THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

INVITATIONAL QUALITY IMPROVEMENT SYMPOSIUM

September 24–25 2018

SYMPOSIUM PROCEEDINGS

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Executive Summary

The College of Family Physicians of Canada (CFPC), the Canadian Foundation for Healthcare Improvement (CFHI), Health Quality Ontario, and Réseau-1 Québec co-hosted the Canadian Invitational Quality Improvement Symposium in Mississauga, Ontario, September 24 to 25, 2018. This two-day conference brought together key stakeholders and leaders in family medicine quality improvement (QI) from across Canada, leaders from the United States and Sweden, and patient representatives. The first day consisted of a family medicine residency stream, a family practice facilitation stream, and a combined session on QI courses and programs across Canada. The second day consisted of a National QI Symposium.

Key Messages: Family medicine residency programs

- Residents should be provided with some introductory knowledge and some basic QI skills to help them when they go into practice
- There are learning methods that allow these competencies to be introduced without adding much burden to residents and teachers
- There are some successful QI education programs in which family medicine teachers and residents learn about QI together

Key Messages: Family practice facilitation support

- There is evidence that practice facilitator programs result in practice improvements in primary care
- Practice facilitation programs offer a significant return-on-investment (ROI), and the capacity built can support future initiatives
- Provinces such as British Columbia, Alberta, and Quebec have invested in practice facilitator programs to support family physicians and the teams they work in

Key Messages: National Symposium

- QI provides tools, ranging from simple easy-to-use approaches to sophisticated methods, to help family physicians and their teams improve the care they provide and improve their own work experience
- QI is a core activity within everyday practice and within the role of being a family physician. However, support and resources are needed.
- Electronic medical record (EMR) data provide a rich source of information to guide practice improvement. However, they need to be accessible in report form to family physicians and teams; resources are needed to help teams analyze them.
- Patient representatives at the meeting highlighted the importance of QI and the need to include patients in QI activities that affect patient care
- New partnerships have been forged within and across provinces, including closer collaboration between CFPC Chapters, provincial organizations and ministries, and departments of family medicine

- There is a need for increased, targeted advocacy efforts to regional, provincial, and federal policy-makers for resources to support QI in family medicine and primary care

Symposium Next Steps

1. Increased provincial-level advocacy for resources to support QI in family medicine and primary care.
2. Increased country-wide advocacy to ensure access to EMR data for QI
3. A guide to help residency programs incorporate QI and research in their curricula, including clarification of what the competencies entail and ideas about how to teach and assess them.
4. Explore continuing professional development credit incentives for QI-related activities in daily practice.

Background, Context, and Goals

The CFPC launched its Practice Improvement Initiative (Pii) in 2017 to promote QI in family medicine. The CFPC conducted an in-depth needs assessment and undertook an environmental scan from February to May 2017 to explore the status of QI in the provinces and territories and to identify existing curricula approaches and programs in the departments of family medicine across the country, as well as assess the respective needs, gaps, and resources. This environmental scan identified needs and opportunities for two main streams: one to support family physicians and their teams, the other to support the departments of family medicine in Canada. These became the two main streams of the Pii and highlighted the need across the streams to bring people from the provinces together. In both areas, there were excellent programs and initiatives, but it emerged that there was considerable variability across the country regarding resources and programs and a strong wish by all to advance QI in family medicine and primary care.

A crucial component of this work was this symposium, which the CFPC co-hosted with partners CFHI, Health Quality Ontario, and Réseau-1 Québec. The symposium brought together educators, clinicians, policy-makers, representatives from government and CFPC provincial Chapters, patients, and other Canadian and international stakeholders.

Symposium Goals

The symposium brought together key stakeholders from across Canada who work, or are strongly interested, in QI, practice facilitation, research and data.

The symposium consisted of two days with streams that addressed areas the areas of practice facilitation, residency programs, summaries of different QI programs and opportunities for increasing intra- and inter-provincial/territorial collaborations. It also incorporated international perspectives, including the work being done by the Agency for Healthcare Research and Quality (AHRQ) and in Sweden, as well as understanding the patient perspective.

In undertaking the environmental scan and planning the symposium, there existed a wonderful spirit of collaboration and a willingness to share and help, as well as to invite others to help. Current innovations were discovered, which could be spread and scaled up.

Day 1: Practice facilitation, residency, and QI courses

The first day had two parallel streams in the morning: a) QI and research in family medicine residency programs; and b) practice facilitation to support family physicians and their teams undertake QI. The afternoon was a joint session that explored QI workshops, courses, and other education programs available across Canada for family physicians, their colleagues from other professions and their teams, as well as family medicine residents and faculty.

Stream 1: Practice facilitation

The Pii environmental scan indicated that while many family physicians and the teams they work in generally support undertaking continuous improvement in their practices, they often do not have the capacity, experience, and support to undertake that work. Practice facilitation was identified in the scan as a way of addressing these challenges and barriers to QI in the workplace.

The practice facilitation stream participants included experts, organizations, clinicians, administrators, and policy-makers from many jurisdictions across Canada involved in practice facilitation or work that could be supported by practice facilitation. The objectives of the stream were to:

- Explore the evidence base underlying practice facilitation
- Explore the various roles and competencies required of practice facilitators
- Become acquainted with programs and models across Canada that support practice facilitation, what they look like, and how they are resourced and funded
- Identify enablers, challenges, and opportunities for practice facilitation support for primary care providers across Canada
- Identify infrastructure and approaches needed to build and spread practice facilitation competencies based on requirements and contributions from local and national organizations

Evidence and Spread for Practice Facilitation: Dr. Bill Hogg

Dr. Bill Hogg of the University of Ottawa explored the evidence base underlying practice facilitation by contrasting how practice facilitation started and the role evidence played in its spread in different regions of the world. He cited several studies that showed a positive ROI for practice facilitation activities and programs. Using examples from Canada, the United States, Australia, and The Netherlands, he highlighted how practice facilitation programs successfully supported QI activities. He also shared an example of a successful practice facilitation program in Ontario that was discontinued due to funding cuts, highlighting the importance of sustained financial commitment to such programs.

Moreover, he shared two relevant articles on practice facilitation. The first being a cost-consequences analysis on the cost savings associated with improving appropriate and reducing inappropriate preventive care. Bill highlighted that "the literature has shown that outreach facilitation is one of the most effective means of improving the delivery of primary care preventive health services." Crucial to this is "a facilitation approach that incorporates a number of intervention strategies tailored to the

environment and needs of the practice." [*] The second article was an overview of a systematic review and a meta-analysis about effectiveness of practice facilitation in primary care. The study suggested that "practice facilitation has a moderately robust effect on evidence-based guideline adoption with primary care". [†] However, it was highlighted that fidelity factors such as tailoring, the number of practices per facilitator, and the intensity of the intervention, have important resource implications. (See Table 1).

Table 1: Highlights of practice facilitation benefits

Benefit	Description
Prevent patient acuity[‡]	Practice facilitation enables new processes that support an increase in appropriate preventive acuity for patients within a practice
ROI	Savings occur at patient, practice, and physician levels. Some studies set the ROI at 40 per cent.
Better care for less money	A meta-analysis of 19 practice facilitation interventions showed that each demonstrated improvements in care and costs.
Enables scale up of initiatives	In some models, practice facilitators continue to reach new physicians and enable improvements in practice teams even after a specific initiative ends.
Increase team-based QI	Practice facilitators engage multidisciplinary teams to plan, test, and implement improvements together.

Models and Programs: In Canada and abroad

A panel provided an overview of the diverse models and organizational approaches of practice facilitators, their strengths, and experiences of success and challenges. This included presentations from Alberta's Toward Optimized Practice (TOP), Quebec's Réseau-1, Ontario's Champlain LHIN, and the AHRQ from the United States. These presentations demonstrated the diverse contexts and approaches driving practice facilitation across the country. The approaches recommended by the panel are listed in Table 2.

[*] Hogg W, Baskerville N, Lemelin J. Cost savings associated with improving appropriate and reducing inappropriate preventive care: cost-consequences analysis. *BMC Health Serv Res*. 2005;5(1):20. doi:10.1186/1472-6963-5-20
[†] Baskerville NB, Liddy C, Hogg W., Systematic review and meta-analysis of practice facilitation within primary care settings., *Ann Fam Med*. 2012 Jan-Feb;10(1):63-74. doi: 10.1370/afm.1312.
[‡] Patient acuity is a patient safety concept and is used to measure staff allocation (and budget determination).

