Competency Profile for Physiotherapists in Team-based Primary Care in Canada

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Team-based primary care is the foundation of strong health systems. Physiotherapists play important roles as members of interprofessional primary care teams.

Physiotherapists working in team-based primary care settings in Canada require the entry-level physiotherapy competencies identified in the **Competency Profile for Physiotherapists in Canada (2017)** and additional or enhanced competencies that are specific to practicing as a physiotherapist within an interprofessional primary care team. Physiotherapy practice within team-based primary care involves collaborating within an interprofessional primary care team, serving a large patient population longitudinally, and addressing the complex needs of individuals and communities.

This Competency Profile for Physiotherapists in Team-based Primary Care in Canada provides a consensus-based list of competencies required to contribute effectively to team-based primary care. It was generated by a panel of primary care experts including physiotherapists, other health professionals, academics, and people with lived experience accessing primary care.

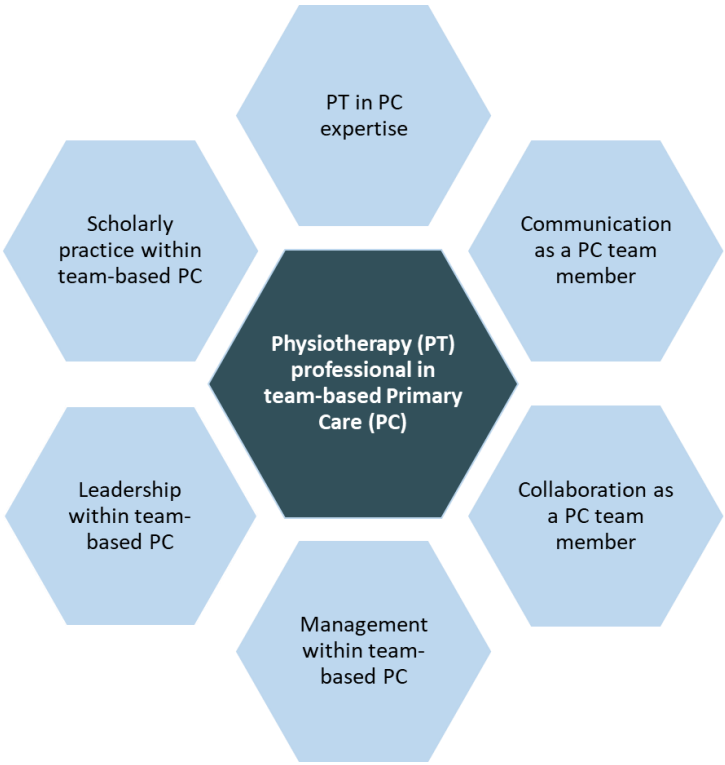
PRIMARY CARE

In alignment with Starfield's four functional attributes of primary care [1,2], Epperly's shared principles of primary care [3], and the Patient Medical Home model as described by the College of Family Physicians of Canada [4,5]; primary care is person- and family-centered, continuous, comprehensive and equitable, adaptive to the community and socially accountable, team-based and collaborative, coordinated and integrated, accessible, and high value. Primary care teams aim to serve the needs of all members of the communities or populations they serve. This includes providing services to persons across the lifespan, persons from diverse cultural and ethnic backgrounds, and persons who may experience barriers to accessing care from other areas within the health system.

COMPETENCIES

A ***competency*** is an observable ability of a health professional; integrating multiple components such as knowledge, skills, and attitudes. Since competencies are observable, they can be measured and assessed to ensure their acquisition. Competencies can be assembled like building blocks to facilitate progressive development throughout training or professional development [6].

The competency profile for physiotherapists in team-based primary care is organized into six domains: primary care expertise, communication as a primary care team member, collaboration as a primary care team member, management within team-based primary care, leadership within team-based primary care, and scholarly practice within team-based primary care. Physiotherapy professional is at the centre indicating that to be an effective physiotherapist in primary care, one needs to build from the entry-level professionalism competencies [comply with legal and regulatory requirements, behave ethically, embrace social responsibility, act with professional integrity, maintain personal wellness] by enhancing or adding competencies for primary care in each domain. Throughout the competency profile, elements of the competencies that were perceived to be unique or requiring enhancement for team-based primary primary care are bolded.



