be—and to create desired outcomes that benefit the end user. Data and Analysis *Measurement for Improvement, EMR, Data Analysis* Data analysis in health care allows for the examination of patterns in various healthcare data in order to determine how clinical care can be improved while limiting excessive spending. Clinical data is collected from electronic medical records (EMR). QI Methods and Tools *Theory, Knowledge, System, Steps, Procedures (TQM, CQI, PDSAs, Run Charts, Fishbone Diagrams)* QI Methods encompass theory and knowledge; systems; steps and procedures and processes that enable improvement. Understanding QI Methods allows the learner to apply the right tool for the right situation. QI Tools are processes and exercises that enable the documentation of current processes so that foster the analysis of systems.
How do you build and sustain Practice Facilitation competencies? • How do you train facilitators and what continuing professional development do you provide them with or encourage them to undertake?	Specific Programs: We offer training and support that is tailored to the team setting. The training is focused to be some didactic with a greater focus on "in situation" learning with supporting improvement advisors to help their clinical teams with change. General competencies: We have mapped all of the courses that are available within AHS to the competencies, and realized that there is too much didactic opportunities, and the didactic opportunities are often away from the work place. As such, we are in the process of shortening learning opportunities into smaller "bite sized" approaches. Using these smaller approaches, we are in the process of building networks.

How is the overall program assessed and evaluated?	<u>AIM Alberta</u> • Among participating family physician teams, the program has enabled reductions in wait times by 54% for long appointments and 37% for short appointments. • Among participating specialist and AHS ambulatory teams, teams have worked down their backlogs and proceeded to reduce waits for new appointments by 32% while also obtaining and 10% improvement in wait times for return visits. <u>Health Change Methodology® (HCM)</u> HCM is a relatively new program and is currently under evaluation. <u>Better Choices Better Health® (BCBH)</u> • 775 participants • Average participant is 57 year old female • Top 5 conditions: Chronic pain, diabetes, weight management, mental health, fibromyalgia • 96 % participants reported that they intend to use the course content to make positive changes to their lifestyle, i.e. eating healthy, dealing with physical symptoms, physical activity • Evaluation showed significant health improvements: increased self-confidence, feel healthier, new health behaviours. 54% participants referred by Health Care Provider <u>Collaboration for Change Initiative (CCI)</u> The CCI has taken a developmental approach to evaluation which has allowed the development of change packages and further program development. <u>Team Strengthening</u> Measurement of team effectiveness is done using the Adaptive Reserve scale.
List successes:	We have recently moved to a number of “microlearning” opportunities that have been received with good success. One approach is to embed our principles into other system wide initiatives. The second is to offer “easy to access” learning opportunities through a podcast approach where subject matter experts, patients and providers are “interviewed” in a very conversational approach that offers a “radio like” experience. There is a high degree of collaboration possible within and across AHS as we build capacity across the system.
List challenges:	Evolving a large program with historical roots in specific delivery approaches (i.e. IHI Collaborative Model) into a more nimble and agile program in the face of significant funding cuts has been a challenge over the past two years. Like many jurisdictions we have many programs and initiatives in the system. There is a crowded space with similar aims, and we need to be able to reflect the needs of the customer in our delivery

	versus a programmatic design. This means we have to adapt how we work as we have reached the "innovators" and have to engage with the early majority and majority. In primary care we have seen a shift in the system from a high degree of local autonomy to some standardization and specific expectations set. While this is a shift in culture that brings about some change issues, it does provide the opportunity to look at skill building for change support.
Key contact person:	Margie Sills-Maerov, Director Quality & Education Primary Health Care Alberta Health Services Margaret.sillsmaerov@ahs.ca 403.472.2917
Website and/or key reference material (i.e. role descriptions)	AIM Alberta AIM Website: https://aimalberta.ca/ For a brief YouTube of AIM, see: https://www.youtube.com/watch?v=4o5UqxMqysY Health Change Methodology® (HCM) and Choices and Changes HCM: http://aimalberta.ca/index.php/course/healthchange-methodology-core-training/ Choices and Changes: http://aimalberta.ca/index.php/course/choices-and-change-program/ Better Choices Better Health® (BCBH) An overview can be found at: https://www.albertahealthservices.ca/services/bcbh.aspx and http://aimalberta.ca/index.php/course/better-choices-better-health/ Collaboration for Change Initiative (CCI) The collaboration website can be found at: http://collaborationforchange.ca/ Team Strengthening Overall: http://aimalberta.ca/index.php/self-serve-resources/team-effectiveness/ Establishing Norms: http://aimalberta.ca/index.php/course/establishing-norms/ Introducing a Team Charter: http://aimalberta.ca/index.php/course/introducing-team-charter/ Leveraging Team Diversity: http://aimalberta.ca/index.php/course/leveraging-team-diversity/
Resources	See website linkages

ALBERTA MEDICAL ASSOCIATION

Program Title:	Toward Optimized Practice
Target learners:	Primary Care Network staff
Level:	☒ Introductory ☒ Intermediate ☐ Advanced ☐ Other
Jurisdiction	Alberta
Overall curriculum design	Improvement Facilitator training provides an introduction to quality improvement methods and tools. Face-to-face instruction is delivered over a total of 4 days (2 days followed by 2 days after two weeks) and supported with "in-the-field" mentorship, annual conference, and community of practice to develop quality improvement skills. Quality improvement methods/tools are built into clinical interventions supporting an applied approach for knowledge/skill acquisition.
Evaluation methods:	The Improvement Facilitator training is evaluated following the Kirkpatrick Model. **Reaction** to training is assessed using daily session evaluations; **Learning** is assessed via pre- and post-session self-assessments; **Behaviour** is assessed through follow-up self-assessments, asking IFs to document their plans to use their learnings, and, importantly, through qualitative data captures that include subjective and objective perspectives ; **Results** are assess through the evaluation of initiative-specific goals, and contributions to system transformation.
Funding source(s):	Various sources of funding to support program activities have been leveraged. Primary source of funding is the Ministry of Health through 1) Alberta Medical Association negotiated agreements for Programs and Services to Physicians and 2) specific grants to address priority clinical topics (e.g. opioid crisis). Additional funding sources include AMA member funding, Canada Health Infoway, Alberta Health Services, and Primary Care Networks.
Successes to date (highlights):	Scaled a primary care screening quality improvement program to reach over 1000 physicians with absolute improvement of 14% across 11 maneuvers. Achieved adoption of primary care panel processes with 69% of family physicians in PCNs (total number of family physicians in PCNs = 3697). Supported the quality improvement knowledge and skill acquisition with over 250 improvement facilitators (106 remain active).
Lessons learned	• Never underestimate the importance of visible engaged leadership for quality improvement. Physicians speaking to physicians about the importance of improvement, championing change and advocating for the right supports is a critical success factor. • Define, communicate and influence systems to create protected time for quality improvement. Side-of-desk expectations for quality improvement and continuing educations sub-optimize outcomes. • Integrate quality improvement principles and methods into practical/clinical application for broad engagement in primary care.

