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SPECIAL ARTICLE

The Value of Learning Collaboratives: Experiences From Several Residency Networks

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ABSTRACT

The 2023 Accreditation Council for Graduate Medical Education guidelines highlight learning collaboratives as the "optimal way to facilitate [family medicine residency] programs' ability to attain their educational and community aims." As a result, many residency programs are seeking to develop, expand, or sustain learning collaboratives. This study aims to provide practical advice, examples, and encouragement for residency programs interested in creating or participating in a learning collaborative, based on lessons learned from the representatives' collective experiences. A purposive sampling of five learning collaboratives at various stages of development and growth was conducted to capture a representative range of models. Data were collected through participatory engagement and refined through iterative rounds of member checking. Despite differences in form and structure, learning collaboratives share commonalities in the support they provide their participants. They encounter common barriers and rely on similar strategies for success.

INTRODUCTION

Although learning collaboratives are not new in graduate medical education, a recent push by the Accreditation Council for Graduate Medical Education (ACGME) in the updated 2023 family medicine requirements,[1] combined with the strong endorsement from the American Board of Family Medicine (ABFM),[2] has brought them to the forefront.[3]

Learning collaboratives in health care education can be traced back to initiatives in the 1970s.[4] These networks emerged to promote peer learning and share knowledge across institutions. Early examples include collaborations within regional health networks or university systems, where groups of medical educators and clinicians worked together to standardize practices and improve educational outcomes. Although evidence exists of many different types of learning collaboratives over the past 50 or more years, little has been published to gain a deeper understanding of their history.

In graduate medical education (GME), learning collaboratives are structured interventions that bring together groups of residency program faculty, residents, administrators, and/or other partners to work on improving medical training and health care outcomes. In his "Update From the American Board of Family Medicine" (ABFM) at the 2024 American Academy of Family Physicians (AAFP) Residency Leadership Summit, ABFM President and Chief Executive Officer Warren Newton, MD, MPH, underscored the importance of learning collaboratives in GME and how they are a "contributor to innovation and wellbeing."[3] Similarly, ACGME's rationale for recommending learning collaboratives includes the promotion of innovation, particularly in scholarship.[5] These collaboratives aim to foster a culture of continuous learning and innovation, enabling participants to share ideas and best practices, engage in quality improvement strategies, and collectively work through and solve common problems in GME.[6] Through learning collaboratives, participants actively commune with their peers, ideally creating a supportive and nurturing environment for professional development and program enhancement and growth. Additionally, learning collaboratives provide a platform for networking and building relationships with colleagues from various institutions.[7] This collaboration promotes a sense of camaraderie and mutual support, fostering a community of learners striving toward the common goal of delivering high-quality medical education.[8]

This special report provides an overview of the characteristics of five established learning collaboratives, including their staff support structures and the services they provide. By examining their shared challenges, successes, and lessons learned, this report aims to provide valuable guidance, illustrative examples, and encouragement to residency programs seeking to establish or participate in a learning collaborative.

METHODS

This project was a purposive sampling designed to provide an overview of various learning collaborative structures in family medicine. We solicited input from five learning collaboratives that were specifically selected to illustrate a variety of possible

structures and breadth of network types. We used the Society of Teachers of Family Medicine directory of collaboratives[9] to consider what currently exists as well as the authors' personal networks and cumulative experience in our work in the WWAMI-Region (Washington, Wyoming, Alaska, Montana, and Idaho) Family Medicine Residency Network (FMRN) to identify which collaboratives might collectively represent this diversity.

After identifying the representative learning collaboratives, we reached out to the leadership of each to inquire about their interest in the project; all accepted and participated. The five collaboratives and the contributors from each that participated are FMRN (the 3 authors [1 director, 1 faculty, and 1 staff]), the Colorado Association of Family Medicine Residencies (CAFMR; 1 program director and 1 staff), OhioHealth Family Medicine Residency Programs (1 program director), the Rural Medical Training Collaborative (RMTC; 1 staff), and the Wisconsin Collaborative for Rural Graduate Medical Education (WCRGME; 1 staff).

