

**Canadian**  
Interprofessional Health  
Leadership **Collaborative**



**Consortium Canadien**  
sur le leadership en matière  
d'interprofessionnalisme en santé

# CANADIAN INTERPROFESSIONAL HEALTH LEADERSHIP COLLABORATIVE FINAL REPORT

JUNE 2015

▶ **APPENDICES**



UNIVERSITY OF  
**TORONTO**



**Queens**  
UNIVERSITY



UNIVERSITÉ  
**LAVAL**



**a place of mind**  
THE UNIVERSITY OF BRITISH COLUMBIA



Northern Ontario  
School of Medicine  
École de médecine  
du Nord de l'Ontario  
L'École de Médecine  
du Nord de l'Ontario

This is the Appendices for the Canadian Interprofessional Health Leadership Collaborative Final Report, June 2015.

The Final Report and individual Site Reports for each partner University can be found at:

[www.ipe.utoronto.ca/community-engagement/cihlc-project/cihlc-final-report](http://www.ipe.utoronto.ca/community-engagement/cihlc-project/cihlc-final-report)

## TABLE OF CONTENTS

<b>Appendix A</b>	Canadian Interprofessional Health Leadership Collaborative Membership .....	<a href="#">4</a>
<b>Appendix B</b>	National Steering Committee Terms of Reference.....	<a href="#">5</a>
<b>Appendix C</b>	National Steering Committee Biographies .....	<a href="#">8</a>
<b>Appendix D</b>	Statement of Collaboration.....	<a href="#">12</a>
<b>Appendix E</b>	Principles of Collaboration: Grants, Knowledge Transfer, Authorship and Ownership .....	<a href="#">33</a>
<b>Appendix F</b>	Collaborative Leadership Program for Transformative Change Logic Model .....	<a href="#">42</a>
<b>Appendix G</b>	CIHLC Evaluation Primer.....	<a href="#">43</a>
<b>Appendix H</b>	Institute of Medicine Workshop Handout: Tools in Assessing Health Professional Education: Canadian Exemplars.....	<a href="#">61</a>
<b>Appendix I</b>	Community Engagement for Health System Change: Starting from Social Accountability .....	<a href="#">65</a>
<b>Appendix J</b>	Collaborative Change Leadership Program 2014-2015 Brochure.....	<a href="#">93</a>
<b>Appendix K</b>	Collaborative Change Leadership Program 2014-2015: Capstone Initiative Descriptions .....	<a href="#">97</a>
<b>Appendix L</b>	Evaluation of the Integrated Collaborative Change Leadership Program 2014-15 .....	<a href="#">98</a>
<b>Appendix M</b>	Collaborative Change Leadership Program 2014-2015: Reflective Themes from Participant Feedback - Faculty Synthesis .....	<a href="#">166</a>
<b>Appendix N</b>	Conference Posters of the Canadian Interprofessional Health Leadership Collaborative.....	<a href="#">169</a>
<b>Appendix O</b>	Canadian Interprofessional Health Leadership Collaborative Publications, Posters, Workshops and Presentations.....	<a href="#">178</a>
<b>Appendix P</b>	Institute of Medicine Global Forum on Innovation in Health Professional Education Workshop Summary Reports.....	<a href="#">182</a>

## Canadian Interprofessional Health Leadership Collaborative Membership

University of Toronto		
Name	Position	Term
Dr. Sarita Verma	Co-lead Project	2011-2015
Prof. Maria Tassone	Co-lead Project	2011-2015
Ms. Jane Seltzer	Director, Secretariat	2012-2015
Mr. Matthew Gertler	Research Analyst	2012-2015
Ms. Jelena Kundacina	Research Analyst	2013-2014
Ms. Deanna Wu	Research Analyst	2012-2013
University of British Columbia		
Name	Position	Term
Dr. Lesley Bainbridge	Co-lead	2011-2015
Dr. Maura MacPhee	Co-lead	2012-2015
Dr. Chris Lovato	Evaluation Consultant	2012-2015
Dr. Marla Steinberg	Research Associate	2012-2015
Northern Ontario School of Medicine		
Name	Position	Term
Ms. Sue Berry	Co-lead	2011-2013
Dr. David Marsh	Co-lead	2011-2015
Dr. Marion Briggs	Co-lead	2014-2015
Mr. Karim Remtulla	Research Associate	2012-2012
Ms. Laurel O’Gorman	Research Associate	2012-2013
Queen’s University		
Name	Position	Term
Dr. Margo Paterson	Co-lead	2011-2015
Dr. Rosemary Brander	Co-lead	2013-2015
Ms. Janice Van Dijk	Research Associate	2012-2015
Université Laval		
Name	Position	Term
Dr. Emmanuelle Careau	Co-lead	2012-2015
Dr. Serge Dumont	Co-lead	2011-2015
Dr. Gjin Biba	Research Associate	2012-2015

## National Steering Committee Terms of Reference

### Purpose:

The National Steering Committee (NSC) will oversee and drive the implementation of the Canadian Interprofessional Health Leadership Collaborative (CIHLC).

### Responsibilities:

#### **A. Governance**

- Oversee the development, implementation, evaluation and knowledge sharing of programs and initiatives that are in alignment with the CIHLC's objectives.
- Establish and have oversight on CIHLC's advisory groups.
- Provide strategic counsel to Secretariat on the execution of CIHLC workplan and activities.
- Guide the Co-Leads, in the representation of the CIHLC at the Institute of Medicine's meetings and workshops.

#### **B. Program Development**

##### **B.1 Implementation**

- In consultation with advisory groups and regional stakeholder networks, develop a transformative collaborative leadership model to be used by health professional learners, faculty and leaders, and which can be adapted and customized for use in any international health care and/or education setting.
- Serve as a key resource for collaborative leadership for health system change implementation by establishing linkages and partnerships and facilitating dialogue among all interested parties.
- Provide recommendations regarding the teaching and practicing of interprofessional educational competencies.
- Address technical structures and processes that will provide the tools to support and facilitate collaborative leadership change including systemic supports that are necessary.
- Oversee the systematic implementation of the collaborative leadership model with health care and educator leaders and decision-makers. This includes:

##### **B.2. Communications**

- Development and execution of the collaborative site's local and regional communications strategy include development of communication tools in advocating and promoting the work of CIHLC.
- Provide regular reports outlining activities and progress to date on CIHLC's website/newsletter.
- Represent the CIHLC at meetings or conferences as agreed upon by the CIHLC NSC in advance.

##### **B.3 Stakeholder Engagement**

- Delivery of the engagement strategy to facilitate and consult with all stakeholders, locally and in their regional area in their participation of CIHLC activities and adoption of CIHLC programs and products.
- Consult with key experts in the creation and development of collaborate leadership modules and programs as needed.
- Identify opportunities to leverage the work of the co-leads of the CIHLC with national and international forums.
- Seek, correspond and facilitate funding opportunities and/or partnerships from external resources for specific pilot projects such as with affiliated networks, health ministries, research institutions and associations.

### **C. Operations**

- Develop policy and procedures as they relate to intellectual property, research ethics and publication of CIHLC products and deliverables.
- Coordinate and regularly brief Presidents, Deans, and/or senior leaders.
- Manage the local and regional financial records of CIHLC business and provide an annual accounting for auditing and reporting to the Secretariat (i.e., end of fiscal year being March 31st).

### **D. Role of Co-Leads of NSC**

- Oversight and overall responsibility for the CIHLC work, reporting and representing nationally and internationally, as well as at the IOM.
- Member and alternate at the Global Forum on Innovation in IHPE.
- Address and make decisions on urgent matters on behalf of the National Steering Committee, as required.
- Oversee communications including national media relations and national/international external communications.
- In consultation with partners, nominate a successor should any existing member be unable to continue to participate in the work of the CIHLC.
- Provide final recommendations on any decisions by majority vote on any conflicts.
- Oversight over the day-to-day activities of the Secretariat.
- Maintain financial accountability for the Secretariat of the project, providing audited statements on an annual basis.

### **E. IOM Communications**

Unless delegated or otherwise agreed to in advance, the member appointed to the Global Forum shall be primarily responsible for relations and communications with the IOM, the four international Innovation Collaboratives, and any national or international potential funders related to the IOM.

The Co-Leads will be primarily responsible for relations and communications with national or international governments, the Executive Heads as a collective, and international partners. To ensure ongoing continuity and 'back-up,' the appointed member and the alternate will regularly inform each other about any matters relating to the CIHLC.

In order to ensure that the deliverables of the CIHLC and the expectations of the Universities and the other members of the CIHLC are met, and that additional expectations or costs are not incurred without the input of the CIHLC, the NSC members agree to advise the Co-Leads of any additional requests made by the abovementioned parties that would in any way impede the primary work of the CIHLC, add expectations or costs that have not been budgeted, or may be interpreted as a representation of the CIHLC .

Any provincial, regional or local communications will be the responsibility of the NSC site lead, including financial accountability and delivery of the expected work plan.

### **Membership Criteria:**

- Two members from each university CIHLC site to be appointed by the participating university in which one member is designated as the lead and the second as an alternate.

- Members have leadership, expertise and experience in evaluation and curriculum development of health professional education through learning and innovation within the undergraduate, graduate, postgraduate, continuing education and professional development sectors as well as interprofessional education, change leadership and training, knowledge translation, community engagement, social accountability, and cultural and clinical competencies.
- Members have or are affiliated with existing networks including regionally-integrated health education, global and health care systems.
- Members and alternates must have authority delegated from the University Executive Heads and Deans to represent the CIHLC site member and to deliver the promised local, regional and national work for the success of the CIHLC work for the IOM.

#### **Membership Term**

Membership is for the duration of the project. All members are to participate in weekly meetings through teleconferencing, Skype, videoconferencing or face-to-face depending on the most efficient use of members' time. On an annual basis, at least one face-to-face meeting will be scheduled and arranged by the Secretariat.

Prepared May 2012

## CIHLC National Steering Committee Biographies

### **Sarita Verma, LLB, MD, CCFP**

Dr. Sarita Verma is a Professor in the [Department of Family and Community Medicine](#), [Associate Vice-Provost, Relations with Health Care Institutions](#), and Special Advisor to the Dean of Medicine at the University of Toronto. She is a family physician who originally trained as a lawyer at the University of Ottawa (1981) and later completed her medical degree at McMaster University (1991). She has been a Diplomat in Canada's Foreign Service and worked with UNHCR in Sudan and Ethiopia for several years. Dr. Verma is the 2006 recipient of the Donald Richards Wilson Award in medical education from the Royal College of Physicians and Surgeons of Canada and the 2009 co-recipient of the May Cohen Gender Equity Award from the Association of Faculties of Medicine in Canada. Along with colleagues at McGill University, University of British Columbia and the University of Toronto, she was one of the lead consultants for the Future of Medical Education in Canada Postgraduate project. At present she is the Co-lead for the Canadian Interprofessional Health Leadership Collaborative (CIHLC) at the Institute of Medicine's Global Forum on Innovation in Health Professional Education.

### **Maria Tassone, MSc, BScPT**

Maria Tassone is the inaugural Director of the [Centre for IPE](#), a strategic partnership between the University of Toronto and the University Health Network (UHN). She is also the Senior Director, Interprofessional Education and Care at UHN. She holds a Bachelor of Science in Physical Therapy from McGill University, a Master of Science from the University of Western Ontario, and she is an Assistant Professor in the Department of Physical Therapy, Faculty of Medicine, University of Toronto. Prof. Tassone is the Co-Lead of the Canadian Interprofessional Health Leadership Collaborative whose work focuses on models and programs of leadership necessary to transform health education and care systems. Her collaborative work and leadership has been recognized through the Ted Freedman Award for Education Innovation, the 3M Quality Team Award and the Canadian Physiotherapy Association National Mentorship Award. Her scholarly interests focus on continuing education, professional development and knowledge translation in the health professions. Throughout her career, she has held a variety of clinical, education, research, and leadership positions across a multitude of professions. She is most passionate about the interface between research, education, and practice and leading change in complex systems.

### **Lesley Bainbridge, BSR(PT), MEd, PhD**

Lesley Bainbridge holds a master's degree in education and an interdisciplinary doctoral degree with a focus on interprofessional health education. She was the Director, Interprofessional Education in the [Faculty of Medicine](#) at the University of British Columbia from 2005 to 2014 and continues to serve as Associate Principal, [College of Health Disciplines](#). She acted as Head of the Physical Therapy program and interim Director of the [School of Rehabilitation Sciences](#), both at UBC, prior to secondment to her current positions. Dr. Bainbridge's areas of special interest are interprofessional health education (IPE), collaborative practice, leadership, evaluation of IPE, curriculum development related to IPE, interprofessional practice education and other areas related to IPE such as rural health and underserved populations. Dr. Bainbridge has been, and is currently, principal or co-investigator on several Teaching and Learning Enhancement Fund grants, two major Health Canada grants focusing on interprofessional education and collaborative practice, and several research grants related to shared decision making, health human resource links to IPE, and other aspects of IPE.



**Maura MacPhee, RN, PhD,**

Maura MacPhee is an associate professor of [Nursing at the University of British Columbia](#). She is Academic Lead for the British Columbia [Nursing Administrative Leadership Institute](#), and she is Deputy Director for the [Chinese University of Hong Kong-University of British Columbia International Centre on Nursing Leadership](#). Dr. MacPhee is a health services researcher who studies healthcare work environments, such as the influence of leadership on staff and patient outcomes. She is the recent recipient of the College of Registered Nurses of British Columbia award for nursing research excellence 2013.

**Chris Lovato, BA, MA, PhD**

Chris Lovato is a Professor in the [School of Population and Public Health](#) and Director of the [Evaluation Studies Unit, Faculty of Medicine](#) at the University of British Columbia. Her research interests focus on evaluation studies in public health, health services, and medical education contexts. She is an applied researcher who over the course of her career developed a strong belief that to address the complex health issues of today requires as much of a focus on generalization and external validity, as internal validity. Her passion in research is to apply the rigor of scientific methods to questions that are significant to policy and decision-makers working in the area of health.

**Sue Berry, DipPT, BA, MCE**

Sue Berry, Associate Professor, within the Division of Clinical Sciences at the Northern Ontario School of Medicine is the Executive Director of [Integrated Clinical Learning](#). She also holds the rank of Assistant Professor within the [School of Rehabilitation Science](#) at McMaster University. For the past 20 years, her experience in academic administration and expertise in developing innovative approaches in health professional education has led to the development of numerous health sciences and interprofessional initiatives. She was the Founding Coordinator of the [Northern Studies Stream](#), a joint Occupational Therapy/ Physiotherapy Program developed between McMaster and Lakehead Universities and her passion for working collaboratively with communities and educational institutions in the health sciences led to the development of the Northern Interprofessional Collaborative for Health Education, in addition to, four successful \$1.5 M grants enhancing interprofessional learning and practice in Northern Ontario. Sue was the NOSM Co-Lead involved in the Canadian Interprofessional Health Leadership Collaborative (CIHLC) until October, 2013.

**David Marsh, MD, CCSAM**

David Marsh graduated in Medicine from Memorial University of Newfoundland in 1992, following prior training in neuroscience and pharmacology. In July 2010, Dr. Marsh joined the [Northern Ontario School of Medicine \(NOSM\) as Associate Dean, Community Engagement](#) and more recently as Deputy Dean. Prior to moving to NOSM, Dr. Marsh served as the Physician Leader, Addiction Medicine with Vancouver Coastal Health and Providence Health Care and Clinical Associate Professor in the School of Population and Public Health, Faculty of Medicine at the University of British Columbia from 2004-2010. Previously, he held leadership roles at the Addiction Research Foundation and the Centre for Addiction and Mental Health in Toronto from 1996-2003, and is the author of over 70 peer-reviewed papers, book chapters and government reports. In 2004 Dr. Marsh received the Nyswander-Dole Award from the American Association for the Treatment of Opioid Dependence. He brings skills and experience with health care administration, strategic planning, community-based research and social accountability as well as a personal background of Aboriginal ancestry to this role.

### **Marion Briggs, B.Sc.PT., MA, DMan**

Marion Briggs is an Assistant Professor in the [Clinical Sciences Division](#), and Director of [Health Sciences and Interprofessional Education](#) at the Northern Ontario School of Medicine. A physical therapist by background (University of Alberta), Dr. Briggs completed an MA in Leadership (Health) at Royal Roads University in Victoria, BC, and a Doctorate in Organizational Development and Change through the Complexity and Management Research Institute at the University of Hertfordshire in England. Her Doctoral work focused on a deep articulation of health care practices – what is happening as we work together in complex, interprofessional environments to improve the health and well-being of patients and communities. Dr. Briggs lives in Sudbury, Ontario.

### **Rosemary Brander, PhD, PT**

Rosemary Brander is Director, [Office of Interprofessional Education & Practice](#), Faculty of Health Sciences and Assistant Professor, School of Rehabilitation Therapy at Queen's University, Kingston, Ontario, Canada. She is also the Senior Researcher & Program Evaluator, [Centre for Studies in Aging & Health](#) at Providence Care in Kingston. Dr. Brander holds a Ph.D. in Rehabilitation Science (Queen's University), M.Sc. (University of Western Ontario), and B.Sc. PT (Queen's University). Her research interests include collaborative practice and customer service in healthcare environments, interprofessional education, quality improvement in geriatric care and organizational change and leadership for improved health outcomes. She has held a number of health leadership roles and is an experienced clinical physiotherapist working with children and adults with long-term neurologic disabilities.

### **Margo Paterson, PhD, OT Reg. (Ont)**

Margo Paterson is Professor Emerita in the [Queen's School of Rehabilitation Therapy](#). Dr. Paterson taught at the graduate and undergraduate levels in the Occupational Therapy and the Rehabilitation Sciences programs. Her scholarly contributions are within the areas of professional practice and theory-practice integration; interprofessional education, care, and practice; clinical reasoning; and qualitative research. She currently teaches a course in *Interdisciplinary Studies in Global Health and Disability* at the [Bader International Study Centre](#), Herstmonceux Castle, Queen's University East Sussex, United Kingdom. Her administrative roles at Queen's included Director of the [Office of Interprofessional Education and Practice in the Faculty of Health Sciences](#) from 2009-2012 as well as former Chair of the Occupational Therapy Program. She is currently the Executive Director of the [Association of Occupational Therapy University Programs](#) which represents the 14 occupational therapy programs in Canada. She was awarded the Canadian Association of Occupational Therapy Leadership Award in 2012.