	• Content delivery in small manageable packages critical to uptake of change. Identify critical behaviours and design content delivery in modules that can be reasonably accessed by primary care teams.
Contact person (& website)	Mark Watt: top@topalbertadoctors.org (TOP Program Development Lead) http://www.topalbertadoctors.org/programs--services/qualityimprovementprograms/
Resources	Available through Dropbox, includes Activity Worksheets, process maps, story Boards, QI Guide, etc. • Training Session Presentations available on request

BRITISH COLUMBIA PATIENT SAFETY AND QUALITY COUNCIL (BCPSQC)

Program Title:	Clinician Quality Academy
Target learners:	Any independently practicing clinicians, including family physicians, specialists, midwives, dentists, nurse practitioners, etc. Participants come from all sectors of health care in British Columbia.
Level:	☐ Introductory ☐ Intermediate ☒ Advanced ☐ Other
Jurisdiction	British Columbia
Overall curriculum design	The Clinician Quality Academy is a professional development program delivered over a eight-month period. The program consists of five in-person residency sessions; the 9 days of classroom sessions are a combination of lectures, group work, interactive discussions. In addition, each participant completes an improvement project in their place of work over the 8 months to apply their learning to real-world challenges. Participants receive support during the program through webinars, one-to-one meetings with an assigned improvement advisor, and access to expert Faculty. The aim of the Clinician Quality Academy is to provide participants with the capability to effectively lead quality and safety initiatives in the process of improving health care quality. Participants build their knowledge, skills and confidence around the core components of quality improvement including : • Improving quality and safety • Process and systems thinking • Engaging others • Leading change • Measurement and using data • Innovation, spread and sustainability

	Participants learn from a variety of leading experts and are exposed to a diverse collection of tools, techniques, and frameworks for quality improvement. The program takes an integrative approach, with a focus on sense-making and analyzing the commonalities among models, as opposed to the promotion of any one particular model. Participants are supported to develop critical thinking skills to apply the most appropriate and effective methods to make improvements in their individual practice contexts.
Evaluation methods:	• Participant pre- and post-program self-assessment to gauge learning and confidence. • Individual session evaluations at the end of each day and webinar. • 1 year follow up to assess impact and perceived learning • Self-assessed project progress scores
Funding source(s):	The BC Patient Safety & Quality Council funds the delivery of the Clinician Quality Academy, subsidized by a registration fee of $1495. Participants are responsible for covering the registration fee, but are supported to secure funding from existing scholarship funds in the province.
Successes to date (highlights):	Two cohorts have completed the program, with a third scheduled to conclude in November 2018 for a total of 71 graduates. Evaluation results show highly positive feedback from participants in the domains of: o Increased knowledge related to 31 QI domains (average increase of 45 points on the 100 point scale between pre- and post-assessment across all domains) o Over 95% positive reaction to delivery of information by faculty (clarity of information and delivered at level that is appropriate for participants current knowledge) o Over 95% positive reaction from participants that residencies met their expectations. o Near universal agreement that skills learned throughout are applicable to participant's current professional roles.
Lessons learned	Education about improvement methodologies geared towards practicing clinicians/physicians must be delivered in a manner that is more supportive of their unique needs, barriers, and professional focus. Compared to the other learning programs offered by the BCPSQC, the Clinician Quality Academy includes additional clinical examples and case studies, condensed in-person time and weekend delivery to facilitate clinical schedules.
Contact	Anthony Gagne Leader, Capability Development, BC Patient Safety & Quality Council learning@bcpsqc.ca https://bcpsqc.ca/sharpen-your-skills/clinician-quality-academy/

Resources	Clinician Quality Academy - https://bcpsqc.ca/sharpen-your-skills/clinician-quality-academy/ Engaging People in Improving Quality (EPIQ) Teaching Toolkit - https://bcpsqc.ca/resources/engaging-people-in-quality-epiq/

CANADIAN PATIENT SAFETY INSTITUTE (CPSI)

The CPSI currently offers the following educational programs:

ASPIRE - Advancing Safety for Patients In Residency Education: The Canadian Patient Safety Institute and the Royal College of Physicians and Surgeons are pleased to offer ASPIRE, an intense, focused four-day workshop dedicated to enhancing the capacity of Canadian medical schools to provide patient safety training.

Canadian Patient Safety Officer Course: Providing an overview of the fundamentals of patient safety, the course equips healthcare professionals and leaders with the information, tools, and techniques to build a strong patient safety culture within their organizations. The CPSO Course is available in two delivery models: in-person or online, and is intended for healthcare professionals and leaders who have the formal responsibility of disseminating patient safety principles and programs throughout the organization.

Effective Governance for Quality and Patient Safety: This one day course is designed to support boards of healthcare organizations and the leadership teams they work with, this program provides a unique opportunity to explore evidence-informed approaches to governance and leadership and which share innovative health governance practices, resources and tools.

Patient Safety Education Program – Canada: This two-day "Become a Patient Safety Trainer" course focuses on how to teach and implement patient safety initiatives with an emphasis on an interprofessional team approach and peer to peer education. PSEP – Canada uses a train-the-trainer curriculum-driven approach grounded in specific adult learning methods.

TeamSTEPPS: An evidence-based teamwork system that optimizes patient care by improving communication and teamwork skills among healthcare professionals, including frontline staff. It includes a comprehensive set of ready-to-use materials and a training curriculum to integrate teamwork principles into a variety of settings.

HEALTH QUALITY COUNCIL OF ALBERTA (HQCA): PATIENT SAFETY AND QUALITY MANAGEMENT COURSE

Program Title:	Patient Safety and Quality Management Course
Target learners:	Healthcare professionals
Level:	☐ Introductory ☒ Intermediate ☐ Advanced ☐ Other
Jurisdiction	Alberta (registration is open to pan-Canadian audience)
Overall curriculum design	• Overall duration: September to March • Duration: In-person: 2 days in September and 2 days in March • Duration: Online sessions: Weekly online sessions with subject matter experts in various aspects of quality and patient safety management ranging from quality improvement ethics, measurement, human factors, teamwork, culture, etc. • Requirement to complete a patient safety/quality improvement related project.
Evaluation methods:	Each of the HQCA courses are evaluated either at the end of the course or on an annual basis. The courses are evaluated through a survey sent to each participant at the conclusion of the course. The course faculty, in consultation with other subject matter experts determine which curriculum changes are likely to improve the delivery of each course.
Funding source(s):	Registration fees cover course expenses
Successes to date (highlights):	• 84 physicians among the 176 students successfully completing the certification to date • 27 participants from outside of Alberta (Canada and United States)
Lessons learned	Important to incorporate robust evaluation into the cycle, listen to your audience and incorporate those findings to make the education meaningful and relevant to their needs. Really important to have case studies to keep it relevant and practical for the learners to 'play' with concepts/theories/frameworks. Even more useful to reflect on their current contexts where applicable. Participants should be prepared to be supported, by a mentor and faculty, through an improvement project that is of importance in their context.
Contact person (& website)	http://hqca.ca/education/certificate-in-investigating-and-managing-patient-safety-events/ Contact person: Nishan Sharma, Education Lead, Ward of the 21st Century (W21C), University of Calgary nishan.sharma@ucalgary.ca