AHRQ: Robert McNellis

EvidenceNOW Initiative (focus on heart health)

- Helps practices identify ways to build their capacity to receive and incorporate other patient-centred outcomes research findings
- Studies how external QI support can help primary care practices
- Builds and disseminates a blueprint of what works to transform care
- Organization: Reaches more than 1,500 small- to medium-sized primary care practices with more than 5,000 primary care professionals that serve around 8 million patients; deployed 70 to 100 practice facilitators; employs more than 500 people
- Funded: $112 million (US) investment over four years resulting, in part:
    - Seven grants to establish regional cooperatives
    - One grant for independent, external evaluation
    - The creation of a technical assistance centre

TOP, Alberta and Accelerating Change Transformation Team (ACTT – Alberta) Arvelle Balon-Lyon

- Builds content for primary care practice change
- Builds capacity in improvement facilitators, physician champions and other change agents
- Supports & Collaborates with stakeholders (e.g. Primary Care Networks, AB Zones, Ministry)
- Funded: Primary source of funding is the Physician Services Budget through the Alberta Medical Association (AMA), additional grants including research grants to address priority clinical topics, Alberta Medical Association (AMA) member funding, Canada Health Infoway, Alberta Health Services grants

Champlain LHIN: Dr. Bill Hogg

Practice Excellence Facilitation Program

- Three practice facilitators provided support to primary care providers
- Facilitators tailored their approach to meet practice needs based on evidence-based QI tools and methods
- Program reached family physicians and nurses from all models across eastern Ontario region
- Funding: Regional health authority for three years (program was discontinued)

Agents d'amélioration continue de la qualité (AACQ): Jean-Luc Tremblay

- The Ministry of Health and Social Services' (MHSS) management framework for GMF-Us came into effect on April 1, 2017, and provides for the integration of a CQI agent in each of the 46 GMF-Us in Québec
- These agents act as practice facilitators in the different areas of the GMF-U, with their primary role being to consolidate a CQI culture and coordinate projects identified as local priorities

- CQI agents are employees of the Integrated Health and Social Services Centres and Integrated University Health and Social Services Centres (CISSS and CIUSSS), who work in the GMF-Us (hybrid facilitation model)
- Funding: Through the MHSS, using a weighted panel size to determine allocation of resources

Discussion

The preceding presentations prompted a discussion between panellists and participants on key features of a practice facilitation infrastructure. The courses specifically designed or relevant for practice facilitators are available in the section Joint Afternoon Session: Quality Improvement Courses (see page 15).

Table 2: Highlights of recommended infrastructure and approaches for practice facilitation

Approach	Description
Provincial frameworks	• Embedded within primary care organizations • Guided and supported through a provincial framework
CQI culture	• Supported via leads at provincial and regional/local levels
Advisory groups	• To provide input and guidance • Collaborate to offer supports

Communities of practice	• Provincial support through:
	  ○ Networks of practice
	  ○ Basic training
	  ○ Regular events

Practice facilitators ratios to practices	• In most cases, a single practice facilitator may be assigned to several practices. In some cases, in some provinces, large practices may be assigned a full-time practice facilitator. Distribution is based on panel size, weighted panel size, and/or voluntary uptake by primary care organizations.
Capacity building	• The investment in practice facilitation is tied to identifiable capacity building for system transformation, such as to advance the Patient's Medical Home

Approach	Description
Strategic plan or blueprint	• These include organizational strategies to identify/recruit, develop, deploy, and monitor progression/retention of practice facilitators within a broader change agent blueprint, including partnership with physician champions
Funded practice facilitation positions	• Quebec's Réseau-1 initiatives employ and deploy practice facilitators within primary care organizations • TOP Alberta and the AHRQ train and develop practice facilitators, who work for primary care organizations

Practice Facilitator Roles: Masters of one or facilitator of all?

The Pii environmental scan identified different ways in which the practice facilitator role is applied in different jurisdictions. These include:

- QI facilitators
- Research facilitators
- EMR data facilitators
- Combinations of any of the above

This phenomenon was explored further during the session, with presentations from various speakers highlighting the different roles or profiles. The presentations also highlighted different competencies developed for the roles by different organizations, as well as the enablers and barriers.

AHRQ: Robert McNellis

Robert McNellis outlined the development of an expanded curriculum for practice facilitator training and shared some lessons learned.

- Objective of curriculum: provide entry-level training for practice facilitators to help primary care practices achieve their QI transformation goals
- Core competencies: Content mastery (e.g., organizational change) and applied skills (e.g., QI methods, use of health information technologies meeting facilitation)
    - Foundational knowledge: Improving primary care, organizational change, patient-centred medical home principles, and the primary care environment
    - General skills: Basic QI methods, practice assessment, and meeting management
    - Specialized skills: Use of health information technology and work process engineering
    - Professional skills, knowledge, and commitment: Effective communication, building trust, and life-long learning

TOP: Mark Watt

- Practice facilitator competencies include:
  - Core competencies—for example, knowledge of the model for improvement, plan-do-study-act testing, and using data to guide decisions
  - Advanced competencies—for example, value stream mapping, quality as a business strategy, and cognitive task analysis
- Assessment and evaluation of practice facilitator roles is done through the Kirkpatrick model
  - Reaction, learning, behaviour, and results
- Enablers and barriers include:
  - Shift from project-based thinking to CQI
  - Shift from supporting independent role of practice facilitator to supporting a team of practice change agents

University of Toronto Practice-Based Research Network (UTOPIAN): Michelle Greiver

- Practice facilitation competencies include:
  - Excellent interpersonal and communication skills
  - Ability to manage multiple research projects
  - Demonstrable computer skills, understanding of statistical software and survey tools
- Enablers:
  - Communication: Team meetings and administrative support
- Barriers:
  - Time, funding, and bureaucracy
- Lessons learned:
  - Recognize that practice coordinators are key members of the team
  - Support and invest in their progress and career development
  - Hire a great operations manager
  - Collaborate with other organizations

Patient-Oriented Research (POR) Facilitation Program in Quebec: Annie LeBlanc

- Practice facilitation competencies include:
  - Facilitation skills development: currently being assessed through an applied, practice-based initiative with the goal of developing an onboarding POR facilitation program
- Enablers:
  - Shared collaborative vision from knowledge users and stakeholders
  - Shared infrastructure
- Barriers:
  - Financial sustainability of POR facilitators
  - Reluctance to conduct research initiatives

- Lessons learned:
  - Adaptation to changing environment needed
  - Importance of assessing respective roles and responsibilities in a targeted environment
  - Similarities (and differences) between research and QI

A Quality Improvement Agent's Experience in a Quebec GMF-U: Edith Bernier

- Practice facilitation competencies include:
  - Teamwork
  - Communication skills and emotional intelligence
  - Creativity
  - Partnerships
- Enablers:
  - QI executive advisers for all provincial GMF-Us
  - Participation in virtual community of practice and creation of local QI committees
  - Proximity, collaboration, and support with the medico-administrative co-management dyad
- Barriers:
  - Insufficient knowledge of role
  - Resistance to change
  - Lack of communication about changes
  - Limited resources (human, financial, material)
  - Insufficient time allocated for some QI agents
- Lessons learned:
  - Team members must be on board before planning a project
  - Efficiency of shared leadership
  - Regular team follow-ups and a good communication plan

Practice Facilitation: Mapping the competencies

Practice Facilitation Competencies: Eileen Patterson (QI Consultant and Facilitator)

Specific competencies developed by leading practice facilitation organizations were outlined by a second panel, consisting of representatives from the AHRQ, UTOPIAN, the AACQ, the Alberta Medical Association (AMA), TOP, and Laval University. These organizations showed that different models of practice facilitation can serve in different circumstances, depending on funder expectations, size of practices, structure of the supporting organization, aligned system level goals, etc.

All practice facilitator roles were built on a foundation of understanding the primary care context in which they operate, the effective use of EMRs for QI and decision making, and change management. Improvement models had QI, facilitation, leadership, and team building as core competencies. Research models focused on data analysis tools and mentorship skills. Appendix C provides an overview of the competencies from each presentation.

Discussion

At the end of the preceding presentations, the floor was opened for further discussions between the participants, panellists, and presenters. Two questions were used to guide the discussions, highlights of which are provided below:

Aside from more money, what would help you advance practice facilitation within your work?

- Sharing physician leadership and engagement is foundational
- Accelerating scale up with a central coordinating practice level QI body
- Using an interdisciplinary approach at local and national levels
- Identifying and supporting local champions as role models and influencers
- Advocating with government on a provincial or national level, and influencing policy making
- Involving patients at all levels of planning and implementation
- Using a capacity building approach for scale and sustainability
- Aligning policy and data infrastructure for access to decision support information
- Acting locally, collaborating nationally, and networking to assist smaller jurisdictions to advance
- Making the case to decision makers for QI and practice facilitation lead to more effective and efficient care
- Linking the importance of team-based QI with reducing/mitigating physician burnout

What could national organizations do to help accelerate your progress?

- Work synergistically using CFPC initiatives such as the Patient's Medical Home (PMH), faculty development, continuing professional development (CPD); leverage non-physician members to help with promotion (don't reinvent the wheel)
- Train facilitators (train the trainers) to draw on and spread nationally existing curricula (working with provincial partners)
- Create a central repository of resources, tools, processes, data for decision making processes, clear examples of implementation approaches, and contacts for collaboration
- Link to existing and emerging national work such as accreditation, patient advocacy, research, etc.
- Address policies to promote health equity and efficiency (data and privacy laws)

Stream 2: Residency programs at departments of family medicine

In 2016 the CFPC was asked to clarify the competencies related to QI and research as outlined in the CanMEDs-FM 2017 and the Red Book. Specifically, the CFPC was asked to provide suggested learning objectives as well as teaching and assessment methods to implement the QI and research competencies in CanMEDS-FM. Following an extensive environmental scan and several iterations of stakeholder consultations, a specially convened advisory group compiled a set of suggested learning objectives for QI and research for residents and the first five years in family practice (FFYFP).

Goals and objectives

The focus of the second stream was to discuss QI and research in residency programs at the departments of family medicine (DFMs). Present at this session were representatives from all DFMs,

including program, QI, and research directors, the CFPC research, education, and accreditation departments, and colleagues from the Royal College of Physicians and Surgeons of Canada (Royal College).

The objectives of the second stream were two-fold: First, to get buy-in on suggested QI and research learning objectives for residency and FFYFPs; and second, to determine appropriate teaching and assessment methods for QI in residency and FFYFP. Prior to the Symposium, the CFPC distributed this list of suggested learning objectives to relevant participants, who reviewed these in advance and provided feedback during the first part of the stream.