This project used a participatory engagement approach, where representatives from each group were asked to respond to a series of questions about their learning collaborative's characteristics and services offered, using a shared spreadsheet with categories initially determined by the authors. The survey comprised 13 questions. All questions were open-ended except for the question regarding services offered, which required yes/no responses to the list of potential services. We first summarized input for consistency within each category, and then all contributors met virtually for a round of member checking to review the responses, revise categories and provide clarification, and discuss some of their experiences to ensure that these were accurately captured in this summary and synthesis process. Immediately following, we used a similar process with the same contributors to virtually solicit input on barriers each collaborative encountered in their development and on the ongoing challenges of maintaining collaboratives, as well as keys to success. To capture this data, we used a second shared spreadsheet comprised of three open-ended questions. Once an initial list of barriers/challenges and keys to success was developed with input from all contributors, we used iterative rounds of follow-up by email, using a shared document, to reach consensus on the final list shared here.

According to the University of Washington Human Subjects Division documentation, this study was institutional review board exempt.

KEY FINDINGS: SERVICES PROVIDED

Because diversity was desired for this comparison, the represented learning collaboratives vary in size, age, funding sources, governance, and staffing, yet offer their member programs many of the same services and resources. The key areas of service include professional development for program directors, faculty, and administrative staff; resident support; accreditation support; faculty and resident recruitment; and advocacy. Each of these service areas is described here, with detailed information about each collaborative in Table 1 .

Professional Development

Supporting the development of the programs' personnel is a primary role for the represented learning collaboratives. Every collaborative engages in program director development, and most provide faculty and administrative staff development. Commonly, collaboratives are providing this service by facilitating peer-to-peer support in sharing best practices and resources through listservs, regular meetings, conferences, webinars, and newsletters. Director development was reported as occurring most frequently during meetings. Examples of director development topics include supporting residents in difficulty, faculty and resident recruitment, ACGME requirements, curricula, faculty and resident evaluations, strategic planning, and advocacy. Professional development offerings range from OhioHealth's monthly program director meeting to FMRN's extensive professional development opportunities for program directors, program administrators, lead residents, and faculty. CAFMR facilitates collaboration among its groups of program directors, faculty, program coordinators, and lead residents at its 10 programs. Development opportunities for rural programs are exemplified in the WCRGME's annual faculty development training series in addition to its Rural GME Coordinator Leadership Institute and Medical Education Administrators and Coordinators annual workshop to support professional growth and development of rural program coordinators. RMTC holds a large annual meeting, where all program personnel are invited to participate in peer-led workshops and lectures. Worth noting is the variation in paid staff support seen in Table 1, due not only to the size of the collaboratives but also to the amount of each collaborative's professional development offerings and the staff required to support these efforts.

Resident Support

In addition to supporting residency faculty and staff, collaboratives create opportunities and offer resources for residents. The collaboratives are helping their member programs' residents by supporting rotations, didactics, and clinical training. One prime example of this is how the OhioHealth collaborative acts as a central point for its quarterly shared didactics, where participants plan educational activities by postgraduate year, utilizing the strengths of each program to offer education across all programs. Two of the collaboratives offer chief/lead resident leadership training through conferences and workshops. Some of the collaboratives also support resident research and scholarship. CAFMR hosts a research forum, and FMRN assists with research and scholarship by providing programs with access to the Family Physicians Inquiries Network (FPIN) and resident access to the University of Washington Health Sciences Library resources. While the collaboratives do not offer loan repayment programs themselves, they often are conduits for connecting residents to loan repayment programs and opportunities.

TABLE 1. Characteristics of the Included Learning Collaboratives

	Family Medicine Residency Network	Rural Medical Training Collaborative	Colorado Association of Family Medicine Residencies	OhioHealth Family Medicine Residency Programs	Wisconsin Collaborative for Rural GME
Specialty(ies)	Family medicine	All, but mostly family medicine	Family medicine	Family medicine	All, but mostly family medicine
Number of programs	33 + 10 rural training tracks/programs	75 (+/-)	10 + 4 rural training tracks	5 OhioHealth + 2 peripherally	24
Collaborative type	Regional (AK, ID, MT, WA, WY)	National	State	State	Local
Funding sources	WA State funding, regional affiliation dues, grants	Annual dues, grants	Medicaid GME/State of Colorado	None	Medicaid grant
Year started	1972	2012	1977	2015	2012
Governance	Board, university affiliated	Board	Governor appointed commission	None	Advisory committee
			Staffing support (FTE)		
Paid physician support (total FTE)	2	.2	None	None	None
Paid administrative support (total FTE)	6	1	2	None	1.9
Volunteer support				PDs and 1 medical education manager 1 hour/month for meetings, and additional time for any shared activities planned by collaborative	Collaborative advisory committee (8–10), rural coordinator network advisory committee (8–10).
			Services offered		
Program director development	X	X	X	X	X
Faculty development	X	X	X		X
Chief/lead resident development	X		X		
Administrative/ staff development	X	X	X		X
Scholarship and research	X	X	X		
Program development	X	X			X
Program accreditation support	X	X		X	X
Clinical training					X
Faculty recruitment	X		X	X	
Resident recruitment	X	X	X		X
Advocacy	X	X	X		X
Job postings	X		X		
Other services	Access to library resources; shared access to FPIN; shared access to residency tracking software; listservs (email groups based on job type or topic of interest); internal program reviews	Newsletter; social media; website with listing of all rural training programs; annual meeting; scholarly intensives	Rural workforce development; website; rural rotation coordination; grant writing; coordination of rural training track funding from state	Shared didactic offerings; volunteer project coordination; sharing among programs under a single sponsoring institution	Newsletter; social media; program videos

