UNITÉ DE **SOUTIEN**
SSA | QUÉBEC
Ensemble pour un système de santé qui apprend

ORIENTATIONS FOR LEARNING

FAMILY MEDECINE GROUPS

Authors: Catherine Bouffard-Dumais and Sophie Boies
Under the direction of Antoine Groulx
MAY 2024

CONTENTS

01. Summary page

03. Learning FMG mandate and methodology

04. Definition of a learning FMG

05. Objectives of a learning FMG

05. Findings and orientations

18. Learning FMG model

19. Conclusion

21. Glossary

23. References

To cite this document:
Groulx, A., Bouffard-Dumais, C., Boies, S., Belval-Nadeau, V., Drolet, M., Lévesque, M. and Plouffe-Malette, M. (2024). *Orientations for learning family medecine groups*. Ministère de la Santé et des Services sociaux.

WHAT IS A LEARNING FAMILY MEDICINE GROUP (FMG)?

It is an FMG that uses science and data to drive continuous improvement.

All clinic staff are involved in the process, as are all relevant partners.

In a learning culture, we aim to contribute to the quintuple aim of improving the patient experience and outcomes, improving the health of the population, improving the efficiency of the healthcare system, improving equity in health and social services, and improving the well-being of health and social services human resources.

VISION

Mobilized FMGs toward the quintuple aim, helping to create a healthy, engaged community.

Dimensions of a learning culture in FMGs

- Continuous quality improvement and best practices
- Data and technology culture
- Interprofessional collaboration
- Community and sustainable health
- Research
- Patient partnership
- Governance
- Co-management

Principles for deploying a learning culture in FMGs

Considering that each FMG is unique, with its own characteristics, strengths and challenges, the orientations are supported by the following key principles:

- Respecting the uniqueness of environments;
- Voluntary commitment;
- Non-linear, personalized and non-competitive approach;
- Follow-up based on measurable indicators;
- Emphasis on coaching and support rather than assessment and sanction (training/mentoring, facilitation);
- Appropriate financial framework.

THE LEARNING FMG

Learning health systems (LHS) enable the quality of health care to be optimized efficiently and continuously, based on experiential, scientific, clinical and organizational knowledge. This document proposes orientations and a model to support and guide family medicine groups (FMGs) in adopting a learning culture.

Indeed, despite the associated benefits, this approach remains little known and applied in Quebec primary care settings. There are a number of issues to consider in order to deploy a learning culture effectively and ensure the sustainability of the approach. In addition, such an initiative must involve and consider all stakeholders, both within the clinics themselves and within the communities.

The orientations are structured around eleven (11) mutually influencing themes:

1. The deployment of a learning culture ;
2. Continuous quality improvement (CQI) and best practices;
3. Change management and training ;
4. Medical leadership ;
5. Data culture and technologies;
6. Interprofessional collaboration;
7. Community and sustainable health ;
8. Research ;
9. Patient partnership ;
10. Governance ;
11. Medico-administrative co-management.

The findings and possible solutions raised call for both locals and systemics reflections.

LEARNING FMG MANDATE AND METHODOLOGY

The Unité de soutien système de santé apprenant (SSA) Québec has been mandated to submit recommendations to encourage and support FMGs to adopt a learning culture. More specifically, the approach is organized around two major questions: how can we extend the learning culture to the entire front line and thus foster the emergence of learning FMGs, mobilized to achieve the quintuple aim? and how can we mobilize these FMGs towards organizational and care improvement, thus creating a healthy, engaged community?

To answer these questions and formulate recommendations, a literature review was carried out by a research team collaborating on the project. Among other things, the results were used to define learning culture and support the identification of related themes. The results were also used to identify facilitators and barriers to the deployment of a learning culture in primary care.