COMPETENCIES FOR PHYSIOTHERAPISTS IN TEAM-BASED PRIMARY CARE

Physiotherapy expertise in team-based primary care	
1.1	Provide person-centered care that considers the **complex personal, social, cultural, and environmental factors** contributing to a person's functioning and health.
1.2	Establish trusting, collaborative, and often **longitudinal therapeutic relationships** with persons seeking care, along with their families, and support networks.
1.3	Create and maintain **spaces for physically, emotionally, and culturally safe interactions** with communities and persons seeking care, along with their families and support networks.
1.4	Conduct a comprehensive physiotherapy assessment that addresses **complex personal, social, cultural, and environmental factors** contributing to the functioning and health of individuals and communities.
1.5	Apply advanced clinical reasoning to establish a physiotherapy diagnosis, prognosis, and management plan that considers the **complex personal, social, cultural, and environmental factors** that contribute to a person's functioning and health.
1.6	Collaborate with persons seeking care, their families and support networks, and **interprofessional primary care team members** to develop, implement, and evaluate treatment or management plans that address **complex personal, social, cultural, and environmental factors** contributing to a person's functioning and health.
1.7	Provide education and support to persons seeking care, their families, and support networks, to **promote successful self-management** of their functioning and health.
1.8	Facilitate successful transitions in care among **interprofessional primary care team members, external health service providers, and community service providers.**
1.9	Use virtual and/or digital health service delivery when appropriate to **improve access to team-based primary care for individuals and communities.**
1.10	Plan, deliver, and evaluate group programs, **in collaboration with other interprofessional primary care team members,** to improve the functioning and health of individuals and communities.
1.11	**Identify and assess the unique and evolving health service needs, health inequities, and social determinants of health affecting the communities or populations served.**
1.12	**Develop, implement, and evaluate services to actively address social determinants of health to address the needs of the communities or populations served.**
1.13	**Demonstrate adaptive expertise to create solutions to individual or community health challenges as a member of the interprofessional primary care team**
1.14	**Apply trauma-informed care principles when supporting persons seeking care, along with their families or support networks when appropriate**
1.15	Practice with cultural humility and provide culturally safe care.
1.16	Apply anti-oppressive practice approaches (including anti-racism, anti-weightism, anti-ablism, anti-settler colonialism, anti-heterosexism, anti-cisgenderism, anti-classism, anti-sexism)

Communication as a primary care team member	
2.1	Communicate clearly, openly, respectfully, empathetically, in a culturally safe and person-centered way to encourage participation of persons seeking care, their families and support networks.
2.2	Communicate clearly, openly, respectfully, empathetically, and in a culturally safe and person-centered way to **encourage the participation and collaboration of all members of the interprofessional primary care team.**

Collaboration as a primary care team member	
3.1	Engage the person seeking care, together with their family and support network, as **core members of the interprofessional primary care team.**
3.2	Collaborate with all **primary care team members in a way that leverages the expertise and full scope of all team members to provide comprehensive health services** that meet the needs of individuals and communities.
3.3	**Support persons seeking care, along with their families and support networks, to navigate health services, social services, and other community resources.**
3.4	Apply evidence-informed approaches to enhance **team collaboration and effective team functioning in primary care.**
3.5	Collaboratively and constructively engage in addressing and seeking to resolve **disagreements among interprofessional primary care team members.**

Management within team-based primary care	
4.1	Contribute to the development and implementation of organizational policies which **promote optimal service delivery by the interprofessional primary care team**
4.2	**Triage persons seeking care to facilitate timely access to appropriate services.**
4.3	Contribute to the development, implementation, and evaluation of organizational policies that promote the safety of persons seeking care and interprofessional team members.
4.4	Lead or actively participate in program evaluation and quality improvement activities **in team-based primary care**
4.5	Supervise and/or mentor team members who participate in the delivery of physiotherapy services in primary care.
4.6	Safely manage data from persons seeking care in accordance with pertinent institutional and jurisdictional policies.