QI and Research Learning Objectives: Feedback

Overall, there was agreement on the proposed learning objectives and a willingness to use them as a resource for curriculum planning and assessment, pending some further clarifications related to the core and exemplary learning objectives. Participants noted that more clarity is needed about how the core learning objectives for QI should be used within an already compressed two-year residency program to avoid resident burnout. Burnout was also identified as a concern for program directors themselves. It was suggested that residents in a research stream could take on more work if specific research learning objectives were included in an enhanced third year. The choice of a QI or research project during residency would also need to be addressed within the individual programs. Participants stated that more discussion is needed on when to teach QI: some students are taught about QI during their undergraduate programs, some during their residency, and others in their FFYFP. The CFPC was also asked to provide guidance and clarity about whether residents need to do both QI and research projects, and if this level of activity will be mandated in the Red Book.

Regarding the FFYFP, it was suggested that learning objectives should be made more specific for clinicians in academic practices reflecting the need to know how to teach QI and do research. In addition, specific learning objectives for those on a clinician research track are needed. It was recommended that there also should be continuity in QI from residency to FFYFP and CPD for physicians in practice. Awareness of what constitutes a QI activity should be raised as there may be family physicians who are conducting or participating in QI activities but may not be aware of it.

QI Learning Methods

Three approaches to learning about QI and research were suggested:

1. The need for a culture shift (change management).
2. The need to tailor the teaching approach to the context of the learners and the programs.
3. The need to create a national standard.[§]

The minimum outputs for residents for research and QI combined could include:

- Demonstrate the ability to formulate a general question (research or aim statement)
- Demonstrate an understanding of the appropriate methods and data
- Demonstrate the ability to articulate results and documentation

[§] However, it was stated that a national standard would not be feasible as an accreditation standard.

QI Assessment Methods

Brent Kvern, the CFPC's Director for Certification, Assessment, and Examinations presented some key considerations for assessing QI in residency.

- QI has a skill set that builds on, and can be tied to, information literacy skills. These skills could be demonstrated through the production of a project.
- Brent recommended that for critical appraisal/PEARLs for residents/planning a QI project:
    - Recognize we often mix the skills of identifying literature with the skills of critiquing literature; these are two very different skills sets
    - Start literature critique skills with a guideline and determine if it is constructed in such a way that its findings apply to the patients the resident cares for
    - Choose a good quality systematic review from the guideline's bibliography, then critique it
    - Choose a good quality primary therapeutic study from the systematic review's bibliography, then critique it
- Use the critiques to help build the background rationale for their QI project
- Have an extremely clear and transparent marking rubric for the QI project outlining all the expected project components

Suggestions From Departments of Family Medicine

Some ideas were expressed by the group to support the development of and nurturing of teaching of research and QI in residency programs and during the FFYFP in practice.

Synergize

There is a need to build connections between QI and research.

Culture change and change management

There is a need for a cultural shift in family medicine, which should start in residency, so that QI is embraced as part of everyday practice. Implementing meaningful change management will need to be a deliberate, planned approach and there should be a national strategy in place coordinated by the CFPC.

Approach that allows tailoring to the specific context of departments of family medicine

There is an acceptance of QI into the scholarly process but DFMs need customizable programs and access to, or awareness of, existing resources. More specifically, there is a need to tailor the approach to the context of the learners and the programs. DFMs in turn need to value QI as a scholarly activity that is included in promotions of faculty.

Learning Objectives for QI and Research

The development of the Learning Objectives will enable the DFMs to graduate family physicians and the FFYFP at the required level of competence as outlined in the Red Book.

Program QI Lead

Each DFM should have a QI program lead as a best practice.

Teacher Preparedness

Teachers should have some basic QI knowledge and skills to support their residents. Faculty development in this area is needed. Accessible learning opportunities need to be provided. The CFPC could support advocating for training by provincial Health Quality Councils. For FFYFPs there is a need for guidance on QI-related competencies and their supporting learning objectives that can inform CPD opportunities in this area.

Assessment and Accreditation

Minimal requirement assessment standards could be defined, reflecting what is needed for licensing a family physician. Accreditation cycles could be used for peer consultation opportunities.

Guidelines

The CFPC should produce some guidelines on fundamental (basic), intermediate, and advanced level streams related to QI and research.

Resources

Bilingual catalogues of successful prototypes that have tools and/or results for QI and research should be made available (e.g., SPIDER). It would be helpful to have a repository of QI projects and successful examples. Vignettes/videos could help.

Marketing and Communications

Material about QI and research needs to be provided on the CFPC's website, including videos of successful QI projects. In addition, videos of rural physicians who have integrated QI into practice should be shared. These stories need to be shared with residents to encourage culture change.

Awards

It would be beneficial to have QI and practice improvement awards at events such as Family Medicine Forum (FMF).

Collaboration

A DFM's QI and research directors should work together to find opportunities to share experiences and collaborate. To further support this work and provide an opportunity, it would be useful to create a place to meet for half a day at FMF.

Creating communities of practice for QI was also identified as a crucial tool for collaboration.

Advocacy and Engagement

CFPC needs to engage stakeholders (including patients, community) to advocate for QI and research. The importance of QI in residency and in practice needs to be clearly articulated via an elevator pitch as part of this advocacy and engagement strategy.

Practice-based Research Networks

Graduates should be encouraged to join a practice-based research network (PBRN).

Joint Afternoon Session: Quality improvement courses

In the afternoon session, participants from the Residency Stream and the Practice Facilitation Stream came together to hear briefings about QI initiatives across the country. This included Health Quality Ontario-IDEAS, ASPIRE from the Royal College, the Canadian Patient Safety Institute, University of Toronto's CQUIPS, CPSI Patient Safety Education Course, HQCA Online Course, British Columbia's Clinician Quality Academy, the Compas+ program, and the Saskatchewan CQIP Intermediate Course, as well as a focus on Residents.

CFPC provided a summary of QI Courses at introductory and intermediate levels, and practice facilitation programs, which are outlined in Table 4.

Table 4: Introductory QI and practice facilitation courses and programs

Introductory	
Title and Provider	**Additional Information**
Advancing Safety for Patients in Residency Education (ASPIRE) Royal College of Physicians and Surgeons of Canada	Available in English and French
Canadian Patient Safety Officer Course Canadian Patient Safety Institute	Available in person or online
Certificate in Investigating and Managing Patient Safety Events Health Quality Council of Alberta	
Group-Based Quality Improvement Workshops Centre for Quality Improvement and Patient Safety (C-QuIPS)	One-day workshop
Effective Governance for Quality and Patient Safety Canadian Patient Safety Institute	One-day course
Foundations of Quality Improvement Program Improving & Driving Excellence Across Sectors (IDEAS)	Two-day course: three hours online; one day in-person workshop
Lean Improvement Leader's Training (LILT) Saskatchewan Health Quality Council	Traditional and flipped classroom**; 12 to 18 months
Practice Improvement Essentials (PIE Part 1 and 2) College of Family Physicians of Canada	Half-day workshop
Resident Quality Improvement Program (RQIP) Saskatchewan Health Quality Council	Flipped classroom; total duration 24 hours (completed in one to two years)
University departments of family medicine	

** A flipped classroom is a hybrid delivery approach with both online learning and classroom learning

Intermediate	
Title and Provider	**Additional Information**
Certificate Course Centre for Quality Improvement and Patient Safety (C-QuIPS)	Program duration is 10 months (60 hours)
Certificate in Investigating and Managing Patient Safety Events Health Quality Council of Alberta	Two-and-a-half-day course
Certificate in Patient Safety & Quality Management Course Health Quality Council of Alberta	Available in person and online; seven to eight months
Clinical Quality Improvement Program (CQIP) Saskatchewan Health Quality Council	Flipped classroom and online modules; 10-month program
Clinician Quality Academy BC Patient Safety & Quality Council	In person; five days of residency sessions, nine days of classroom sessions; eight months to complete QI project
Excellence in Quality Improvement Certificate Program (EQUIP) University of Toronto Faculty of Medicine	Advanced course; five days in person (completed over nine months)
IDEAS Advanced Learning Program (ALP) Improving & Driving Excellence Across Sectors (IDEAS)	Five months
Practice Improvement Essentials College of Family Physicians of Canada	Half-day workshop
Introductory/Intermediate	
Title and Provider	**Additional Information**
EXTRA: Executive Training Program Canadian Foundation for Healthcare Improvement	Available in English and French; 14-month program
Faculty Resident Co-Learning Curriculum in Quality Improvement Centre for Quality Improvement and Patient Safety (C-QuIPS)	Two workshops
IHI Open School Online Courses Institute for Healthcare Improvement	Offers certificate programs
Quality Improvement Programs Toward Optimized Practice (TOP)	In-person course; four days (two days at a time, two weeks apart)

Table 5: Practice facilitation courses and programs

Practice Facilitation Programs	
Amélioration continue de la qualité Réseau-1 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+ Réseau-1 Québec	Workshop duration: up to one full day
Primary Care Quality Practice Facilitation Program Pinecrest-Queensway Community Health Centre	Duration: 6–24 months
Patient Safety Education Program — Canada Canadian Patient Safety Institute	
TeamSTEPPS Canada Canadian Patient Safety Institute	Delivered in Alberta, in collaboration with Health Quality Council Alberta

Day 2: Provincial stakeholder stream

The second day of the symposium focused on advancing collaboration within and between provinces to support QI in family medicine and primary care across Canada. Key stakeholders included provincial and territorial health ministries, health quality councils, CFPC Chapters, departments of family medicine, and other national organizations.[††] There were representatives from Alberta, British Columbia, Manitoba, New Brunswick, Newfoundland and Labrador, Northwest Territories, Nova Scotia, Prince Edward Island, Ontario, Quebec, and Saskatchewan.