Secondly, a number of experts and partners from different backgrounds (health and social services network, independent organizations, associations, etc.) were interviewed, as well as members of medical clinics identified as being innovative or in difficulty. In all, 37 experts and partners took part in the discussions, and ten clinics were visited, across several regions (Montréal, Montérégie, Estrie, Capitale-Nationale, Bas-Saint-Laurent and Gaspésie). The following partners were consulted: the Fédération des médecins omnipraticiens du Québec (FMOQ), the Fédération des médecins spécialistes du Québec (FMSQ), the Institut national d'excellence en santé et en services sociaux (INESSS), the Collège québécois des médecins de famille (CQMF), the Collège des médecins du Québec (CMQ), the Canadian Medical Association (CMA) and the Institut national de santé publique du Québec (INSPQ). During these meetings and consultations, the topics discussed included:

- FMG strengths and challenges;
- Governance ;
- Co-management ;
- Partnership (patient, community, research) ;
- Local policies ;
- Strategic planning ;
- Continuous quality improvement (CQI) and research ;
- Interprofessional collaboration ;
- Information technology;
- Physical organization of FMGs.

Thirdly, the findings of these meetings were discussed during a day of exchange and reflection involving the volunteer consultees (25), in the form of a "World Café". This is a method based on the power of conversation, enabling participants to exchange ideas by circulating between small groups to hold conversations lasting around twenty minutes. This enabled us to modulate the proposals to arrive at a more accessible presentation of the concepts and thus encourage the adoption of a learning culture within FMGs.

The following text presents the findings of this process, as well as the recommended orientations.

WHAT IS A LEARNING FMG?

The learning FMG is an FMG that is part of a learning culture, in which the various players work in partnership and draw on science and data to continuously improve management, care and services. This culture also enables the emergence of new knowledge, which in turn contributes to improvements (Unité SSA, 2024; Institute of Medicine, 2013).

For continuous improvement to be possible, the learning cycle must be conducted continuously:

1. From practices to data: This dimension refers to the assessment and prioritization of needs, the definition of problems, the measurement of results (determination of indicators) and the planning of mechanisms to be put in place to collect the data.
2. From data to knowledge: This dimension refers to the mechanisms for analyzing and interpreting results, as well as the methods planned for disseminating them.
3. From knowledge to practices: This dimension refers to the application of a practice that addresses the problems identified, as well as its evaluation. (Zomahoun et al.).

In a learning culture, this cycle is repeated endlessly. This is what makes continuous improvement possible.

WHAT ARE THE OBJECTIVES OF THE LEARNING FMG?

The learning FMG contributes to the quintuple aim:

FINDINGS AND ORIENTATIONS

A number of findings emerged from the reflections shared during the consultations and FMG visits. These findings have been categorized according to the dimensions of a learning culture. They are associated with possible solutions and orientations for the learning FMG. It should be noted that all these dimensions influence each other.

THE ESSENTIALS

Certain elements, developed in the following sections, appear to overlap with the various dimensions of a learning culture: strategies for deploying a learning culture, *continuous quality improvement* (CQI)1 and best practices, change management and training, and medical leadership. These are the foundations of this culture. They must be developed as a priority to ensure the sustainability of the learning FMG. Some of the solutions associated with these elements can be implemented by the FMGs themselves, but most are linked to the social context and should therefore be considered and supported by public institutions.

DEPLOYING A LEARNING CULTURE

Deploying a learning culture (measurement, reflexivity, change) is demanding work and can be perceived as challenging. It therefore requires clear and flexible guidelines. To ensure that clinics have the motivation to actively engaged in a learning culture and that the learning FMG is successful, it is essential to :

- Establish guidelines and indicators, while respecting the autonomy of clinicians and the uniqueness of each clinic;
- Establish public policies in this area;
- Develop a shared vision of the deployment of a learning culture within each clinic;
- Develop a shared team vision of the deployment of a learning culture and a partnership between the various clinics and establishments.

There are a number of initiatives in this direction, but no overall coordination. How can we link the clinics and get them to work together to achieve the quintuple aim?

[1]Words in italics are defined in the glossary at the end of the document.