Resources	http://hqca.ca/health-care-provider-resources/systematic-systems-analysis/ http://hqca.ca/health-care-provider-resources/physician-panel-reports/ http://hqca.ca/education/

HQCA: CERTIFICATE IN INVESTIGATING AND MANAGING PATIENT SAFETY EVENTS

Program Title:	Certificate in Investigating and Managing Patient Safety Events
Target learners:	Healthcare professionals
Level:	☒ Introductory ☒ Intermediate ☐ Advanced ☐ Other
Jurisdiction	Alberta (open to national audience)
Overall curriculum design	**Introductory Investigating and Managing Patient Safety Events** • Focus: Using a practical case based approach provide an introduction to the Systematic Systems Analysis methodology https://d10k7k7mywg42z.cloudfront.net/assets/5501df86c0d67106cf02ae61/HQCA_SSA_PSR_111913.pdf • Duration: 2 ½ day course • Methods of learning: Face-to-face **Advanced Investigating and Managing Patient Safety Events** • Focus: understanding various aspects of managing the occurrence of harm and patient safety events as well as application of the SSA:PSR methodology (n.b. completion of the Introductory program is a pre-requisite) • Duration: 2 ½ day course • Methods of learning: Face-to-face followed by completion of a mentored patient safety review
Evaluation methods:	Each of the HQCA courses are evaluated either at the end of the course or on an annual basis. The courses are evaluated through a survey sent to each participant at the conclusion of the course. The course faculty, in consultation with other subject matter experts determine which curriculum changes are likely to improve the delivery of each course.
Funding source(s):	Registration fees cover course expenses
Successes to date (highlights)	– *"It was well thought out and planned. Learning about systems review vs. review of patient complaints."* – *"Knowledge to conduct systematic investigations."* – *"I really enjoyed the content of how each section built on the other."* – *"Practical, based on solid values, ethics and experience."*

	– *"Practical. Good stories that was central in Alberta. Varied education models (PowerPoint group work, case study).* – *"Great atmosphere – very approachable staff. Very applicable and a great overview of process, which will help me in my current role and responsibilities."*
Lessons learned	Important to incorporate robust evaluation into the cycle, listen to your audience and incorporate those findings to make the education meaningful and relevant to their needs. Really important to have case studies to keep it relevant and practical for the learners to 'play' with concepts/theories/frameworks. Even more useful to reflect on their current contexts where applicable.
Contact	http://hqca.ca/education/certificate-in-investigating-and-managing-patient-safety-events/ Contact person: Nishan Sharma, Education Lead, Ward of the 21st Century (W21C), University of Calgary nishan.sharma@ucalgary.ca
Resources	http://hqca.ca/health-care-provider-resources/systematic-systems-analysis/ http://hqca.ca/education/

HQCA: TeamSTEPPS – MASTER TRAINER

Program Title:	**TeamSTEPPS – Master Trainer**
Target learners:	Healthcare professionals
Level:	☒ Introductory ☒ Intermediate ☐ Advanced ☐ Other
Jurisdiction	Alberta (HQCA is the regional training centre for Alberta and delivers in collaboration with the Canadian Patient Safety Institute CPSI)
Overall curriculum design	TeamSTEPPS – Master Trainer • Focus: optimizing patient care and patient safety by improving communication and teamwork skills that integrates teamwork principles in to a variety of settings. • Duration: 2 days • Method of learning: face-to-face
Evaluation methods:	Each of the HQCA courses are evaluated either at the end of the course or on an annual basis. The courses are evaluated through a survey sent to each participant at the conclusion of the course. The course faculty, in consultation with other subject

	matter experts from CPSI, among others, determine which curriculum changes are likely to improve the delivery of each course.
Funding source(s):	Registration fees cover course expenses The next course is scheduled for October 23/24 in Edmonton, Alberta, Canada. Cost: $550 Canadian/person + GST
Lessons learned	Important to incorporate robust evaluation into the cycle, listen to your audience and incorporate those findings to make the education meaningful and relevant to their needs.
Contact	http://hqca.ca/education/teamstepps-canada-master-trainer/ Contact person: Rhonda Pouliot, Education Lead, HQCA: rhonda.pouliot@hqca.ca
Resources	• http://hqca.ca/health-care-provider-resources/systematic-systems-analysis/ • http://hqca.ca/health-care-provider-resources/physician-panel-reports/ • http://hqca.ca/education/

HQCA: PRIMARY CARE PHYSICIAN PANEL REPORTS

Program Title:	**Primary Care Physician Panel Reports**
Target learners:	Healthcare professionals
Level:	☐ Introductory ☒ Intermediate ☒ Advanced ☐ Other
Jurisdiction	Provincial within Alberta, reports are available for: • Primary Care Networks • Clinics, • - Physicians
Overall curriculum design	1 CME credit per hour attending a panel report webinar 5 CME credits – Linking Learning to Assessment 6 CME credits – Practice Audits / Quality Assurance Program **Complementary education resources using a microlearning approach is an evolving priority for these reports within HQCA, notably oriented towards how to use the data for improvement** Currently, learning 'on-demand' is provided through: • explicit side-bars and complementary notes within the body of the reports • brief videos that support using data for common 'problems' • in-person and virtual training sessions on how to use the reports in practice.