The morning featured presentations from organizations across Canada, Sweden, and patient representatives, which provided an insight into the successful programs across the country, some of them supported and resourced by provincial governments. The afternoon was dedicated to facilitating provincial discussions, an opportunity for key stakeholders to discuss their programs and map out a plan on how to best approach and advance QI in family medicine and primary care across their jurisdictions. More specifically, provinces were asked to agree on a vision for 2020, define goals for the next 18 months, and to set specific action items to be accomplished.

The symposium proceedings are organized based on the day's program.

Patient Reflection

The presentations started with a patient reflection by Donald Lepp, who shared his personal experience and highlighted that:

- Health care, at its core, is about relationships
  - Communication builds relationships, which builds trust
- Individual efforts make all the difference
  - Individuals have consistently gone the extra mile
  - These individuals have literally saved his family
- Patients can be an agent of change
  - Patients are increasingly becoming more sophisticated
  - Can common sense patient input overcome ideology?

Global Perspective: Primary Care Quality Sweden

Ulrika Elmroth, the project manager at the Swedish Association of Local Authorities and Regions (SALAR) Primary Care Quality, provided a global perspective. She highlighted that important factors drive improvement:

- Cooperation of professional organizations and authorities
- Automatic data collection, using existing structured EMR documentation
- Evidence and primary care core values
- Follow the law: Dataflow
- Support for users

[††] The full list of organizations represented is available in Appendix B.

The Canadian QI Landscape

Several provincial QI family medicine and primary care-related programs were highlighted by invited presenters.

Health Quality Ontario: Lee Fairclough

Health Quality Ontario's role is to bring about meaningful improvement in health care:

- Partner with patients
- Connect and build capacity for QI, support implementation
- Monitor and report on variations in quality

Three types of levers for large scale change:

- Type 1: Product mechanism
  - Targets performance management, price payment incentives, regulation, competition
- Type 2: Proactive support
  - Relies on building intrinsic motivation in staff to make the right change to improve
- Type 3: People focused
  - Education and training, national contracts, professional regulation, clinical quality

Saskatchewan Health Quality Council: Dennis Kendel

Clinical Quality Improvement Program (CQIP)

- By the end of the program, physicians will be able to:
  - Lead and facilitate CQI projects
  - Serve as internal consultants on CQI work
  - Teach clinical improvement tools and methods
- Program components:
  - Guided preparation and course pre-work
  - Flipped classroom learning
  - Action periods
  - Coaching support

Physician Panel Reports

- Designed to provide physicians with information about the population, or panel, of patients that they serve
- Initial offering is specifically for Saskatchewan's 1,200 family physicians

Primary Care Redesign

- The goal is to reduce reliance on acute care services by strengthening team-based care in the hospital and community, and applying an evidence-based approach for transferring patients from one care team to another (high quality care transitions)

Agents d'amélioration continue de la qualité pour les GMF-U du Québec: Jean-Luc Tremblay

Building on the presentation from the previous day, Jean-Luc went into more detail about the management framework of the CQI agents in the GMF-Us in Quebec.

Coordination and support at the provincial level:

- CIUSSS de la Capitale-Nationale was mandated by the province to provide support and coordination for the QI agents in the GMF-Us
- The executive adviser supports the consolidation of a CQI culture within the GMF-Us
- An advisory committee guides the executive adviser on strategic priorities

What works well:

- Regular communication from the CQI executive adviser
- A very active virtual community of practice of CQI agents
- Creation of the CQI executive adviser's advisory committee
- Local leadership in each GMF-U to determine, prioritize, and coordinate their CQI projects; local consultation and partnership strategies for CQI activities

What could be done differently:

- Hiring the executive adviser at least six months prior to the arrival of the first CQI agents to help facilitate their arrival in collaboration with the different partners
- Development and implementation of a quantitative and qualitative feedback mechanism linked to CQI project activities and results

Alberta Medical Association (AMA): Arvelle Balon-Lyon

Vision:

Engage all Alberta physicians and clinic teams in doing their part in building an integrated health system. To realise this goal, change management support for physicians is provided through what is known as the AMA ACTT programs. The change management program for physicians and their teams has 69 team members

Five strategic objectives of the AMA programs:

- Accountable & Effective Governance
- Patient's Medical Home
- Strong Partnerships & Transitions of Care
- Health Needs of the Community & Population
- Medical Neighbourhood

Role of the AMA change management team

- Support Alberta Physician Leaders
- Training the practice facilitators & physician champions on change packages, key engagement and influence tactics, quality tools and methods
- Host Networks to share learnings

- Support Boards & Leaders within the 42 primary care networks
- Support Provincial Zonal Committees
- Provincial Strategy

British Columbia Patient Safety Quality Council – Clinician Quality Academy: Andrew Wray

Program aim: To provide participants with the capability to effectively lead quality and safety initiatives in the process of improving health care quality.

Curriculum domains: Improving quality and safety; process and systems thinking; engaging others; leading change; measurement and using data; innovation, spread, and sustainability.

Successes: Seventy-one graduates, extremely positive feedback, and self-reported increases to skills and confidence.

Challenges: Time to apply skills to projects; commitment required of participants; support beyond the program; investment in mentors.

QI Supported by Data: Tara Kiran

Tara Kiran gave a presentation on data driven improvement, sharing the St. Michael's Hospital Academic Family Health Team journey over the last seven years. She shared 5 reflections from this journey:

- Listen to patients
- Take a 'big' picture
- Use data to understand the problem
- Look beyond the total
- Prioritise what matters

She told the story using examples from improvement initiatives related to timely access, cancer screening, high-risk prescribing, and patient-centredness, and equity. She ended by reflecting on the possibilities to support physicians to use data for learning and improvement moving forward.

Practice Facilitation and QI Training and Education Programs: Highlights from Day 1

Bill Hogg gave a brief presentation which highlighted the main discussion points from the previous day about the practice facilitation stream and the afternoon session on QI courses and programs across Canada.

Departments of Family Medicine Across Canada: Highlights from Day 1

Elizabeth Muggah and Donna Manca gave a brief presentation, highlighting the main discussion points from the residency stream from the previous day.

Other Canadian QI Activities

Practice-Based Research Networks

Michelle Greiver gave a presentation on UTOPIAN, outlining the main strategies, key achievements, and future directions of the PBRN.

Key components:

- Fourteen teaching units and approximately 400 practices, 1,500 faculty, and one million patients
- Provides support for primary care research (practice facilitators, data management and analysis, courses on research methods/writing)
- Holds primary care EMR database: UTOPIAN Data Safe Haven (more than 550k patient records in 2018)

Main strategies and key achievements:

- We build on existing excellent clinical care, QI, and research by:
  - Improving access to our practice—living laboratories for clinical research
  - Providing a Data Safe Haven
  - Increasing capacity and capability for research
  - Facilitating the process of high quality research
- Sixty-nine investigators trained through the Idea to Proposal course
- Data Safe Haven: More than 550k EMR records
- Clinical research and running more than 25 projects

Future directions

- Continue contributing to the culture of curiosity in primary care, by increasing participation in research—EMR data and clinical research

Canadian Primary Care Sentinel Surveillance Network (CPCSSN): Data Presentation Tool (DPT)

Sabrina Wong presented an overview of the network, its functions, and data.

- Statistics
  - 1.8 million Canadian patients
  - 1,250 practices
  - 12 PBRNs in eight provinces and one territory
  - Some EMR data date back to 2003
  - Started in 2008
  - $12.5M funding from PHAC
- Functions
  - CPCSSN's functions focus on QI (practice, jurisdictional level), chronic disease surveillance and research
- Data

- Provider profile, patient socio-demographics; disease/health condition; encounters; risk factors; examination; prescribed medications; laboratory tests; referrals; procedures

Provincial Round Tables: Discussion highlights and emerging plans

During the provincial and territorial discussion, each group was asked to identify some goals for advancing primary care QI work in their jurisdiction. The groups were asked to summarize their vision and suggest short- and long-term goals.

Alberta

The group committed to a better understanding of what really matters to primary care physicians in order to draw them into this conversation about QI and improve the provider experience. Like other provinces, they will be working on brokering deals with vendors to liberate and merge data to ease access. Lastly, Alberta is looking for ways to ensure patients and the public are more engaged by using advanced surveying tools.

One significant goal was to explore the re-establishment of a central coordinating committee to share experiences, address challenges, streamline advocacy efforts, and provide a provincial forum for relevant stakeholders to update others on ongoing work related to QI.

By 2020, Alberta will have:

- Resolved data ownership with EMR vendors, and reduced or removed the data extraction charges
- Advanced CPCSSN/HQCA reports/services across Alberta/PCNs
- Increased the QI interest quotient among family physicians and their health teams in primary care
- Incentivized and recognized QI efforts
- Improved patient engagement

In the next 18 months, Alberta will have:

- Re-established the provincial coordinating centre
- Started advocacy efforts to reconcile the provincial, national, and primary care network aims of QI
- Explored opportunities to further expand training and practice facilitation (or coaching)

Atlantic Provinces and Northwest Territories

The group emphasized the need to disseminate the information and knowledge gained at the symposium with others in their regions. Echoing the goals of the others, the group emphasized the need to create a coordinated strategy for the province or region by undertaking a needs analysis, and engaging stakeholders from government to front-line physicians and patients. This needs assessment will help create a value proposition and form a basis to generate support for resources (both financial and human) from the relevant ministries and health authorities.