CQI AND BEST PRACTICES

CQI is an integral part of the learning culture. It is therefore important to ensure that this approach is embedded. There must be coherence between all actors in the health system.

This means recognizing the importance and value of CQI, in both words and actions. Furthermore, given the limited availability of physicians and professional staff, it is essential to recognize the time they dedicate to continuous improvement.

Current situation

- Knowledge of and commitment to CQI varies widely among FMGs and is often nonexistent; .
- There is little financial recognition for physicians involved in CQI; .
- There is no responsibility or accountability for CQI in the clinics;
- Clinic staff live with a sense of urgency, with high turnover of administrative and even professional staff;
- Clinics involved in CQI initiatives can inspire others;
- U-FMG and its continuous Quality Improvement (CQI) representatives benefit greatly from the Académie Qualité Santé training.

Challenges and barriers

- Increasing popularity of clinic networks, a potential barrier to implementing approaches that respect the uniqueness of each clinic;
- Lack of support, training, and people responsible for facilitating CQI in the field;.
- Lack of connections between CQI actors in Quebec;
- Success stories poorly documented and disseminated;
- Time and resources constraints (financial and human);
- Physician compensation not conducive to participation in CQI activities.

Systemic solutions

- Ensure that each clinic is aware of and has access to external CQI support provided by regional continuous quality improvement officers, and anticipate growing needs;
- Provide dedicated, paid time for CQI activities, including a bank of hours approved by the CQI manager;
- Provide dedicated, paid time for CQI activities for the responsible physician and members who wish to participate (e.g., using packages or a bank of hours approved by the CQI manager);
- Support research with CQI methodology;
- Support the development of skills and knowledge among CQI actors in Quebec, particularly through the Académie Qualité Santé (ensure long-term funding);
- Promote links between CQI actors in Quebec, notably by strengthening the community of practice;
- Promote consistency in the recognition and importance of supporting CQI;
- Avoid reinventing the wheel: establish a structure for tracking and disseminating successes.

Solutions and directions for the learning FMG

- Identify an internal physician responsible for CQI; .
- Develop, as a team, a clear structure for developing CQI approaches, including mechanisms for data extraction. .

CHANGE MANAGEMENT AND TRAINING

There is a natural resistance to any change. Moreover, clinic staff need knowledge and support to implement any new initiative. Otherwise, there's a risk that ideas will be undermined and staff will become exhausted. Change management and coaching are therefore essential if the vision of the learning FMG is to be implemented concretely and effectively in the clinics.

Current situation

- Change management is often overlooked when implementing new initiatives, yet it is essential because of the inevitable resistance to change from teams;
- There is little awareness of the training available to support clinics: work teams often don't know where to turn for help with their challenges or projects.

Challenges and barriers

- Needs vary from clinic to clinic;
- Underdeveloped training on certain subjects.

Systemic solutions

- Strengthen the change management capabilities of ARACQs and AACQs; .
- Develop a toolbox of all possible forms of assistance to support the development of all dimensions of a frontline learning culture;
- Moving forward one small change at a time (theory of small steps), allowing time for the development of a learning FMG.

MEDICAL LEADERSHIP

The type of leadership and personal qualities of medical management greatly influence organizational culture, and seem to be a cornerstone of success for the learning FMG.

Current situation

- Physicians receive little training or evaluation in leadership;
- Leadership is a difficult concept to evaluate.

Challenges and barriers

- This is a relatively new skill in the learner's curriculum and one that is still poorly mastered by teaching physicians;
- Many physician leaders base their actions on personal experience and natural qualities, and very few back it up with the training that is available;
- Little known training available;
- Limited time available for training;
- Unlike clinical training, there is little recognition of the relevance of leadership training.

Systemic solutions

- Democratize leadership concepts in work teams;
- Ensure that this aspect of family physicians' professional development is recognized and valued;
- Support the development of leadership skills among medical directors, including through training and mentoring (both during training and in practice).