Evaluation methods:	The panel reports are evaluated on an annual basis through a survey sent to each recipient and qualitative interviews with a smaller sample of users. Subsequent improvements are guided by a reference committee as well as a subject area working group.
Funding source(s):	free resource provided to primary care physicians that enroll in the program
Successes to date (highlights):	1,042 family physicians have requested, and received, a copy of their panel reports For every dollar the HQCA invests in the reports, a systemic cost saving of $17.99 is realized.
Lessons learned	Data reports need to include considerations for interpretation and action. Each measure, or section of the report, should contain 'what do you see?' and 'what might this mean for you?' kinds of questions. Further connections to the 'now what?' is important should action want to be taken towards improvement. HQCA is currently working on short educational videos that complement the data reports and support these sections. To provide increased flexibility and usability for using data for improvement, providing a digital environment for viewing the data is important – and is a priority in the HQCA
Contact	http://hqca.ca/health-care-provider-resources/physician-panel-reports/ Contact person: Markus Lahtinen – Director, Health System Analytics markus.lahtinen@hqca.ca
Resources	https://www.youtube.com/watch?v=-qFquNxi-Uw&t=

HEALTH QUALITY ONTARIO (HQO): IDEAS

Program Title:	**Improving and Driving Excellence Across Sectors (IDEAS)**
Target learners:	All health care professionals in Ontario
Level:	☒ Introductory ☐ Intermediate ☒ Advanced ☐ Other
Jurisdiction	Ontario
Overall curriculum design (length, methods of learning, etc.)	This is a training program focused on quality improvement. It's designed for all health care professionals in Ontario – both emerging and established. Gain the knowledge and practical skills for participating in and leading quality improvement initiatives through two progressive programs: • introductory course, • advanced learning course. Foundations of Quality Improvement Program (Introductory Course) • Formerly known as the 2-Day introductory program • Duration: 2 days • Method of learning: 3 hour online component prior to a one-day in-person workshop • Accreditation: CFPC and the Royal College • Objectives: Introduce participants to: Key quality improvement concepts, foundational methods of quality improvement and practical tools in order to improve patient care, processes and outcomes Advanced Learning Program (ALP) • Duration: 5 months ○ Applicants apply as a team with an executive sponsor • Method of learning: Classroom and application • Accreditation: CFPC and the Royal College • Objectives: To equip healthcare professionals with the knowledge, practical skills and tools to lead quality improvement initiatives that aim to improve patient care, experience and outcomes. At the completion of the ALP, participants will have all of the preparation necessary to apply their leadership to high quality patient care. Partners: Health Quality Ontario, the Institute for Clinical Evaluative Sciences, the University of Toronto's Institute of Health Policy, Management and Evaluation, and seven Ontario universities.
Successes to date (highlights):	Since 2013, IDEAS has produced close to 6000 graduates of the Foundations Program and over 600 graduates of the ALP.
Contact	Email: ideas@utoronto.ca Website: http://www.hqontario.ca/Quality-Improvement/E-Learning-and-Events/IDEAS

HQO: QUORUM

Program Title:	Quorum
Target learners:	Online community for those working on or interested in quality improvement
Level:	☒ Introductory ☒ Intermediate ☒ Advanced ☐ Other
Jurisdiction	Provincial
Overall curriculum design (length, methods of learning, etc.)	Quorum is an online community dedicated to improving the quality of health care across Ontario – together. Quorum can support your quality improvement work by allowing you to: • Find and connect with others working to improve health care quality • Identify opportunities to collaborate • Stay informed with the latest quality improvement news • Give and receive support from the community • Share what works and what doesn't • Browse completed quality improvement projects • Learn about training opportunities • Join a Community of Practice To join Quorum, please visit the website and click on the button
Evaluation methods:	N/A
Contact	Website: https://quorum.hqontario.ca

LE RÉSEAU-1 QUÉBEC : A PRIMARY CARE KNOWLEDGE NETWORK

Jurisdiction	Québec
Description	**Overview** Réseau-1 Québec is a knowledge network in integrated primary health care services, made up of four practice-based research networks (RRAPPLs) which include all family medicine teaching units in Quebec **Vision** The goal of Réseau-1 Québec is to encourage a culture of collaboration in the field of research and in integrated primary health care services in Québec, in order to produce and apply knowledge that will improve the quality of patient care. **Strategic objectives:** • **RRAPPL**: Federate and strengthen an infrastructure of four practice-based research networks (RRAPPL), enabling them to become leaders in continuous improvement in the quality of care and in application and production of knowledge in primary care. • **Research**: Facilitate the collaboration between researchers-clinicians-patients-managers in the application and generation of knowledge in primary care. **Practice-Based Research Networks** (RRAPPL) Réseau-1 is built on a clinical infrastructure that includes clinics from across Québec (GMF-U, GMF, CLSC, private clinics, and emergency departments). These clinics are each affiliated with one of the four practice-based research networks (RRAPPLs). Each RRAPPL is under the responsibility of a Department of Family (and Emergency) Medicine at Laval University, McGill University, the University of Montréal or the University of Sherbrooke, which function in the context of Québec's four integrated university health networks (RUIS). For more information, or to get in touch with RRAPPL officials, please visit the following pages: • RRAPPL Université Laval • RRAPPL Université McGill • RRAPPL Université de Montréal – RRSPUM • RRAPPL Université de Sherbrooke **General information about the courses** Each practice-based research network (PBRN or « RRAPPL » in French) facilitates the involvement of clinical staff and professionals in research activities with relevance to clinical practice. Clinicians with questions emerging from their practice can qualify for R1Q funding under its Call for projects in development (http://reseau1Québec.ca/projets-de-developpement/), and will benefit from support from a researcher and the 'home' PBRN in order to develop the research protocol. They will subsequently be eligible for funding and support via the R1Q

	Call for projects – research on innovations (http://reseau1Québec.ca/innovation-projects/). **Webinars** Réseau-1's webinars cover a variety of topics of interest to our members - patient-partners, clinician-practitioners, researchers, managers / decision makers, and residents. The webinars are offered free of charge from 12 to 1 pm every third Friday of the month. The objectives of the webinars are described here. Our webinars are also available on our YouTube account. Webinars are accredited by the Faculty of Medicine at McGill University.
Funding source(s):	Fonds de recherche du Québec en Santé (FRQS), Canadian Institutes for Health Research (CIHR); match funding from the Québec SPOR SUPPORT Unit (practice facilitation study)
Successes to date (highlights):	Undertaking a study to describe the role of practice facilitation in our PBRNs, as well as to understand the needs of the participating clinical sites in relation to this role.
Lessons learned	To date: http://reseau1Québec.ca/wp-content/uploads/2018/07/Poster-JourneeR1Q_FacilitationRech_ALeBlanc.pdf Results from the study are currently being analysed, and a second phase will be launched in Fall 2018.
Contact person (& website)	Shandi Miller: Shandi.Miller@USherbrooke.ca Website: http://reseau1Québec.ca/
Resources	http://reseau1Québec.ca/ressources/

