

## Practice-Based Research Network (PBRN) MEETING

### SUMMARY OF PRESENTATIONS AND DISCUSSION GROUPS

TORONTO 5-6 DECEMBER 2014

#### Friday 5 December

**Presentations** (available at: <http://www.chiropractic.ca/guidelines-best-practice/research-network/> on the CCGI website 'Networks' accessible to members only)

**Speaker:** Kent Stuber DC, MSc, CMCC, private practice, Alberta, Canada

**Topic:** Overview of the results from pre-workshop activities.

- *Pre-meeting environmental scan among attendees:* Perceived challenges and benefits of creating a chiropractic PBRN in Canada, types of research activities that the PBRN could facilitate, use of the PBRN to disseminate and implement guidelines.
- Research utilization in chiropractic: *Scoping review:*
  - Most of the 53 included studies were undertaken in Canada, USA, UK and Australia.
  - 70% of studies were surveys addressing issues related to research beliefs and skills among chiropractors.
  - Thematic analysis for the three categories (EBP, KT, Research Utilization) revealed three themes under EBP (*Attitudes and beliefs of DCs, Guideline adherence, and Implementation of evidence-based practice*) as well as under KT (*Knowledge practice gaps; 2. Barriers and facilitators to knowledge use; and selection, tailoring, and implementation of interventions*). Only three articles were related to RU.
  - Gaps were noted in the areas of assessment of activity limitation, psychosocial function, and general health indicators; establishing a prognosis; and exercise prescription.
  - While most practitioners believed EBP and research to be important, and a few studies suggested that traditional and online educational strategies can improve patient care, guideline adherence varied widely.
- Canadian chiropractors' current level of knowledge of and attitudes toward evidence-based clinical practice: *National e-base survey:*
  - As education level (post grad) increases, attitudes, skills, and use scores on EBP increase.
  - Those with a musculoskeletal focus have higher attitudes, skills, and use scores.
  - As number of patients increase, attitudes, skills and use scores decrease.
  - Those in rural areas have lower scores in attitudes, skills, and use.
  - Chiropractors with onsite imaging have lower scores in attitudes, skills, and use.
  - As the percentage of patients receiving radiographs increases, the attitudes, skills, and use scores decrease.

**Speaker:** Cheryl Hawk DC, PhD, Logan University, MO, United States (Skype)

**Topic:** Rationale for creating a Network in chiropractic.

- It's a partnership between clinicians and academics.

- PBRNs are good for studying organizational structures in the real world, epidemiology and socio-demographic surveillance, and for studying the management of delivery systems and what works best for whom.
- Information goes in to the practices and out in KT.
- KT=information out (TRIP=translate research into practice), best practice information and guideline dissemination & implementation.
- “new clinical laboratories for primary care research and dissemination” \*Westfall 2007
- Relationship to translational research
- Of 146 AHRQ registered PBRNs in US, only one is chiropractic (pediatric)

**Speaker:** Marshall Godwin MD, Memorial University, NF, Canada,

**Topic:** Establishing and maintaining a local network and expanding nationally: anticipated challenges and strategies for meeting these.

- Stressed the importance of individual practitioners, building cells, collaboration between academics and practitioners.
- Described a PBRN where an EMR-based network was put into a central database (The Canadian Primary Care Sentinel Surveillance Network (CPCSSN). This project was funded by Health Canada. Data were collected through EMRs with specific questions in mind, rather than just data mining.
- Can start and build around a funded project with an RA.
- When recruiting practitioners, send a letter, call them, meet with them, take them for lunch and include the clinic manager in the process, as well as the clinic staff.
- Review of top-down vs. bottom-up model

**Speaker:** Ian D Graham PhD, FCAHS, OHRI, Ottawa, Canada

**Topic:** PBRN as an innovative strategy for knowledge translation (KT) and exchange (KTE).

- Solutions-focused research should engage the network in end user collaboration (integrated KT = PBRN paradigm).
- Knowledge/End users who have collaborated are more likely to implement in the end.
- Cluster/pragmatic RCTs can be done.
- Clinicians must see the results and the implications for their work.
- The PBRN encompasses all the elements of CIHR’s definition of knowledge translation:
  - Knowledge synthesis
  - Dissemination
  - Knowledge exchange (iKT)
  - Ethically sound application of knowledge
  - to improve health, provide more effective health services and products and strengthen the health care system.
- If research is to be used it must:
  - Answer important questions of concern to knowledge users (KUs)
  - Be integrated with contextual evidence to become actionable in a specific setting
  - Undertaken with the genuine engagement of knowledge users (practitioners, patients stakeholders) from the beginning of the process. However, this doesn’t mean all KUs need to be involved in all phases of research.
- Qs. If the network only includes those who are on board, is knowledge representative/generalizable?