ORIENTATIONS OF THE LEARNING FMG AND ITS SYSTEM

Seven dimensions of learning culture were identified: data culture and technologies, *interprofessional collaboration*,community and *sustainable health*, research, *patient partnership*, *governance* and *medical-administrative co-management*. The development of certain aspects related to these dimensions depends on the clinics and the initiative of their staff, while others are more closely linked to the system in which FMGs operate. The latter remain essential, but cannot be driven by the clinics themselves.

DATA CULTURE AND TECHNOLOGIES

Data is at the heart of a learning culture. It is what enables healthcare organizations to improve objectively and continuously, and to respond effectively to the needs of patients and staff. It is important to support the development of a data culture within healthcare organizations by developing a clear vision and plan. "Data culture is the set of shared values and behaviors that promote the use of data to improve decision making"2. Access to relevant data must therefore be guaranteed, as well as support for its effective use.

Current situation

Organizational: Data Access and Organization

- Data is collected in siloed environments with little or no real-time access and analysis, even on demand. This includes, but is not limited to:
  - Hub, electronic medical records (EMR), Régie de l'assurance maladie du Québec (RAMQ), institutions (ex: emergency), Software (ex: NAVIG);
- There is currently a lack of transparency and data sharing (individual and comparative); .
- Monetization of data by private companies;
- The use of artificial intelligence (AI) is still in its infancy and we can't afford to ignore its benefits. However, it is important to develop an ethical framework specific to health care.

Clinical and educational

- Institut national d'excellence en santé et services sociaux (INESSS)
  - Front line content is poorly developed; .
  - Information is difficult to access and find.

- Electronic medical records (EMR)
  - The quality of data entry is uneven from person to person and from platform to platform;
  - Data extraction involves additional costs for clinics and is not available in all DMÉs;
  - EMRs are not required to comply with data extraction.

Patients

- Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs) are not developed within EMRs.

Clinicians

- Clinician-reported experience measures (CREMs) are not developed within EMRs.

[2] https://www.tableau.com/fr-fr/why-tableau/data-culture

DATA CULTURE AND TECHNOLOGIES (PART 2)

Challenges and barriers

- Difficult access to data, requiring considerable effort from the FMGs; .
- Availability of trained human resources, lack of knowledge;
- Availability of financial resources;
- Complex and often restrictive regulatory environment;
- Private nature of EMRs (no obligation on providers, almost systematic monetization of data);
- Lack of norms and standardization for data interpretation;
- Inadequate interoperability among the various systems that produce or mobilize data;
- Lack of tools and support for extracting and structuring data for analysis and interpretation.

Systemic solutions

Draw inspiration from the FAIR principles (findable, accessible, interoperable, reusable) to:

- Establish local regulations and mechanisms to facilitate permanent access to data and the procedures for obtaining them for all stakeholders, in consultation with private providers; .
- Use the principle of meta-consent with respect to data confidentiality, while informing users;
- Develop interoperable technologies;
- Develop super-identifiers to link data;
- Provide support and tools for easily extracting, structuring, analyzing, and interpreting data so that clinics can continuously improve themselves;
- Allow FMGs and facilities to compare themselves to others, anonymously;
- Set aside dedicated, paid time in each clinic to discuss data, its usefulness, and related projects; .
- Ensure that at least one person in each clinic is trained to extract and analyze data, and ensure redundancy of expertise; .
- Identify regional facilitation managers dedicated to data extraction and analysis; .
- Further integrate AI and develop an ethical framework for AI;
- Identify a person responsible for facilitating data-related practices in each clinic;
- Establish a means for sharing data within clinics;
- Establish common, standardized norms and indicators for PREMs, PROMs, and CREMs, and facilitate the technology needed to integrate these indicators.

INTERPROFESSIONAL COLLABORATION

In a learning culture, we want to eliminate silos to work in collaboration.

Current situation

- The idea of interprofessional collaboration is generally accepted, but remains a daily challenge in practice;
- There is a lack of standards and qualitative and quantitative measures (efficiency) for health professionals;
- Knowledge and expertise vary widely among FMGs.