Leadership within team-based primary care	
5.1	Advocate for services to address the health and social needs of persons seeking care, along with their families and support networks.
5.2	Identify, implement, and evaluate opportunities for **innovation in delivering primary care services.**
5.3	Provide leadership for the advancement of **physiotherapist roles within primary care teams.**
5.4	**Mentor physiotherapists or physiotherapy students to prepare them for future primary care roles.**
5.5	Participate in **collaborative leadership within the primary care team.**

Scholarly practice in team-based primary care	
6.1	Deliver evidence-based and person-centred approaches **to team-based primary care.**
6.2	Participate in research **to advance the delivery of physiotherapy services within team-based primary care.**
6.3	Engage in critical self-reflection, self-directed learning, and professional development **to advance contributions to service delivery as a primary care team member.**
6.4	Support the professional development of students **and other interprofessional primary care team members.**

DESCRIPTION OF TERMS

Below are descriptions of key terms or concepts used throughout the Competency Profile for Physiotherapists in Team-based Primary Care in Canada.

Access to care – the opportunity to reach and obtain appropriate health services when a person perceives a need for care. Access to care results from the interface between the person(s) identifying the need for care and the health systems, organizations, and provider(s). Access to care involves the possibility to: identify healthcare needs, seek healthcare services, reach the healthcare resources, obtain or use health care services, and actually be offered services appropriate to the needs of the person seeking care [7].

Adaptive expertise – the ability to balance efficiency and innovation. Adaptive experts efficiently apply previously acquired knowledge when facing well-known problems and use existing knowledge flexibly to create new knowledge or innovative solutions in response to novel and complex situations. Adaptive experts both know what to do (procedural fluency) and why they are doing it (conceptual understanding). It is their conceptual understanding that allows them to adapt to novel practice situations. If known solutions are insufficient, adaptive experts generate new solutions that address the 'why'. Adaptive expertise requires an approach to practice that recognizes daily problem-solving as an opportunity to learn and improve [8-12].

Advocacy – contributing expertise and influence when working with persons seeking care, communities, or populations to improve health. Advocacy includes working with the persons or communities being served to understand needs and supporting the mobilization of resources to meet those needs.

Anti-oppressive practice - recognizing the oppression that exists in our society and aiming to mitigate the effects of oppression and eventually equalize the power imbalances that exist between people [13,14].

Clinical reasoning – a multilayered, context-dependent way of thinking and decision-making in health professional practice. The purpose of clinical reasoning is to make sound, person-centered decisions with the person seeking care that guide practice actions to improve health and well-being choices, pathways, and outcomes [15].

Collaborative leadership - sharing of leadership responsibilities amongst a team. Collaborative leadership involves: Breaking down silos so that team members can work together and share responsibilities to reach common goals and health outcomes; Maintaining accountability through shared decision-making; Leveraging the diversity of opinions and strengths across all team members to generate strategies and solutions to problems; Valuing each other's knowledge, skills, expertise, and the different strengths and perspectives each practitioner brings to the table [16].

Complex personal, social, cultural, and environmental factors contributing to functioning and health – multiple interrelated determinants of functioning and health. The International Classification for Functioning, Disability and Health describes how a person's functioning is influenced by contextual factors. Contextual factors include environmental factors (e.g. social attitudes, legal and social structures, and physical environments) and personal factors (e.g. age, gender, education, past experiences) [17]. Similarly, the World Health Organization and Canada Health recognize multiple determinants of health including social and economic environments, physical environments, and the person's individual characteristics and behaviours [18,19].

Critical self-reflection and self-directed learning – Critical self-reflection and self-directed learning are important components of self-regulated learning. Self-regulated learning is an active, constructive process in which learners set goals for their learning, and monitor, regulate and control their cognition, motivation, and behavior to work towards their learning goals [20].

Cultural humility - the dynamic and lifelong process of self-awareness, self-reflection, and identification of how our assumptions and biases may be aligned with dominant cultural narratives. Cultural humility involves an approach that notices, recognizes, and responds to different viewpoints while considering systemic issues [21,22].

Cultural safety - what is felt or experienced by a person when a health service provider communicates with the person in a respectful, inclusive way. This empowers the person in decision-making and builds a relationship in which the person and provider work together as a team towards the person's health goals [23,24].

Evidence-based practice – the integration of the best available evidence, client context and preferences, and experiences of the health professional to inform clinical decision-making and problem-solving [25].

Functioning – an umbrella term for all body functions, activities, and participation [17].

Health - a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity [26].