- Answer: If you have improved healthcare that is already good. We will know at least if the KT strategy is effective.

## Discussion groups 1

**Task 1.** Participants will discuss opportunities and challenges to establishing a chiropractic PBRN in Canada using findings from the pre-meeting activities (including environmental scan, scoping review, national e-survey).

### Challenges:

- Operationalizing and coordinating a PBRN
- Privacy issues
- Electronic health records utilization (collecting same data across different EHRs)
- Sustainability – ongoing funding
- Identifying champions
- Need buy-in from practitioners/stakeholders
- Conformity concern for practitioners
- Clinician fear of research, mistrust
- Clinician workload and time
- Perceived value to clinicians
- Language and communication
- Understanding clinicians' perspective
- Maintaining interest
- Prioritizing research projects

### Opportunities:

- Stakeholder current interest
- Momentum (local PBRN's already underway)
- CCRF research chairs as champions
- Growing research capacity in chiropractic in Canada
- External and Internal agencies/professional associations
- Crowdfunding (the use of small amounts of capital from a large number of individuals to finance a new venture)
- Chiropractic Institutions (CMCC, UQTR)
- Curricula in schools
- DCs working in multidisciplinary settings
- Answer questions from real practice settings
- Prestige for practitioner
- Recent graduates (electronic savvy, in tune with EIP)
- Use of technology for communication
- CE hours as possible incentive to participate
- Individual recruitment by champions/opinion leaders
- Potential benefits to improve DC care and patient health

1. Obtaining clarity on the purpose of the PBRN-this should be a first step. Is the PBRN about KT and the CCGI OR is it about creating opportunities for practice based research? The challenge is to find a way to marry curiosity based research (pure science) with increasing the quality of practice.
2. Engaging the profession on why a PBRN would be beneficial is a challenge. Most practitioners are not engaged in research or in evidence informed practice. We may need to appeal to the culture in health care where the focus is on improving patient care and this would be the motivator for chiropractors to be willing to participate.
3. Practitioners also respond well to having their own data so they can compare themselves to the bench marks for the profession at large and this would be a motivator. The PBRNs would need to commit to providing individual reporting to participating chiropractors as this is an important benefit (Audit and Feedback).
4. Funding is a significant barrier to the development of a PBRN. The focus should be on building the individual cells with researchers and chiropractors based on available research funding. Start small and build out from there.
5. Engagement of the profession is critical so begin by focusing on the segment of the profession that is pre-disposed to this kind of opportunity and once there is demonstrated success the word of mouth and advantages will sell the others to become involved.
6. Focus on CCGI as an opportunity to begin building a PBRN and create Relative Advantage—meaning demonstrating how the guidelines provide a distinct advantage for those that are engaged and it is an additional value.
7. PBRNs can be a great way to connect practitioners if you can provide the clear advantage for them to belong, such as increase referrals, improved patient care and better patient outcomes.
8. Start Simple and be iterative in the approach so this is not overwhelming. Build excitement so it is attractive for chiropractors to become involved...this will result in strengthening the PBRN community.
9. Can we begin with using existing communities of practice... there are some chiropractic societies across the country and informal gatherings of chiropractors both in person and online. This may be the way to begin without much effort in organizing.
10. Sustaining the relationships is a challenge---how do we sustain a 'culture of science' in chiropractic. Engagement is key.

**Task 2.** Where and how to begin?

Launching the PBRN first in the provinces of Ontario and Quebec with the intent to expand the PBRN nationally? Please consider findings from the pre-meeting activities (environmental scan, scoping review, national e-survey).