Challenges and barriers

- Instrumentalization of interprofessional collaboration;
- Communication difficulties: A multitude of professionals don't always speak the same language;
- Issues of hierarchical and functional relationships, as well as support and backup for professionals;
- Occasional discrepancies between collective orders (COs) and best practices;
- Issues of direct access to professionals;
- Issues arising from the complexity of governance in understanding and applying functional and hierarchical relationships for FMG professionals;
- Perceived disparity in efficiency between professionals and primary care physicians, which hinders teamwork to meet patient and community needs;
- Physician compensation methods that do not encourage time spent collaborating.

Systemic solutions

- Establish efficiency standards for professionals, monitor the qualitative and quantitative measurement of clinical practice, and provide support as needed to achieve these standards (level up);
- Better define the must-haves of the FMG professional's area of practice and support professional development to achieve them (as well as new arrivals);
- Develop strategies to decompartmentalize professional areas;
- Develop provincial clinical tools;
- Develop guidelines for interprofessional collaboration and "innovation".

Solutions and directions for the learning FMG

- Provide paid time and space for interprofessional exchange, especially for planning care;
- Provide space for informal exchange among professionals;
- Clearly identify the roles and responsibilities of all, while remaining flexible about this vision;
- Strengthen the skills and abilities of professional staff, especially by encouraging continuing education.

COMMUNITY AND SUSTAINABLE HEALTH

A learning healthcare organization is one that is rooted in its community, knows it and works in partnership with it.

How can we create strong, lasting links between the FMGs and the Centres intégrés universitaires de santé et services sociaux (CIUSSS)/Centres intégrés de santé et services sociaux (CISSS), as well as with community organizations and cities, for the benefit of the quintuple aim?

Current situation

- Few clinics have strong ties to their community and the people who work in public health;
- Projects are developed based on impressions and interests rather than documented community needs;
- Clinics have no means of measuring the social impact of their actions and initiatives.

Challenges and barriers

- Little knowledge of public health;
  - Health determinants of their community
  - Sustainable health indicators
  - Role of the Institut national de la santé publique
- Centralization of public health;
- Communication and partnership issues between CIUSSS/CISSS and FMGs.

Systemic solutions

- Create formal spaces for FMGs and community members to get to know each other and work together;
- Establish formal links with people working in public health, particularly to develop a socioeconomic and health portrait of the population and area served by the clinic, as well as its interaction with the health system;
- Identify regional public health officers who will work in close proximity to frontline environments.

Solutions and directions for the learning FMG

- Identify a person responsible for community relations within the FMG;
- Strengthen the role of social workers in establishing reciprocal relations with the community;
- Identify concrete ways to further integrate prevention goals into the FMG services;
- Develop and promote the adoption of an Equity, Diversity and Inclusion (EDI) policy;
- Develop a framework strategy for partnership with the community.

RESEARCH

Research plays an important role in a learning culture, particularly to ensure that we act on the basis of evidence.

Current situation

- Few clinics have links with scientists;
- Few clinics have physician-researchers on staff;
- Clinic staff have little interest in getting involved in scientific research.

Challenges and barriers

- Perceived gap between field realities and research;
- Few formal meeting places;
- Scientific research is poorly covered in the school curriculum of professional staff and physicians.

Systemic solutions

- Ensure that each clinic is aware of and has access to external research and evidence-based support, such as the Réseaux de recherche axé sur les pratiques de première ligne (RRAPPL), in order to promote win-win partnerships between the frontline and research communities;
- Provide incentives to participate in research projects and encourage the emergence of projects based on real local problems (living lab type) rather than theoretical or identified outside clinical settings.

Solutions and directions for the learning FMG

- Identify opportunities to develop and maintain relationships with universities, research networks, and research centers;
- Develop win-win partnerships between research and FMGs.

PATIENT PARTNERSHIP

In a learning culture, patients are partners in the FMGs and are involved at various levels.