Health inequities - differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work, and age. Health inequities are unfair, unjust, and modifiable [27,28].

Innovation - the realization of a new or improved product, service, method, or approach.

Interprofessional Collaboration – A partnership between a team of health service providers and a person seeking care [and others who are important to them to the extent that the person desires] in a participatory, collaborative, and coordinated approach to shared decision-making around health and social issues [16].

Mentorship - a professional, working alliance in which individuals work together over time to support the personal and professional growth, development, and success of the relational partners through the provision of career and psychosocial support [29].

Person-centered care – care that involves eliciting individuals' values and preferences. Once expressed, the individuals' values and preferences guide all aspects of their health services which are provided in support of their realistic health and life goals [30].

Persons seeking care, families, and support networks – The person seeking care is the person around whom the care is centered. Depending on the context, that person may also be a client or a patient. Person-centered care is achieved through dynamic relationships among individuals, others who are important to them, and all relevant health service providers. Each of these groups informs decision-making to the extent the person seeking care desires [28]. This competency profile explicitly names families and other support networks as the other individuals who are important to the persons seeking care.

Professional development – a life-long process focused on gaining new abilities through continuing education, training, mentorship, or networking.

Program evaluation – activities completed to inform decisions, identify improvements (i.e., formative evaluation), and provide information about the success of programs (i.e., summative evaluation) according to predefined goals and objectives. Program evaluation involves the systematic collection and analysis of information about a program. It seeks multiple sources of information as a means to improve program implementation and to understand program effectiveness [31].

Quality improvement (QI) – activities completed to enhance internal processes, practices, or productivity related to a specific intervention. They aim to determine the impact of an intervention on a specific group of participants in a given setting. Additionally, quality improvement is usually carried out to evaluate an already approved or proven effective practice [32].

Research - an undertaking intended to extend knowledge through a systematic investigation or rigorous inquiry.

Self-management - the day-to-day tasks an individual undertakes to control or reduce the impact of disease on their health [33].

Social determinants of health - the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life [34]. Example categorizations of social determinants of health include: housing; employment and work; social support; access to health services; culture, race, and ethnicity; education and literacy; food security; gender identity and expression; disability; indigenous status [26].

Spaces for physically, emotionally, and culturally safe interactions – physical and social environments in which all persons feel safe interacting with members of the interprofessional primary care team. Safe spaces are necessary for trauma-informed and culturally safe care that makes primary care more accessible and equitable.

Team collaboration and effective team functioning – include three process dimensions: role enactment, boundary work, and perceptions of team effectiveness. Effectively functioning teams communicate well, involve all team members in decision-making, are cohesive, coordinate care, solve problems, and focus on the needs of the person seeking care, as well as their family and support network [35].

Team members who participate in the delivery of physiotherapy services - support personnel, assistants, volunteers, and other health professionals who may provide physiotherapy services under the direction and supervision of a physiotherapist.

Therapeutic relationships - a purposeful, goal-directed relationship between a health professional and a person seeking care that is aimed at advancing the best interest and outcome of the person seeking care. Positive therapeutic relationships are characterized by trust, caring, empathy, mutually perceived genuineness, supportive nonjudgmental behavior, and the wish to support the person seeking care [36-43].

Transitions in care – a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different health service locations, different health professionals, or different levels of care [44].

Trauma-informed care - an approach to providing services and support that recognizes the impacts and causes of trauma. A program, organization, or system that is trauma-informed *realizes* the widespread impact of trauma and understands potential paths for recovery; *recognizes* the signs and symptoms of trauma; *responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively *resist re-traumatization* [45].

Triage – a process to make early decisions about the care the person seeking care will receive. Triage allows for prioritizing patients with the most urgent health needs and making decisions about the most appropriate health professional and health service to meet the person's needs.

Virtual and digital health service delivery - any interaction between persons seeking care and health professionals using any form of communication, digital, or information technologies to facilitate health service delivery [46].