### **Emmanuelle Careau, erg. PhD**

Emmanuelle Careau is Assistant Professor in the Rehabilitation department at the [Faculty of Medicine of Université Laval](#) (Québec, Canada). Dr. Careau received her Ph.D. in Experimental Medicine from Université Laval and did her post-doctoral training on evaluation of interprofessional education and practice. She has conducted many training sessions on this topic at healthcare organizations, and has been invited as a guest speaker at many universities from the province of Quebec (Canada). Dr. Careau is also the scientific director of the Réseau de collaboration sur les pratiques interprofessionnelles en santé (RCPI), which involves the faculties of medicine, nursing, pharmacy and social sciences as well as the clinical network Réseau universitaire intégré en santé de l'Université Laval (RUIS-UL). The RCPI supports IPE activities in academic programs, such as course developments as well as continuing education initiatives in clinical environments. Dr. Careau is currently the lead for Université Laval on the National Steering Committee of the Canadian Interprofessional Health Leadership collaborative (CIHLC).

### **Serge Dumont, PhD**

Serge Dumont is a Professor at Faculty of Social Sciences, Laval University. He is the Scientific Director of the Centre de santé et de services sociaux de la Vieille-Capitale (Quebec City, QC, Canada). Career Award holder from the Canadian Institutes of health research (CIHR) (2000-2005) and former Director of the School of Social Work (2006-2010), professor Dumont has been leading the development and the implementation of the Réseau de collaboration sur les pratiques interprofessionnelles en santé (RCPI), which involves the faculties of medicine, nursing, pharmacy and social sciences as well as the clinical network Réseau universitaire intégré en santé de l'Université Laval (RUIS-UL). The RCPI supports IPE activities in academic programs, such as course developments as well as continuing education initiatives in clinical environments.



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THE UNIVERSITY OF BRITISH COLUMBIA



## STATEMENT OF COLLABORATION

AMONG

University of Toronto  
University of British Columbia  
Northern Ontario School of Medicine  
Queen's University  
Université Laval

Regarding the

***Canadian Interprofessional Health Leadership Collaborative (CIHLC)***

For the

IOM Board on Global Health  
***Global Forum on Innovation in Health Professional Education: Health Professional Education  
Innovation Collaborative***

***2012-2015***

## Table of Contents

1. <i>Purpose</i> .....	3
2. <i>Scope of the Collaboration</i> .....	3
a) Objectives.....	3
b) Implementation.....	4
3. <i>Governance &amp; Leadership</i> .....	5
a) Governance.....	5
b) Leadership.....	5
c) Roles and Responsibilities.....	6
d) Accountability/Evaluation .....	6
4. <i>Budget and Resources</i> .....	6
5. <i>Statement of Guiding Principles for the Collaboration</i> .....	6
6. <i>Communication and Use of Names and Logos</i> .....	7
7. <i>Conflict Resolution</i> .....	7
8. <i>Commencement/Expiration Date and Termination</i> .....	7
9. <i>Signatures</i> .....	8
<i>Appendices</i> .....	10

## 1. Purpose

This Statement of Intent describes the intention of the following five Canadian universities (collectively referred to as “Participants”) to collaborate in initiatives to lead innovation in health education.

University of Toronto  
University of British Columbia  
Northern Ontario School of Medicine  
Queen’s University  
Université Laval

The ***Canadian Interprofessional Health Leadership Collaborative (CIHLC)*** was chosen in January 2012 in a prominent international competition to represent North America as one of four global innovation collaboratives to work with the prestigious U.S. Institute of Medicine (IOM) on a project to lead innovation in health education across the globe. The CIHLC is a multi-institutional and interprofessional collaboration that includes the faculties and schools of medicine, nursing, public health and programs of interprofessional education (IPE), representing numerous health care professions at each of the five universities.

CIHLC will develop collaborative leadership curricula, evaluation frameworks, tools for implementation and test their feasibility in health education curricula. The vision of collaborative leadership for health system change builds upon global initiatives to enable faculty and learners to become collaborative leaders, ultimately improving health outcomes through innovation in education and care. Appendix A provides additional background information on this initiative.

## 2. Scope of the Collaboration

The CIHLC is a pan-Canadian collaborative that will act as a central resource and facilitator in the co-creation, development, implementation and evaluation of a global collaborative leadership model. The Participants will support the CIHLC in realizing its vision, objectives, implementation and activities, which include the following:

### a) ***Objectives***

1. Develop a collaborative leadership model for health system change that can:
  - a. identify collaborative leadership competencies required to build teamwork across health professions and health care workers in community, hospital and primary care settings;
  - b. identify the collaborative leadership competencies that will be required for health system change;
  - c. develop a collaborative leadership curriculum that is flexible and meets clinical, regional, local, cultural and global needs;
  - d. ensure that the leadership curriculum will meet and inform common accreditation standards to be applied across all health professions; and

- e. address the needs of educators and learners by identifying the resources, infrastructure and supports needed in order for them to become collaborative leaders.
2. Build and leverage existing partnerships within Canada and abroad that will be enhanced through the facilitation and implementation of collaborative leadership programs and knowledge translation.
3. Utilize existing IT mechanisms (e.g., videoconferencing, multi-disciplinary simulation, online resources) and social media to maximize cost-effective methods to effectively support communities in leadership training.
4. Develop new academic productivity and scholarship that will influence global policy reform.
5. Develop an evaluation framework that measures planned and emergent change at the educational, practice and system levels.

Appendix B provides additional information on CIHLC's objectives.

### ***b) Implementation***

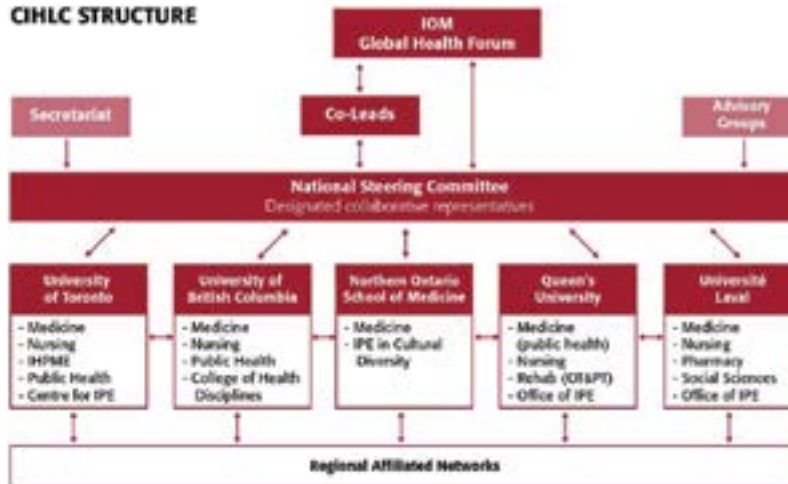
All Participants have agreed to support the implementation of the CIHLC initiatives over the next three years. Appendix C provides the outline and timelines for the implementation process in principle. The CIHLC's governance and infrastructure will be responsible for developing the specific work plan and its execution in the roll-out over the three-year period.

The CIHLC will develop policies and standards for its activities and, as projects are developed, will put in place appropriate structures for Roles and Responsibilities, Work Plans, Business Cases and fundraising as required.

### 3. Governance & Leadership

#### a) *Governance*

The following structure will enable the CIHLC to achieve its objectives:



The National Steering Committee is composed of identified leads and alternates from each Participant. The nominated co-leads who are representing the CIHLC at the IOM Global Health Forum of the Institute of Medicine, also represent the University of Toronto. The above illustration identifies the participating units at each of the universities. Each university has relationships within its own institution among its programs in medicine, nursing, public health and IPE. Each Participant lead will network across a region within Canada as a result of pre-existing regional and local affiliated networks in IPE. The structure above acknowledges that each of the universities is already affiliated with national organizations and their regional counterparts (for example the three Ontario Universities are members of the Ontario IPE Network and UBC is a member of the Western Canadian Interprofessional Health Collaborative (WCIHC) as well as a leader in the Canadian Interprofessional Health Collaborative (CIHC)).

The CIHLC structure and National Steering Committee will be supported by a Secretariat. The National Steering Committee will establish advisory groups based on further consultation with the Global Health Forum and meeting the objectives.

#### b) *Leadership*

The work of the CIHLC will be led by a National Steering Committee whose membership includes representation from each Participant. Each Participant will be responsible for appointing or nominating an individual as well as an alternate from their institution to be part of the National Steering Committee. Appendix D provides the names of the individuals who will provide leadership in the inaugural infrastructure of the CIHLC. In the event that any individual is unable to continue their participation in the work of CIHLC during the term of this Statement of Collaboration, the



university Participant that the individual is representing must appoint another individual. The National Steering Committee will be responsible for establishing the Secretariat.

### ***c) Roles and Responsibilities***

The general roles and responsibilities of the CIHLC's National Steering Committee (NSC) and the Secretariat are highlighted in Appendix E and are laid out in detail by the NSC's Roles and Responsibilities document.

### ***d) Accountability/ Evaluation***

The Secretariat will report to the National Steering Committee and will provide progress reports. In turn, the members of the National Steering Committee will report back to their own institutions as needed and in any event, on an annual basis. The secretariat will evaluate the effectiveness and efficiency of the overall CIHLC function including the NSC, timelines for deliverables, etc. For the short term, within the parameters of the activities of the CIHLC, the proposed plan will utilize logic models and methodologies as a guide to assess and evaluate output activities and processes.

## **4. Budget and Resources**

The Participants will contribute to the required resources and funding in support of the CIHLC throughout the term of this Statement of Collaboration. Appendix F provides additional information on the proposed business case and resource requirements by the Participants. Annual funding requirements for the Secretariat will be determined as sources of support are confirmed from donors, grants, governments and foundations. The Participants agree to conduct an annual review of the sustainability of the Secretariat's business case through the National Steering Committee. The University of Toronto's Centre for Interprofessional Education will oversee the administration of the Secretariat.

## **5. Statement of Guiding Principles for the Collaboration**

In supporting the CIHLC vision and objectives, the Participants will work under the following principles:

- Participants and their representatives share information transparently to enhance the work of the CIHLC.
- Participants and their representatives engage in communications that are open and collaborative.
- Participants will collaborate on public statements and communications with external groups.
- Responsibility for ensuring the success of CIHLC resides with all Participants.
- Participants and their representatives will engage in transparent, open and ongoing dialogue among Participants and external groups.
- Mutual respect will be practiced when exploring all ideas and issues.
- Participants will actively participate in addressing or leading certain components and/or activities of CIHLC's work.

- Respect for the policies of the Participants and the rights of faculty, particularly with respect to academic freedom will be acknowledged.
- Intellectual property will be shared as appropriate, recognizing that rights will be governed by the applicable policies of the Participants and determined in accordance with those policies as projects are developed.
- Adherence to all applicable ethical standards.

#### **6. Communications and Use of Names and Logos**

A Participant may not use the name(s) or logo(s) of any other Participant(s) without first obtaining their written consent.

Any communication from the CIHLC that includes the names(s) or logo(s) of one or more Participant(s) must be approved in advance by a National Steering Committee representative of each affected Participant.

#### **7. Conflict Resolution**

In the event of a *substantive* conflict among the five university Participants, such conflicts will be resolved by a meeting of the five Deans or their delegates.

#### **8. Commencement/Expiration Date and Termination**

CIHLC activities are to commence immediately following the selection announcement by the IOM Board on Global Health in January 29, 2012. This Statement of Collaboration expires December 31<sup>st</sup>, 2015.

This Statement of Collaboration may be terminated at any time during its term by any Participant by giving three months notice to the other Participants.

## 9. Signatures

By signing this Statement of Collaboration the Participants confirm their support for the activities of CIHLC as described above.



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Renald Bergeron, MD  
Dean, Faculté de Médecine  
Université Laval



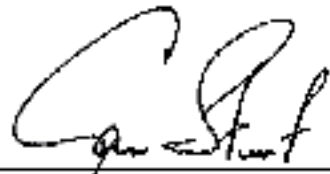
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Richard F. Reznick, MD, MEd, FRCSC, FACS  
Dean, Faculty of Health Sciences  
Queen's University



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Roger Strasser, MD  
Dean and CEO  
Northern Ontario School of Medicine



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Gavin E. Stuart, MD, FRCSC,  
Vice-Provost Health, Dean, Faculty of Medicine  
University of British Columbia



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Catharine Whiteside, MD, PhD, FRPC(C)  
Dean, Faculty of Medicine  
Vice-Provost, Relations with Health Care Institutions  
University of Toronto

CIHLC Member Signatures:



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Sarita Verma, LLB, MD, CCFP  
University of Toronto Co-Lead  
Deputy Dean, Faculty of Medicine, Associate Vice Provost, Health Professions Education



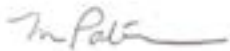
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Maria Tassone, MSc, BScPT  
University of Toronto Co-Lead  
Director, Centre for Interprofessional Education



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Lesley Bainbridge, BSR(PT), MEd, PhD  
University of British Columbia Lead  
Director, Interprofessional Education, Faculty of Medicine, Associate Principal, College of Health Disciplines



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Margo Paterson, PhD, OT Ref (Ont)  
Queen's University Lead  
Professor, Occupational Therapy Program and Director, Office of Interprofessional Education and Practice



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Sue Berry PT, MCE  
Northern Ontario School of Medicine Lead  
Assistant Dean, Integrated Clinical Learning, Community Engagement



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Emmanuelle Careau, Ph.D.(c)  
Université Laval Lead  
Professor, Rehabilitation Department, Faculty of Medicine

## APPENDIX A: BACKGROUND

The CIHLC was established in response to the Institute of Medicine (IOM) Board on Global Health's international call to establish four Innovation Collaboratives in Health Professional Education across the globe. In January 2012, the CIHLC was chosen by the IOM as the sole North American Innovation Collaborative.

The CIHLC acknowledges that there are existing frameworks and programs that have articulated and implemented IPE and collaborative care at the organizational, practice and policy levels<sup>1,2,3,4,5</sup> within the education and health care systems across Canada. The concept of **collaborative leadership for health system change** is based on the Canadian Interprofessional Health Collaborative's paper entitled "A National Interprofessional Competency Framework."<sup>6</sup> Within this framework, it defines collaborative leadership as one of six key competency domains to enable interprofessional care. Descriptors that support the domain include the ability of learners and practitioners to (a) work together with all participants, including patients/families, to formulate, implement and evaluate care/services to enhance health outcomes; (b) support the choice of leader depending on the context of the situation; and (c) assume shared accountability for the processes chosen to achieve outcomes. In a shared leadership model, patients may choose to serve as the leader or leadership may move among learners/practitioners to provide opportunities to be mentored in the leadership role. This is an anchor and starting point describing potential curriculum content, learning strategies, learning outcomes and methods to determine if collaborative leadership practice competencies are an outcome. It provides structure for continuing faculty development so that learning facilitators are aware of the different processes they need to acquire in order to teach collaborative leadership.

In Canada, there are examples of collaborative leadership initiatives for health system change, such as transformative work in chronic disease management and social determinants of health that create the linkages among nursing, public and community health,<sup>7</sup> building primary health care systems,<sup>8</sup> leadership capacity framework,<sup>9</sup> and collaborations for system-wide change.<sup>10</sup> These examples could form part of the building blocks in addressing population health needs and could be adapted globally as part of the CIHLC as well as addresses some topic areas outlined in the piloted projects as suggested by IOM.

## APPENDIX B: ADDITIONAL OBJECTIVES

The CIHLC objectives are designed to develop a generic and flexible collaborative leadership model that would encompass a series of programs that will:

- Leverage current training programs within the Collaborative that have already been successful in their local context;
- Identify trends in collaborative leadership research;
- Allow for customization for rural, urban, and geographically diverse settings;
- Address education gaps in leadership across the health professions;
- Enable curricular reform that will:
  - include collaborative leadership competencies, based on the definition of collaborative leadership, covering supervision, interprofessional and provider-patient communications, clinical medical ethics, and clinical analytical skills that are evidenced-based - areas that are in alignment with suggested IOM projects;
  - address emerging population health that include social, cultural diversity and health disparities in order to identify learning opportunities through community engagement;
  - address emerging health system changes in service delivery; and
  - embed interprofessional education.
- Support evaluation and performance measurements of efficacy and outcomes; and
- Ensure sustainability for health system change and reform using key performance indicators.

## APPENDIX C: IMPLEMENTATION

Over the next three years, the CIHLC will collectively conduct several phases of work. These include:

- **Phase 1** - engage the core Participants in establishing the CIHLC Secretariat and related infrastructure located at the University of Toronto. As this organizational implementation work is underway, the National Steering Committee will confirm levels of interest among Canadian, regional and international groups who wish to be involved in this initiative and the key informants to be invited to a consultation process in the next phase.
- **Phase 2** - conduct a comprehensive literature review of both peer-reviewed and grey literature to establish the level and rigour of evidence related to leadership, collaborative leadership and health system change. Secondly, conduct an environmental scan of collaborative leadership models that includes an international survey and a series of regional consultations with schools of medicine, nursing, public health, business and programs of IPE. The scan will identify any existing innovative and transformative programs of leadership training within and external to health care as well as identifying best practice examples at both entry and post licensure levels. Best practice models and evidence from the literature review will be triangulated with regional, national and international experiences of collaborative leadership. Results of the survey and consultations will assist in conducting a needs assessment. During this phase, the evaluation framework will also begin to emerge, identifying key indicators that can be measured over time in both the leadership and the system contexts.
- **Phase 3** - will focus on the development of a continuum of collaborative leadership modules, made up of the best practices identified in Phase 2 and new training modules that would be developed during this phase. New modules will be tested in a variety of contexts (i.e., academic, clinical and cultural) before finalization. Experiential learning, in both education and practice sectors, will be key to this training. Bringing students and educators together with practitioners and patients in clinical settings to develop a collaborative leadership model could enable the use of quality improvement as an anchor for collaborative leadership training in a relevant and real world setting. A community of practice will be used to link the students, educators, practitioners and patients to share the lessons learned and to provide individual and organizational support. Tools for learning collaborative leadership will be developed using complex systems. Co-creation of the models with international partners identified in Phase 1 will assure cultural verification of the educational continuum and learning approaches. Community engagement principles and processes will be embedded in all these phases and components.