By 2020, the Atlantic provinces and Northwest Territories will have:

- Built awareness and deepened the understanding of what QI means in family medicine and primary care

- Identified partners and key stakeholders in the field of QI for the respective provinces and territories and established clear roles and responsibilities
- Formulated a strategy for QI in their jurisdictions

In the next 18 months, the Atlantic provinces and Northwest Territories will have:

- Engaged the CFPC and other national organizations to support advancing QI in the provinces and territories
- Clarified the roles and responsibilities of key stakeholders working in the field of QI within the regions
- Started to build capacity for a practice facilitator role
- Engaged patients and families in the discussion around a QI strategy

British Columbia

The group highlighted that there was value in more coordination of QI activities to support ongoing and new activities in the province. This includes consistent and aligned messaging to family physicians on a provincial level to encourage a culture shift.

By 2020, British Columbia will have:

- Resolved data ownership with the EMR vendor and made data accessible
- Identified key players and outlined roles and responsibilities to reduce silos
- Centralized support and advocacy

In the next 18 months, British Columbia will have:

- Demonstrated the value of QI and the infrastructure that supports it to the Ministry to ensure there are no budget cuts
- Started to prepare a cost analysis and value proposition to support advocacy efforts
- Explored opportunities for practice facilitation

Manitoba

The group spoke about a need to conduct an environmental scan to identify the resources available provincially and identify possible gaps. Based on this assessment, a plan of action would be developed. It was suggested that strategies might include different sessions targeted to physicians (from one-hour lunch sessions, all the way to full day workshops). The group acknowledged accomplishing a great deal on their existing strategic plan and talked about the ongoing need for QI. They also identified funding opportunities through the pan-Canadian SPOR Network in Primary and Integrated Health Care Innovations (PIHCI) networks.

By 2020:

- Manitoba will have a plan to coordinate and implement interdisciplinary QI within primary care, including a marketing strategy with different intensities of information based on a readiness to change

In the next 18 months, Manitoba will have:

- Conducted a local environmental scan to synthesize what is already available to support QI and identify gaps
- Determined a strategy to both conduct QI and engage physicians in a grassroots, phased approach, rather than disjointed short term projects
- Enhanced coordination of QI through networks that involve all stakeholders, such as PICHI

Ontario

The group put forward a bold goal for their work: "By March 2020 we want an increase of 30 per cent of primary care practices participating in QI." In terms of the first steps, the group suggested collating all the lessons learned to date and publishing a state of QI in Canada as a catalyst to talk about QI. It was also suggested that a QI app could be developed, which would link physicians and their health teams with a facilitator and provide a framework to address specific themes (e.g., Choosing Wisely Campaign). Crucial to achieving these goals was the need for advocacy for QI to ensure sustained support, particularly regarding change management resources.

By 2020, Ontario will have:

- Created provincial strategies and defined priorities for QI in family medicine and primary care
- Invited the Alberta Medical Association to speak with Ontario Medical Association to advocate for change management resources for family physicians
- Expanded CPCSSN as a data repository

In the next 18 months, Ontario will have:

- Optimized the use of EMRs and addressed issues with EMR vendors
- Started developing strategies to engage family physicians, and their health teams in QI activities (e.g., through local champions)
- Started developing a provincial advocacy strategy to secure funding and resources

Québec

The group emphasized the need to avoid the duplication of efforts and the importance of sharing existing tools available beyond the GMF-Us. Collaboration was the key to achieving the provincial goals and the participants agreed that all key provincial actors need to be on the same page and work toward defining a shared goal. The first step for closer collaboration was to develop a position paper and garner input from relevant provincial partners. The second step that was agreed upon was to organize a QI Symposium Day in 2019 in Quebec in collaboration with the Collège québecois des Médecins de famille.

By 2020, Quebec will have:

- A clear understanding of the impact of the AACQ Phase 2 across in the province
- Shared knowledge of existing provincial QI tools and resources
- Ensured that there is sufficient education and are sufficient training opportunities for QI
- Ensured there is continued collaboration between the QI agents and research
- Ensured the sustainability of research facilitators through the Réseau de recherche axée sur les pratiques de première ligne (RRAPPL)

In the next 18 months, Quebec will:

- Prepare a position paper and develop a strategy for next steps for the province
- Hold a QI Symposium Day in 2019 in Quebec
- Carry out a consultation and develop an integrated strategy for data access
- Conduct an assessment of what different EMR providers offer
- Develop a strategy to enhance the level of engagement among family physicians and their health teams in QI activities

Saskatchewan

The group highlighted the need to coordinate provincial QI efforts and bring together scholarly work on QI. As an immediate next step, the group committed to establishing a provincial committee on QI in primary care, and to identifying committee members from across the province. This committee will help formulate clear goals and benchmarks for QI. There was a strong emphasis on the need to reduce the silos and to build capacity for QI in primary care.

By 2020, Saskatchewan will have:

- Tailored the Resident Quality Improvement Program (RQIP)[‡‡] to family medicine
- Improved EMR capacity
- Promoted and fully established CPCSSN across the province
- Have an established coordinating committee to bring together scholarly work on QI

In the next 18 months, Saskatchewan will have:

- Provided clarity on the roles by defining leadership and the proper governance structure
- Developed metrics to understand progress made
- Promoted and moved CPCSSN forward provincially
- Explored CME credits for QI Power Hour and other initiatives

National and International Table

In addition to the provincial and territorial representatives there were representatives from different national and international organizations. This group echoed the comments made by the other representatives and highlighted the important role for academic institutions in QI initiatives in primary care. It was suggested that integrating and aligning these with provincial initiatives could improve patient outcomes and lower system costs.

By 2020, at a national level:

- There will be an increase of 30 per cent of primary care practices participating in QI activities (doing and learning QI)
- There will be standard quantitative metrics set for family medicine and primary care
- Family medicine practices will have defined competencies in QI
- There will be a repository of completed QI projects that could be used as a resource nationally
- A "QI Coach" app will be developed to support QI activities and link people to QI facilitators

[‡‡] This program is currently delivered in partnership by the Health Quality Council (HQC) and the University of Saskatchewan's College of Medicine Postgraduate Medical Education (PGME) office.

Themes From Discussions and Insights From Action Planning

The discussions following the presentations suggested that there is a significant alignment of ideas and that similar challenges are being faced across the country. The primary themes that emerged from the provincial discussions fell into six broader categories and, by the end of the day, a sense of momentum around key drivers of change emerged. Participants highlighted the importance of dialogue between organizations, and national collaboration to advance quality in family medicine and primary care to improve the health of Canadians.

- Demonstrate the value and impact of QI activities to engage provincial and national actors

  It was agreed that there was an urgent need to demonstrate the value and impact of QI activities specific to family medicine and primary care. By demonstrating the value of QI and the infrastructure that supports it to the federal, provincial, and territorial ministries, budget cuts could be avoided, and a sustained source of funding could be secured. The added value and importance of QI could be demonstrated by preparing value propositions and a cost analysis.

- Outline a coordinated strategy and approach to QI both provincially/territorially and nationally

  As much as there are unique issues and needs in each of the provinces, the symposium highlighted that there are far more similarities. One important message was that there is a need for a concerted advocacy effort to reconcile the provincial/territorial and national aims.

  - Reduce duplication of work and reduce the number silos

    Several provinces raised concerns about the different groups trying to increase QI capabilities in their system, introducing the risk of silos and the duplication of work. To address this, it was suggested that sustained local, regional, and provincial/territorial efforts are needed to identify key players and define the different roles and responsibilities of these actors. It was suggested that this could be done by setting up provincial/territorial committees with representatives from organizations present at the symposium (and others who were not at the symposium but were identified as key players) to share information and provide updates about ongoing activities.

  - Creating big dot goals

    Adopting a 'big dot' national goal or one for each jurisdiction would provide a clear call to action and help focus advocacy efforts. For instance, representatives from Ontario put forward the goal: "By March 2020 we want to increase of 30 per cent of primary care practices participating in QI."

    To identify and formulate such assertive goals a report on the status of QI in Canada would be beneficial. Understanding where different regions were in terms of their work on QI would also strengthen provincial/territorial advocacy work.

- Improve access to, and the use of, meaningful data for QI work

  The importance of accessing and using meaningful data was stressed by participants from all provinces and territories. This included practice-driven data from sources such as EMRs and billing data as well as other data sources such patient surveys, administrative databases, and interviews. As the example from Sweden illustrated, the power of access to meaningful data is indisputable.

  - EMR and data providers

All provinces highlighted the problems they were having with EMR vendors and gaining access to their data. It was suggested that an immediate, key goal of the provincial, territorial, and national advocacy efforts would be to resolve the vendor ownership and ensure that data are accessible for all primary care providers across the country.

- Training about EMR data

  The EMRs are a valuable resource for family physicians and their health teams as they contain comprehensive data which can be used to support QI activities. However, as some participants highlighted, QI depends on high-quality and meaningful data, which is only possible if the data collected is entered in a standardized and consistent format. To ensure accurate data collection, training is needed. It was recognized that support for this is available, but family physicians may not be aware of the programs. Therefore, it would be necessary to raise awareness of existing resources through, for example, more assertive marketing.

- Leverage the Canadian Primary Care Sentinel Surveillance Network (CPCSSN)

  There was recognition that CPCSSN has the potential to unlock significant resources and tools for QI across Canada. CPCSSN supports physicians and family health teams with cleaning their data and provides basic training on this. Not all participants were aware of the services that CPCSSN provides, which demonstrates need for a coordinated effort to publicize related resources and tools.

- Identify and bring together the existing work for QI in each province

  Saskatchewan, Manitoba, and the Atlantic provinces identified a need for a local environmental scan to help identify progress made and potential gaps to be addressed. Such a local needs assessment would synthesize what is already available to support QI and identify provincial stakeholders and their roles. Using this as a foundation, concrete goals and a streamlined provincial strategy could be developed.

