Background We designed a collaborative, US-Canadian study to increase generalizability and explicitly consider potential for spread across different systems. Addressing ethical requirements for multiple Institutional Review Boards (IRBs) and Research Ethics Boards (REBs) presents challenges when conducting one trial in two countries.

Methods Our trial includes 42 primary care practices from practice-based research networks (PBRNs) in 5 US states and 2 Canadian provinces. A centralized, single IRB process was used in the US with Clinical and Translational Science Award authorization to the PI for the 5 IRBs to rely on one unassociated IRB. In Canada ethics oversight required different approaches in each province. Ontario used a partially centralized and an institutional REB while Quebec used a fully centralized REB. Similar study protocols were submitted to all IRBs/REBs. The joint coordinating center harmonized research workflows and procedures to respond to a variety of concerns and requests.

Results The number and nature of concerns requiring clarifications and modifications varied across the IRBs and REBs. The IRBs/REBs considered the trial to present different levels of risk and viewed the training, implementation and evaluation of ACP differently. There were differences regarding informed consent, survey language and data sharing. While the process and approvals took longer than expected and posed issues for consistency, addressing them facilitated development of a robust intervention and protocol.

Conclusion Differences in research ethics perspectives and procedures could be significant barriers to US-Canada research. We demonstrated that variation could be addressed, knowledge-sharing strengthened the project protocol, and future collaborations are possible.

Background Implementation of ACP is challenging, requiring a multi-pronged approach in primary care. We sought to provide a toolkit that would facilitate practices’ adoption of the Serious Illness Care Program, as a means of improving the quality of care and engaging patients in serious illness care discussions and planning.

Methods The joint coordinating center established a working committee to compile implementation resources. We used an iterative approach to identify key issues, materials, and discussion points necessary to engage practices in ACP implementation. We involved stakeholder groups representing patients, clinicians, practice facilitators, researchers, and informatics. The group identified, adapted, and reached consensus on materials and approaches to facilitating ACP in primary care practices.

Results We identified potential implementation barriers, including knowledge, attitudes, workflow, health information technology constraints, and sensitivity of the topic to engaging practices in ACP. We gathered materials to address these barriers including checklists, adaptable templates for dissemination and documentation, and developed a guide to facilitate conversations with practices. The key topics included practice readiness, patient identification, use of prognostic algorithms, workflow enhancement, effective documentation, and sustainability. We are using the TiDier checklist to monitor implementation fidelity to the ACP models in the trial.

Conclusion We created a toolkit to support implementation of ACP in primary care practice that can be used by practice facilitators. It covers the major topics identified by stakeholders as essential for ACP implementation. We will evaluate and revise this, making an enhanced implementation guide available to the trial practices as well as to others.