SASKATCHEWAN HEALTH QUALITY COUNCIL

Program Title:	1) **Clinical Quality Improvement Program (CQIP)** 2) **Lean Improvement Leader's Training (LILT)** 3) **Resident Quality Improvement Program (RQIP)**
Target learners:	**LILT**: Managers, supervisors and other improvement champions **CQIP:** Actively practicing clinicians in a clinical context or setting, incl non-physicians **RQIP**: Physicians during first year of resident training
Level:	**LILT** is an introductory program. **CQIP** is an intermediate program. .
Jurisdiction	Saskatchewan
Overall curriculum design	LILT Focus: This is an applied learning program. It is designed to develop improvement leaders who manage and direct care, services and processes, and help them learn to use improvement tools and philosophies in their areas. Duration: Recommend that participants complete the program within 12-18 months. Methods of learning The program is currently offered using two different delivery methods. The **traditional classroom** approach follows a format of: • **Workshop attendance**. Participants attend an in-classroom workshop where key concepts are reviewed. Workshops include a mix of lecture, discussion, and activities. • **Hands-on assignment**. Following the workshop, participants are given a hands-on assignment to practice using the skills and concepts in their area. • **Report out and evaluation**. Each module concludes with a report out to share what they have learned and the outcomes of their assignment. The **flipped classroom** approach includes an online component that participants review ahead of the workshop. The online modules include a mix of reading, videos, and discussion forums. **Note:** While two different delivery methods are being used, the learning objectives and evaluation criteria are consistent between both approaches. CQIP Focus: The program includes a mix of theory and experiential learning, along with individual coaching and a community of practice. CQIP is a sister program to Intermountain Healthcare's internationally recognized mini-Advanced Training program; it has been adapted for Saskatchewan.

Duration: 10 months

Methods of learning

Guided Preparation and Course Pre-Work: An essential part of the program is the hands-on learning through a clinical improvement project. Some initial work is completed on the project prior to the first face-to-face learning workshop. As well, to ensure that all participants have a common understanding of improvement science language and theory, there is one online module intended to support participants in selecting and refining a project focus.

Flipped Classroom Learning: The program uses a flipped classroom methodology. Online modules are designed for self-paced learning, and are to be completed prior to the workshop session.

Action Periods: Between workshop sessions participants are actively working with their teams on a clinical improvement project. Each action period focuses on moving through the stages of the improvement cycle, from problem identification to implementing changes. The action period also includes other workshop preparation, such as completing the online modules and participating in discussion forums.

Coaching Support: Throughout the program there are multiple opportunities for coaching support. During the guided pre-work, participants will have an opportunity to check-in with their assigned coach to ensure the project is on track. As well, for each action period there is a coach check-in to support participants through project challenges. In between coaching check-ins, faculty support is also available through the online discussion forums.

RQIP

Focus: This is an introductory program, designed to introduce participants to the fundamentals of quality improvement science with a particular focus on patient safety. The program is aligned with the competencies as outlined in CanMEDS 2015.

Duration: The time commitment to complete this course is approximately 24 hours. It is recommended that participants completed the program within 12 – 24 months.

Methods of learning: The program includes a mix of theory and application. The content is structured in modules and offered using flipped classroom; participants complete the didactic portions online at their convenience and attend a series of interactive sessions to dive deeper into the concepts. Participants are expected to complete a small-scope personal improvement project, focused on something that is within the individual's sphere of influence. They are also encouraged to participate in a department or system project to learn how quality improvement methodology can be applied on a larger scale.

Evaluation methods:	<u>LILT</u> • Participants receive feedback on each assignment, using an evaluation rubric. • A standard evaluation package is available that includes optional evaluation tools (post-workshop fast feedback forms, mid-point check in) and a required end of program evaluation (for participants and coaches). • A formal program evaluation was completed by an external researcher in April 2016. <u>CQIP</u> • Participants receive peer and coach feedback on their project progress. The final workshop includes a capstone presentation and poster. • During the program, participants are asked to provide feedback on each workshop using a fast feedback form. As well, during each workshop they are asked to provide an update of their project using a progress score tool. • There is an end of program survey that is sent to participants, sponsors, coaches and faculty. Participants also receive a 12-month follow-up survey. • A formal program evaluation was completed by an external researcher in April 2017. <u>RQIP</u> • The evaluation tools are administered by the University of Saskatchewan, College of Medicine, Post-Graduate Medical Education. • The evaluation includes: o Interactive Session Evaluations o Comprehensive end of program evaluation that includes feedback on the online modules, overall value of the learning, and a self-assessment on development of relevant CanMEDS competencies. • Each module includes a multiple-choice exam. Upon successful completion of the exam, participants are awarded CME credits.
Funding source(s):	<u>LILT</u> • Health Quality Council provided initial in-kind support for the design and development of the program materials. HQC continues to provide ongoing financial support for the learning management system, which includes hosting fees and staff time to manage accounts and upgrades. • LILT is delivered locally; each area is required to resource their cohort by providing release time for participants and providing facilitation and coaching support for the program. <u>CQIP</u> • Program funding is provided by the Saskatchewan Medical Association and the Ministry of Health. Health Quality Council provides in-kind support. <u>RQIP</u> • Program is offered by each program/department – they provide in-kind support for facilitation and coordination of interactive sessions. The program

	is typically offered during academic half-days, as part of the resident curriculum. • PGME provides administrative support to the program, including evaluation administration and working with program departments to set up cohorts. • HQC provides in-kind support by managing the online learning platform. As well, HQC provides coaching and mentorship support to program facilitators.
Successes to date (highlights):	<u>LILT</u> • There are currently 1320 participants enrolled in LILT across the province. Of those, 721 (~55%) have completed the program. • The external evaluation of LILT was very positive and demonstrated that participants were developing the skills outlined in the program objectives. <u>CQIP</u> • The program is now on its third cohort of participants. The first cohort graduated 14 participants; cohort 2 graduated 22; and cohort 3 has 29 participants enrolled. In both cohorts 1 and 2, participants showed progress in their quality improvement projects. • The external evaluation of CQIP was very positive. Participants particularly appreciated the learning program's online modules and workshop format, the opportunities for networking, and the applied nature of the program. <u>RQIP</u> • The program completed the first year of pilot testing. Two cohorts completed the program – Surgery and Physical Medicine & Rehabilitation. • The results from the program evaluation were very different between the two groups – some very positive, some with more critical feedback. Program delivery (including clear expectations) seems to be the greatest factor in the variation between cohorts.
Lessons learned	<u>LILT</u> • Although both delivery methods are effective, participants in the flipped classroom cohorts tended to rate the program more positively. • A de-centralized approach to program delivery can increase the spread and accessibility of the program; however, facilitators also expressed a need for networking opportunities to share experiences and learn from each other. • Participants valued the hands-on aspects of the program but time was one of the greatest constraints to participating in the program. <u>CQIP</u> • Managing expectations regarding pace of change, return on investment. • Power of collaboration – unique partnership of the SMA and Ministry of Health. • System buy-in and alignment – start with the willing, engage more strategically. • Benefits of investing in physicians as peer coaches. • Potential for spread – several projects show strong potential for greater provincial impact.