- In **Phase 4** the whole model will be rolled out through a number of local, regional and international partners. A comprehensive evaluation will be evident as part of Phase 4.
- In the final **Phase 5**, the complete model, comprising a continuum of modules, will be packaged for use and adaptation in any context and any region. Evaluation indicators and tools will be included so that users can effectively assess the impact of the collaborative leadership training program on health systems globally. Refer to page 21 of this LOU for an in-depth logic model of the implementation approach.

### **Timelines**

<b>Phase</b>	<b>Timeline</b>	<b>Objective</b>
<b>One: Set-Up</b>	February – June 2012	<ul style="list-style-type: none"> <li>- Secretariat in place</li> <li>- Identify sources of funding and accountability with a comprehensive business plan to be approved by each university</li> <li>- Develop detailed work plan for 3 years</li> <li>- Set up coordinating committees – international, national and regional</li> <li>- Stakeholder &amp; Community Engagement/Consultation (include informant interviews) - report</li> <li>- Communication and knowledge translation strategy established including media relations</li> <li>- Launch CIHLC website</li> </ul>
<b>Two: Reviews and Scans</b>	July 2012 to November 2012	<ul style="list-style-type: none"> <li>- Conduct literature review and environmental scan</li> <li>Reports on findings of literature review and environmental scan</li> <li>- Conduct needs assessment including with foreign partners</li> <li>- Develop evaluation framework</li> </ul>
<b>Three: Creation, Development and Testing</b>	2012-15	<ul style="list-style-type: none"> <li>- Develop collaborative leadership model including a continuum of modules (existing and those to be piloted)</li> <li>- Select pilot sites and develop template for pilot sites on reporting and evaluation</li> </ul>
<b>Four: Implementation and Evaluation</b>	2012-15	<ul style="list-style-type: none"> <li>- Execute pilot sites and monitor progress</li> <li>- Create scholarship and dissemination track</li> <li>- Conduct evaluation on all sites – issue a report</li> <li>- Evaluate communication and knowledge translation strategy</li> </ul>
<b>Five: Production</b>	2015	<ul style="list-style-type: none"> <li>- Develop packaged education and training modules including evaluation indicators and tools</li> </ul>
<b>Outcome: Transformative System Change</b>		



## APPENDIX D: LEADERSHIP

The CIHLC is based on a co-leadership model. Leadership is a shared responsibility and therefore having co-leads allows the CIHLC to demonstrate co-ownership, mentorship, continuity, progressive leadership development and transparent collaboration across the multiple health professions that will form this pan-Canadian collaboration.

At its initial stage of the CIHLC, the two individuals co-leading the CIHLC are Dr. Sarita Verma, Deputy Dean, Faculty of Medicine & Associate Vice-Provost, Health Professions Education at the University of Toronto, and Ms. Maria Tassone, Director, Centre for Interprofessional Education, University of Toronto and Lead, Interprofessional Education and Care, University Health Network. Members of the National Steering Committee are also leaders and they include:

- Dr. Lesley Bainbridge, Director, Interprofessional Education, Faculty of Medicine, University of British Columbia
- Dr. Margo Paterson, Professor, Occupational Therapy Program and Director, Office of Interprofessional Education and Practice Queen's University
- Ms. Sue Berry, Assistant Dean of Integrated Clinical Learning, Northern Ontario School of Medicine
- Dr. Emmanuelle Careau, Professor, Rehabilitation Department, Faculty of Medicine, Université Laval

In the event that a CIHLC member is unable to participate in the activities of the CIHLC, all Participants agreed to provide the name of an alternate member to ensure continuity and sustainability and to ensure that the views of all Participants are representative on the CIHLC.

## APPENDIX E: ROLES AND RESPONSIBILITIES

### A) Role of National Steering Committee/Participants

- Develop a transformative collaborative leadership framework/model to be used by health professional learners and which can be adapted and customized for use in any international health care and/or education setting.
- Oversee the development and implementation of programs and initiatives that are in alignment with the project's objectives.
- Provide strategic counsel to Secretariat on the execution of CIHLC workplan and activities.
- Serve as a key resource for collaborative leadership for health system change implementation by establishing linkages and partnerships and facilitating dialogue among all interested parties and promoting evidence-based models and concepts.
- Address technical structures and processes that will provide the tools to support and facilitate collaborative leadership change including systemic supports that are necessary.
- Provide recommendations regarding the teaching and practicing of interprofessional educational competencies as they relate to collaborative leadership across the continuum of learning.
- Identify opportunities to leverage the work of the CIHLC with national and international forums.
- Seek, correspond and facilitate funding opportunities and/or partnerships from external resources.
- Consult with key experts in the creation and development of collaborate leadership modules and programs as needed.
- Provide annual reports outlining activities and progress to date.

### B) Role of Co-Leads

- Address and make decisions on urgent matters on behalf of the National Steering Committee, when required.
- Responsibility in overseeing communications strategy including media relations and external communications.
- In consultation with Participants, nominate a successor should any existing member be unable to continue to participate in the work of the CIHLC.
- Provide final recommendations on any decisions by majority vote on any conflicts.
- Oversight over the day-to-day activities of the Secretariat.
- Financial accountability for the project, in collaboration with the National Steering Committee.

### C) Role of Secretariat

The Secretariat provides overall management and support of the CIHLC and will be housed within the Centre of IPE at the University of Toronto, with financial oversight by the Faculty of Medicine. The Secretariat will be comprised of a Project Manager/Director, staff coordinators /researchers and administrative support. Key responsibilities include:

- Manage, facilitate and coordinate all CIHLC activities.
- Develop comprehensive business plan on the CIHLC initiative.
- Develop detailed three-year work plan and budget and oversee its implementation.
- In consultation with the Committee, develop and arrange agreements with pilot sites.
- Develop written reports, briefings, correspondence, presentations and/or documents related to CIHLC activities and deliverables.
- Develop and conduct the research methodology regarding reviews/scans and stakeholder/community engagement.
- Write proposals for external funding for certain activities/projects as required.
- Development, communications and management of CIHLC website.
- Act as liaison among partners and their respective institutions as well as with pilot sites.
- Develop and maintain contacts and relationships with all interested parties as required.
- Monitor and manage issues that may impact CIHLC activities.
- Provide progress reports to Committee.
- Ensure that timelines and budget are being met including development of accountability reports to funders.
- Maintain records and documentation of CIHLC activities.

## APPENDIX F: Business Case

The CIHLC membership, who are faculty members, researchers and administrators, have already contributed in-kind resources. The budget to establish the Secretariat to support the CIHLC is estimated at \$300,000 per annum for three years as outlined in the CIHLC submission. The University of Toronto will provide additional in-kind funding sources to house the Secretariat on its campus. Queen's University commits \$200,000 (direct and indirect contributions) for CIHLC for the fiscal year May 2012 to April 30, 2013. The University of British Columbia, Université Laval and the Northern Ontario School of Medicine also have agreed to contribute the required amount (direct and indirect resources) for the fiscal year May 2012 to April 30, 2013. These amounts will be reviewed annually.

### a) Proposed Budget for Secretariat

#### Personnel

The role of the Secretariat is to support the National Steering Committee and to ensure that activities are aligned with the objectives of the CIHLC. Staff will also act as the liaison among all the members and external participants to ensure effective communication and dialogue is sustained and nurtured. All personnel will report to the Co-Leads.

The Project Manager/Director will provide strategic support to the National Steering Committee. This individual will oversee and manage the coordination and implementation of activities identified by the Committee to ensure that deliverables and timelines are being met. This individual must have significant knowledge and experience concerning interprofessional education and care with highly developed oral and written communications skills, a solid background in stakeholder relations and consensus-building and senior level experience in leading, managing and executing projects.

The research associates will provide analytical support and writing under the direction of the Project Manager/Director. A key role is to assist in the gathering and synthesizing literature reviews and published and grey literature. The research associates will be required to act as the central information resource and will create a database of program and policy initiatives regarding collaborative leadership programs and competencies. They will conduct analysis and synthesize and write documents as requested. As well, they must have the knowledge and experience in health care education and the health care system and demonstrated experience in research and report writing of the health care system. Additional research associates may be brought on board either in-kind or through other funding sources. Research Associates, or other roles that relate to a specific deliverable of the project, (i.e., curriculum, evaluation, community engagement or francophone translation) will be provided in-kind by the partner who has agreed to lead that component. The details for the roles of each site will be laid out in a work plan agreed to by the CIHLC NSC.

The administrative support will be required, on a full-time-time basis, to provide organizational and administrative support to resource staff. Specific responsibilities will include assisting in the

coordination of meetings, drafting agendas, maintaining documentation management system and preparing presentations. Budget management will come in-kind from the U of T's Center for IPE.

#### Meetings

While most meetings will be conducted via teleconferencing, there will be some meetings that may be face-to-face at which point, they will take place in Toronto and/or in a location of strategic convenience (i.e., national conferences). Further information on scheduling of meetings will be outlined in the CIHLC's work plan.

#### Travel

All international travel must be approved by the Secretariat, and allowable expenses for travel are as outlined in each University's guidelines. The partners acknowledge that they understand that expenses for travel that is not covered within the Secretariat's budget may be expected to be an in-kind contribution or to come out of the budget allocated to the Participant university.

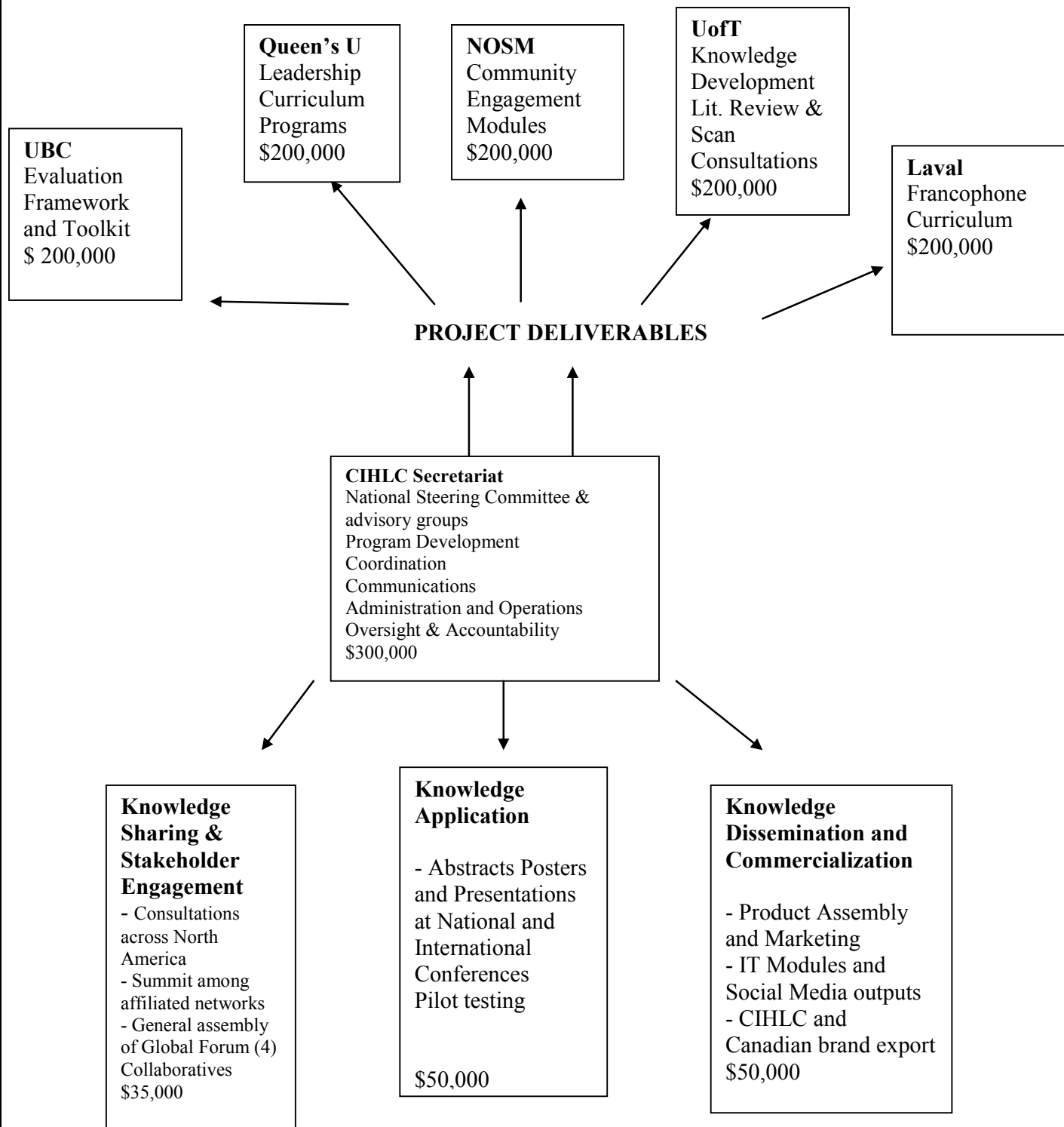
#### Supplies/Stationary

Supplies include stationery, printing costs, courier, photocopying, postage, and teleconferencing.

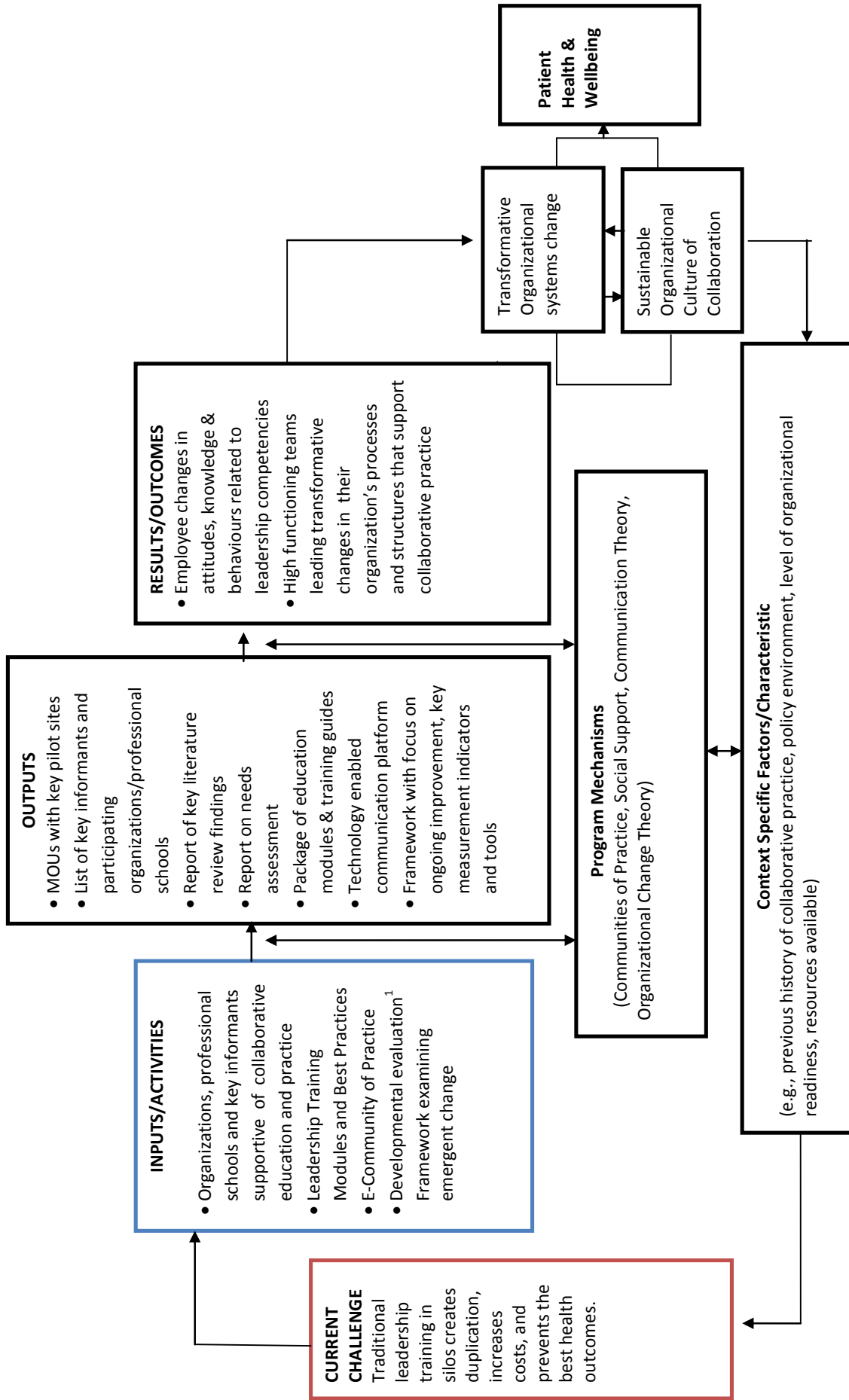
#### Professional Services

Throughout the CIHLC project, the National Steering Committee will require the services of professionals and/or experts to assist on specific activities.