- Secure funding for a project (question) that will be engaging
- Start local, slowly grow
- Chiropractic Institution outpatient Clinique's may help start the process
- Select opinion leaders/champions (enthusiasm and trust)
- Explore inter-professional collaboration/opportunities

## Presentations

**Speaker:** Cheryl Hawk, DC, PhD, Logan University, MO, US (via Skype)

**Topic:** Strategies to overcome identified challenges for creating a PBRN.

- Requires attention to process: infrastructure and funding.
- Personnel (e.g., program director, data manager, biostatistician, coordinator, RAs) is usually the greatest expense
- Participation factors for clinicians (interest, time, paperwork, follow up)
- Personnel challenges: PBRNs are complex organizations with complex data management and analysis needs. Requires program director, data manager, biostatistician and coordinator. Importance of effective communication to clinicians.
- Develop collaborations
- Data collection technology challenges: EHRs may not be used by all. Use standard outcome measures (Patient Reported Outcomes Measurement Information System (PROMIS) at: <http://www.nihpromis.org/#2> .
- Participation challenges: buy-in from clinicians and office staff is key
- Time and participation challenges: do not add excessively to their burden. Patients completing EHRs is an issue.
- Strategies to overcome: Ask clinicians what they think is important. Ask office staff how best to administer forms. Provide incentives. Calculate time required. Conduct pilot study first.
- Start with a cross-sectional study and find out what are the most effective incentives.

**Speaker:** Marshall Godwin. MD, Memorial University, NF, Canada **Topic:** Governance and administrative structures in PBRNs.

What types of study designs are possible?

- Descriptive studies of beliefs, opinions, attitudes (provider or patient/client)
- Cross-sectional descriptive studies of care
- Quasi-experimental methods (Before and After)
- Outcome Studies/Longitudinal cohorts
- Randomized Control Trials
- The presence/absence of an EHR affects what and how studies can be done

**Speaker:** Sil Mior, DC, CMCC

**Topic:** Electronic Health Records usage in a PBRN: The OSCAR example.

- Digital infrastructure increasingly used in healthcare
- Templates aid adoption of treatment guidelines
- Prompts/reminder systems improve safety & pathway adherence, enhance preventive activities
- Improve reimbursement and financial management
- Research: academic health centres vs community
- Community important to facilitate research
- Recruit variety of patients, diverse case mix
- EHRs can be used to recruit, identify potential subject
- Developing standards for exchanging clinical data is expanding rapidly
- Need assurances for privacy, standards for remote data capture, searchable anonymized database

- Identify knowledge-practice gaps
- Tracking change and implementation strategy
- Demonstration of OSCAR was presented

## Discussion Groups 2

**Task 1:** Establishing the ethics and governance structure of the chiropractic PBRN.

**Task 2:** Strategies to engage knowledge-users and end-users in various projects to be undertaken by the PBRN.

- Set up advisory/steering committee to which the project director reports
- Identify local champion
- Start with a network of people using EHRs (e.g., Oscar at CMCC)
- Flow chart to map this (see article by Axen and Yde-Leboeuf)
- Governance structure may include: network director and advisory/steering committee, researchers, project coordinator and RAs
- Steering, advisory, researchers at the local level could be another model
- From a KT perspective, the language has to be about exchange not just about data collection
- Participant rather than patient/subject
- We could use more of a systems diagram - not necessarily a linear process
- Each regional network submitted a proposal to a local Ethics Board for ethical approval for extracting and combining data.
- Draft charter was presented:
  - The group reviewed the draft vision and mission that was put together by the PBRN planning committee. The vision was seen to be good but the mission was too uni-directional and did not define who this was for. Should be multidirectional. Also, translating to what?
  - Need to refine the strategies; they are not prioritized, new research, facilitating data transfer?
  - Too big and abstract for clinicians, doesn't engage people, needs to be simplified and more direct.
- PBRN steering committee should revise the charter and circulate to PBRN members for feedback.

### Engaging partners/stakeholders/professional associations for funding and partnerships

- Requires a business model.
- Key organizations need to be committed to support the project.
- Need to create the relationship with the organization and part of the steering committee
- Should align with the stakeholders objectives so that it is of benefit them
- Need first level of accomplishment (pilot study).
- Creating small PBRNs with research chairs?