  There is an opportunity for the CFPC to provide frameworks and tools to support strategy creation. A generative strength-based framework to generate momentum across the country was identified as one approach to spread QI in primary care. This approach would support provincial groups to identify and build on strength and to highlight actions that match aspirational goals.

- Mobilize a culture of QI and reflective practice to engage front-line physicians and their teams
  - Understanding what really matters to primary care providers

    At least three provinces spoke about the need to better understand what matters to physicians in their region as they develop strategies for change. Identifying pain points in practice can support the uptake of QI, create a healthier workforce, improve the quality of care for patients and result in reduced system costs. Moreover, a deeper engagement of primary care provider voices aligns with the quadruple aim—improving the experience of providers.

  - Engaging the patient and listening to the family voice

    Throughout the sessions, the need to keep the patient and family voice at the centre was emphasized. It was agreed that, as the CFPC and provincial groups move forward, there will be a

need to determine how best to access, integrate, and leverage patient and family voices to create cases for support for QI work in primary care.

- Recognize QI efforts

  The importance of recognizing QI efforts was stressed by different groups. Several suggestions were made about how to support this recognition; for instance, through practice audits for QI, a visible recognition for participation in QI (e.g., awards at FMF) and encouraging the application of QI Mainpro+® credits.

- Share and market QI resources and tools across the country

  Crucial to building, supporting, and sustaining the capacity building and advocacy for QI across Canada is sharing existing tools and resources. Throughout the presentations and discussions, participants shared their knowledge of existing and planned resources to support QI activities. A consensus was reached that awareness of existing tools and resources is crucial and that the best vehicle to raise awareness would be a central repository. There was support for the CFPC to host such a platform and to build communities of practice to support these efforts.

  - Practice facilitation

    Alberta, British Columbia, and Quebec have invested in practice facilitator programs to support family physicians and their health teams. Their shared experiences and research provide evidence that such programs offer a significant ROI and result in successful process improvements that improve the quality of care. Several provinces agreed that investing in practice facilitators, separate from training for cleaning and using EMR data, would be valuable. In the short-term it was suggested that local champions could provide the initial momentum for those provinces and territories that have not yet fully explored this model.

  - Change management support

    Several provinces mentioned the need to have more change management resources to support the efforts of advancing QI in primary care.

Conclusion and Next Steps

The symposium ended with an expression of a desire to continue to collaborate to advance QI and practice facilitation within family medicine and primary care at all levels. Attendees recognized this opportunity to strengthen and expand the practices described at this national event, for the benefit of Canadians across the country.

- Increase provincial-level advocacy for resources to support QI in family medicine and primary care
- Increase countrywide advocacy to ensure access to EMR data for the purposes of QI
- Create a guide to help residency programs incorporate QI and research in their curricula, including clarification of what the competencies entail and ideas for teaching and assessing them
- Explore CPD credit incentives for QI related activities in daily practice

Symposium evaluation

On September 28th, an evaluation survey was sent out to all participants to assess the impact of the symposium and plan the next steps. The key findings include:

- Response rate was 26 per cent
- Fifty-four per cent agreed that this symposium would advance QI in family medicine in Canada
- Forty-eight per cent strongly agreed and 40 per cent agreed that the symposium made them aware of resources related to QI outside of their province that they were not previously aware of
- Forty-seven per cent agreed that the symposium forged new collaborations within and across provinces
- Forty-five per cent agreed that the symposium strengthened existing collaborations and partnerships
- Sixty-nine per cent strongly agreed that the CFPC has a key role to play in hosting such meetings

Appendices

Appendix A – QI Symposium Agenda

24 September 2018

STREAM 1 – PRACTICE FACILITATION (Room A)

Time	Topic	Lead
8:00–9:00 a.m.	Breakfast and registration	
9:00–9:20 a.m.	• Welcome and review of day • Overview of the Practice Improvement Initiative (Pii)	• Maria Judd (CFHI) • Yves Couturier (Réseau-1, Québec) • Jean-Sébastien Paquette (Université Laval) • José Pereira (CFPC)
9:20–9:45 a.m.	Practice Facilitation: Its evidence and spread	Bill Hogg (University of Ottawa)
9:45–10:30 a.m.	Practice Facilitation: Models and resources • Agency for Healthcare Research and Quality (AHRQ) • Toward Optimized Practice (TOP) • Champlain, Ontario • Agents d'amélioration continue de la qualité (ACQ) dans les groupes de médecine de famille universitaires (GMF-U), Québec	Eileen Patterson (Facilitator) Presenters • Robert McNellis (AHRQ) • Arvelle Balon-Lyon (TOP) • Bill Hogg (Champlain, Ontario) • Jean-Luc Tremblay (Agents d'ACQ pour les GMF-U du Québec)
10:30–10:50 a.m.	Break	
10:50–11:40 a.m.	Practice Facilitator Roles: Master of one or facilitator of all? • QI facilitator • EMR facilitator • Research facilitator • Hybrid role	Eileen Patterson (Facilitator) Presenters • Robert McNellis (AHRQ) • Mark Watt (TOP) • Michelle Greiver (UTOPIAN) • Annie Leblanc (Laval University) • Édith Bernier (Agente d'ACQ au GMF-U de Maria du CISSS de la Gaspésie, Québec)
11:40 a.m. – 12:15 p.m.	Practice Facilitation: Mapping the competencies	Eileen Patterson (Facilitator)
12:15–1:00 p.m.	Lunch	
1:00–2:00 p.m.	Next Steps	Eileen Patterson and José Pereira (Facilitators)
2:00–2:30 p.m.	Break	

STREAM 2 – QI and RESEARCH in FAMILY MEDICINE RESIDENCY PROGRAMS (Room B)

Time	Topic	Lead
8:00–9:00 a.m.	Breakfast and registration	
9:00–9:45 a.m.	• Welcome and review of day • Overview of the Practice Improvement Initiative (Pii) • Section of Residents GIFT Project	• Nancy Fowler (CFPC) • Ivy Oandasan (CFPC) • Deirdre Snelgrove (CFPC) • Kelsi Cole (Section of Residents)
9:45–10:30 a.m.	QI, Data, and Research Learning Objectives: Review work to date and give further input (for residency and first five years in practice)	Ivy Oandasan (CFPC, Facilitator)
10:30–10:50 a.m.	Break	
10:50–11:15 a.m.	QI Learning and Assessment Methods: Insights from the Royal College of Physicians and Surgeons of Canada	Roger Wong (Royal College)
11:15–11:50 a.m.	QI, Data, and Research Learning Methods: • Insights from departments of family medicine across the country • What is realistic in family medicine residency and the first five years in family practice?	Group work: Brainstorming ideas and concepts Facilitators: • Ivy Oandasan (CFPC) • Elizabeth Muggah (University of Ottawa)
11:50 a.m. – 12:15 p.m.	Report back from group tables	
12:15–1:00 p.m.	Lunch	
1:00–1:05 p.m.	Considerations for assessment methods	Brent Kvern (CFPC)
1:05–1:30 p.m.	QI, Data, and Research Assessment Methods: Residency and first five years in family practice: Getting the ball rolling	Group work: Brainstorming ideas and concepts Facilitators: • Ivy Oandasan (CFPC) • Donna Manca (University of Alberta)
1:30–1:45 p.m.	Report back from group tables	Rapporteur
1:45–2:00 p.m.	Opportunities for collaboration and next steps	Ivy Oandasan (Facilitator)
2:00–2:30 p.m.	Break	

JOINT AFTERNOON SESSION – QI COURSES STREAM (Room A)

Time	Topic	Lead
2:30–2:40 p.m.	Welcome	José Pereira (CFPC)
2:40–3:00 p.m.	What's on the menu? Introductory, intermediate, and advanced QI courses	Eileen Patterson (Facilitator) Presenter: • Alexandra Salekeen (CFPC)
3:00–4:00 p.m.	Elevator Briefings I • IDEAS and QUORUM: Health Quality Ontario • Patient Safety Education Course (CPSI) • Health Quality Council Alberta • C-QuIPS, co-learning, and certificate course	Eileen Patterson (Facilitator) Presenters • Joshua Tepper (Health Quality Ontario) • Maryanne D'Arpino (CPSI) • Tony Mottershead (HQC Alberta) • Joanne Goldman (C-QuIPS)
4:00–4:10 p.m.	Break	
4:10–5:10 p.m.	Elevator Briefings II • CQIP and LILT: Health Quality Council Saskatchewan • Clinician Quality Academy: British Columbia Patient Safety and Quality Council (BCPSQC) • Teaching residents to use their EMRs • TELFER Quality Improvement and Patient Safety Leadership Program	Eileen Patterson (Facilitator) Presenters • Shari Furniss (HQC Saskatchewan) • Andrew Wray (BCPSQC) • Noah Crampton (Teaching residents to use their EMRs) • Catherine Caron (Graduate of advanced course TELFER)
5:10–5:30 p.m.	Next Steps	Eileen Patterson and José Pereira (Facilitators)

25 SEPTEMBER 2018 – NATIONAL SYMPOSIUM

Time	Topic	Lead
8:00–9:00 a.m.	Breakfast and registration	
9:00–9:20 a.m.	• Welcome and review of day • An overview of the CFPC Practice Improvement Initiative (Pii) • Canadian Foundation for Healthcare Improvement: Primary care initiatives	• Guillaume Charbonneau (CFPC) • José Pereira (CFPC) • Jennifer Zelmer (CFHI)
9:20–9:30 a.m.	Patient reflection	Donald Lepp
	Q&A	Danny Nashman (Facilitator)
9:30–9:55 a.m.	Global Perspective: The QI experience	Ulrika Elmroth (The Swedish Association of Local Authorities and Regions)