**Costs of the CIHLC Infrastructure and Project Deliverables**



## Collaborative Leadership for Health System Change – Implementation Logic Model



<sup>1</sup>Patton M.Q. 2010. *Developmental Evaluation: Applying Complexity Concepts to Enhance Innovation and Use*. New York, NY: Guilford Press

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- 1 Health Canada. Interdisciplinary Education For Collaborative, Patient-Centred Practice  
[http://www.ferasi.umontreal.ca/eng/07\\_info/IECPCP\\_Final\\_Report.pdf](http://www.ferasi.umontreal.ca/eng/07_info/IECPCP_Final_Report.pdf)
  - 2 Blueprint for Action in Ontario.  
<http://www.healthforceontario.ca/upload/en/whatishfo/ipc%20blueprint%20final.pdf>
  - 3 <http://www.healthforceontario.ca/WhatIsHFO/AboutInterprofessionalCare/ProjectResources.aspx>
  - 4 <http://www.chd.ubc.ca/>
  - 5 2003 Canada Health Accord. <http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2003accord/index-eng.php>
  - 6 CIHC A National Interprofessional Competency Framework.  
[http://www.cihc.ca/files/CIHC\\_IPCompetencies\\_Feb1210r.pdf](http://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210r.pdf)
  - 7 Transforming Care for Canadians with Chronic Health Conditions. Canadian Academy of Health Sciences  
<http://www.caahs-acss.ca/reports/ences>.
  - 8 Accelerating Primary Care. Series of Papers sponsored by Public Health Agency of Canada.  
<http://www.buksa.com/APCC/sessions.asp>
  - 9 The Pan-Canadian Health Leadership Capability Framework Project. Canadian Health Services Research Foundation. [http://www.chsrf.ca/Migrated/PDF/Health\\_Leadership\\_Framework\\_E.pdf](http://www.chsrf.ca/Migrated/PDF/Health_Leadership_Framework_E.pdf)
  - 10 Stronger Together: Collaborations for System-Wide Change. Canadian Health Interprofessional Collaborative.  
[http://www.cihc.ca/files/publications/CIHC\\_KEStrategy\\_Jan09.pdf](http://www.cihc.ca/files/publications/CIHC_KEStrategy_Jan09.pdf)





## Principles of Collaboration for the Canadian Interprofessional Health Leadership Collaborative

*Grants, Knowledge Transfer, Authorship and Ownership*  
December 11, 2013

### Purpose

This document attempts to lay out principles and processes around grant applications and funding, knowledge transfer and intellectual property amongst the following five Canadian universities that comprise the Canadian Interprofessional Health Leadership Collaborative (CIHLC):

University of Toronto (UofT),  
University of British Columbia (UBC),  
Northern Ontario School of Medicine (NOSM),  
Queen's University (Queen'sU) and  
Université Laval (ULaval).

This is a document of communication, clarification and intent. It is not a legal agreement. Each university's policies apply to their own staff and faculty.

This is a companion document to the *Statement of Collaboration* among the five universities regarding the CIHLC, signed by the Deans of Medicine and the project leads in May 2012. That document can be referred to for details on the CIHLC objectives, governance, leadership and roles and responsibilities, as well as for broad guiding principles for collaboration.

### Document Definitions

The CIHLC is an inter-institutional and interprofessional collaboration that includes the faculties and schools of medicine, nursing, public health and programs of interprofessional education (IPE), representing numerous health care professions at each of the five universities. The CIHLC acts as a central resource and facilitator in the co-creation, development, implementation and evaluation of a global collaborative leadership model and program, in addition to, the collaborative in itself.

CIHLC's vision is collaborative leadership for health system change to globally transform education and health.

The goal, objectives and governance structure are identified in Appendix A and B.

This project was chosen by the U.S. Institute of Medicine's (IOM) Board on Global Health as one of four innovation collaboratives from an international competition of academic institutions around the world in January 2012. The collaboratives are intended to incubate and pilot ideas for reforming health professional education called for in the Lancet Commission report, and are a key part of the IOM's new Global Forum on Innovation in Health Professional Education.



## CIHLC Membership Terminology

The CIHLC refers to the project and its team as outlined below:

The **participating universities** and founding institutional members of the CIHLC (**the Participants**) include U of T, UBC, NOSM, Queen's U and U Laval.

The **National Steering Committee (NSC)** guides / directs, advises on, and represents the scholarly work of the CIHLC. It is composed of identified institutional leads and co-leads (**the Leads**) as well as **Alternates** from each university.

The **Alternates** will act as Leads when the Leads are not available.

The nominated **CIHLC Co-leads** are representatives at the IOM Global Health Forum of the Institute of Medicine, and also represent the University of Toronto.

The **Secretariat**, which is composed of a Director, Research Associates, Project Coordinator and others supports the CIHLC structure and the National Steering Committee.

The **Research Associates (RAs)** provide analytical support and writing under the direction of each of the individual Leads, collectively as a Committee of Research Associates, and/or the Secretariat.

**Project Consultants** provide specific expertise or products under the direction of the hiring institutional Lead in collaboration with the Secretariat.

**Collaborators** are scholars, researchers, administrators, policy and decision makers who contribute to the work of the CIHLC.

**Support staff** are individuals employed to assist the CIHLC.

The **Research Team** refers to any of the members working with the Leads on a CIHLC activity.

**Education Program Administrators** are university or hospital employees who provide administrative support to one or more members of the CIHLC.

The **IOM Global Forum on Innovation in Health Professional Education (IOM)** is the sponsor of the CIHLC and provides the CIHLC with a forum for its work.

**Authorship Guidelines** refer to "authorship credit" as defined by the International Committee of Medical Journal Editors (ICMJE) <http://www.icmje.org/>. The Authorship Guidelines require all three conditions below to be met:

- 1) substantial contributions to:
  - a. conception and design
  - b. acquisition of data, or
  - c. analysis and interpretation of data;
- 2) drafting the article or revising it critically for important intellectual content; and
- 3) final approval of the version to be published.



### General Principles of Collaborative Work

In general, a CIHLC grant application, project, scholarly presentation or publication is considered a component of work related to the mission of CIHLC, where there has been **collaboration** across institutions. With the consensus of the National Steering Committee, **individual work** may be directed to a Lead at one of the collaborative institutions and identified as part of the overall collaborative work project.

The CIHLC recognizes that a significant strength is the diverse mix and expertise of program leaders, researchers, and others, across the member organizations.

### Grant Applications and Funding Principles

1. A primary intent of the collaboration between the institutions and faculty involved is to access grant funding for the activities of the research collaboration, so both the grant writing and the naming of investigators will be done strategically.
2. When preparing grant applications, the National Steering Committee (NSC) may suggest and will approve who will be the Principal Investigator(s) (PIs) on the grant and who will serve as the co-investigator(s).
3. The number of Co-PI's and co-investigators will vary according to the granting agency. Normally, there will be one PI or two Co-PIs on a grant and the remaining Leads will serve as co-investigators. The PIs and co-investigators will be determined at the start of the grant application process. However, all members of CIHLC may be involved in providing feedback during the writing phase of the grant. Basic information regarding the research project proposal (title, granting agency, researchers involved) must be shared with the CIHLC NSC and Secretariat prior to the submission to the granting agency. The team compiling the grant may also share drafts and timelines with the NSC.
4. Education program administrators may contribute to a grant through determining and supporting the feasibility of a project, and may provide a letter in support of the grant. The CIHLC will acknowledge this work in writing, even if this does not lead to investigator status on the grant itself.
5. It is agreed that grant monies, accountability and oversight will reside at the university or organization of the PI who applied for the grant. In the case of Co-PIs, the Co-PIs will make a decision between them prior to the grant submission and communicate this decision in writing to the team and the National Steering Committee. The identified PI must carry grant funds at his/her institution, supervise the ethics application process, and manage the budget and work plan. However, for grant applications that involve the activities of the CIHLC as a whole, the funds, financial and deliverables accountability and oversight will reside at the Secretariat/ U of T.
6. The researchers and organizations are not prevented from other research activities on their own or with others. Some granting agencies are provincial, and the organizations/ researchers can apply independently to provincial organizations using their own research questions and data. However, use of existing project data or reference to and the possible overlapping work or other collaborations will



be disclosed to the National Steering Committee prior to formalizing any research activities with other organizations or researchers.

7. CIHLC will adopt a transparent approach to budgeting and expenditures from each grant. A copy of the annual report and the budget of any CIHLC grant will come to the National Steering Committee for information. A copy of any related grant submitted, paper, presentations, etc., will be submitted to the CIHLC Secretariat for information purposes.
8. For grants that involve work across institutions, the budget will be developed together, and the budget will be agreed upon in terms of funds available for work to be done at each participating organization, with a description of the work output expected where appropriate. The collaborating institution will then invoice the primary grant holder up to the maximum allocated in the budget. Although there may be a need to adjust the budget during the research activity, this adjustment will be done through open discussion among the PI, co-PI, and Research Team. In the event of disagreement, the budget changes will be discussed by the National Steering Committee. In general, the budgets cannot be changed without agreement from the collaborating institutions unless the agreed upon outcomes are not being obtained. However, we recognize that the final authority for the budget is the PI who must ensure compliance with budget policy and granting agencies.
9. When preparing Research Ethics Board applications, all communication for potential participants should be written on behalf of the CIHLC on CIHLC letterhead, even when an institutional lead/PI may make the contact. If the institution receiving the REB application requires communication to be on its own letterhead, the CIHLC must be acknowledged by including the CIHLC logo or other prominent CIHLC identification on the application form.

### **Abstracts, Presentations and Conference Principles**

1. It is the intent of CIHLC to participate in conferences and other knowledge transfer activities.
2. At the point when a Lead is considering a submission involving the work of the CIHLC, the Lead will advise the NSC. When an abstract is being submitted, the abstract will be circulated to all authors prior to submission and copied to the Secretariat for tracking purposes.
3. Accepted abstracts will be copied to the National Steering Committee and the Secretariat to give an opportunity for team members to always know what work is being presented and will be included in the CIHLC's reports.
4. All abstracts and presentations will comply with institutional policies (of the home institution of the first author) related to data.
5. CIHLC members will be sensitive about the potential impact and consequences of the data that is published. Information will be presented to stakeholders and collaborators that are impacted prior to any presentation or publication for information and feedback but not approval. CIHLC will seek to avoid negative impact on institutions.
6. As a general principle, authorship should be determined in advance to beginning a draft and discussion continue as the project evolves.



All those listed as authors must meet Authorship Guidelines. Others who contribute significantly will be acknowledged as contributors.

The CIHLC member who writes the first draft of an abstract should be the first author. The first author must be a Lead; however, the Lead has the discretion to pass primary authorship to another Lead or Alternate, or a Research Associate under his/her supervision. In these cases the name of that Lead will be the second author. Otherwise, following the first author are the Leads and Alternates in order of the second and senior researchers. Unless there is a clear differentiation in the contribution of Leads, names will be listed in alphabetical order. Only the Research Associates who meet the Authorship Guidelines will have their names listed, in alphabetical order, following the names of all of the Leads and Alternates. The names of any Consultants and other individuals including faculty and staff who meet the Authorship Guidelines will follow.

Those who make significant contributions but do not meet the authorship guidelines will be acknowledged as contributors along with a description of their contribution.

Whenever grant funds are used for conference travel, the travel funding policy of the institution holding the funds must be followed, and/or if specified, in compliance with the terms of the grant.

7. All conference abstracts and other knowledge transfer will be collected and tracked by the Secretariat and placed in a report.
8. All conference and knowledge transfer presentations should acknowledge the CIHLC as well as the funders, the participating universities, and the Institute of Medicine (IOM) for driving the work of the CIHLC. Whenever possible, the logos of the 5 participating universities should be included in communication material.

### **Publication and Authorship Principles**

1. It is the intent of the CIHLC to publish results as extensively as possible.
2. Authorship rules for papers will be the same as abstract/presentation rules. That is, all those listed as authors must meet Authorship Guidelines. Others who contribute significantly but do not meet these guidelines will be acknowledged as contributors.
3. As a general principle, authorship should be determined in advance to beginning a draft and discussion continue as the project evolves.

The CIHLC member that writes the first draft of the paper should be the first author. The first author must be a Lead; however, the Lead has the discretion to pass primary authorship to an Alternate, or a Research Associate under his/her supervision. In these cases, the name of that Lead will be the second author. Otherwise, following the first author are the Leads and Alternates who meet the Authorship Guidelines, in order of second and then senior researchers. When there is not a clear differentiation in the contribution of Leads, names will be listed in alphabetical order. Only the Research Associates who meet the Authorship Guidelines will have their names listed in alphabetical



order, following the names of all of the Leads and Alternates. The names of any Consultants and other individuals including faculty and staff who meet the Authorship Guidelines will follow.

Individuals who make significant contributions but do not meet the Guidelines will be acknowledged as contributors, along with a description of their contribution. (examples in # 9)

4. The CIHLC Leads and their Research Team will map out potential papers that are expected to result from the research project and their specifics: topic, lead, authors, journal, timeline, as early as possible, recognizing that this may change over time. The Research Team will communicate this information to the National Steering Committee.
5. All papers submitted and/or published will be sent to the Secretariat and used in the CIHLC's reporting.
6. All presentations and papers submitted will acknowledge the CIHLC, funding bodies, participating universities for in kind and other contributions, and any other significant contributors as well as the Institute of Medicine (IOM) for driving the work of the CIHLC.

The CIHLC must acknowledge the support of the Ontario government in any publication of any kind in relation to the project, and indicate that the views expressed in the publication are the views of the CIHLC and do not necessarily reflect those of the province.

7. Data/evidence will reside with and belong to the PI's lead institution, with the agreement that the CIHLC may use this data/evidence for project purposes and that it may be transmitted to the IOM when needed. Permission must be sought from the Participants for any other purpose.
8. Increasingly, authorship of multicenter trials or research groups such as the NSC members of the CIHLC and their staff/employees is attributed to a group. All members of the group who are named as authors should fully meet the above criteria for authorship/contributorship. The group should jointly make decisions about contributors/authors before submitting the manuscript for publication. The corresponding author/guarantor should be prepared to explain the presence and order of these individuals. It is not the role of editors to make authorship/contributorship decisions or to arbitrate conflicts related to authorship.
9. All contributors who do not meet the criteria for authorship should be listed in an acknowledgments section. Examples of those who might be acknowledged include a person who provided purely technical help, writing assistance, or a department chairperson who provided only general support. Editors should ask corresponding authors to declare whether they had assistance with study design, data collection, data analysis, or manuscript preparation. If such assistance was available, the authors should disclose the identity of the individuals who provided this assistance and the entity that supported it in the published article. Financial and material support should also be acknowledged. Groups of persons who have contributed materially to the paper but whose contributions do not justify authorship may be listed under such headings as "clinical investigators" or "participating investigators," and their function or contribution should be described—for example, "served as scientific advisors," "critically reviewed the study proposal," "collected data," or "provided and cared for study patients." Because readers may infer their endorsement of the data and conclusions, these persons must give written permission to be acknowledged.



10. The draft of the attributions, the listing of the group of the CIHLC members and the acknowledgements will be created so that there is consistent wording agreed to in advance.

### **Products**

All final products and scholarship will be housed at the Secretariat for the purpose of dissemination and accessibility. If and when the Secretariat no longer exists, the contents of the Secretariat will be transferred to an organization that can provide the sustainability and accessibility required. The CIHLC co-leads will be identified as the corresponding authors for all outputs so that requests for reprints or future correspondence can be managed in the future through one address.

### **Intellectual Property**

While it is unlikely that issues of intellectual property will arise within the CIHLC, when such issues are identified they will be dealt with according to each institution's policy.

### **Conflict Resolution**

Conflicts may arise that cannot be resolved informally by the NSC. The individual(s) can write an official letter to the CIHLC Co-leads who will respond within 30 days. If the situation is not resolved, it will be referred for advice to the Deans of the institutions involved for resolution. In the event of a substantive conflict among the five university participants, such conflicts will be resolved by a meeting of the five Deans or their delegates.



## **APPENDIX A**

### **Canadian Interprofessional Health Leadership Collaborative (CIHLC) Goals and Objectives**

#### **Goal**

The goal of the CIHLC is to use a pan-Canadian approach, with global engagement, to co-create, develop, implement and evaluate a global model for collaborative leadership targeted to health care practitioners and health organization administrators with a learner and patient centered perspective.

#### **Key Objectives**

1. Develop a collaborative leadership (see appendix 1) model for health system change.
2. Build and leverage existing partnerships within Canada and abroad - enhance the facilitation and implementation of collaborative leadership programs.
3. Utilize existing IT mechanisms and social media to maximize cost-effective methods to effectively support communities in leadership training.
4. Develop new academic productivity and scholarships that will influence global policy reform.
5. Develop an evaluation framework that measures planned and emergent change at the educational, practice and system levels.