- If the network is a potential solution, the stakeholders need to see it as such. They will be willing to fund it provided that they see the potential benefits for them.
- Engage stakeholders as early as possible. Find out what they are interested in doing. Our messaging needs to align with stakeholders objectives so they see the merit right away and would be willing to invest. They need to feel that they are part of the solution (key message). We should start with a quick demonstration project that can produce deliverables and outcomes for us to illustrate the advantages.
- Provinces will have to get involved.
- Involve the Opinion Leaders with the PBRN.
- We need to have an overarching administrative model and smaller PBRNs which are operating.
  1. Consider establishing: A Director/Research Director; Network Coordinator; Research Assistants; Experts/Consultants; Biostatisticians; Content Specialists. This can be done over time.
  2. Do we need a separate BOD/Steering committee (other than the CCGI) that will be made of clinicians, community members, academics, experts? This will be the group that sets the vision, mission and terms of reference.
  3. A key task is identifying local champions.
  4. Set guidelines and ensure you have folks who use EHRs already.
  5. Make sure that the flow chart and governance structure reflects the needs of both patients and clinicians along with the researchers. It can't be top down, it needs to reflect knowledge engagement in order to be effective and sustainable over time.
  6. It must be interactive and participatory.
  7. Ethics is a key step in any proposal and there needs to be an ethics process of review for each proposal.

## SATURDAY 6 DECEMBER

### Presentations

**Speaker:** Hani El-Gabalawy MD, FRCPC – IMHA Scientific Director **Topic:** CIHR's Strategic Priorities and Directions for Musculoskeletal Research.

- Work and Health and SPOR Initiative would be the most likely places to look for funding.
- Chronic Pain and Fatigue Network doesn't have matching requirements.
- In the UK NIHR system, research infrastructure is provided. This helps to engage clinicians.
- Importance of linking with partners: insurance industry, workers compensation board, groups with a vested interest in this research area.

**Speaker:** Charlotte Leboeuf-Yde DC, PhD, University of Southern Denmark, IFEC (Skype)

**Topic:** Practical aspects of a PBRN with some examples.

- Why use a PBRN?
  - Need more knowledge
  - Lots of cheap data
  - Participation and ownership
  - Expertise among clinicians
  - Future interest

- How to do it - Key principles: ownership, military organization ('Napoleon'), disciplines and communication, has to be fun.
- PBRN manual by Axen & Leboeuf-Yde (2013)
- Examples of different projects undertaken by the PBRN, including the LBP trajectories project in Norway, Sweden, Finland, Netherlands, and Internationally (S.Africa, USA, Canada, Australia, Hong Kong, Japan):
  - Results: Can treatment outcome be predicted? Not really. Look for early improvement as prediction for outcome later
  - Outcomes of this PBRN research project:
    - Increased our knowledge on many practice-relevant topics
    - Steering group members have published
    - Help in academic career
    - Promote cultural authority
    - Steering group members understand research process
    - Steering group members have developed sense of "belonging"
    - Data collecting chiropractors are happy to have helped

**Speaker:** Marshall Godwin MD, Memorial University, NF, Canada

**Topic:** Importance of town/gown collaboration

- Sustainability: difficult to do if you need a lot of money to start. So build a local network, develop personal relationships with local clinicians, and find a champion. 7 existing local networks came together. Champion should know clinicians in the area and be able to keep in touch with them.
- Do we look for smaller networks or look at something more national? Smaller networks would be the prerequisite for doing things on a larger scale. Build an ecology around which you can build something bigger and demonstrate what you've already done.
- Where is the investment from within the community? Leadership and commitment is required. Champion requires freedom from an academic perspective.
- Finding initial funding: Suggestion to increase CCA membership by 10\$ to start up a PBRN. Engagement and ownership of the project: members need to feel ownership to get engagement so it is important to set the priorities carefully and in collaboration with them.
- Maintenance funding: will it die when the initial funding runs out?
- Importance of proximity for sustainability and collaboration. Need to focus more on robust regional or local networks or a couple of specific pilot projects first. Get a picture of what is happening in practice, surveys about what is actually happening, data about chiropractic practice, and then we will have data on what needs to be researched. Then you have a platform to go on. Pick a couple of provinces where you can score some wins.
- We need a clearly defined model for clinicians so they know what they are expected to do.