Current situation

- There are few clinics that work with patient partners;
- There are few clinics that are aware of the benefits of working with patient partners;
- There are few clinics that are aware of the resources available to support them in their relationship with patient partners.

Challenges and barriers

- A culture of partnership that has yet to be integrated into FMGs;
- Relationship building is time-consuming;
- Lack of an accepted framework for the remuneration of patient partners;
- Lack of a dedicated budget for partnership in FMGs;
- The degree of openness varies greatly from one setting to another.

Systemic solutions

- Provide basic training to raise awareness of patient partnership and its benefits, and share success stories;
- Simplify and disseminate the guide to implementing frontline patient partnership governance;
- Integrate or develop frontline patient partners in the Experience Community;
- Develop formal support and guidance links with institutional user offices for FMGs, especially if they have a patient partnership angle;
- Integrate patient partnership at all levels of the health system governance.

Solutions and directions for the learning FMG

- Use means such as patient surveys to collect data on patient experience;
- Involve citizen patients and patient partners in the various aspects of the clinic (governance, research, care and services, patient and citizen groups, training and information);
- Use means such as technological tools to enable patients to access their medical records and be partners in their care.

MEDICO-ADMINISTRATIVE COMANAGEMENT

Managers play a fundamental role in clinic operations. However, despite all the advantages associated with comanagement, it can quickly become a challenge.

Current situation

- Medical and administrative managers in clinics are poorly trained for management roles;
- Skill levels therefore vary enormously from one clinic to another.

Challenges and barriers

- Individual characteristics (availability, lack of training, personality type);
- Communication (difficulties related to understanding and trusting each other, clearly defining roles and responsibilities);
- Organizational aspects (understanding governance);
- Institutions (comanagement with CISSS-CIUSSS);
- Broader context (turnover and shortage of manpower, complex HR challenges, lack of recognition for management positions).

Systemic solutions

- Provide basic management training as part of the academic curriculum for physicians and other professionals;
- Recognize the importance of comanagement (time and compensation) and better define the issues related to comanagement in frontline settings;
- Develop and support mentoring;
- Provide specific funding in the FMG program to hire qualified managers and provide management training for less experienced managers.

Solutions and directions for the learning FMG

- Ensure that each manager continuously develops his or her management skills, both clinical and administrative;
- For managers, formally schedule regular opportunities for sharing and integrating comanagement concepts.

GOVERNANCE

Governance is a key element in making FMGs part of a learning culture. Clinics must have the tools they need to develop a clear vision and way of working, while enabling the participation of all stakeholders.

Current situation

- There is often an absence of established, transparent governance.

Challenges and barriers

- Medical governance with little participation.

Solutions and guidelines for the learning FMG

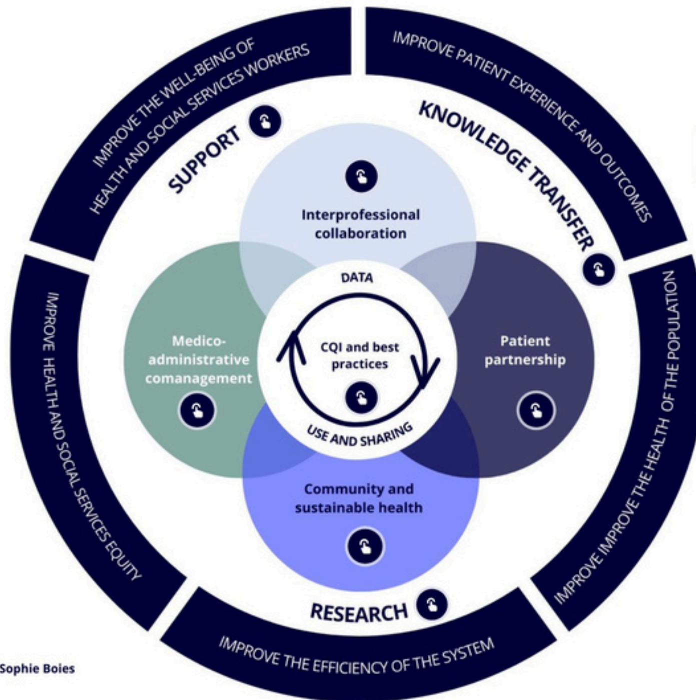
- Implement transparent, participatory governance;
- Involve patient partners in governance;
- Develop an organizational vision and strategic plan for the team.