Abbreviations: FTE, full-time equivalent; GME, graduate medical education; PD, program director, FPIN, Family Physicians Inquiries Network

Program Development/Accreditation

Nearly all the represented collaboratives offer formal resources supporting program development and accreditation. Learning collaboratives recognize the importance of creating new opportunities for training residents and the need to maintain established residencies and support their continued accreditation. The collaboratives are mainly offering this assistance through consultations and funding support. However, collaboratives, due to their nature, give one another a great deal of informal support for developing new programs and maintaining accreditation through sharing advice and experiences.

Resident and Faculty Recruitment

The learning collaboratives also assist programs with resident and faculty recruitment. Most of the collectives combine efforts in recruiting residents. One example is the collective recruitment at the AAFP National Conference. For FMRN and CAFMR, each member program is grouped together with members of its collaborative. This way, students see programs as part of a larger entity that provides more resources than a single program can offer on its own. The proximity of the collaborative programs with one another also facilitates the programs to share or introduce interested students to programs within the collaborative where mission alignment may exist.

Faculty recruitment is a common and ongoing challenge for residency programs, and learning collaboratives can leverage their collective efforts to address this issue. Programs within a learning collaborative often are promoted on the collaboratives' websites and public venues; two of the represented collaboratives feature dedicated web pages for faculty job postings. Likewise, programs can highlight their membership in a learning collaborative along with the benefits of the collaborative, such as faculty development, support with scholarship, and curricular resources, to attract prospective faculty. Nearly all the represented collaboratives offer robust faculty development programs, which serve not only as effective recruitment tools but also as valuable retention incentives. Additionally, all the collaboratives offer program director development with a focus on strategies for faculty recruitment, including "growing your own" initiatives that prepare and mentor residents to transition into faculty roles upon graduation.

Advocacy

Collaboratives also engage in advocacy work. CAFMR uses joint lobbying to expand funding for its programs. These collective advocacy efforts have increased state Medicaid GME funding to support existing programs, created additional slots, and developed new rural training programs. These efforts also successfully gained resident and faculty loan repayment opportunities. Often advocacy includes collaboration with external partners. WCRGME and FMRN have similarly benefited from developing strong partnerships to financially support GME in their regions.

KEY FINDINGS: CHALLENGES AND STRATEGIES FOR SUCCESS

We heard similar challenges and strategies for success from each of the learning networks included, which we have summarized in Table 2 and Table 3. Participants in learning collaboratives have busy schedules, making allocating time for collaboration and engagement challenging. Additionally, limited resources, including funding and staff, can hinder the successful implementation of collaboratives. All the collaboratives in this review faced challenges around time allocation and limited resources (eg, funding, staff). These challenges were particularly difficult during the initial phases, but not unsurmountable. As seen with the youngest of the collaboratives, OhioHealth operates with no dedicated funding or paid administrative support yet uses volunteered time that is essential to organize and facilitate their meetings and shared activities.

Sustaining the momentum and impact of a learning collaborative beyond its initial phase can also be difficult. Without proper planning and ongoing support, the gains achieved during the collaborative's initial start-up are difficult to maintain in the long run. The collaboratives with funding generated by membership fees noted the importance of striking a balance between keeping fees low enough to be affordable for member programs but high enough to sustain the programming required to make the membership feel worthwhile. Grant-funded collaboratives require special attention to the grant requirements and life cycle. Opportunities such as the ABFM Foundation's seed funding for learning network infrastructure development also can be sought out to overcome this barrier. Collaboratives depending on state-appropriated dollars require coordinated advocacy. However resourced, successful collaboratives develop strategies for sustaining their efforts beyond the initial phase.