**Speaker:** Ian D Graham PhD, FCAHS, OHRI, Ottawa, Canada

**Topic:** Strategies to encourage knowledge uptake in a PBRN.

- Strategies to encourage knowledge uptake and KTA framework (Integrated knowledge translation)
- Can guidelines be adapted to the context? What do you need to adjust in your practice to do this?
- Be careful with language (e.g., not recruiting but engaging, etc).



- Think about applying to practices, other roles to promote uptake of finding. Quick and good is better than perfect. Need to develop a KT strategy.
- RNAO piloted guidelines: Best Practices Spotlight Organizations (<http://rnao.ca/bpg/bps>). Organizations who qualify are given a plaque. Implement a certain number of guidelines. Not an accreditation process. *You could be a best practice organization if you commit to doing these things.*
- Qs. Need to assess barriers/facilitators for all behaviours we intend to change?
  - Answer: Look at the evidence: To what extent is chiropractic similar to medicine? e.g. Effectiveness of interventions to influence nurses to use guidelines. (Grimshaw)
- Opinion Leaders (OLs) work some of the time (medicine), didn't work in nursing. Depends on the culture of the organization/profession. Are DCs more like MDs, nursing or allied health.
- Start with the converted. Then later on, audit and feedback can help to soften up clinicians who find the evidence inconvenient.

### Discussion Groups 3

**Task 1:** Current gaps in knowledge (i.e., what is known and unknown) about the delivery of chiropractic services in Canada, types of services provided and outcomes of care.

**Task 2:** Strategies to identify and recruit clinicians and their patients, how to instruct participants and follow-up with them.

#### Current gaps in knowledge

- PBRN perspective - go for low hanging fruit/opportunities
- What do chiropractors want to know?
- Will this be easy (easier) for clinician and improve patient outcomes?
- Most amenable to practice-based setting
- Determine what can be done with limited funding
- Lack of data in North America compared to Europe
- A lot of data is self-reported
- Quality of the data not optimal
- Lack of standardization
- Age of existing data may not reflect current practice
- Professional isolation
- What data sources can we access currently? Are these data out of date?
- Many organisations have conducted surveys but results are not publically available (e.g., CCA). Chiropractic protection.
- Ask the stakeholders what gaps they perceive; what do they need to know to do their job better?
- Very small numbers of clinicians are involved in research
- Ability to engage and train graduate students
- Need to favour clinical research. Basic science needs to be explained to justify clinical effects.
- Pilot study: take practices and find out how to use administrative data.
- Administrative data cannot be linked to complex conditions. Thus, important to merge clinical practice and administrative data.
- Changing demographics in society (ageing population)

- Asking potential partners such as insurance companies for whiplash data
- Limited or no baseline data from practices
- Start small with e-surveys (e.g., FluidSurvey) with a few questions, easy to access, collect and analyse
- Gradually move toward the use of EHRs to extract data and requirement for clinicians to use these will ultimately be important. EHRs can be used to establish a baseline.
- What?
  - Baseline data (practice profile): who sees us, for what reasons and what do we do to/for them; utilisation rates (e.g., imaging)
  - Identify gaps in practice protocols, practice patterns and variations of care
  - Outcomes data: Effects of treatment in “real world chiropractic”
  - Feeding back data to the clinicians to show their performance (Audit & Feedback)
  - Patient satisfaction data (“including did I get to where I needed to be?”) as well as objective outcomes.
  - Adverse events? e.g., VA model; treatment of children
  - Showing trajectories of patients with longitudinal data

