Appendix 2 – Innovation description

Description adapted from innovation booklet: http://cqmf.qc.ca/wp-content/uploads/2020/01/PDF-2-Livret-des-innovations-2017.pdf

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Innovation	Brief description
CoMPAS + : *Collectif pour les meilleures pratiques et l'amélioration des soins et services+* (Collective for best practices and improvement of care and services +)	Facilitated reflective quality improvement workshops – based on performance indicators, problem-solving, improvement targets and action plans – support local health networks and primary healthcare teams to implement best practices for chronic disease prevention and management (e.g. diabetes, mental health, COPD).
BASE™ eConsult : Building access to specialists through eConsultation	Primary care providers (e.g. family physicians, nurse practitioners) consult with specialists regarding their patients' medical issues in over 80 specialities (e.g. psychiatry, dermatology, geriatrics, cardiology, oncology) through asynchronous communication via a secure online platform.
Canadian Primary Care Sentinel Surveillance Network	A secure national database extracts clinical and administrative primary healthcare data from electronic medical records (adapted to 13 electronic medical records – 3 in Quebec) for research, surveillance and quality improvement. A web tool allows sentinel providers (i.e. local champions, nominated by peers) to autonomously explore their clinics' data.
Accueil clinique + (Clinical reception +)	To reduce overcrowding, emergency department providers and specialists refer subacute or semi-urgent patients – based on detailed and safe referral protocols – to family physicians in primary healthcare, who then have privileged access to technical and diagnostic platforms and specialist consultations.
V1SAGES (Faces): **Case management for frequent service users**	Case managers (nurses) in family medicine groups each support up to 30 patients with complex health needs (chronic diseases, frequent service users). They evaluate patients' needs, co-develop a tailored care plan with patients and providers, coordinate health, social and community services, and offer self-management support to patients and their families.
Maison bleue (Blue House):	To support optimal child development from pregnancy to age 5, a non-profit organisation helps pregnant women and their families, who live in vulnerable contexts, through interdisciplinary care (family physicians, midwives, nurses, social workers, specialized educators, and psycho-educators).
Patient-partner governance	A team with expertise in patient-partnership supports university family medicine groups (workshop, implementation guide, coaching) to integrate patient-partners in their clinic's governance structure (recruitment, mandate co-development, training, coaching, facilitating meetings)

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Collaborative mental healthcare	A workshop that brings together experts in collaborative mental healthcare, the regional adult mental health teams, a patient-partner and a family medicine group/university family medicine group to: 1) raise awareness of collaborative care and treatment for anxiety disorders and depression with regional adult mental health teams, 2) present two tools that support collaborative care, 3) create an opportunity for collaboration and support for primary healthcare teams.
Interdisciplinary pain program	A chronic pain prevention and management program integrates collaborative care between a nurse, physiotherapist, psychologist, physician with expertise in chronic pain) to support patient empowerment.
SPOT community and teaching clinic: a team and collective engagement for more health equity	A nurse-led clinic with interns/residents from a wide range of disciplines – co-constructed by community, healthcare and academic partners – offers integrated primary healthcare to persons living a situation of marginalization or social disaffiliation, in close collaboration with family physicians from university family medicine groups.
Practicing Wisely	An evidence-based interactive program to reduce negative impacts of unnecessary care (overdiagnosis, overprescribing) for family physicians and residents (case studies, decision-support tools, reflective evaluation, and websites) supports teams to reflect on their practice, identify issues and develop action plans.
REFLET and reflective practice	The REFLET tool produces, presents and exports clinical indicators (provider or practice-level) from electronic medical records to support primary healthcare teams in their reflective practice (e.g. to improve follow-ups for diabetes or accessibility), while data remains under the teams' control.
SEKMED: Software for the Evolution of Knowledge in MEDicine	A technological platform recognizes terms used by providers in their usual care processes (e.g. electronic medical records) and provides them with relevant just-in-time high quality evidence (e.g. guidelines, recommendations, Choosing Wisely)
Group prenatal care	To improve social support and pregnancy outcomes, midwives and physicians facilitate educational sessions (e.g. pregnancy, childbirth, newborn care, breastfeeding, contraception) for groups of women of similar gestational ages, following a brief medical assessment.
Discutons santé (Let's Discuss Health)	A website with tools and self-learning modules for both patients and providers (e.g. family physicians, nurses, pharmacists) supports effective communication and collaboration