## **APPENDIX B**

### **CIHLC National Steering Committee Membership**

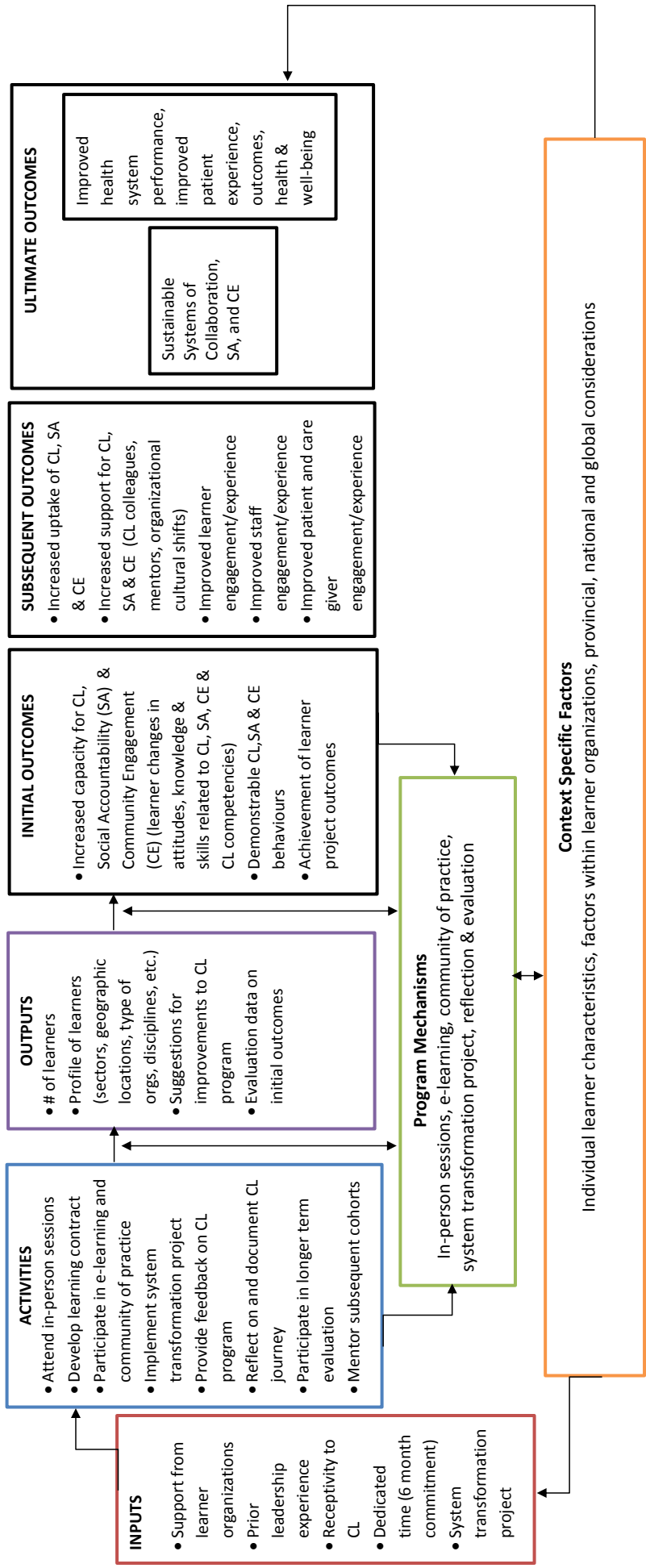
#### **Leads and Alternates**

- Co-Lead - **Sarita Verma**, Professor of Family Medicine, Deputy Dean, Faculty of Medicine, Associate Vice Provost, Health Professions Education
- Co-Lead - **Maria Tassone**, Director, Centre for Interprofessional Education, University of Toronto & Senior Director, Health Professions and Interprofessional Care, University Health Network
- **Lesley Bainbridge**, Director, Interprofessional Education, Faculty of Medicine, University of British Columbia
- **Sue Berry**, Assistant Dean of Integrated Clinical Learning, Northern Ontario School of Medicine (NOSM) - NOSM Co-Lead (to October 2013)
- **Rosemary Brander**, Assistant Professor, School of Rehabilitation Therapy, Director, Office of Interprofessional Education & Practice, Queen's University; Senior Researcher and Program Evaluator, Providence Care, Kingston, ON
- **Marion Briggs**, Director, Health Sciences and IPE, NOSM Alternate
- **Emmanuelle Careau**, Professor in Occupational Therapy Program, Université Laval
- **Serge Dumont**, Professor, Faculty of Social Science, Université Laval
- **Maura MacPhee**, Associate Professor, School of Nursing, UBC Alternate
- **David Marsh**, Associate Dean, Community Engagement, NOSM – NOSM Co-lead
- **Margo Paterson**, Professor, Occupational Therapy Program and Director, Office of Interprofessional Education and Practice Queen's University

#### **Research Assistants**

- **Gjin Biba**, Professionnel de Recherche, Université Laval
- **Laurel O'Gorman**, Research Assistant, Centre for Rural and Northern Health Research, NOSM (to September 2013)
- **Marla Steinberg**, Evaluation Consultant, University of British Columbia
- **Janice Van Dijk**, Research Assistant, Queen's University

Collaborative Leadership (CL) Program for Transformative Change Logic Model



2013

# CIHLC Evaluation Primer

Overview of Relevant Frameworks and Tools

University of British Columbia

Marla Steinberg, PhD  
Evaluation Consultant  
1/28/2013



## Table of Contents

About this Document .....	2
About the CIHLC.....	2
About the Evaluation .....	3
Scope of Work.....	3
Guiding Principles, Frameworks, and Tools .....	4
Developmental Evaluation.....	4
Complex Adaptive Systems.....	5
Social Accountability .....	5
RE-AIM .....	6
Kirkpatrick Framework for Evaluating Training Programs .....	6
Framework for Promoting and Assessing Value Creation in Communities and Networks .....	7
Network Functioning – Partnership Self-Assessment Tool.....	8
Participatory and Utilization-Focused.....	9
Knowledge Mobilization .....	9
Summary .....	9
References .....	10
Appendix A: Original Logic Model.....	11
Appendix B: Table 1- Application of RE-AIM: Evaluation Questions, Indicators, and Data Sources.....	12
Appendix C: Partnership Self-Assessment Tool .....	15
Appendix D: Sample Partner Survey Questions.....	16

## About this Document

This document presents an overview of existing evaluation frameworks and tools that can be incorporated into the evaluation work of the CIHLC. It has been drafted for information purposes for the NSC.

## About the CIHLC

The Canadian Interprofessional Health Leadership Collaborative (CIHLC) is a multi-institutional interprofessional partnership involving the University of Toronto, the University of British Columbia, the Northern Ontario School of Medicine, Queen’s University, and Université Laval. The objective of the CIHLC is to develop, implement, evaluate, and disseminate a global evidence-based program for collaborative leadership for health professionals. The education program, as it is currently termed<sup>1</sup>, will be targeted to health care executives, practitioners, practice-leads, and students. The initiative is sponsored by the Institute of Medicine (IOM) Board on Global Health and is one of four initiatives implemented as part of the Global Forum on Innovation in Health Professional Education.

The CIHLC has established a co-lead structure that is guided by a National Steering Committee (NSC) composed of the leads and alternates from the five universities. A secretariat has been established at the University of Toronto to coordinate and manage the project. Each university has assembled a team to support its work. A research assistants’ committee has also been established to support the NSC, foster information sharing across the project, and ensure coordination and collaboration across the multiple streams of work.

The project is being implemented in five phases over a three year period (2012 – 2015). The project is currently in Phase 2 completing a comprehensive literature review of leadership curricula, key informant interviews, and an environmental scan of leadership development programs offered through post-secondary institutions. Work is also underway to test a working definition of collaborative leadership and refine the skills and practices or competencies associated with collaborative leadership.

It should be noted that even though the project is sponsored by the IOM, the IOM does not provide funding. Instead, each university partner contributes in-kind and financial support in order to implement the project. Additional financial support is also being sought from other sources.



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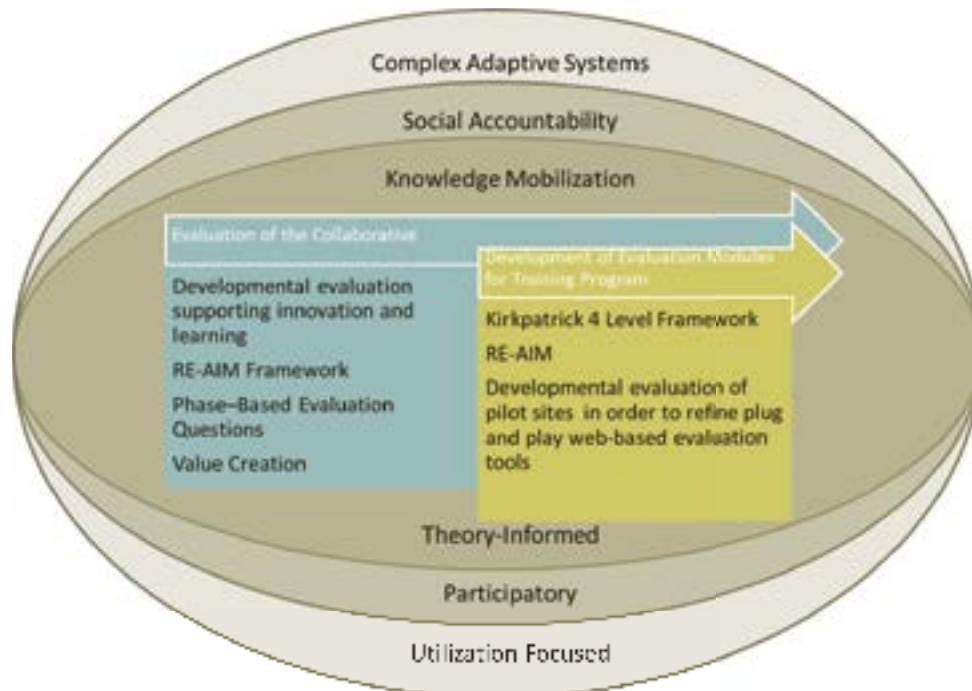
<sup>1</sup> NSC is in the process of refining the vision and accompanying language for the project deliverables. The language of “the deliverable” has shifted from being called a model, modules or curriculum to “a program”. Undoubtedly the language used in this project will continue to evolve as thinking progresses and the deliverables begin to take shape.

## About the Evaluation

### Scope of Work

The original CIHLC proposal to the IOM indicated that evaluation would be conducted during the pilot phase of the collaborative leadership program (Phase 4) in order to develop evaluation modules for the program that learners could use to assess the impact of the collaborative leadership training program on health system transformation. A logic model was developed and included in the proposal (see appendix A) and shows the initial thinking about program activities, outputs, and expected outcomes. Discussions that have taken place since project initiation have led to refinements in the scope of the evaluation work. The NSC has indicated it is interested in an evaluation that provides information that can be used to improve the project and to demonstrate the return on investment of the collaborative and the leadership development program. This dual focus on learning and accountability lends itself to a developmental evaluation approach that permits the collection of data to support ongoing development of the initiative (Patton, 2011). Upon approval from the NSC, the scope of evaluation work has been adjusted accordingly and includes the original stream of work and a second stream that focuses on an evaluation of the collaborative itself and its added value or return on investment. Figure 1 below shows a graphic representation of the evaluation work along with the guiding principles and frameworks that are under consideration.

Figure 1: Evaluation Framework



## Guiding Principles, Frameworks, and Tools

The evaluation work undertaken through the CIHLC will be guided by a set of principles and when appropriate, existing evaluation frameworks and validated data collection tools. Some of the principles are taken from the CIHLC proposal, others have been brought forward because they represent best practices in evaluation or will provide appropriate touchstones for the evaluation work. The frameworks and tools under consideration for this evaluation have been selected because of their relevance to the CIHLC. What follows is an overview or primer on these principles, frameworks, and tools with illustrations of how they could be used in this evaluation.

### Developmental Evaluation

As mentioned, NSC is interested in a developmental evaluation approach. This can be applied to both the collaborative as it is developing the collaborative leadership program and to the pilot testing of the program. In the words of Michael Quinn Patton, the developer of developmental evaluation: “Developmental evaluation isn’t some particular set of methods or recipe-like steps. It doesn’t offer a template of standardized questions. It’s a mindset of inquiry into how to bring data to bear on what’s unfolding so as to guide and develop that unfolding” (2011, p. 75). In developmental evaluation, the evaluator participates in the planning process as planning and evaluation are intertwined: the innovators are continuously evolving the intervention as they try new things and the evaluator provides data to document the effect of the innovations. But in developmental evaluation, the evaluator’s role expands beyond providing data to include acting as an observer, questioner, and facilitator. According to Jamie Gamble:

*“As observer, the evaluator is watching both content and process. What is being tried? What is being decided? How is it being done? How is it being decided? The primary purpose of making observations is to generate useful feedback for the team; for example, by asking: “We seem to have changed direction, are we OK with that?”, “There are implicit goals that we haven’t yet stated but that are shaping our actions – should we clarify those?”, “There are assumptions that underlie what we are talking about – let’s frame them as assumptions so we can better check for their validity as we move forward.” As facilitator, the evaluator may help move a conversation forward. There are times when a group has sufficiently explored a set of ideas but cannot seem to move forward. By framing and synthesizing these ideas for the group, the evaluator can help the group to make sense of its deliberations, fine-tune and move on. In the same way, the evaluator as facilitator supports the group as it interprets data so that it can feed directly into the development process” (2008, p. 30).*

The foregoing description positions the developmental evaluator in roles that may overlap with project management or meeting facilitation. The intent here is not for the evaluator to take on these roles, but to “infuse team discussions with evaluative questions, thinking, and data, and to facilitate systematic data-based reflection and decision-making in the developmental process (Patton 2011, p. 1-2). When developmental evaluation succeeds, evaluative thinking becomes the way of being for the entire team.

## Complex Adaptive Systems

Systems thinking and concepts will serve this project and the evaluation work well. There are a variety of systems-based concepts that can be drawn upon (see Finegood et al. (forthcoming) for an overview of complexity concepts). For this evaluation, systems thinking should underpin the development and uptake of the collaborative leadership program as well as tracking of the learner’s educational journey from the acquisition of collaborative leadership capabilities to the achievement of transformative change.

When working in complex adaptive systems, evaluation can best support a project by articulating a theory of change, paying attention to the components and dynamics of systems (actors, believe systems, structural elements, feedback loops, and interconnections, as illustrated in Figure 2) and monitoring how they are affected by the project and the program of collaborative leadership.

Common questions traditionally asked in evaluations, like was the program effective, can be answered through an examination of changes that have occurred at the systems levels (paradigms, relationships, resources, practices, program, policies, and infrastructure (Huz et al., 1997)).

For the CIHLC, this could involve examining the spread or endorsement of the concept of collaborative leadership (e.g., changes to paradigms) and the infrastructure, resources, and policies that support leaders in collaborative leadership.

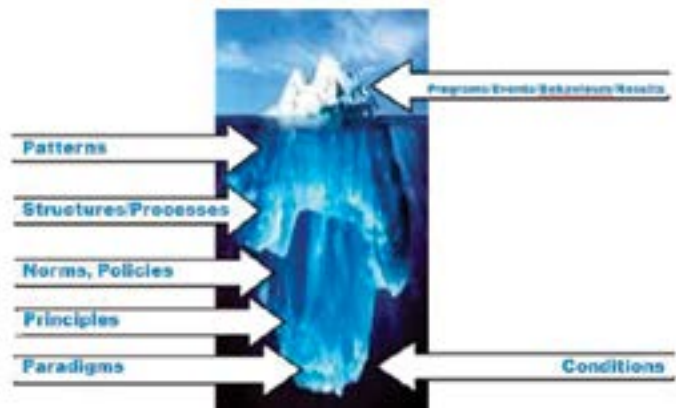


Figure 2: System Components  
Source: InSites (2012).

## Social Accountability

Within health professional education, social accountability has emerged as a driving force. Social accountability is defined as “an institutional responsibility to orient teaching, research, and service activities to addressing priority health needs with a particular focus on the medically underserved” (The Training for Health Equity Network, 2011, p. 5). As indicated by the NSC, the collaborative leadership program is going to be built upon the concepts embodied by social accountability (quality, equity, relevance, efficiency, and partnership, as shown in Figure 3) and the evaluation work should follow suit. Social accountability will also be a collaborative leadership competency. The incorporation of social accountability into the evaluation work can involve evaluating the extent to which the project is being implemented in accordance with social accountability principles (e.g., community engagement/partnership, contextually relevant curriculum, a needs-based program, equity-orientation, quality and efficiency). In addition, it can include indicators and tools within the program for learners to



Figure 3: TheNET Framework.  
Source: The Training for Health Equity Network (2011)



assess the social accountability of their leadership and change efforts in addition to the acquisition of social accountability competencies. THEnet’s Evaluation Framework for Socially Accountable Health Professional Education (ibid) can serve as source for evaluation questions, indicators, and data collection tools. As a start, CIHLC should be keeping track of the engagements undertaken through funding discussions and key information interviews and periodically reflecting on how well these engagement are serving the project (e.g., are these the right groups, is anyone missing, are these the best ways to engage with these groups, etc.).

## RE-AIM

Originally developed in 1999 by Russ Glasgow, Shawn Boles, and Tom Vogt, RE-AIM is a program planning and evaluation framework for use within public health. RE-AIM was originally developed as a framework for consistent reporting of research results and later used to organize reviews of the existing literature on health promotion and disease management in different settings. The acronym stands for Reach, Effectiveness, Adoption, Implementation, and Maintenance which together determine public health impact (RE-AIM.org). As a generic evaluation framework, it can be applied beyond public health. Its use ensures that information will be collected on the essential program elements (the reach of the program, its effectiveness, uptake or adoption, implementation, and maintenance or sustainability). RE-AIM also provides a methodology for calculating the impact of an intervention at the individual level (for the CIHLC this would be the impact for individual learners) and the impact at system level (collective impact of collaborative leadership program across organizations, settings or jurisdictions). Table 1 presented in Appendix B, shows how RE-AIM can be operationalized in this evaluation for guiding the evaluation of the collaborative, the pilot test, and questions to be asked on an on-going basis once the collaborative leadership program has established a permanent home. As shown in Table 1, these questions will require the use of multiple data sources and the collection of both quantitative and qualitative data.

## Kirkpatrick Framework for Evaluating Training Programs

A commonly used framework for evaluating training programs including leadership training programs (when they are evaluated, see Tourish, Pinnington, & Braithwaite-Anderson, 2007 who found in their review of Scottish programs, that about one quarter of programs are never evaluated) is the Kirkpatrick Framework developed and named for its founder, Donald Kirkpatrick (Kirkpatrick 1998). The framework offers four levels of outcomes and attempts to move the evaluation of training beyond measures of learner satisfaction. While the model is not without its criticisms (e.g., Watkins, Lyso-Ingunn & deMarrais, 2011), the main criticisms center on static methodologies that are typically used to assess leadership behaviour and the linearity implied in the model, rather than on the concept of different levels of



Figure 4: Kirkpatrick Four Level Model

Source:

[http://www.camlefa.org/documents/Kirkpatrick\\_levels\\_of\\_evaluation.pdf](http://www.camlefa.org/documents/Kirkpatrick_levels_of_evaluation.pdf)

outcomes. It is the range of outcomes or levels of outcomes that should be incorporated into the CIHLC evaluation work using Kirkpatrick's framework (the pilot test and the evaluation modules to be embedded within the collaborative leadership program).

In the Kirkpatrick model, level 1 measures the reaction of trainees to the training program. The purpose of measuring reaction is to ensure that trainees are motivated and interested in learning. Here the main indicators to be developed should focus on the quality and relevance of the program. This level will provide useful data during the pilot tests but should be continuously monitored throughout program delivery to ensure quality and relevance remain high when the program is delivered globally.

Level 2 of Kirkpatrick's four-level model measures the knowledge acquired, skills improved, or attitudes changed as a result of the training. In this evaluation, the indicators to be developed for assessing learning will be guided by the competencies that will be developed for collaborative leadership. It is fully expected that one of the competencies will be interprofessional practice. The outcomes, indicators, and tools will be drawn from the work of the Canadian Interprofessional Health Collaborative (e.g., Quantitative Tools to Measure Interprofessional Education and Collaborative Practice, CIHC, 2012).