REFERENCES

1. Starfield B. Primary Care: Concept, Evaluation, and Policy. Oxford: Oxford University Press; 1992.
2. Starfield B. Toward international primary care reform. Canadian Medical Association Journal 2009;180(11):1091-2.
3. Epperly T, Bechtel C, Sweeny R, Greiner A, Grumbach K, Schilz J, Stream G, O'Connor M. The Shared Principles of Primary Care: A Multistakeholder Initiative to Find a Common Voice. Family Medicine 2019; 51(2):179-84.
4. College of Family Physicians of Canada. A vision for Canada. Family practice— the patient's medical home. College of Family Physicians of Canada, 2011.
5. Gutkin C. The future of family practice in Canada: The Patient's Medical Home. Canadian Family Physician 2011;57(10):1224.
6. Frank JR, Snell LS, Cate OT, Holmboe ES, Carraccio C, Swing SR, Harris P, Glasgow NJ, Campbell C, Dath D, Harden RM. Competency-based medical education: theory to practice. Medical teacher 2010;32(8):638-45.
7. Levesque JF, Harris MF, Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. International Journal of Equity and Health 2013; 12, 18.
8. Cupido N, Fowler N, Sonnenberg LK, Karwowska A, Richardson D, Snell L, Thoma B, Mylopoulos M. Adaptive Expertise in CanMEDS 2025. Canadian Medical Education Journal 2023; 4(1):18-21.
9. Cupido N, Ross S, Lawrence K, Bethune C, Fowler N, Hess B, van der Goes T, Schultz K. Making Sense of Adaptive Expertise for Frontline Clinical Educators: A Scoping Review of Definitions and Strategies. Advances in Health Sciences Education: Theory and Practice 2022; 27 (5): 1213–1243.
10. Hatano G, Inagaki K. Two courses of expertise. Child Development and Education in Japan 1984; 6: 27–36.
11. Mylopoulos M, Kulasegaram K, Woods NN. Developing the experts we need: Fostering adaptive expertise through education. Journal of Evaluation in Clinical Practice 2018; 24: 674–677.
12. Mylopoulos M, Woods NN. When I say … adaptive expertise. Medical Education 2017; 51: 685-686.

13. Aqil AR, Malik M, Jacque KA, Lee K, Parker LJ, Kennedy CE, Mooney G, German D. Engaging in anti-oppressive public health teaching: Challenges and recommendations. Pedagogy in Health Promotion 2021; 7(4): 344–353.
14. Baines D. Doing anti-oppressive practice: social justice social work, 3rd Edition. Fernwood Publishing, 2017.
15. Higgs J, Jensen GM, Loftus S, Christensen N. Clinical Reasoning in the Health Professions, 4th edition. Elsevier Health Sciences, 2019.
16. Canadian Interprofessional Health Collaborative. A National Interprofessional competency Framework. Canadian Interprofessional Health collaborative, 2010. Retrieved November 2024 from https://www.cihc-cpis.com/publications1.html
17. World Health Organization. Towards a common language for functioning, disability and health: The International Classification of Functioning, Disability and Health. World Health Organization, 2002.
18. World Health Organization. Determinants of Health. World Health Organization, 2017. Retrieved November 2023 from https://www.who.int/news-room/questions-and-answers/item/determinants-of-health
19. Public Health Agency of Canada. Social determinants of health and health inequalities. Government of Canada, 2023. Retrieved November 2023 from https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html#a2
20. Pintrich PR. The role of goal orientation in self-regulated learning. In Boekaerts M, Pintrich PR, Zeidner M (Editors). Handbook of self-regulation Academic Press, 2000.
21. Agner J. Moving from cultural competence to cultural humility in occupational therapy: A paradigm shift. The American Journal of Occupational Therapy 2020; 74(4): 1-7.
22. Alsharif NZ. Cultural humility and interprofessional education and practice: A winning combination. American Journal of Pharmaceutical Education 2012; 76(7): 120.
23. Jull JE, Giles AR. Health equity, Aboriginal Peoples and occupational therapy. Canadian Journal of Occupational Therapy 2012; 79(2): 70–76.
24. National Aboriginal Health Organization. Cultural competency and safety: A guide for health care administrators, providers, and educators. National Aboriginal Health Organization, 2008.
25. Sackett DL, Straus SC, Richardson WS, Rosenbert W, Harnes RB. Evidence Based Medicine: How to practice and teach EBM. (2nd ed). Edinburgh: Churchill Livingston, 2000.
26. World Health Organization. Health promotion glossary of terms, 2021. Retrieved November 2023 from https://www.who.int/publications/i/item/9789240038349
27. Public Health Agency of Canada. Social determinants of health and health inequalities. Government of Canada, 2023. Retrieved November 2023 from