In addition to funding, structure and governance is vital for maintaining collaboratives. Collaboratives require a framework for deciding priorities, convening members and partners, coordinating activities, and managing projects. At the very least, this framework necessitates someone's time to coordinate the involved programs. At more established collaboratives, their structure could include a formal governance like the Advisory Committee of the WCRGME and the governor-appointed commission at CAFMR. The structure should provide clearly defined and agreed upon goals and objectives, ensuring that all participants are aligned and focused on a common purpose. Strong leadership and facilitation are also essential for guiding the collaborative toward achieving these goals and objectives.

Resistance to change can be another challenge for collaboratives; some participants may be hesitant to adopt new approaches or revise existing practices. Often programs in similar locations view one another as competitors and not as collaborators. They see themselves vying for the same residents and faculty. Programs receiving state funding may not want to share with other programs or grow state GME, fearing diminishing the pot of funds. Developing a culture of

TABLE 2. Common Challenges/Barriers in Developing Learning Collaboratives

Challenges/barriers	Description
Time constraints	Lack of time required for meetings and working on collaborative's objectives
Lack of resources	Funding and FTE limitations
Resistance to change	Challenges in moving from a competitive to a cooperative relationship
Varying institutional cultures	Struggles when programs have different sponsoring institutions that have their own missions and relationships with GME

Abbreviations: FTE, full-time equivalent; GME, graduate medical education

TABLE 3. Keys to Success in Developing Learning Collaboratives

Keys to success	Description	Examples
Dedicated resources and support	Commit time, funding, and FTE needed to effectively perform activities and offerings.	FMRN's combination of state funding, dues, and grants, and paid faculty and staff FTE
Sustainability	Develop a funding and staffing model that can maintain viability.	RMTC's membership dues model, which increases funding as membership grows OhioHealth's investment from all programs, and recognition that the efforts benefit all to reduce overall work
Structure and governance	Establish a strategy for managing priorities and goals.	CAFMR's governor-appointed commission, set up as a 501(c)6 nonprofit
Strong partnerships	Create trust and mutual benefit among programs and state or regional U/GME partners.	WCRGME's bimonthly meeting that includes nonresidency program attendees with a mutual interest in supporting and expanding rural GME
Coopetition	Enhance the strength of the group while minimizing weakness of individuals.	All represented learning collaboratives combining efforts to recruit residents and/or faculty

Abbreviations: FTE, full-time equivalent; U/GME, undergraduate/graduate medical education; FMRN, Family Medicine Residency Network; RMTC, Rural Medical Training Collaborative; CAFMR, Colorado Association of Family Medicine Residencies; WCRGME, Wisconsin Collaborative for Rural Graduate Medical Education; GME, graduate medical education

cooperation, or at least of "coopetition," an approach that enhances the strengths within the group while minimizing individual weaknesses,[10] is critical to the ongoing success of a collective.

Similarly, overcoming resistance and building buy-in from faculty, staff, residents, and institutional leadership can be a significant hurdle in implementing collaborative initiatives. Combating this resistance can be approached by emphasizing the benefits of partnerships. These partnerships focus on the needs and concerns of the group and how the collaborative can work together to meet the needs of the programs (internal partners) and external partners. Partnership within collaboratives is an investment from all programs, recognizing that the work being done benefits all programs and reduces overall work. The represented learning collaboratives have found that partnerships to identify best practices, resources, and opportunities for collaboration are invaluable and help sway the minds of those reluctant to join.

For collaboratives involving programs from multiple sponsoring institutions, dealing with the variability in institutional cultures can be difficult. Different institutions may have unique structures, values, and priorities, which can be at odds with the goals and approaches within a learning collaborative. Navigating these differences and finding common ground are essential to ensure effective collaboration.

Notwithstanding the challenges, addressing these issues through careful planning, effective leadership, and ongoing support can help mitigate these challenges and maximize the benefits of learning collaboratives in GME.

CONCLUSIONS

Learning collaboratives offer an opportunity for participants to learn from one another, tapping into a wide range of experiences, perspectives, and expertise. Despite the range of models and infrastructures that best fit the specific mission and needs of a collaborative, the challenges and barriers that collaboratives confront are often universal. By sharing successes and challenges, programs can expand their knowledge and skills with the goal of improving educational outcomes for all involved.

As neither a sponsoring institution nor an accrediting body, a learning collaborative has a unique nature that fosters innovation, encourages professional development, and creates opportunities for networking and building on one another's strengths. Learning collaboratives don't have a ship in the race but rather function to be the rising tide that lifts all boats.

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