Level 3 measures the transfer of training; if and how trainees are applying new knowledge, skills, or attitudes on the job. Level 4 measures the result of training as it relates to business objectives or key result areas (KRAs) such as sales, productivity, profit, costs, employee turnover, product/service quality, etc. Within health systems, key business objectives typically include quality, equity, patient outcomes, patient satisfaction, patient engagement, efficiency, in addition to a host of measures related to health human resources (retention, engagement, provider satisfaction, etc.). The selection of the outcomes of relevance for the CIHLC program will be identified by the NSC as part of the program planning process.

There are a variety of options for collecting data from learners, the method selected should match the nature of the collaborative leadership program. For example, if a web-based asynchronous program is developed, the evaluation can use surveys and telephone interviews to collect data from learners. In contrast, if the program involves a locally implemented project-based learning experience, and if resources permit the allocation of local developmental evaluators, then more engaging methods of data collection can be used like journaling, reflective practice, and focus groups. The collaborative leadership development program will need to be more fleshed out before the data collection methodology can be finalized and the data collection tools developed. Data collection from the staff of the participating leaders should also be included to add more rigour to the evaluation. It would also be worthwhile to explore the establishment of control groups within the pilot sites in order to add additional rigour to the design.

## **Framework for Promoting and Assessing Value Creation in Communities and Networks**

Developed by Etienne Wenger, Beverly Trayner, and Maarten de Laat (Ruud de Moor Centrum, 2011) this framework provides tools to assess the learning impact of participating in communities of practice or networks. It is based on the Kirkpatrick framework discussed above and identifies changes at multiple levels. This framework and tools can be used in this evaluation to capture the impact of

participating in the collaborative (one set of indicators of ROI), and should a community of practice be established as part of the pilot testing of the collaborative leadership program, these tools can be used here.

A community of practice is defined as “a learning partnership among people who find it useful to learn from and with each other about a particular domain. They use each other’s experience of practice as a learning resource. And they join forces in making sense of and addressing challenges they face individually or collectively” (Wenger, Trayner & de Latt 2011, p. 9). A network is defined as “a set of connections among people, whether or not these connections are mediated by technological networks. They use their connections and relationships as a resource in order to quickly solve problems, share knowledge, and make further connections” (Wenger, Trayner & de Latt, 2011, p. 9). Consideration should be given to whether the CIHLC is best characterized as, or evolving into, a community of practice or a network, although Wenger and colleagues prefer to think of communities and networks as two aspects of social structures in which learning takes place:

“The network aspect refers to the set of relationships, personal interactions, and connections among participants who have personal reasons to connect. It is viewed as a set of nodes and links with affordances for learning, such as information flows, helpful linkages, joint problem solving, and knowledge creation.”

“The community aspect refers to the development of a shared identity around a topic or set of challenges. It represents a collective intention – however tacit and distributed – to steward a domain of knowledge and to sustain learning about it.” (p. 9).

The conceptualization of the CIHLC as a community of practice or a network will influence the types of outcomes that would be expected to result. Regardless, the framework offers indicators for assessing the networking and engagement that will be taking place beyond CIHLC members as each CIHLC member reaches out to his or her affiliated networks across Canada, the United States and globally.

### **Network Functioning – Partnership Self-Assessment Tool**

While the Wenger et al. framework will be useful for documenting the impact of the CIHLC as a collaborative, it does not speak to the functioning of the collaborative. As collaboratives, networks, and communities of practices have become more common, frameworks and tools to guide their evaluation have also proliferated. The evaluation of collaboratives or networks can involve an assessment of the functioning of the collaborative and/or the impact of the collaborative (e.g., Wenger et al.). Within the evaluation literature, there are many tools that assess the functioning of partnerships or collaboratives, but most of the tools have not been empirically validated. The one exception is the Partnership Self-Assessment Tool (PSAT). It is a self-administered tool that taps the main dimensions of partnership functioning (leadership, governance, communications, etc.). A copy of the tool is included in Appendix C.

The PSAT can be administered through an annual survey which can be supplemented with additional questions that tap the enactment of collaborative leadership, social accountability, and the impact of the CIHLC (using questions derived from the Wenger et al. framework).

To provide more “real-time” data, consideration should also be given to posing a series of reflective questions at face-to-face meetings that permit the CIHLC to check-up on its functioning, collective vision, achievement of project milestones, and engagements. These questions will be drawn from the Partnership Self-Assessment Tool and developed based on project activities and concerns. A number of reflective questions were included in the Table 1.

Information on the effect of the collaborative should also be collected from other leadership development and health system stakeholders. While the Secretariat can keep track of engagements as part of its project monitoring functions, for certain partnerships, it would be beneficial to collect data on the partner’s perceptions of the engagement and the value-add of the engagement from their perspective. A survey can be used to collect data from partners on a yearly basis (if sufficient numbers and level of engagements have transpired) or during the final year of the project. The survey will incorporate the questions from the Wenger et al. framework in addition to questions tapping the indicators of system change. A sample survey has been included in Appendix D.

### **Participatory and Utilization-Focus**

In keeping with best practices in evaluation and in line with the collaborative and social accountability, the evaluation should be developed and conducted in a participatory manner (Patton, 2008; Trochim, 2006) to provide information of value to project participants and stakeholders (Patton, 2008). NSC and other stakeholders will be involved in all aspects of the evaluation from reviewing and selecting evaluation frameworks and data collection tools to engaging with and animating the findings.

### **Knowledge Mobilization**

As mentioned, the intent of the evaluation work is two-fold: to provide information that can be used to support the development, implementation, evaluation, refinement, uptake, and sustainability of the collaborative leadership program and to demonstrate return on investment. Both of these intentions require knowledge mobilization. In order to support learning, improvement, and ongoing development, information on project functioning needs to be available in a timely manner. The evaluation work will be planned to provide real-time feedback to the NSC and other stakeholders when it is needed. The need to demonstrate return on investment will involve focusing the evaluation work on the value-created by the CIHLC for members, partners, the leadership development community, health systems, and the contribution of this project to the knowledge economy.

### **Summary**

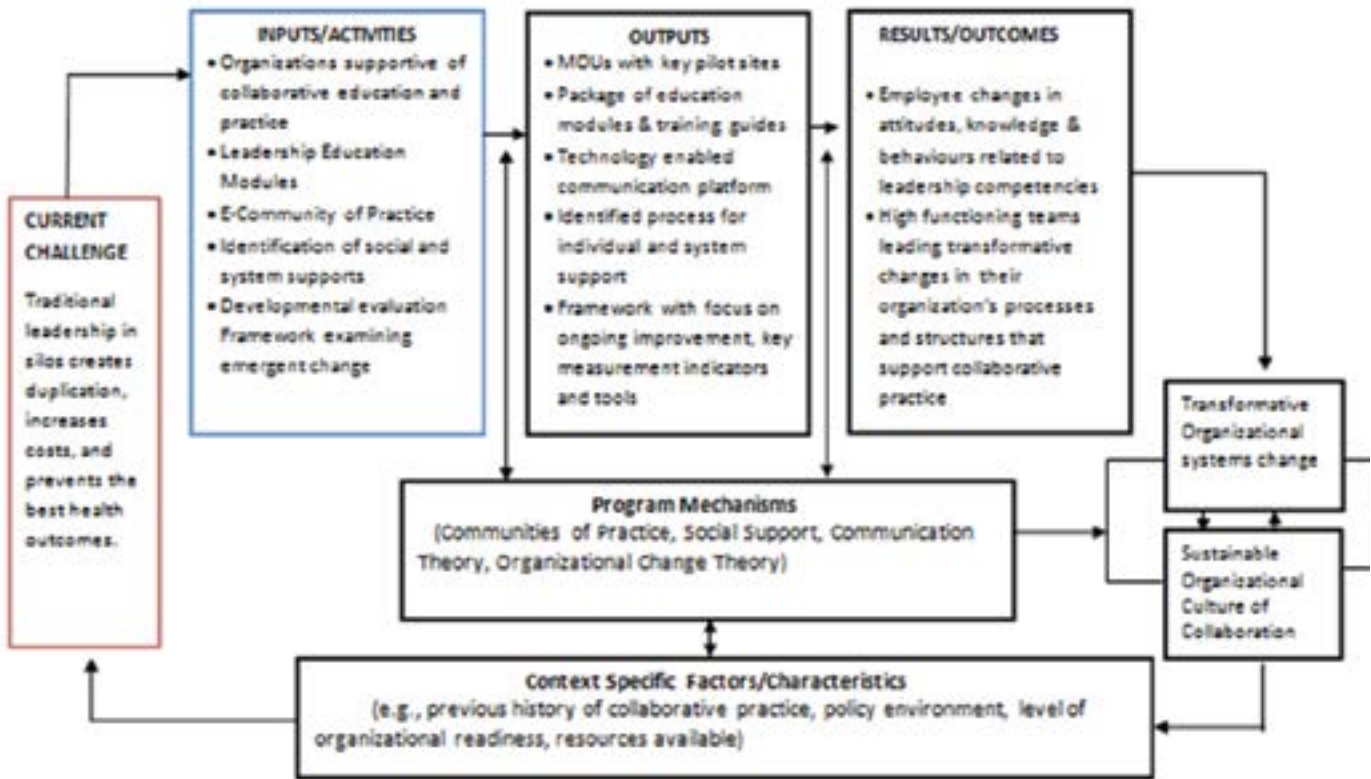
This document has provided an overview of the principles, frameworks, and tools that can be used to shape the evaluation of the CIHLC. This primer has been created so the NSC can make informed decisions about the conduct of the evaluation. Once planning has progressed in determining the target audience(s), the collaborative leadership competencies, the format of the collaborative leadership program, and the scope of the pilot testing, the evaluation framework for the CIHLC can be fully developed.

## References

- Canadian Interprofessional Health Collaborative (2012). Quantitative Tools to Measure Interprofessional Education and Collaborative Practice. Report of the CIHC Research & Evaluation Committee's Quantitative Tools Working Group.
- Finegood, D.T., Johnston, L., Giabbanelli, P.T., Deck, P., Froot, S., Burgos-Liz, L., Steinberg, M. & Best, A. "Complexity and Systems Theory." In Oxford Bibliographies in Public Health. Ed. Lawrence Green. New York: Oxford University Press, forthcoming.
- Gamble, J.A.A. (2008). A Developmental Evaluation Primer. The J.W. McConnell Family Foundation.
- Huz, S., Andersen, D.F., Richardson, G.P. & Boothroyd, R. (1997). A framework for evaluating systems thinking interventions: an experimental approach to mental health system change. *System Dynamics Review*, 13(2), 149-169.
- InSites (2012). System Tools and Concepts. Presentation given at UBC CIHLC Evaluation Consultation Meeting, Vancouver, British Columbia.
- Kirkpatrick, D.L. (1998). Another look at evaluating training programs. Alexandria, VA: American Society for Training & Development.
- Patton, M.Q. (2008). *Utilization-Focused Evaluation* 4th Ed. Thousand Oaks, CA: Sage.
- Patton, M.Q. (2011). *Developmental Evaluation. Applying Complexity Concepts to Support Innovation and Use*. Thousand Oaks, CA: Sage.
- Tourish, D., Pinnington, A., & Braithwaite-Anderson, S. (2007). *Evaluating Leadership Development in Scotland*. Aberdeen Business School, the Robert Gordon University.
- The Training for Health Equity Network (2011). *THEnet's Social Accountability Evaluation Framework Version 1. Monograph I (1 ed.)*. The Training for Health Equity Network.
- Trochim, W. (2006). *Research Methods Knowledge Base*. Retrieved March 9, 2009, from Web Center for Social Research Methods: <http://www.socialresearchmethods.net/kb/intreval.php>
- Watkins, K., Lyso-Ingunn, H. & deMarrais, K (2011). Evaluating executive leadership programs: A theory of change approach. *Advances in Developing Human Resources*, 13 (2), pp. 208-239.
- Wenger, E., Trayner, B. & de Laat, M. (2011). Promoting and assessing value creation in communities and networks: a conceptual framework. Rapport 18. Ruud de Moor Centrum.

## Appendix A: Original Logic Model

Collaborative Leadership for System Change – Systems-based Logic Model



**Appendix B: Table 1- Application of RE-AIM: Evaluation Questions, Indicators, and Data Sources**

Focus	Collaborative	Pilot Test	Sustained
R	1. How many people and organizations were engaged in this project and in what ways?	1. How representative of the target populations were the pilot sites?	1. What % of target populations has participated in the training program?
E			
A	• # of people & organizations per sector (project logs)	• # and description of pilot participants/sites (size of org, sector, location, area of practice) (project logs)	• Penetration
C		2. What strategies were effective in recruiting pilot sites?	○ % of Canadian and international universities, health service organizations & professional associations offering program/enrolling learners
H	2. Are the right groups/partners being engaged in the right ways? Who is missing?	• NSC perceptions (reflective questions and pilot surveys or interviews)	○ % of learners from target populations
	3. Are the engagements and partnerships leading to the desired results?		
	• NSC perceptions (reflective questions and partner surveys)		
E	1. How well is the collaborative functioning?	1. How do learners rate the program and the evaluation tools?	1. What has been the collective impact of the collaborative leadership program?
F	• Ratings on partnership survey	• % of learners reporting relevance, usefulness, and engagement and other indicators of quality TBD (learner survey)	• Collated learning across learners
F			• Collated behaviour across learners
E	2. How has the collaborative affected individual members (increased capacity - KSAB <sup>2</sup> , access to resources, relationships)	2. Do learners improve their knowledge, skills and attitudes towards collaborative leadership & acquire the collaborative leadership competencies?	• Collated results across learners and organizations
T	• % of members indicating increased capacity (partnership survey)	• % of learners reporting increased KSAB (learner survey)	
I		• 360 degree assessments (360 degree feedback)	
V		3. Are learners able to effectively use the evaluation tools?	
E	3. To what extent is collaborative leadership understood, endorsed and practiced within Canada and abroad?	• % of learners reporting ease of use	
N	• KSAB of target population (learner survey and partner survey)	4. Do learners apply their learnings in their workplaces?	
E	4. How has the collaborative affected the leadership training systems regionally, nationally and internationally? (partner survey)	• % of learners reporting applications (learner survey)	
S	• Changes to:	• % of colleagues/supervisors/staff reporting enhanced collaborative leadership	
S	○ Relationships		
	○ Practices		
	○ Programs		

<sup>2</sup> KSAB stands for knowledge, skills, attitudes, and behaviour.

Focus	Collaborative	Pilot Test	Sustained
	<ul style="list-style-type: none"> <li>o Policies</li> <li>o Resources (\$ and in-kind)</li> <li>o Infrastructure</li> </ul> <p>5. What contributions have been made to the knowledge economy?</p> <ul style="list-style-type: none"> <li>• Reach or significance of publications (# downloads, Journal Impact Factor etc.)</li> <li>• Use of publications (contributions to practice, programs, policy) (partner survey)</li> </ul>	<p>competencies (360 feedback)</p> <ul style="list-style-type: none"> <li>• Additional supports required (learner survey)</li> </ul> <p>5. What improvements changes resulted from leader's projects?</p> <ul style="list-style-type: none"> <li>• List of improvements (learner survey)</li> <li>• % of learners reporting improvements (learner survey)</li> </ul>	
A D O P T I O N	<p>1. What work has been undertaken to enable wide-spread adoption?</p> <ul style="list-style-type: none"> <li>• List of activities (project logs)</li> </ul> <p>2. How does the program support adaptation?</p> <ul style="list-style-type: none"> <li>• Description of adaptable elements (project logs)</li> </ul>	<p>1. What attracted organizations/learners to participate in the pilot? (learner and/or pilot org survey)</p> <ul style="list-style-type: none"> <li>• List of reasons for participating (learner survey)</li> </ul> <p>2. How could other learners and organizations be encouraged to participate?</p> <ul style="list-style-type: none"> <li>• List of suggestions from pilot participants (learner survey)</li> </ul>	<p>1. How effective are the different mechanisms for engaging learners and organizations?</p> <ul style="list-style-type: none"> <li>• % of learners engaged through each mechanism (learner survey)</li> <li>• Target audience feedback on attractiveness of program (learner survey)</li> </ul>
I M P L E M E N T A T I O N	<p>1. To what extent and how is collaborative leadership being enacted in this project?</p> <ul style="list-style-type: none"> <li>• NSC perceptions (survey and reflective questions)</li> </ul> <p>2. What were the learnings from the pilot implementation sites? How have they been fed back into the program?</p> <ul style="list-style-type: none"> <li>• List of learnings (learner survey and NSC reflections)</li> </ul> <p>3. To what extent has social accountability been operationalized in this collaborative?</p> <ul style="list-style-type: none"> <li>• NSC perceptions (survey)</li> </ul>	<p>1. What supports were required to support learners?</p> <ul style="list-style-type: none"> <li>• List of facilitators and barriers (learner survey)</li> </ul> <p>2. What projects were undertaken by learners?</p> <ul style="list-style-type: none"> <li>• List of projects (learner survey)</li> </ul> <p>3. What is required to continue to offer the program?</p> <ul style="list-style-type: none"> <li>• Operational requirements (NSC reflective questions)</li> </ul>	<p>1. Do learners find the program and materials engaging and of interest?</p> <p>% of learners providing positive ratings (learner survey)</p>
M A I N T E	<p>1. What supports have been established for leaders to continue to expand collaborative leadership practices?</p> <ul style="list-style-type: none"> <li>• List of on-going support available (project logs)</li> </ul>	<p>1. What do learners require to sustain collaborative leadership practice?</p> <ul style="list-style-type: none"> <li>• List of support needed (learner survey)</li> </ul> <p>2. Have learners been able to sustain their collaborative leadership practices?</p>	<p>1. How do learners engage with on-going support?</p> <ul style="list-style-type: none"> <li>• % of "graduates" participating in on-going support (graduate survey)</li> </ul> <p>2. What additional support is needed to sustain</p>



Focus	Collaborative	Pilot Test	Sustained
<p>N</p> <p>A</p> <p>N</p> <p>C</p> <p>E</p>	<p>2. What supports have been developed to support adoption and adaptation?</p> <ul style="list-style-type: none"> <li>List of operational procedures (project logs)</li> </ul> <p>3. What infrastructure will remain or has been developed to continue to offer the collaborative leadership program?</p> <ul style="list-style-type: none"> <li>Description of sustainability plan (project logs)</li> </ul>	<ul style="list-style-type: none"> <li>% of pilot learners reporting sustained actions (follow-up learner survey)</li> </ul>	<p>collaborative leadership?</p> <ul style="list-style-type: none"> <li>List of support suggested (graduate survey)</li> </ul>

## **Appendix C: Partnership Self-Assessment Tool**

Included as separate attachment.