https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html#a2

28. World Health Organization. It's time to build a fairer, healthier world for everyone, everywhere: Health equity and its determinants. World Health Organization, 2021. Retrieved November 2024 from https://cdn.who.int/media/docs/default-source/world-health-day-2021/health-equity-and-its-determinants.pdf?sfvrsn=6c36f0a5_1&download=true
29. National Academies of Sciences, Engineering, and Medicine; Policy and Global Affairs; Board on Higher Education and Workforce; Committee on Effective Mentoring in STEMM. The science of mentoring relationships: What is mentorship? In Dahlberg ML and Byars-Winston A (Editors). The science of effective mentorship in STEMM. National Academies Press, 2019.
30. American Geriatric Society Expert Panel on Person-Centered Care. Person-centered care: A definition and essential elements. Journal of the American Geriatric Society 2016; 64: 15–18.
31. Centers for Disease Control and Prevention. Framework for program evaluation in public health. Morbidity and Mortality Weekly Report, 1999, 48: RR-11.
32. Harvey G, Wensing M. Methods for evaluation of small scale quality improvement projects. Quality and Safety in Health Care, 2003; 12(3), 210–214.
33. Barlow J, Wright C, Sheasby J, Turner A, Hainsworth J. Self-management approaches for people with chronic conditions: a review. Patient Education and Counselling 2002; 48(2): 177-187.
34. World Health Organization. Social determinants of health. World Health Organization. Retrieved November 2023 from https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1
35. Kilpatrick K, Paquette L, Bird M, Jabbour M, Carter N, Tchouaket É. Team Functioning And Beliefs About Team Effectiveness In Inter-Professional Teams: Questionnaire Development And Validation. Journal of Multidisciplinary Healthcare 2019; 12: 827–839.
36. Mottram A. Therapeutic relationships in day surgery: a grounded theory study. Journal of Clinical Nursing 2009;18(20):2830–2837.
37. Priebe S, McCabe R. The therapeutic relationship in psychiatric settings. Acta Psychiatrica Scandinavica 2006; 113:69–72.
38. Koole SL, Tschacher W: Synchrony in psychotherapy: a review and an integrative framework for the therapeutic alliance. Frontiers in Psychology 2016; 7: 862.
39. Gelso C: A tripartite model of the therapeutic relationship: theory, research, and practice. Psychother Res J Soc Psychother Res 2014; 24(2): 117–31.

40. Jung E, Wiesjahn M, Rief W, Lincoln TM: Perceived therapist genuineness predicts therapeutic alliance in cognitive behavioural therapy for psychosis. British Journal of Clinical Psychology 2015; 54(1): 34–48.
41. Fuertes JN, Toporovsky A, Reyes M, Osborne JB: The physician-patient working alliance: theory, research, and future possibilities. Patient Education and Counselling 2017; 100(4): 610–5.
42. Wiechula R, Conroy T, Kitson AL, Marshall RJ, Whitaker N, Rasmussen P: Umbrella review of the evidence: what factors influence the caring relationship between a nurse and patient. Journal of Advanced Nursing 2016; 72(4): 723–34.
43. Hall AM, Ferreira PH, Maher CG, Latimer J, Ferreira ML: The influence of the therapist-patient relationship on treatment outcome in physical rehabilitation: a systematic review. Physical Therapy 2010; 90(8): 1099–110.
44. Coleman EA, Boult C. Improving the quality of transitional care for persons with complex care needs: position statement of the American geriatrics Society health care systems committee. Journal of the American Geriatric Society 2003;51(4):556–7.
45. Substance Abuse and Mental Health Services Administration (SAMHSA)Trauma and Justice Strategic Initiative. SAMHSA's concept of trauma and guidance for a trauma-informed approach. SAMHSA, 2014. Retrieved November 2023 from https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf
46. Shaw J, Jamieson T, Agarwal P, et al. Virtual care policy recommendations for patient-centred primary care: findings of a consensus policy dialogue using a nominal group technique. Journal of Telemedicine and Telecare 2018;24(9):608–15.

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RCPS Réseau canadien des personnels de santé / CHWN Canadian Health Workforce Network

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