	RQIP
	• Key enables for success included:
	  ○ Program orientation and onboarding, including clear communication of expectations at first session and reinforced throughout program.
	  ○ Faculty facilitator preparation and development. This included being prepared for each interactive session – reviewing materials and co-developing a facilitation plan – and debriefing after each session with the HQC coach.
	  ○ Collaborative model - shared ownership and involvement within the department.
	• Barriers to success included:
	  ○ Variation in expectations, both between departments as well as within departments.
	  ○ Challenges with interactive sessions - scheduling challenges due to limited facilitator availability resulted in limited time to co-design interactive sessions, as well as cancelled or postponed interactive sessions.
	  ○ Low attendance and/or limited participation among resident physicians in the interactive sessions.

Contact	LILT: Shari Furniss (sfurniss@hqc.sk.ca); 306-668-8810 ext 133) CQIP: Jocelyn Watson (jwatson@hqc.sk.ca; 306-668-8810 ext. 141) or cqip@hqc.sk.ca RQIP : Angie Palen (apalen@hqc.sk.ca; 306-668-8810 ext.127)
Resources	Find more information on our website: www.hqc.sk.ca. Follow CQIP on Twitter @CQIP_SK

TOWARD OPTIMIZED PRACTICE (TOP), ALBERTA

Name of program or service:	Improvement Facilitator (IF) Training
Overall program goal(s):	IF training provides participants with practical skills and knowledge, including: the Patient's Medical Home (PMH) approach, panel, quality improvement (QI) tools, facilitation skills, administering the PMH assessment, and much more.
Program description: • How many facilitators? • What is their focus- QI, EMR or Research facilitation? • How do they engage physicians/practices? • Outcome measures (how many practices/physicians etc. supported since inception?	Structure: 4 Days (2-day blocks, 2 weeks apart) Facilitated by TOP with ongoing mentoring and support from TOP Improvement Advisors, as well as provincial Community of Practice, open network supports and additional group learning opportunities. Number of facilitators: 106 Improvement facilitators (working on average 0.5 FTE per IF; average 2.5 IFs per PCN) 424 Panel managers (working on average 0.7 FTE per PM; average 10 PMs per PCN) 30 EMR experts (working on average 0.9 FTE per EMR expert; average 0.7 EMR experts per PCN) Focus: Improvement facilitators have a broad skillset which allows them to adapt focus depending on the needs of individual practices. The skillset is anchored in a deep understanding of primary care to bring quality improvement methods and modes of influence in supporting Patients Medical Home changes. How do you engage physicians/practices: TOP supports Alberta's Primary Care Networks (41) to invest in change agents, including improvement facilitators, to establish and maintain a supportive relationship with their member physicians. PCN's use multiple strategies to engage physicians with these supports including: practice outreach, continuing medical education events, and compacts. Outcome measures: 79% of PCNs have at least 1 improvement facilitator 76% of PCNs have at least 1 Panel manager 40% of PCNs have an EMR expert Scaled a primary care screening quality improvement program to enrol 972 physicians (over 1500 with shadow participation) resulting in an absolute improvement of 16% across 11 maneuvers. Achieved adoption of primary care panel processes with 69% of family physicians in PCNs (total number of family physicians in PCNs = 3697).

Program's funding model and sources	Various sources of funding to support program activities have been leveraged. Primary source of funding is the Ministry of Health through 1) Alberta Medical Association negotiated agreements for Programs and Services to Physicians and 2) specific grants to address priority clinical topics (e.g. opioid crisis). Additional funding sources include AMA member funding, Canada Health Infoway, Alberta Health Services, and Primary Care Networks.
Who does your program target?	Primary Care Networks, Physicians and primary care teams
• How many family physicians and/or family medicine and primary care practices does your program support? • Are PF hired by your program or by the primary care organizations?	TOP supports 41 PCNs in their efforts to support up to ~3700 primary care providers. PCNs have been successful in supporting 69% of primary care providers to adopt panel processes using practice facilitation and other strategies. TOP has 5 Improvement Advisors who support the Improvement Facilitators hired by PCNs or other primary care organizations.
Describe the Practice Facilitation role(s) in terms of competencies	The core set of competencies for Improvement Facilitators includes the following within a broad understanding of primary care: 1. Optimizing Patient's Medical Home and Integration a. Panel & Continuity b. Team based care c. Organized Evidence Based Care d. Patient Centered Care e. Access to Care f. Coordination of Care g. System Integration h. System Supports 2. Quality Improvement a. Model for Improvement b. PDSA testing c. Understand System Variation d. Using Data to Guide Decisions e. Scale-Up, Sustain and Spread f. Value Stream Mapping g. Quality as a Business Strategy h. Cognitive Task Analysis 3. Modes of Influence a. Leadership & Facilitation i. Engaging Others ii. Forming a team iii. Conflict Resolution iv. Leading Effective Meetings

	b. Transformational Change Management c. Diffusion of Innovations d. Influencing Complex-Adaptive Systems e. Influencing Clinical Behaviour Change
How do you build and sustain Practice Facilitation competencies? • How do you train facilitators and what continuing professional development do you provide them with or encourage them to undertake?	Practice facilitation competencies are developed and maintained within Improvement Facilitators through self-directed and formal approaches: 1. Training courses and modules (TOP, AHS, IHI Open School, others) 2. Practice based learning (Applied learning) 3. Coaching and mentoring (Experienced Improvement Advisors) 4. Community of learning (Hosted network webinars, open network supports) 5. Professional dyads (Physician Champions and Change Agents) 6. Group learning opportunities (Change Agent Day)
How is the overall program assessed and evaluated?	Capacity building in practice facilitation is evaluated focusing on two components: capacity (e.g., provincial investment in practice facilitation, ratio of practice facilitators to physicians/practice), and capability (e.g., the competencies, skills, access to tools and resources and confidence to perform as a change agent). Capacity is evaluated using the RE-AIM model, tracking adoption, growth, deployment, effectiveness and retention. Improvement facilitators who participate in the Improvement Facilitators training program provide the opportunity to assess capability overtime. The Improvement Facilitator training is evaluated following the Kirkpatrick Model. **Reaction** to training is assessed using daily session evaluations; **Learning** is assessed via pre- and post-session self-assessments; **Behaviour** is assessed through follow-up self-assessments, asking IFs to document their plans to use their learnings, and, importantly, through qualitative data captures that include subjective and objective perspectives ; **Results** are assess through the evaluation of initiative-specific goals, and contributions to system transformation.
List successes:	• Increased primary care system capacity for change with significant commitment to and investment in change agents, including improvement facilitators. • Building and engaging change agents in multi-modal supports to transfer knowledge, skill, attitudes and confidence in practice facilitation. • Demonstrated ability to scale primary care interventions using change agents. • Measure collective impact of capacity building approach through initiatives such as Alberta Screening and Prevention (ASaP) • Partnership with researchers to conduct research in and research on primary care practice resulting in tailored primary care interventions focusing on clinical behaviours.