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	between patients and providers and encourages patients with chronic diseases to actively engage in their care.
Effectiveness and teaching excellence at Clinique de Santé Jacques-Cartier	Early adopters of the university family medicine group model implemented many pillars of the patient's medical home, while maintaining a large patient roster and a high-quality teaching program. The clinic offers mentorship to other clinics striving to implement a similar model.
Centralized waiting lists for patients without a primary care provider	Centralized waiting lists, in Quebec the *guichet d'accès aux clienteles orphelines,* help match patients looking for a primary care provider to an available family physician or nurse in their area.
Advanced access	To improve timely access to primary healthcare for patients, advanced access reorganizes primary healthcare teams' work according to 5 principles: balancing supply and demand for services, reducing appointment backlog, revising scheduling system, integrating interprofessional practice, and developing contingency plans.
Programme Service d'orientation individual (Individual orientation service)	A community health worker/navigator inspired model supports patients from disadvantaged neighborhoods when they are newly attached to a family physician and primary healthcare clinic (e.g. prepare for first appoint, understand clinic process, address access barriers, support health system navigation), in collaboration with social workers in family medicine groups.
VITASANTÉ: community engaged in chronic disease management	To empower patients and build community-patient-provider partnerships, an interdisciplinary team (nurses, kinesiologist, nutritionist, pharmacist, respiratory therapists, family physician, specialists in internal medicine) consults and coordinates around the patient. Services are offered in the patient's community through telehealth at home and through social clubs, community organisations, and municipal partners.
Method for reviewing medications in university family medicine groups	Residents meet with a pharmacist to discuss real patient cases and together they review patients' pharmacotherapy using a systematic method (*méthode R.I.P.)* and tool containing hyperlinks to relevant evidence (e.g. withdrawal plan, risks of suboptimal use).
Educational sessions on global review of medication use	A pharmacist offers interactive training sessions to residents, family physicians and allied health professionals in university family medicine groups. Each session, they revise a class of medication using clinical situations, practice guidelines and the latest evidence and discuss pragmatic implications (e.g. costs, risks, advantages, necessary follow-ups)

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***Contresens* arts-based workshops: Thinking differently to treat better**	Using works of art, a physician and psychologist facilitate thematic workshops (e.g. motherhood, death, aging, power, identity) to develop family medicine residents' desire and ability to identify issues at stake through patients' attitudes, diseases, ailments and demands.
Troubleshooting activity: 'with this one, it's not working anymore!'	A psychologist facilitates a troubleshooting activity where family medicine residents take turns presenting patient cases that they are having trouble with. Practical learning related to personalities, therapeutic relationships, ethical considerations, and supervision are discussed in the group.
Physical activity group	A kinesiologist facilitates a weekly physical activity group training session for patients from a family medicine group, improving patients' adherence to their training programs through frequent follow-ups, training supervision and rapid program adjustments.
MRCR : *Méthode reflexive centrée sur la relation* (reflective method centered on the relationship)	To help residents develop their reflective capacity (e.g. quality of care for difficult patients, patient compliance), a supervisor facilitates a discussion with residents in 5 steps: explaining the situation, describing emotion, making an explanatory hypothesis, accepting the hypothesis, and adopting new perspectives.
Baromètre (Barometer)	A clinical digital tool used in interprofessional care empowers patients by highlighting their mental health strengths, progress in their community, changes in quality of life, based on their priorities.
Open Studio Projects @ Patient Medical Neighbourhood	Accessible and sustainable immersive environments utilize art as a tool for social change In healthcare and provide creative experiences that promote community engagement, trusting relationships and interprofessional collaboration.
CONCERTO – Digitial clinical intelligence for chronic disease management	Digital care pathways, based on Canadian clinical guidelines, include functional flowcharts, diagnostic, therapeutic and monitoring algorithms, care protocols, decision support tools, and toolkits for patients and professionals. The database produces indicators that allow simultaneous follow-ups for concomitant pathologies.
Programme UPF: Urgences en Pratique Familiale (Emergencies in family practices program)	An 8-hour training session for all clinic staff (physicians, nurses, administrative staff, allied health professionals) on emergency situations (e.g. certification in cardiopulmonary resuscitation [CPR] and automated external defibrillator use, a complete medical kit, emergency simulations)
Patient's Medical Home Self-Assessment	An online self-reflective questionnaire helps teams analyze how closely their practice aligns with the principles of the patient's medical home and identify areas for improvement.

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