THE LEARNING FMG MODEL

Based on these findings and orientations, a model to support and measure the deployment of a learning culture in FMGs is proposed:

Learning FMG

Orientations



Foundations

Governance

Policies

Medical leadership

Authors: Catherine Bouffard-Dumais and Sophie Boies
Directed by Antoine Groulx
April 2024

SEE ONLINE

DOWNLOAD

CONCLUSION

Finally, from a systemic point of view, there are six key messages to consider in order to ensure the sustainability of the learning FMG orientations. These are developed in the following sections.

01 Medical clinic networks

The issue of networks of medical clinics, a model that is gaining popularity in some regions, was raised several times during the visits and consultations. These are networks in which the same management models and processes are applied uniformly everywhere, which is an obstacle to the application of a learning culture adapted to the uniqueness of each clinic.

02 Data and technology

Data plays a central role in a learning culture, enabling healthcare organizations to objectively and continuously improve and effectively respond to the needs of patients and staff. It is critical to support the development of a data culture within healthcare organizations by developing a clear vision and plan. Data culture involves using data to improve decision making by ensuring access to relevant data and supporting its effective use, in accordance with the FAIR principles (easy to find, accessible, interoperable, reusable). In addition, clinics must have the tools and means to structure and analyze their data and compare themselves with others. The monetization of data, as well as issues of confidentiality and consent, must also be considered.

03 Change management and deployment of a learning culture

There's a significant gap between the vision and dimensions of a learning culture and where learning FMGs currently stand. There is also natural resistance to any change. Change management and local support are therefore essential if the vision of the learning FMG is to become a reality. Recommendations include providing the means to democratize the learning culture, strengthening the change management skills of actors already in the field, developing a comprehensive toolbox tailored to the front line, and adopting an approach of small, incremental changes. It should be noted that there are currently few sources of support and coaching for the front line and the learning culture, a major challenge to overcome. In addition, in order to encourage compliance with the guidelines by the FMGs, it is recommended that a committee of independent experts be formed to be responsible for analyzing the annual reviews.

CONCLUSION (PART 2)

04 Community

A learning health organization is rooted in and works in partnership with its community. It is important to create spaces for FMGs and community actors to get to know each other and work together through formal and reciprocal links. Formal links should also be established with public health actors to provide access to the socio-economic and health profiles of the populations served by the clinics. To this end, it is recommended that regional public health officers work closely with frontline workers.

05 Interprofessional collaboration

In a learning culture, working in silos is replaced by interprofessional collaboration. Efficiency standards need to be established for health and social care professionals, accompanied by qualitative and quantitative monitoring of clinical practice and support in the field. It is also necessary to better define the scope of practice of FMG professionals and to support their development. Provincial clinical tools and guidelines for interprofessional collaboration could be developed to promote innovation.

06 Continuous quality improvement

It is essential to ensure access to external support for CQI, such as provided by the Regional Agents for Continuous Quality Improvement (ARACQ). Indeed, CQI is at the heart of a learning culture. Recommendations include providing dedicated, paid time for CQI activities within the clinics themselves (physician in charge), promoting consistency and collaboration among CQI specialists, and establishing a structure to track and effectively disseminate successes. It also remains essential to secure long-term funding and support for CQI training, including the Académie Qualité Santé.