List challenges:	• Additional change agent capacity required to achieve Patient's Medical Home. • Focusing effort of change agents on early majority vs. early adopter physician practices. • Supporting PCN Boards with evidence, outcomes and evaluation of their change agent resources. • Supporting PCNs to actualize full potential of improvement facilitator skills and abilities.
Key contact person:	Mark Watt: top@topalbertadoctors.org (TOP Program Delivery Lead)
Website and/or key reference material (i.e. role descriptions)	http://www.topalbertadoctors.org/events/improvementfacilitatortraining/
Resources	Available through Dropbox 1. Elevator Speech Worksheet 2. Meeting Agenda Template 3. Action Log template 4. Colours Exercise Worksheet 5. Position Descriptions 6. General and vendor specific EMR tip sheets 7. Improvement Tracking tools 8. Quality Improvement Guide 9. Guide to Panel Identification Training Session Presentations available on request

UNIVERSITY OF TORONTO: CQUIPS

Program Title:	Centre for Quality Improvement and Patient Safety (CQUIPS): Certificate Course
Target learners:	Health professionals including clinicians, administrators and senior trainees
Level:	☐ Introductory ☒ Intermediate ☐ Advanced ☐ Other
Jurisdiction	Canada
Overall curriculum design	Summary The Certificate Course is aimed at health professionals (e.g., clinicians, allied health professionals, administrators) whose work relates to patient safety or quality improvement, as well as senior trainees considering a focus on patient safety and quality improvement for their careers. Length: 1 day a week for in-person classes, assignment and / or individual project work The course consists of approximately 60 hours over ten months, covering core concepts in patient safety and quality improvement, using a mixture of didactic lectures, interactive workshop-type sessions, workplace-based exercises and

	presentations by class participants. Throughout the course, participants will carry out a patient safety or quality improvement project as a means of getting practical, hands on experience, while simultaneously applying the core learning concepts. Methods of learning Participants will frequently engage with various mentors one-on-one throughout the course, creating a rich learning environment, and increasing the success of their proposed projects. This course also provides an opportunity for participants to network with other individuals passionate about patient safety and quality improvement. The relationships built often continue beyond the duration of the course, which many previous participants have found beneficial as they continue to build their careers. Participants will learn key concepts such as: • Core definitions and epidemiology in safety and QI • Approaches to measuring healthcare quality and performance • Methods for assessing quality and safety problems • Quantitative methods: Run charts and control charts • Qualitative methods in safety and quality • Patient safety topics: (safety culture, human factors, incident analysis, communication and teamwork) • Patient engagement • Resource stewardship • Leadership (leading change, stakeholder engagement) • Health informatics • How to teach QI to others • Health policy and the clinical microsystem
Evaluation methods:	In order to successfully obtain the Certificate of Completion, participants must complete three exercises/assignments that are based in their clinical work (e.g., a PDSA cycle, a stakeholder interview, a process map of a clinical process related to a larger QI project)
Funding source(s):	Program funded by tuition fees paid by participants.
Successes to date	The Certificate Course received the 2010-2011 Colin Woolf Excellence in Course Coordination from the University of Toronto and we will be applying for accreditation by the University of Toronto CPD for 2018-2019.
Contact	Lisha Lo : lisha.lo@sickkids.ca | 416 813 7654 ext. 228513 Website: https://www.cquips.ca/

UNIVERSITY OF TORONTO: EQUIP

Program Title:	**The Excellence in Quality Improvement Certificate Program (EQUIP)**
Target learners:	Clinicians
Level:	☐ Introductory ☐ Intermediate ☒ Advanced ☐ Other
Jurisdiction	National / International
Overall curriculum design	**Overview:** The EQUIP program is intended for academic faculty seeking to more meaningfully integrate QI into their clinical work or scholarly activities, faculty members who have a role in operational QI work for their department or hospital and would like to develop advanced skills to increase their likelihood of success, and senior trainees wanting to make QI an academic career focus. It's enriched content and deeper dive into QI methodologies should make projects more likely to succeed, and will prepare participants to maximize their project's impact and receive academic recognition for their work. **Length:** The EQUIP program consists of 5 days of in-person training over the course of 9 months. Participants travel to Toronto, Canada twice – once for 3 days in the summer (July 25-27, 2018) and then again for 2 days 9 months later (May 9-10, 2019). Upon completion of the program, participants will be granted an academic certificate from the University of Toronto **Methods of Learning** EQUIP harnesses the experience of practicing academic clinicians with extensive expertise both executing successful quality improvement projects and developing successful advanced training programs in QI. The course goes beyond a superficial introduction to QI principles, and is particularly well suited to clinicians who have had some exposure to QI, but want to take their skills to the next level and/or achieve academic goals such as developing educational programs or publishing related to QI. EQUIP's enriched content and deeper dive into QI methodologies will not only make your projects more likely to succeed, but also foster: • Scholarly writing for optimal dissemination of QI innovations; • Teaching QI including curriculum design; • Advanced evaluation methods; • Preparing a portfolio for academic promotion on the basis of QI EQUIP places a strong emphasis on project mentorship and coaching – in addition to regularly scheduled teleconferences where participants can share their project progress and get feedback from EQUIP faculty, we will assign individual participants an EQUIP faculty mentor with a wealth of experience successfully

	executing QI projects in academic settings who can provide one-on-one coaching and support for their projects over the course of the program
Evaluation methods:	Program evaluation has consisted mainly of end-of-session evaluations of the course content and delivery methods. Overwhelmingly, the participants have rated the course very highly (typical satisfaction scores range from 9.5 to 9.9 out of 10).
Funding source(s):	Program funded by tuition fees paid by participants.
Successes to date (highlights):	We have trained one cohort of 15 academic clinicians, and have just enrolled the second cohort of 14 academic clinicians. They represent a wide range of specialties (including 1-2 from family medicine) from across Canada and the United States.
Contact	Brian Man-Fai Wong: BrianM.Wong@sunnybrook.ca Website: https://www.cpd.utoronto.ca/equip/

UNIVERSITY OF TORONTO: Faculty-Resident Co-Learning Curriculum

Program Title:	**Centre for Quality Improvement and Patient Safety (CQUIPS) and University of Toronto Department of Medicine: Faculty Resident Co-Learning Curriculum in Quality Improvement**
Target learners:	Faculty and residents
Level:	☒ Introductory ☒ Intermediate ☐ Advanced ☐ Other
Jurisdiction	Canada
Overall curriculum design	Background In Canada, both the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada have explicit requirements that mandate that residency programs formally teach quality improvement (QI) concepts and skills to residents. Despite this expectation, many training programs lack faculty capacity to deliver a QI curriculum. Advanced training opportunities in QI exist for practicing physicians, but those courses are not designed to develop faculty to teach QI to learners. The Faculty-Resident Co-Learning Curriculum in QI, created by Drs. Brian Wong and Kaveh Shojania in the Department of Medicine at the University of Toronto, addressed this need by taking the innovative approach of teaching faculty and residents together, with the goal of developing a cadre of expert faculty who could

eventually teach QI to others. The idea was that faculty could attend the curriculum, observe how QI was being taught, and then develop the necessary skills to become teachers and mentors themselves

Objective

To achieve the dual goal of addressing the residency training and faculty development gap as they relate to quality improvement education

Curriculum design

We conducted a needs assessment to inform the design and delivery of our co-learning curriculum in QI by reviewing the literature for teaching QI to residents and interviewing QI curricular leads in the United States and Canada to establish the most successful and feasible approaches that have led to successful implementation of a QI curriculum.