Time	Topic	Lead
9:55–10:45 a.m.	Panel: The Canadian QI landscape	• Joshua Tepper (Health Quality Ontario) • Dennis Kendel (Saskatchewan Health Quality Council) • Jean-Luc Tremblay (Agents d'amélioration continue de la qualité pour les GMF-U du Québec) • Arvelle Balon-Lyon (Toward Optimized Practice, Alberta) • Andrew Wray (British Columbia Patient Safety Quality Council)
	Q & A	Danny Nashman (Facilitator)
10:45–11:00 a.m.	Break	
11:00–11:25 a.m.	QI supported by data	Tara Kiran (University of Toronto)
11:25 a.m. –12:30 p.m.	Panel: Other Canadian QI activities • Practice facilitation • Departments of family medicine and residency programs • QI training highlights • PBRN • CPCSSN Data Presentation Toolkit (DPT)	Danny Nashman (Facilitator) • Bill Hogg (University of Ottawa) • Elizabeth Muggah (University of Ottawa) • Donna Manca (University of Alberta) • Michelle Greiver (University of Toronto) • Sabrina Wong (CPCSSN)
	Q & A	Danny Nashman (Facilitator)
12:30–1:15 p.m.	Lunch and networking	
1:15–2:15 p.m.	Provincial Discussions: What can we do collectively to move this forward?	A table for each province will be set up and participants will be seated around these tables for discussions
2:15–2:55 p.m.	Highlights from the Provincial Discussions	Group report back
2:55–3:15 p.m.	Break	
3:15–4:00 p.m.	Provincial Discussions: Reconvene for further discussion	Group report back
4:00–4:30 p.m.	Next steps and closing of symposium	• Guillaume Charbonneau (CFPC) • José Pereira (CFPC)

Appendix B – Participants

		September 24		September 25
Organization/University	**Province**	**Residency**	**Practice Facilitation**	
University of Alberta	AB	3	3	6
University of Calgary	AB	3	-	3
University of British Columbia	BC	3	1	4
University of Manitoba	MB	3	2	5
Memorial University	NL	2	-	2
Dalhousie University	NS	2	-	2
McMaster University	ON	4	1	5
University of Ottawa	ON	3	2	5
Northern Ontario School of Medicine	ON	1	-	1
University of Toronto	ON	3	6	9
Queens University	ON	3	-	3
Western University	ON	1	1	2
McGill University	QC	2	1	3
Sherbrooke University	QC	2	3	5
Laval University	QC	3	3	6
University of Montreal	QC	2	2	4
University of Saskatchewan	SK	2	2	4
University of Prince Edward Island	PEI	-	1	1
Toward Optimized Practice	AB	-	2	2
Alberta Health Services	AB	-	2	2
Health Innovation Group	AB	-	1	1
Health Quality Council of Alberta	AB	Day 2	2	2
British Columbia Patient Safety & Quality Council	BC	-	1	
Health Data Coalition of BC	BC	Day 2	1	1
Manitoba e-health	MB	-	1	
College of Physicians and Surgeons of Manitoba	MB	-	1	
Manitoba Health, Senior and Active Living	MB	-	1	
Winnipeg Regional Health Authority	MB	-	1	1
Manitoba Institute for Patient Safety	MB	-	1	1
New Brunswick Health Council	NB	Day 2	1	1
Nova Scotia Health Authority	NS	Day 2	2	2
Government of Newfoundland and Labrador	NL	Day 2	1	1
Family Practice Renewal Program	NL	-	2	2
Fort Smith NWT Health and Social Services Authority	NWT	-	1	1

		September 24		September 25
Organization/University	**Province**	**Residency**	**Practice Facilitation**	
UTOPIAN	ON	-	1	1
Sunnybrook Health Science Centre	ON	-	1	1
Ontario MD	ON	-	1	1
Bruyere Family Medicine Centre	ON	-	1	1
Institute for Quality Management in Healthcare	ON	-	1	1
Health Quality Ontario	ON	-	2	2
Canada Patient Safety Institute	PEI	-	1	1
Agente d'amélioration continue de la qualité (ACQ)	QC	-	1	1
Réseau-1 Québec	QC	-	1	1
Québec GMF-U	QC	-	1	1
PARS3	QC	-	1	1
Health Quality Council Saskatchewan	SK	-	2	2
Practice Enhancement Program of Saskatchewan	SK	-	1	1
Canadian Armed Forces	SK	-	-	1
University of Buffalo	USA	-	1	
Agency for Healthcare Research and Quality	USA	-	1	
Swedish Association of Local Authorities and Regions (SALAR)	SWEDEN	-	1	1
Federation of Medical Regulatory Authorities of Canada	CAN	-	-	1
The Society of Rural Physician of Canada	CAN	-	1	1
HealthcareCAN	CAN	-	1	
Canadian Institute for Health Information	CAN	-	3	
Canadian Foundation for Healthcare Improvement	CAN	-	3	3
CPCSSN	CAN	-	2	2
Choosing Wisely Canada	CAN	-	2	2
CFPC	CAN			
CFPC Board of Directors	CAN	0	1	1
CFPC Section of Residents	CAN	1	1	1
CFPC Chapters	CAN			

Appendix C – Practice Facilitation Competencies

Compilation of Organizational Practice Facilitation Competencies, as presented at the CFPC QI Symposium

Organization	Competency	
Agency for Healthcare Research and Quality	Core Competencies • Content Mastery: Knowledge of primary care, organizational change • Applied Skills: QI methods, use of health information technologies, meeting facilitation Knowledge and Skills Domains • Foundational Knowledge: Improving primary care, organizational change, PCMH principles, primary care environment • General Skills: Basic QI methods, practice assessment, meeting management • Specialized Skills: Use of health information technology, work process engineering • Professional Skills, Knowledge, and Commitment: Effective communication, building trust, life-long learning Professional Standards • Transparency • Self-evaluation • Commitment to continuous learning • Commitment to QI	
Alberta Medical Association (TOP)	Overarching Context of Primary Care Quality Improvement: Core • Model for improvement • PDSA testing • Understand system variation • Using data to guide decisions • Scale-up, sustain, and spread Modes of Influence: Core • Leadership and facilitation • Engaging others • Forming a team • Conflict resolution • Leading effective meetings Optimizing Patient's Medical Home and Integration • Panel and continuity • Team-based care • Organized evidence based care • Patient-centred care • Access to care • Coordination of care • System integration • System supports	QI Advanced • Deeper dive into level 1 KSAs • Value stream mapping • Quality as a business strategy • Cognitive task analysis Modes of Influence Advanced • Transformational change management • Diffusion of innovations • Influencing complex-adaptive systems • Influencing clinical behaviour change

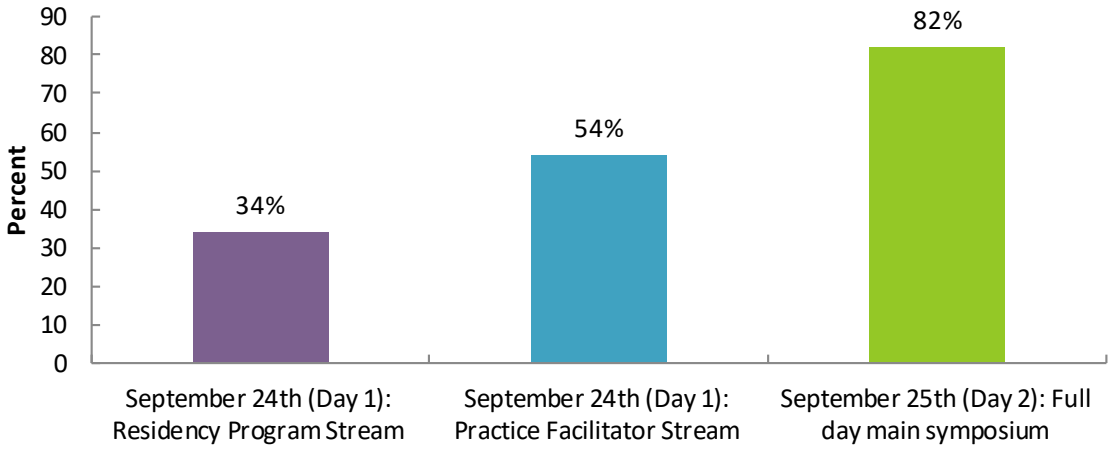
Organization	Competency
UTOPIAN	Skills • PC platforms (MS Word, Power Point, Excel, etc.) • Statistical software (SPSS, R) • Survey tools: Qualtrix, qualitative software: Nvivo Abilities • Excellent interpersonal and communication skills • Independence • Ability to manage multiple research projects; recruitment; lit review; writing; presentations; REB applications; project management; coordination with practices; contacting patients; searching EMRs
Patient Oriented Research (POR) Facilitation Program, PQ	Currently assessing the required/preferred skills of POR facilitators through an applied, practice-based initiative, with the goal of developing an On-Boarding POR Facilitation Program
Quebec Family Medicine Group QI Agent Experience	Leadership • Facilitate the identification of the GMF-U's QI priorities • Facilitate decision making by consensus within the team • Direct initiatives towards the agreed upon priorities • Support change through follow-ups and encouragement • Consolidate QI culture Project management • Start, plan, coordinate, execute, monitor, evaluate Rigorous organization of tasks • Coordinate the various projects, maintain clear and detailed action plans, respect the capacity within the environment Teamwork Listening skills • Openness with all stakeholders involved in the QI projects (users, learners, local decision makers, physicians and other professionals) Communicate • Internal and external Creativity Emotional Intelligence • Recognize and control one's emotions, deal with emotions of others Create partnerships