#### **Strategies to recruit PBRN participants:**

- Sell to practitioners the benefits of participation
- Giving feedback – practice profile, meeting targets for recording (EMR)
- Compare to others (across provinces, national)
- Improves patient perception of practice (prestige)
- Incentives to participate: reduced rates for membership of organisation: Associations, PI Insurance, specialty Colleges, provide university/CMCC library access, etc.
- Free structured/ regulatory Board: mandatory CE credit
- Publication opportunities (Group author; Acknowledgements)
- Plaque/certificate/window decal (sign to attach to clinic window to advertise to the outside that clinic is a member of the PBRN)
- Access to the other network members (other members)
- Recruitment strategies: approach first who you know, who are already engaged in other activities (e.g., CMCC members, Association engagement, who is donating to the Research Foundation), find out what DCs are doing, call for volunteers
- Look at and build on existing examples of multidisciplinary practice
- Leveraging ongoing projects to build groups of interested clinicians
  
- Do we start with existing projects and networks?
- Developing a research agenda should involve clinicians, stakeholders and patients from the start or only researchers?
- Each local network could have its own local agenda and set its own agenda
- Need to specify what kind of questions we could answer and the kind of data we want to collect
- Patients should be at the heart of priority-setting and other organizations can be partners.
- James Lind Alliance (non-for profit org) - Steering group of clinicians and patients to identify top priorities for investment of resources at: <http://www.lindalliance.org/>

#### **Ian's summary:**

- Two steps: 1) what is the big picture (the moon)? 2) Operational

- Local networks & research interests
- Fact finding: Identify existing practices/clinicians/champions
- Provide mechanism to facilitate discussions
- Identify collaborative projects

## Presentation

What's next: published paper, demonstration project, advisory committee, identifying existing networks

**Moderators:** Simon French DC, PhD, André Bussi eres DC, PhD

**Topic:** Generating a practice-based research agenda - Preliminary findings and discussion.

**Four demonstration projects were presented** (promoting or scaling up 1-2 projects to rapidly show the potential benefits of this PBRN to stakeholders):

1. Jeff Q. Spine Flex project in BC. A network of DCs to implement spine care pathway. Evidence-based practitioners would become knowledge champions. Clinicians are paid fee per patient. Patients get education about exercise and prevention. MDs are allowing patients to return to DCs. Clinicians just have to tick off a couple of boxes.  
- Steven P. is doing something similar in Winnipeg. PBRN could identify clinic sites. Compliance: there is a family physician specialist in spine care and DC who encourages practitioners to take on evidence-based maintenance care. If DCs can cooperate for 6 weeks they can see clinicians after at their own discretion.
2. Simon F. O-COAST study in Ontario (OCA, Queens' funded project): 48 DCs randomly selected, 13 of which have now completed data collection on 100 consecutive patient encounters. A bit burdensome for practitioners. High volume practices had a lot of support staff. PBR (not a network). Could be a demonstration to illustrate baseline data and the beginning of a PBRN. 48% response rate.
3. Sil M. Showcasing what we CMCC is doing with OSCAR within their 6 outpatient clinics: utilizing one software program and answering questions where people think there are gaps. Download data into one server. Could leverage by sending out a few practices to try it.
4. Andr e B. Doc-Can-Do pilot KT intervention study across Canada: Feasibility measures for recruitment, randomization and data collection. Recruiting 30 DCs. Half of DCs in the intervention arm will receive the KT strategy (neck pain guideline webinar series, online clinical vignettes and a self-management learning module/video) vs controls (copy of the neck pain guideline only).

### Summary of prior discussions:

- A Network (national) of networks (local)
- Existing and new networks need to be identified (low-hanging fruit)
- Advisory/Steering committee to represent PBRN
- Under CCGI to begin with
- Agree to some basic principles, facilitate discussion, knowledge gaps, explore funding and sustainability, EHR and data collection
- Opinion Leaders in each province could be matched to CCRF researchers
- Identify graduate students, methodologists, statistician, etc.

## Discussion Groups 4

**Topic:** The Nuts & Bolts of the PBRN

1. Ethics and governance structure, roles of the research coordinator, RA
2. Methods to identify and recruit partners
3. Strategies to identify/recruit clinicians and their patients.
4. Research agenda and Funding opportunities
5. Involvement of PBRN members: sharing responsibilities and staying connected

### **Discussion groups reported back and discussed together:**

#### *Discussion group 1:*

- PBRN national advisory/steering committee: include people from GAC, content experts. Researchers are at next level down. They could look after ethics etc., repository of resources and documents. GSC would look after finances etc.
- PBRN is already part of CCGI strategic plan, but we may need to add PBRNs as ‘non-CCGI type’ research in the strategic plan as well as guideline implementation.
- Stakeholders-GSC-GAC-PBRN advisory/steering committee (public/patient, clinician, content expert, researchers, legal expert, insurance/stakeholders, health informatics and data management, research ethics boards).
- We need to be careful to have buy-in from all stakeholders who are not currently included in CCGI activities.