Our key curricular design principles were as follows:

(1) residents and faculty are co-learners and will attend the formal teaching sessions together to participate in experiential learning activities to develop knowledge and skills in QI;
(2) residents from a given subspecialty division work in teams with a faculty lead in their division to plan and carry out their QI project, which allows for individual team members to take a more active role during lighter clinical rotations, while handing the project off to other team members while on busier rotations; and
(3) wherever possible, QI projects should align with departmental quality priorities and ongoing initiatives.

Method of learning:

The curriculum consists of 2 workshops, typically in September and January, and a final session in June that involves a keynote speaker and group project presentations. Each group of residents is expected to conduct a QI project supervised by their Co-learning faculty.

Outcome and successes

Based on positive participant feedback, the program saw rapid expansion from a pilot program for 3 subspecialty medicine programs in 2011-2012 to over 35 programs in the Departments of Medicine, Paediatrics, Surgery, Obstetrics & Gynaecology, and Ophthalmology. As of June 2018, we have taught over 100 faculty members across all academic job descriptions and ranks from these clinical departments, and developed over 25 QI teachers and over 50 QI mentors. The emergence of these skilled QI teachers and mentors illustrates both the positive impact that the curriculum has had from a faculty development standpoint, and its long-term sustainability.

Evaluation methods:	We have undertaken both a preliminary evaluation to address acceptability and feasibility, as well as a more in-depth longitudinal qualitative evaluation, both of which have been published in peer-reviewed journals: 1) Journal of graduate medical education 2013, 5(4), 689-693. 2) Academic Medicine 2017, 92(8), 1151-1159.
Funding source(s):	Department of Medicine, Centre for Quality Improvement and Patient Safety
Successes to date (highlights):	Many of the projects carried out as part of the Co-Learning Curriculum have been extremely successful, and have been presented as abstracts at national and international meetings. As of June 2018, 6 projects won conference awards, the most notable being the Presidential Poster Competition Award Winner awarded to the residents in the Endocrinology training program at the international Endocrine Society meeting. Six projects have also been published in the form of peer-reviewed manuscripts.
Contact	Brian Man-Fai Wong: BrianM.Wong@sunnybrook.ca Website: https://www.cquips.ca/
Resources	1) Journal of graduate medical education 2013, 5(4), 689-693. 2) Academic Medicine 2017, 92(8), 1151-1159.

UNIVERSITY OF TORONTO PRACTICE-BASED RESEARCH NETWORK (UTOPIAN)

Organization:	University of Toronto Practice-Based Research Network (UTOPIAN)
Name of program or service:	Practice Based Research Network
Overall program goal(s):	• Conduct and support high-quality research to better serve the primary care community and patient population • Improve the quality and cost-effectiveness of services offered by the healthcare system • Secure lasting improvements to health nationally and internationally
Program description: • How many facilitators? • What is their focus- QI, EMR or Research facilitation? • How do they engage physicians/practices? • Outcome measures (how many practices/physicians etc. supported since inception?	Focus #1: EMRs The UTOPIAN Data Safe Haven is a secure researchable database comprised of de-identified patient records extracted from electronic medical records (EMRs) in contributing primary care practices associated with the University of Toronto. The data stored in the UTOPIAN Data Safe Haven are used by researchers at the DFCM to answer questions about primary health care (secondary data analyses or clinical research). As of March 31, 2018 total of 376 family physicians contributes data to the DSH, it contains 578k patient records. Subset of the data is contributed to trusted third parties such as CPCSSN, Diabetes Action Canada and ICES. Focus #2: Clinical research PFs assist PIs with conduction of a wide range of clinical studies covering REBs, recruitment and consenting, data collection and results dissemination. Number of facilitators 2FTE out of which 1.2 FTE assigned to two large, funded projects. How do you engage physicians/practices Website and e-mail. Contact through UTOPIAN Scientific Advisory Committee (site reps). Phone/ in-person when recruiting for studies. Outcome measures For DSH number of contributing physicians & patient records; publications for secondary data analyses. For clinical research: # of projects; overall demand and feedback.
Program's funding model and sources	Cost recovery model for services (http://dfcm.utoronto.ca/getting-utopian-support). Grants and projects. Yearly contribution from the FMTUs.

Who does your program target?	Family Physicians in practice, allied health professionals and other staff members. Researchers from outside family medicine conducting studies in primary care.
• How many family physicians and/or family medicine and primary care practices does your program support? • Are PF hired by your program or by the primary care organizations?	14 family medicine teaching units affiliated with Dept of Family & Community medicine at UofT, around 1,500 family physicians. It is estimated that 5-10% of these faculty members are actively involved in primary care research on an ongoing basis. PFs are hired by University of Toronto and assigned to work with physicians/ practices based on needs of the project and specific skills required.
Describe the Practice Facilitation role(s) in terms of competencies	See attached job description.
How do you build and sustain Practice Facilitation competencies? • How do you train facilitators and what continuing professional development do you provide them with or encourage them to undertake?	CPD is encouraged and supported by UTOPIAN & UofT. Staff waivers for up to 4 courses through School of Continuing Studies are available every year (value of $3,000). In addition, wide range of soft skills and computer courses are offered through UofT's Organizational and Learning Development Centre (3 PD days are available every year). Starter courses include Foundations of Project Management and consequent PMP designation; Leadership course (conflict management, negotiation). Two of the PF are currently enrolled in MSc program. Attendance at core conferences (NAPCRG PBRN & ICPF; FMF; local ON ones) encourages networking and connections to similar programs provincially, nationally and internationally.
How is the overall program assessed and evaluated?	No formal assessment yet. Informal feedback from PI and participating physicians is collected on regular basis.
List successes:	Ability to retain staff members on a long-term basis. Capacity to and proven track record of facilitating primary care research. Trained 65+ family physicians, AHPs and research staff from across the FMTUs on conducting research in primary care (Idea to Proposal course). Established relationship with the sites, physicians, research and administrative staff in practices.

	Developed robust procedures around data extractions and use (SOPs); development of SOPs for clinical research well under way (Aug 2018)
List challenges:	Budgetary challenges. Engagement with wider number of physicians and team, collaborations tend to involve the same ones.
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