GLOSSARY

Term	Definition
Meta-consent	An approach that allows citizens to determine when and how their data can be used. This avoids the need to seek consent for every project, saving time and facilitating access to data.
Continuous quality improvement	"A management method that favors the adoption of gradual improvements that are part of a daily quest for efficiency and progress by calling on the creativity of all the organization's players" [Traduction] (Ministère de l'Économie, de l'Innovation et de l'Énergie, 2022).
Leadership	"[...] The ability of an individual to lead or direct other individuals or organizations to achieve certain goals" (World Perspective, 2024). "As Leaders, physicians engage with others to contribute to a vision of a high-quality health care system and take responsibility for the delivery of excellent patient care through their activities as clinicians, administrators, scholars, or teachers." (Royal College of Physicians and Surgeons of Canada).
Interprofessional collaboration	A patient-centred approach that involves the joint action of different professionals. There are several types of interprofessional collaboration (multi-, inter-, etc.) (Dumont, 2010).
Governance	A set of rules and processes that determine how decisions are made and implemented.
Medico-administrative comanagement	A management style in which responsibilities are shared jointly by a medical manager and a clinical-administrative manager (Gaudreau, 2006). "Co-management encourages [...] a perspective oriented towards patient needs and experiences at strategic levels of the organization, while raising physicians' awareness of administrative constraints" [Traduction] (Fortin, p.6, 2020).

GLOSSARY (PART 2)

Patient partnership	''An approach based on the relationship between users, their families and health and social care professionals. This relationship is based on complementarity and the sharing of knowledge, as well as on the way in which the different partners work together. More specifically, the relationship fosters the development of a bond of trust, the recognition of the value and importance of everyone's knowledge, including the experiential knowledge of users and their families, as well as co-construction" [Traduction] (Ministère de la Santé et Services sociaux, 2018).
Sustainable health	''Healthy minds and bodies living in healthy environments on a healthy planet." (VITAM, 2024).

REFERENCES

Dumont, S. (2010). Enjeu du suivi interprofessionnel. Le médecin du Québec, 45 (12).
Fortin, A-H (2020). *La cogestion médico-administrative au Québec : définitions et enjeux de mise en œuvre. Pôle santé HEC Montréal.* https://polesante.hec.ca/wp-content/uploads/2021/09/Revue-de-la-litterature-Cogestion-VF6.pdf

Institute of Medicine (US) Roundtable on Evidence-Based Medicine, Olsen, L., Aisner, D., & McGinnis, J. M. (Eds.). (2007). *The Learning Healthcare System: Workshop Summary. National Academies Press (US).*

Royal College of Physicians and Surgeons of Canada (2024). *Understanding the CanMEDS Roles: Leader*. https://www.royalcollege.ca/fr/canmeds/canmeds-framework/canmeds-role-leader.html

Ministère de la Santé et des Services Sociaux (2018). *Cadre de référence de l'approche de partenariat entre les usagers, leurs proches et les acteurs en santé et en services sociaux*. https://publications.msss.gouv.qc.ca/msss/fichiers/2018/18-727-01W.pdf

Ministère de l'Économie, de l'Innovation et de l'Énergie (2022). *Amélioration continue et résolution de problèmes.* https://www.economie.gouv.qc.ca/bibliotheques/guides-et-outils/gestion-dune-entreprise/production/amelioration-continue-et-resolution-de-problemes#:~:text=L'am%C3%A9lioration%20continue%20est%20un,les%20acteurs%20de%20l'organisation

Perspective Monde (2024). *Leadership.* https://perspective.usherbrooke.ca/bilan/servlet/BMDictionnaire/1619#:~:text=Le%20leadership%2C%20un%20terme%20emprunt%C3%A9,'influencer%20et%20d'inspirer.

Unité SSA Québec. (2024, 25 mars). *Système de santé apprenant.* https://ssaquebec.ca/lunite/systeme-de-sante-apprenant/

VITAM. (22 avril, 2024). *What is sustainable health?* https://vitam.ulaval.ca/sante-durable

Zomahoun, H., Giroux, C., Boies, S., Kengne Talla, P., Poitras, M., Couturier, Y., & Ahmed, S. (In preparation). *Evaluating health organization readiness for implementing a learning health system: An integrative literature review to inform questionnaire development*