#### *Discussion group 2:*

- 10-member committee with national & provincial association representatives. Stakeholders may not be the same as CCGI but needs a strong link to CCGI. Chair would represent clinicians. Also need people in organizations who have influence.

#### *Discussion group 3:*

- Small group of 5 at first (having too many people can lead to inefficiency). The committee should be comprised of a patient, provider (non-researcher), a funder (i.e., insurance board of Canada, Workers Compensation Board), someone who knows the vision of the PBRN/CCGI, and someone who was involved in the early networks and who is at CMCC and/or UQTR, who can interact with students, and who is involved with OCSAR
- The advisory committee can act as a resource for the leaders/directors of the local PBRNs, provide guidance to them and help draft the vision, mission and values of the PBRN initiative
- The leaders/directors of the local PBRNs ought to be local chiropractor/champions, and they can function and be paired with the research chairs OR other designated researchers with a strong background in research and who have an ability to apply to the REB. Some concern that the research chairs may not have the capacity nor would the projects of the PBRN necessarily fit within their research program and that designating another point person might be a better idea.
- We need to establish the goal of the PBRN first before we decide how to set up the governance structure so that it fits with the goals. Purpose has to be clearly stated. Either formally integrate research first (non-guideline-related projects), may have to be different from attaching it to CCGI. It depends on whether it is top-down or bottom-up.
- Do not involve all the provinces initially (ON and QUE ok to start – or wherever the already naturally occurring PBRNs are taking place)
- We also had some discussion on how linked the PBRN initiative ought to be with the CCGI.
- It is important to maintain a practitioner and patient focus and, as such, having the PBRN initiative be strongly linked with the CCGI governance structure may lead to the perception of

the PBRN initiative being related primarily to having practitioners use guidelines, versus having practitioners be an integral part of the process of establishing research questions and assisting with data collection.

**Task:** Participants will discuss the development of a research agenda.

Chair: Pierre Côté DC, PhD

**Summary of final discussion:**

- A PBRN advisory/steering committee would be independent of the CCGI but funding could be managed by GSC.
- Advisory/steering group would be a small group of people with more administrative role. Will practitioners want to be involved if it is about research questions or about guidelines? Is it data collection or KT? The perception from practitioners might be different if it is perceived as a collaborative process rather than pushing information at them. Creating a research culture is important (information in and out fall under common umbrella).
- This initiative was meant originally to be a lab setting for testing KT strategies. But we could expand to other areas.
- Mathieu: it would be easy to find 25 people in Qc and thought it would be easy to start with a small, simple project.
- Practices need to have a clear understanding of what the plans are (e.g. introducing guidelines and testing for improvement).
- Guideline implementation: PBRN could provide a core group who were interested where you could study it and test.
- KT research is using the lab of PBRN to find out if it is working. Research comes first. Some will be related to guidelines, but not all. How much is research and how much is uptake?

**Propositions approved by attendees:**

1. **A network (national) of networks (local)**
2. **PBRN mission:** research and KT activities.
3. **Advisory/steering committee (national level):** Its role is to advise local PBRNs and acts as a central repository. This committee will be tasked to develop the vision and mission which will be presented to PBRN members for consideration, but each individual PBRN may develop their own.
4. **Proposed composition of the PBRN advisory/steering committee:**
  - CCGI rep from GAC/Patient rep/Research/ IT & data management/Practitioners/REB consultant as needed/Funders/CMCC/Rep from existing PBRN (n=9).
  - Experts could be brought in as necessary but would not need to attend every meeting.
  - GSC would still oversee the funding part and could pitch to stakeholders if we had evidence of benefit to them (sustainability).
  - As it grows, one local PBRN rep could sit on the advisory/steering committee.
5. **Local PBRNs will have to be linked to a funded researcher.**