## Appendix D: Sample Partner Survey Questions

### Partnership Survey

1. Please indicate your involvement with the CIHLC? (categories to be refined based on engagement typology)

- We provide access to population of interest
- We provides access to decision-makers
- We provide subject matter expertise
- We provide additional funding
- We provide in-kind support
- We provide the perspective of a particular stakeholder group
- Other, please explain:

2. The CIHLC has helped to:	A great deal	To some extent	Not at all	Not Certain
a) Increase my interest and awareness about collaborative leadership				
b) Increase my access to information and tools on collaborative leadership				
c) Change my thinking or attitude about collaborative leadership				
d) Increase my understanding or knowledge about collaborative leadership				
e) Enhance my collaborative leadership competencies and skills				
f) Provide opportunities for me to further a professional relationship or develop a new professional relationship (e.g., expanded my network)				
g) Provide opportunities for me to discuss issues surrounding collaborative leadership				
h) Connect me with others for work on collaborative leadership				
i) Increase my awareness of other organizations interested in collaborative leadership				
j) Form new relationships with other organizations or enhance existing relationships				
k) Provide opportunities for me to become involved in collaborative leadership training				
l) Disseminate my work or the work of my organization				
Other, please explain:				

3. Within my organization or within my work, the work of the CIHLC has contributed to:	A great deal	To some extent	Not at all	Not Certain	Not Applicable	
a) Increased interest in collaborative leadership						
b) Changes to an existing program or implementation of a new program to support collaborative leadership						If yes, please describe the change or program.
c) Changes to practices or the implementation of a new practice to better support collaborative leadership						If yes, describe the change in practice or the new practice.
d) Changes to a policy or the development of a new policy to support collaborative leadership						If yes, please describe the change or new policy
e) Increased funding or allocation of other resources for supporting collaborative leadership						If yes, describe what was done.
f) Development of new material or revisions to existing materials to incorporate collaborative leadership						If yes, describe what was created.
g) Changes to curriculum or educational practices to reflect collaborative leadership						If yes, please describe the change.
h)	The work of the CIHLC has contributed to my organization or my work in other ways, please explain.					
i)	Have there been any activities that would not have been undertaken without the work of the CIHLC?  Yes, please describe No Not certain					

4. Would you consider this partnership a success? Please explain.

5. How could this partnership be improved?

6. Demographic questions:

- a. Sector (policy, training, health service)
- b. Location (postal or zip code)
- c. Other questions TBD



## About the CIHLC

The **Canadian Interprofessional Health Leadership Collaborative** (CIHLC) has been chosen by the U.S. Institute of Medicine's (IOM) Board on Global Health as one of four innovation collaboratives around the world tasked to incubate and pilot ideas for reforming health professional education.

The CIHLC, which comprises of the University of Toronto as the lead and the University of British Columbia, Northern Ontario School of Medicine, Queen's University and Université Laval as partners, has a goal to develop, implement, evaluate and disseminate an evidence-based program in collaborative leadership that builds capacity for health systems transformation.

### CIHLC Contact Information

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Dr. Lesley Bainbridge [lesleyb@mail.ubc.ca](mailto:lesleyb@mail.ubc.ca) **University of British Columbia** Dr. Maura MacPhee [maura.macphee@nursing.ubc.ca](mailto:maura.macphee@nursing.ubc.ca)

Please visit our website at <http://cihlc.ca> or email us at [info@cihlc.ca](mailto:info@cihlc.ca)

# Tools in Assessing Health Professional Education:

## Canadian Exemplars

The Canadian Interprofessional Health Leadership Collaborative (CIHLC) has compiled information on four examples of Canadian exemplars of health professional education assessments for the Institute of Medicine's (IOM) Global Forum on Innovation in Health Professional Education workshop, *Assessing Health Professional Education – A Public Workshop of the Global Forum on Innovation in Health Professional Education* (October 9-10 2013, Washington, DC).

The Canadian exemplars of health professional education assessments included in this package are:

- Canadian Interprofessional Health Collaborative (CIHC) competency framework (pg 3)
- Collaborative Practice Assessment Tool (CPAT) (pg 4)
- Interprofessional Collaborative Organizational Map & Preparedness Assessment (IP-COMPASS) (pg 5)
- Interprofessional Collaborator Assessment Rubric (ICAR) (pg 6-7)



The CIHLC is sponsored by:



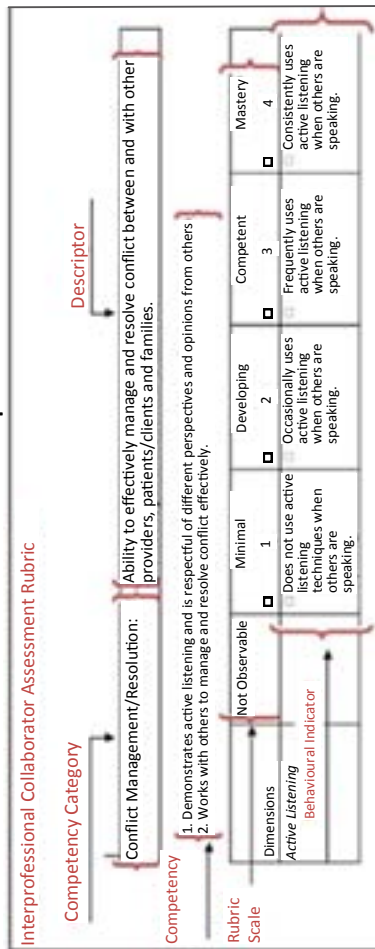


## Acknowledgements

We would like to acknowledge and thank the individuals that provided information for this package on Canadian exemplars of health professional education assessments. Thanks to Dr. Lesley Bainbridge and the evaluation team at the University of British Columbia for the CIHC handout; Drs. Margo Paterson and Rosemary Brander (Queen's University) for the CPAT handout; Dr. Vernon Curran and the research team at Memorial University for the ICAR handout; and Drs. Kathryn Parker (Holland Bloorview Children's Rehabilitation Hospital) and Ivy Oandasan (University of Toronto) for the IP-COMPASS handout.

We would also like to acknowledge that the Canadian exemplars presented in this package are examples only; they do not represent the full breadth of health professional education assessments in Canada. The exemplars in this package have been chosen as examples of competency, team, organizational and learner-based assessments.

## ICAR Sample



## Reliability

Reliability analysis of the original and modified versions of the Rubric demonstrate high levels of internal consistency (original,  $\alpha = .939$ ; modified,  $\alpha = .981$ ) and high levels of inter-rater percent agreement. Raters' profession did not influence overall scores when modified ICAR version used in Multi-Source Feedback (MSF) assessment process (Hayward et al., 2013).

	Internal Consistency Reliability	Inter-Rater Agreement
	Cronbach's Alpha	Percent Agreement
Stage I - Pilot Test (Original Form)	$\alpha = .939$	66.8%, 95% CI [64.5, 69.2]
Stage II - Field Test (Modified Form): Multi-Source Feedback	$\alpha = .981$	91.5%, 95% CI [90.3, 92.7]

## List of Institutions/Organizations using the ICAR

- Dalhousie University
- Toronto General Hospital
- East Carolina University, College of Nursing
- University of Arkansas
- Gundersen Lutheran Health System
- University of British Columbia
- Memorial University of Newfoundland
- University of Miami
- Monash University
- University of Michigan
- Ohio State University
- University of Otago Wellington
- Regis University, School of Physical Therapy
- University of Ottawa
- Spectrum Medical Education
- University of Pittsburgh
- Tehran University of Medical Sciences
- Washington State University
- Texas Tech University Health Sciences Center

## References

- Hayward, M, Curran, VR, Schulz, H, Curtis, B, Murphy, S. (2013). *Reliability of the Interprofessional Collaborator Assessment Rubric (ICAR) in Multi Source Feedback (MSF) with Post-Graduate Medical Residents*. Submitted Manuscript.
- Curran, VR, Hollett, A, Casimiro, L, McCarthy, P, Banfield, V, Hall, P, Lackie, K, Oandasan, I, Simmons, B, Tremblay, M, Wagner, SJ. (2011). *Development and Validation of the Interprofessional Collaborator Assessment Rubric (ICAR)*. J Interprof Care 25:339-344.
- Curran, VR, Casimiro, L, Banfield, V, Hall, P, Lackie, K, Simmons, B, Tremblay, M, Wagner, SJ, Oandasan, I. (2008). *Research for Interprofessional Competency-Based Evaluation (RICE)*. J Interprof Care 23(3):297-300.
- ICAR Website: <http://www.med.mun.ca/CCHPE/Faculty-Resources/Interprofessional-Collaborator-Assessment-Rubric.aspx>

## Interprofessional Collaborator Assessment Rubric (ICAR)

The Interprofessional Collaborator Assessment Rubric (ICAR) is intended for use in the assessment of interprofessional collaborator competencies. Development of the Rubric tool was guided by an interprofessional advisory committee comprising educators from the fields of medicine, nursing, and the rehabilitative sciences.

### Development

#### Stage I – Competency Development

The first stage of development was to identify, develop, and validate a set of interprofessional collaborator competencies that would be relevant to a variety of health and social care interprofessional learning environments. The second stage of development was to construct and evaluate the Rubric across partner sites.

#### Literature Review

A comprehensive analysis of the peer-reviewed and grey literature pertaining to interprofessional collaborator competencies was conducted. Typological analysis was used to compare, contrast, and categorize competency themes, statements, and descriptors related to knowledge, skills, and attitudes that corresponded with successful interprofessional collaboration. Investigators then constructed a final list of competency statements and associated performance criteria/behavioral indicators. These items were translated and cross-referenced by Francophone educators active in the field and were adjusted accordingly to produce a document equivalent in both official languages.

#### Stage II – Rubric Development

#### Delphi Survey

A Delphi survey was utilized to gather opinions of a pan-Canadian interprofessional group of English and French speaking experts in interprofessional education (IPE) and collaborative care. The Delphi survey asked experts to rate the importance and clarity of the competency statements and associated performance criteria/behavioral indicators. A list of categories, competency statements, and a corresponding set of performance/behavioral indicators were organized into English and French language assessment rubrics.

#### Focus Groups

Multi-site focus groups were conducted across research sites (Toronto, Ottawa, St. John's). Student and faculty focus groups were comprised of an interprofessional mix of pre-licensure students or faculty currently instructing in programs of pre-licensure education in their respective profession. Based on feedback concerning the utility, clarity, practicality, and fairness of the Rubric, revisions were made to produce the final, validated version.

## CIHC Competency Framework

The Canadian Interprofessional Health Collaborative (CIHC) commissioned a national competency framework for interprofessional collaboration. The framework was developed by a national working group and the co-authors of the final framework were Dr. Lesley Bainbridge (University of British Columbia) and Dr. Carole Orchard (Western University). The competency framework uses an integrated approach and emphasizes not only knowledge, skills and attitudes but also judgments. It also grounds the concept of interprofessional collaboration in the context of practice, the simple to complex continuum and quality improvement.

Over the 2 years since the framework was released, it has been increasingly used in many contexts not only as a framework for structuring and evaluating interprofessional education, but also as a means of assessing collaborative practice. More specifically, the framework as a self-assessment tool has been used in the practice setting to help determine areas for professional development.

## Who uses it?

The CIHC framework is used increasingly by health education programs across many professions and universities/colleges and by provincial/regional health authorities to frame their interprofessional education strategies for students and practitioners. In both education and practice contexts, the framework is being used in ways that meet the local needs to assess/self-assess competence in collaboration and to help determine the most needed areas for further training.

## Impacts & Outcomes

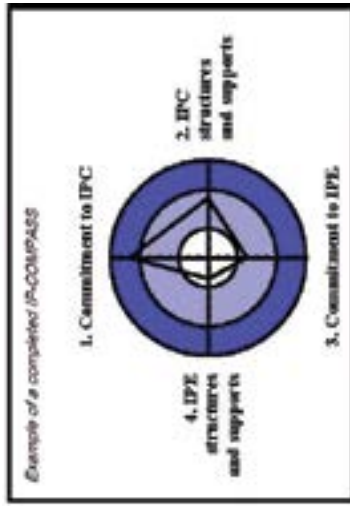
- A common language across the country is helping to bring some consistency to interprofessional education in both education and practice contexts.
- Because people can see themselves in the framework, they are able to determine the areas in which they need to improve and so in the practice setting especially, there has been a greater emphasis on professional development related to collaboration.
- Faculty and professional development programs are using the framework to provide a consistent outline for training programs related to collaboration.
- Repeat application of the framework as an assessment tool is demonstrating positive change in collaboration practices.

For more information, please visit [http://www.cihc.ca/files/CIHC\\_IPCompetencies\\_Feb1210.pdf](http://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf)

## Interprofessional Collaborative Organizational Map & Preparedness Assessment

### What is IP-COMPASS?

IP-COMPASS is a quality improvement framework intended to help clinical settings improve interprofessional collaboration (IPC) and become better prepared to provide intentional interprofessional education (IPE). It provides a structured process to help you understand the types of organizational values, structures, processes, practices and behaviors that, when aligned, can create an environment that is conducive to interprofessionalism.



### Who Can Use IP-COMPASS?

IP-COMPASS is designed to be used in hospital units where there are two or more types of healthcare professionals working together to provide patient care, and that host healthcare students. You can use the IP-COMPASS if you are already providing interprofessional learning experiences to students, or if you would like to do so in the future.

### What Does the Process Involve?

IP-COMPASS is a four step process. It involves:

- Assembling a team of 3-5 interested people;
- As a team, completing a guided self-assessment process;
- Developing and implementing an action plan; and
- Revisiting your action plan to determine next steps.

### Where Can I Get More Information?

Please contact Ivy Oandasan ([i.oandasan@utoronto.ca](mailto:i.oandasan@utoronto.ca)) or Kathryn Parker ([kparker@hollandbloorview.ca](mailto:kparker@hollandbloorview.ca)) for information on access to the IP-COMPASS.

## Collaborative Practice Assessment Tool (CPAT)

The Collaborative Practice Assessment Tool (CPAT) was designed to assess perceptions of constructs of collaborative practice identified in the literature. The survey includes 56 items across 8 domains including: mission, meaningful purpose, goals; general relationships; team leadership; general role responsibilities, autonomy; communication and information exchange; community linkages and coordination of care; decision-making and conflict management; and patient involvement, in addition to three open-ended questions.

The tool is intended for use in a variety of settings involving a diversity of healthcare providers with the aim of helping teams to identify perceived levels of collaboration within the different domains so that professional development needs can be identified, leading to corresponding action plans. The tool is designed to be completed by individual members, however, results are to be aggregated in order to create an understanding of overall team functioning while protecting anonymity. The results of two pilot tests demonstrated that the CPAT is a valid and reliable tool for assessing levels of collaborative practice within teams.

To review the published article see: Schroder, C., Medves, J., Paterson, M., Byrnes, V., Chapman, C., O'Riordan, A., Pichora, D. & Turner, C. (2010) *Development and pilot testing of the Collaborative Practice Assessment Tool*. Journal of Interprofessional Care, 25:189-195.

The CPAT is available upon request from the Office of Interprofessional Education and Practice at: [http://healthsci.queensu.ca/education/oiepep/contact\\_us](http://healthsci.queensu.ca/education/oiepep/contact_us).

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[office.oiepep@queensu.ca](mailto:office.oiepep@queensu.ca) | <http://healthsci.queensu.ca/education/oiepep>





# Community Engagement for Health System Change: Starting from Social Accountability



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This resource was created by the Canadian Interprofessional Health Leadership Collaborative (CIHLC) to support community engagement in the context of an aspirational commitment to social accountability. It was written by Dr. Marion Briggs, Ms. Sue Berry and Dr. David Marsh of the Northern Ontario School of Medicine, and Ms. Marcella Sholdice.

The CIHLC project was funded by the Ontario Ministry of Health and Long Term Care (MOHLTC) and by individual contributions of the partner Universities. The views expressed herein do not necessarily reflect the views of the project funders.

The CIHLC is a consortium of the five partner Canadian universities (University of British Columbia, University of Toronto (UofT), the Northern School of Medicine, Queen's University and Université Laval. For full membership of the CIHLC National Steering Committee, please see our website at: <http://cihlc.ca/about-us/national-steering-committee/>.

# Table of Contents

<b>INTRODUCTION .....</b>	<b>1</b>
WHO SHOULD USE THIS RESOURCE .....	1
HOW TO USE THIS RESOURCE .....	2
<b>COLLABORATIVE LEADERSHIP AND DECISION-MAKING .....</b>	<b>3</b>
<b>SOCIAL ACCOUNTABILITY .....</b>	<b>5</b>
VALUES LINKED TO SOCIAL ACCOUNTABILITY .....	6
FOSTERING A CULTURE OF SOCIAL ACCOUNTABILITY .....	7
<b>COMMUNITY ENGAGEMENT .....</b>	<b>7</b>
WHAT IS A COMMUNITY .....	7
WHAT IS COMMUNITY ENGAGEMENT .....	8
PRINCIPLES OF COMMUNITY ENGAGEMENT IN A SOCIAL ACCOUNTABILITY CONTEXT .....	9
<b>BUILDING CAPACITY .....</b>	<b>11</b>
<b>EMERGENT EVALUATION METHODOLOGIES .....</b>	<b>12</b>
DEVELOPMENTAL EVALUATION .....	14
REALIST EVALUATION .....	16
DEVELOPMENTAL AND REALIST EVALUATION .....	17
<b>CONCLUDING COMMENT .....</b>	<b>18</b>
<b>REFERENCES .....</b>	<b>19</b>
SOCIAL ACCOUNTABILITY .....	19
COMMUNITY ENGAGEMENT .....	20
COLLABORATIVE LEADERSHIP .....	22
CAPACITY BUILDING .....	22
DEVELOPMENTAL EVALUATION .....	22
REALIST EVALUATION .....	23
<b>APPENDIX A: ADDITIONAL DEFINITIONS .....</b>	<b>24</b>
COMMUNITY ENGAGEMENT .....	24
SOCIAL ACCOUNTABILITY .....	25

## Introduction

The Lancet Commission report on Education of Health Professionals for the 21st Century (Frenk et al., 2010) recommends developing leaders as enablers to move seamlessly between health education and practice. To lead collaboratively across boundaries requires new knowledge, skills and vision that extends beyond single profession perspectives (Browning, Torain, & Patterson, 2011; Denis, Lamothe, & Langley, 2001; Dickson et al., 2007; Norman et al., 2011). To prepare for leading through collaborative relationships, The Institute of Medicine (IOM, 2011) and the Josiah Macy Jr. Foundation (Macy, 2011) recommend embedding leadership-related competencies in curricula and enhancing leadership development at practice levels across healthcare settings. The IOM Global forum in 2012 took preliminary steps in this direction by selecting the Canadian Interprofessional Health Leadership Collaborative (CIHLC) as one of four global Innovation Collaboratives.