Appendix D – Post-Symposium Evaluation and Feedback

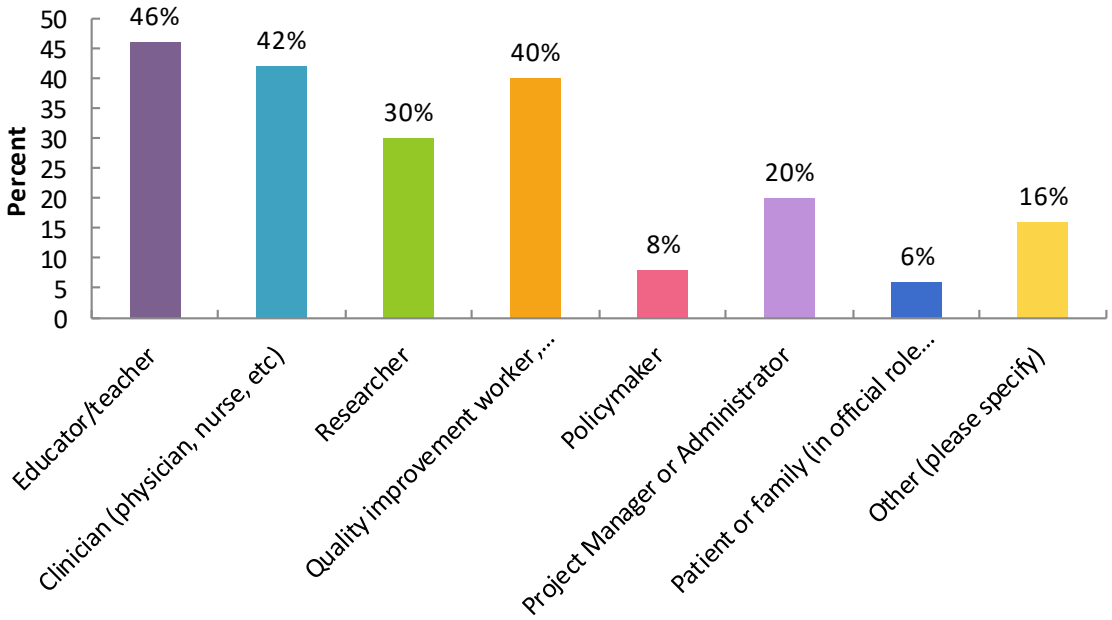
The symposium participants were asked to fill out a post-symposium evaluation survey. The feedback received was largely positive. The detailed report is available upon request.

Overall response rate: 26 per cent (50/194 respondents)

1. Response rate by stream:

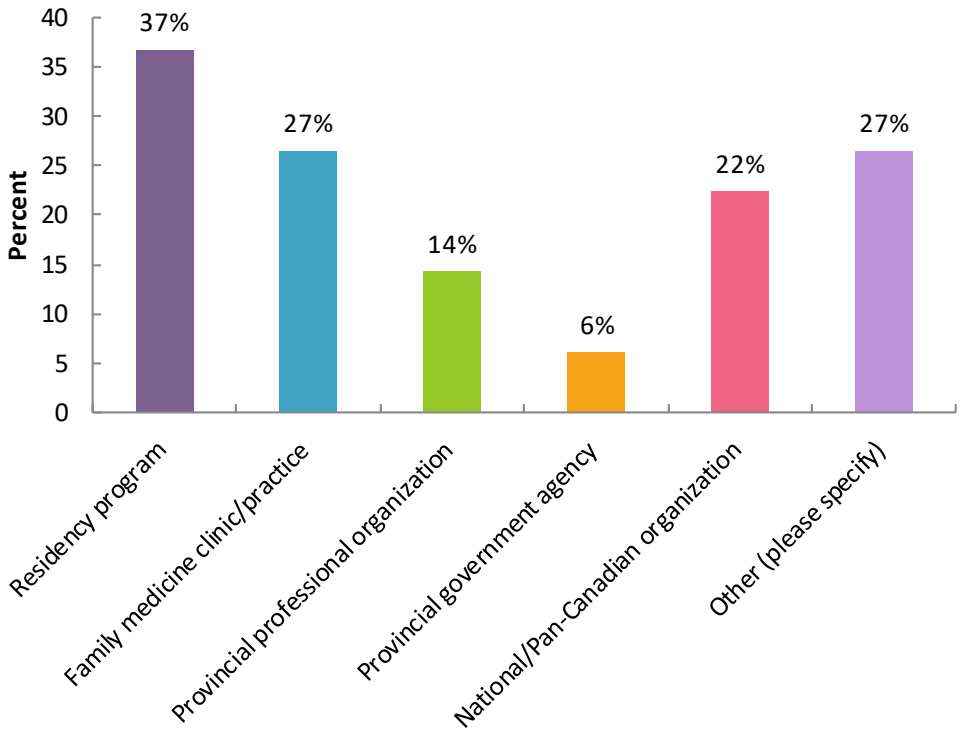


2. Evaluation respondents: Participants' role



The other 16 per cent of participants identified themselves as consultants, quality specialists, program directors, retired physicians, AACQ agents (Québec)

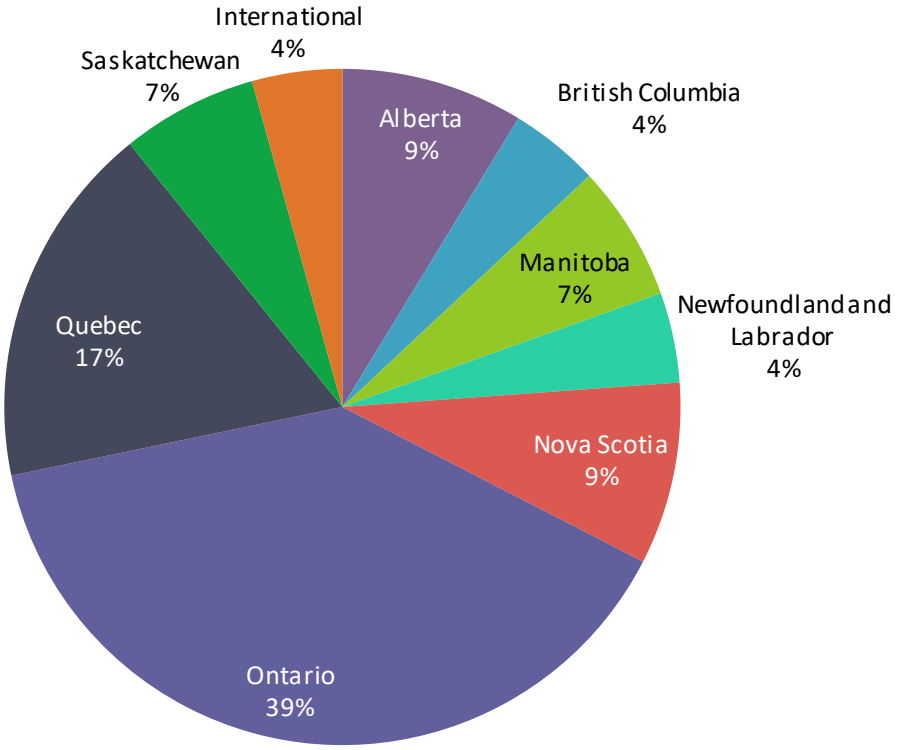
3. Participants' affiliation:



Other:

- CFPC chapter
- Centre de recherche
- Department Family Medicine
- Department of Family Medicine
- Directrice du RRAPPL et directrice du comité amélioration qualité du département de médecine de famille
- PBRN
- Primary Care Renewal
- QI Practice Facilitation Program @ State University of New York
- Réseau-1 Québec
- Subsidiary of the OMA acting on behalf of provincial Ministries of Health
- U.S. Consultant
- Undergrad Quality and Safety Lead
- University of Toronto, Research Program

- 4. Regional representation (based on survey responses):



4. Level of agreement with the following statements:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Not applicable	Responses
Overall, the Symposium will advance quality improvement (QI) in the program, practice or service I work in	-	-	16.3%	44.9%	32.7%	6.1%	49
Overall, the Symposium will advance quality improvement (QI) in family medicine in my province	-	-	28.6%	42.9%	24.5%	4.1%	49
Overall, the Symposium will advance QI in family Medicine in Canada	-	-	16.7%	54.2%	27.1%	2.1%	48
I learned about activities and resources related to QI in my province that I was not previously aware of	-	24.5%	16.3%	36.7%	20.4%	2.0%	49
I learned about activities and resources related to QI outside my province that I was not previously aware of	-	6.3%	4.2%	39.6%	47.9%	2.1%	48
The symposium helped me forge new collaborations with other persons or organizations in my province	-	12.2%	8.2%	46.9%	26.5%	6.1%	49
The symposium helped me strengthen existing collaborations within my province	-	10.2%	12.2%	44.9%	28.6%	4.1%	49
The symposium generated practical next steps for me	-	10.6%	19.1%	51.1%	14.9%	4.3%	47
The symposium generated practical next steps to advance QI in family medicine in Canada	-	4.1%	20.4%	46.9%	22.4%	6.1%	49
The College of Family Physicians of Canada has a key role to play in hosting meetings	-	-	6.1%	22.4%	69.4%	2.0%	49

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Not applicable	Responses
such as this symposium							
I learned a lot from the keynote presentations in general	-	2.0%	10.2%	51.0%	32.7%	4.1%	49
I learned a lot from the panelist presentations in general	-	2.0%	12.2%	53.1%	28.6%	4.1%	49
The provincial table discussions were overall effective to advance collaborations	-	12.2%	14.3%	34.7%	34.7%	4.1%	49