The CIHLC, a multi-institutional and interprofessional partnership, consists of the University of Toronto (lead organization), the University of British Columbia, the Northern Ontario School of Medicine (NOSM), Queen's University, and Université Laval. The CIHLC sees collaborative leadership as essential to the transformation of health systems and to improved health outcomes for those served. The focus of the CIHLC was on the development, implementation, evaluation and dissemination of a collaborative health leadership education program for senior health care system leaders who are able to effect health system transformation.

The CIHLC focuses on the distinct and integrated concepts of collaborative leadership, and community engagement (CE) practices in the context of a deep commitment to social accountability (SA). This resource specifically supports change initiatives through the development, emergent enactment and continuous evaluation of, and adjustment to, the initiatives. Moreover, this resource is focused on strategies that support an organization's mandate for SA. This resource is now being made available to others to support their transformational change initiatives.

### Who Should Use This Resource

This resource can be used by anyone interested in or becoming involved with a socially-accountable, community-engaged transformative change initiative. Interested persons or groups may include:

- Representatives of a community (however community is defined);
- Patient / client representatives;

- Partnerships between communities and institutional providers of health and social services, including leaders, administrators, managers and clinicians;
- Health care professionals;
- Representatives of educational and academic institutions;
- Health system managers and administrators;
- Networks that bring together communities (however defined), service providers, educators, and/or disciplines;
- Health system funders and policy makers; and
- Politicians.

## How to Use This Resource

There are many available guides and tools (published and web-based) that detail established and emerging principles of, and practices in, conducting and supporting community-engaged transformative change initiatives. Many of these resources are specific to the health care environment. However, very few of these resources emphasize social accountability as the starting point for community-engaged initiatives. The definitions, processes and resources identified in this resource reflect the CIHLC's focus on:

- System change in the health care sector, particularly in the context of meeting the health care delivery and education systems' mandate for social accountability.
- The involvement of an identified priority community, with particular emphasis on the needs of those who are marginalized and disadvantaged.
- The development and support of deep and lasting relationships between the interdependent partners of health service providers, educational institutions and the community.
- The need for a collaborative approach to distributed leadership – that is, leadership that is shared by multiple people who lead together and separately, and where leadership shifts smoothly between people in response to specific needs as they arise.
- Emergent approaches to the evaluation of complex programs in complex environments.

This resource is not intended to describe all of the potentially relevant strategies for the identification, planning, execution and evaluation of projects or sustained and ongoing initiatives. Rather, it is meant to encourage the:

1. Review of the definitions and principles that relate to socially-accountable transformative change initiatives and the related

community engagement strategies/processes. This information provides a basis for understanding and the selective use of the available literature, strategies and tools.

2. Review of the following descriptions of some key characteristics of the concepts of collaborative leadership and decision-making, social accountability, community engagement, and emergent evaluation strategies. References to relevant literature and known frameworks or tools that provide additional support are also provided.

While this resource offers ideas and additional supportive resources that may seem to articulate a traditional, linear approach to planning and managing a transformative change initiative, it is important to realize that the change processes are emergent, cyclical and iterative, not linear. Most change initiatives are neither smooth nor predictable. Variables continue to emerge throughout a change process. Life is insistently lived and changes continue that are sensed and iteratively responded to by the (distributed) leaders and partners/stakeholders. In response, plans adapt and evolve, strategies are continuously shaped, even goals are adjusted as the transformative change initiative both endures and transforms.

## Collaborative Leadership and Decision-Making

In the broadest sense, the term “collaborative leadership” is applied to diverse ways of leading through collaboration and it moves away from an “individual expert” model of leadership to one that seeks multiple perspectives for richer responses to complex questions or needs. This is considered to be a necessity in a world of increasing complexity and rapid change, where no one person or perspective could possibly understand or design the actions required for sustainable change.

*Source: Creede, 2013, p 4*

The CIHLC National Steering Committee (NSC) undertook an environmental scan aimed at establishing the definition and level of evidence related to collaborative leadership for health system change that included:

- A scoping literature review of scientific and gray literature on collaborative leadership for health systems change;
- Key informant interviews with senior Canadian thought leaders in interprofessional education, senior Canadian academics, hospital and government leaders, young leaders and students across the health

professions, and international thought leaders in health and in leadership;

- A review of literature on existing educational programs for the development of collaborative leaders in health care;
- A systematic review of non-peer reviewed literature to identify curricula for leadership development programs to identify existing programs for the development of collaborative leaders.

Based on these four data sources, the CIHLC NSC concluded that the health care system has become too complex for traditional leadership models, where a single individual leading or a single organization can independently make sense of or meet all the needs of its community. The influences that must be taken into account exceed what is possible for the perspectives of a single person, profession, organization or sector to identify and comprehend. These research streams point to collaborative leadership as a necessary development to meet the challenges of today's health system (CIHLC, 2013).

The CIHLC NSC also found that collaborative leadership is a relatively new concept and, as such, not well developed or defined in the literature. However, across the four streams of research, certain common themes were identified that define the unique elements of collaborative leadership, including:

- Transformational leadership that drives system change;
- Co-creation of a shared vision;
- Consideration of diverse perspectives;
- Shared decision-making;
- Working within complex systems;
- Bridging across professions, organizations, sectors;
- Ongoing, adaptive practice;
- Appreciative inquiry;
- Generativity; and
- Social accountability.

*Source: CIHLC, 2013*

Other literature supports the relationship between collective reflection (especially under unfamiliar conditions) and collaborative leadership (e.g., Raelin, 2006). Raelin (2006) highlights four principles of collaborative leadership that call on leaders to be:

- **Concurrent** (i.e., more than one leader at a time; no one has to step down when others are contributing);

- **Collective** (i.e., leading together, working together for a common purpose; anyone can serve as leader);
- **Collaborative** (i.e., shared leadership – consecutive or synergistic; be sensitive to the views and feelings of others and consider others' viewpoints as equally valid; everyone is responsible for the whole and can represent the whole through shared development of purpose, vision, goals and processes); and
- **Compassionate** (i.e., each member is valued regardless of background or social standing, and everyone is concerned with preserving the dignity of each individual).

## Social Accountability

Social accountability (SA) has been defined in a number of ways (**Appendix A**). The World Health Organization (WHO), for example, defined the *Social Accountability of Medical Schools* as:

“The obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public.”

*Source: Boelen & Heck, 1995*

Drawing on these definitions, the following statements can be made about SA:

- Health care, health services and educational institutions have a responsibility to be socially accountable (Boelen & Heck, 1995; THEnet, 2011). The Northern Ontario School of Medicine (NOSM) is the only medical school in Canada that was established with an explicit mandate for social accountability;
- Being socially accountable means directing activities to address the health priorities (or inequities) of their communities. There is a specific focus on those who are marginalized (Boelen & Heck, 1995; Sandhu et al., 2013; THEnet, 2011).

From an academic perspective, being socially accountable means that the research skills that partners/stakeholders possess, will match and focus on the current and emerging needs of the community that the organization or institution serves. This is a slightly different approach to the traditional view of scholarship in university settings that has focused more on academic freedom,



publication and generation of research funds. A socially accountable academic enterprise is focused on partnering and working together with communities to solve the very real and significant needs in the jurisdiction that it serves.

Whatever the perspective, health care system or academia, two important elements of social accountability are:

- A collaborative approach to leadership and decision-making throughout the initiative, including identification, planning, execution and continued focus on the desired states; and
- The need for all parties (community partners/stakeholders) to build their own capacity as part of an initiative – that is, there is mutual benefit.

### Values Linked to Social Accountability

The Training for Health Equity Network (THEnet, 2011) is globally recognized for its' operational model and evidence-informed social accountability evaluation framework for health professionals education. Six values underpin THEnet's framework and are linked to the basic principles of social accountability:

- **Equity:** The state in which opportunities for health gains are available to everyone. Health is a social product and a human right, and health equity (that is, the absence of systemic inequality across population groups) and social determinants of health should be considered in all aspects of education, research and service activities. This incorporates the principles of **social justice**, or redressing inequitable distribution of resources, and **access to education**;
- **Quality:** The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. These health services must be delivered in a way which optimally satisfies both professional standards and community expectations;
- **Relevance:** The degree to which **the most important and locally relevant problems** are tackled first. This incorporates the values of responsiveness to community needs. In addition, it incorporates the principle of cultural sensitivity and competency. **Cultural competency** is not seen as specific knowledge, attitudes and practices acquired, but rather a process of **removing barriers to effective and open communication** in the service of the patient;
- **Partnerships:** Partnership with **all key stakeholders** in developing, implementing and evaluating efforts is at the core of THEnet schools' activities. It incorporates the values of **mutual transformation**, equipping students and faculty to be agents of change and open to be changed through their partnerships; and **inter-professionalism**, or a belief that all health professionals must respect each other's knowledge

and culture and understand the role that each team member plays on the health care team;

- **Efficiency:** This involves producing the **greatest impact on health with available resources** targeted to address priority health needs and incorporates the principle of cost-effectiveness;
- **Identifying and Validating Community Health Needs** with the community (or communities).

*Source: THEnet, 2011, p 10*

## Fostering a Culture of Social Accountability

Social accountability is not achieved through an initiative/project or one-off effort. As described above, it is achieved through a change in the overall focus of an organization towards the needs of the underserved. Sandhu et al. (2013) at Queen's University developed the AIDER model (Assess, Inquire, Deliver, Educate, Respond) to help physicians and medical institutions foster an organization that is socially accountable. The AIDER model provides a framework for identifying and engaging stakeholders/partners of underserved communities.

## Community Engagement

### What is a Community

The definition below highlights that a member of a community:

- Can be a member by choice or by virtue of an innate characteristic;
- Has at least one common characteristic with other members;
- Can be a member of more than one community.

“In the context of engagement, “community” has been understood in two ways. It is sometimes used to refer to those who are affected by the health issues being addressed. This use recognizes that the community as defined in this way has historically been left out of health improvement efforts even though it is supposed to be the beneficiary of those efforts. On the other hand, “community” can be used in a more general way, illustrated by referring to stakeholders such as academics, public health professionals, and policy makers as communities. This use has the advantage of recognizing that every group has its own particular culture and norms and that anyone can take the lead in engagement efforts.

...

... A person may be a member of a community by choice, as with voluntary associations, or by virtue of their innate personal characteristics, such as age, gender, race, or ethnicity (IOM, 1995). As a result, individuals may belong to multiple communities at any one time. When initiating community engagement efforts, one must be aware of these complex associations in deciding which individuals to work with in the targeted community.

From a sociological perspective, the notion of community refers to a group of people united by at least one common characteristic. Such characteristics could include geography, shared interests, values, experiences, or traditions.”

*Source: CDC, 2011, p xvi*

## What is Community Engagement

Community Engagement: A fundamentally relational, mutually beneficial practice based on shared values and aspirations and actualized in a range of engagement activities explicitly geared to local community (re)development and social justice outcomes. Members of a specific community and interdependent partners work together as “friends” to identify and develop new ways to resolve issues affecting the well-being and life experience of the members of that community.

*Source: Adapted from Sutherland et al, 2004*

The CIHLC identified the process of CE as a key strategy in the implementation of initiatives to fulfill the health system’s commitment to SA and transformative change. As noted in many of the resources available, CE is often considered to span “a continuum ranging from a low level to a high level of public participation, depending on the goal to be achieved” (EPIC, 2009) and includes a wide range of initiatives from providing only information to the public to fully collaborating on community-empowering efforts.

## Principles of Community Engagement in a Social Accountability Context

The CIHLC describes socially accountable community engagement as having:

- **Mutual benefit.** CE results in changes or outcomes that are mutually beneficial. All parties (the researcher, the health care organization and the community members) stand to benefit from the initiative (Jones & Wells, 2007; Carnegie, 2015 Classification) (see Figure 1);
- **Shared power.** Community participants (partners and non-partners with mutual interests) must be equals with researchers and health care providers (Rifkin, 1986). Just as the benefits are shared, so is the power (e.g., decision-making) within the relationship;
- **Collaboration and non-hierarchical partnerships.** The partnerships in CE do not necessarily progress linearly. Roles within the partnerships (e.g., leadership) may fluctuate depending on the situational circumstances, and roles may be shared by more than one person;
- **Interdependent relationships.** The researcher or health care providers cannot achieve the desired outcomes without the participation of the community; nor can the community achieve the desired outcome without the assistance of the researcher or health care providers. This interdependence is acknowledged by all participating parties;
- **Contextual or situational awareness.** The situations and context for a CE initiative can range from relatively simple (e.g., to improve diabetes care in a neighborhood) to extremely complex (e.g., new approaches to primary care in a broad area), involving few or many stakeholders. The approach to CE must reflect this context.

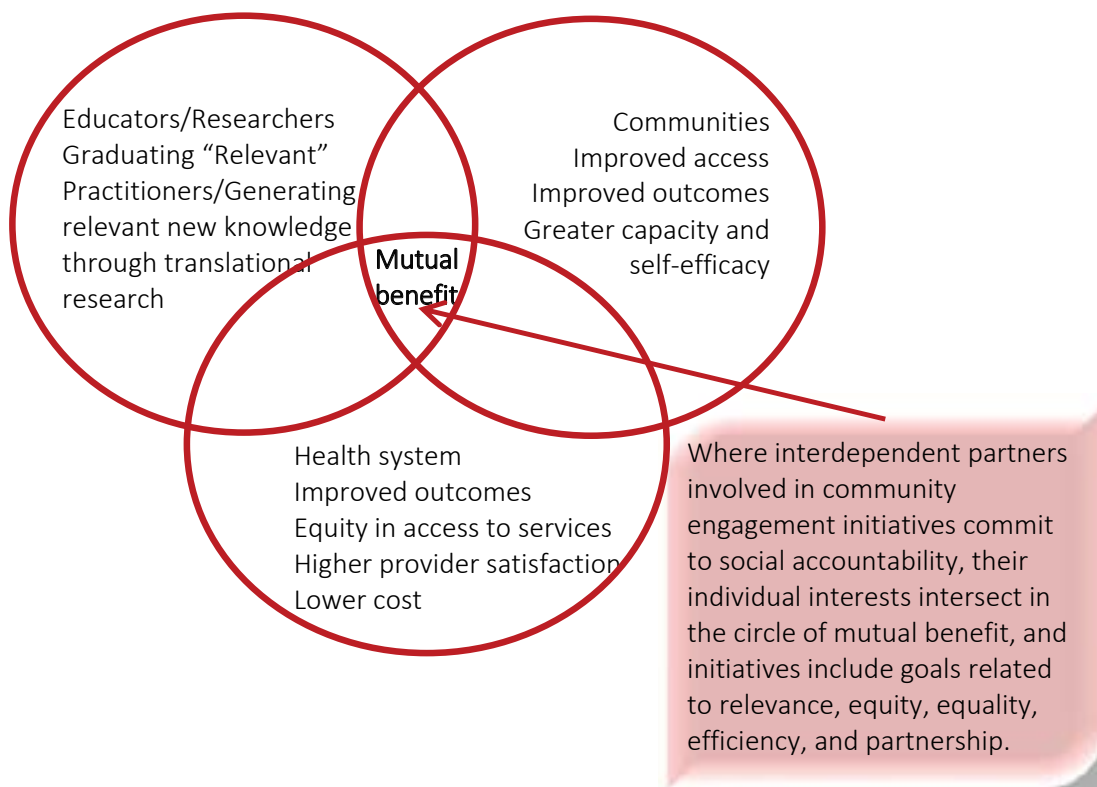
Stated another way, CE in a social accountability context is:

- About inclusivity, multiple perspectives, and multi-directional engagement in building relationships and social networking;
- A way of thinking, not a one-off project/initiative (Jordan, 2007). CE can be defined by inclusion and diversity, listening and learning, transparency and trust, impact and action, sustained participation and democratic culture. It is not a one-size-fits-all approach;
- Not for the *purpose* of generating social capital, even though social capital may be generated.

For successful CE in this context, the investment in partnerships works toward a shared vision where partners (defined as community and its members):

- Recognize, respect, and value the knowledge and perspectives that each brings;
- Understand and acknowledge the interdependence of, and benefit to, all partners;
- Commit to building the capability and capacity of individuals, organizations, and communities; and
- Aim to mobilize resources (e.g., human, physical, technical, and financial) and serve as a catalyst for changing policies, programs, and practices around issues of public concern.

*Figure 1: Convergence of Mutual Benefit in a Relational Community Engagement Initiative*



## Building Capacity

An important element of SA and CE is the concept of mutual benefit, and one important benefit for all parties is building capacity. Building capacity is described as “a process that improves the ability of a person, group, organization or system to meet its objectives or to perform better” (LaFond et al., 2002, p 5). Resources, knowledge, and skills above and beyond those that have already been brought to a particular problem are required before individuals and organizations can gain control and influence and become collaborative leaders, active participants and partners in community health decision-making and action (Fawcett et al., 1995). Participation in CE efforts offers people the possibility of acquiring and developing the resources and skills needed to build capacity. The development of effective partnerships brings together multiple perspectives to address community health and capacity building. To function successfully, partnerships depend on the careful orchestration of a collaborative culture and the facilitation of collective action (Kendall et al., 2012).

Involving a community in a CE initiative often results in new knowledge, new ways of working together, and new ways of learning together as an investment for better and healthier communities. New knowledge can be created through scientific research (e.g., that defines well-regarded practices that can inform change strategies) and socially constructed new knowledge (e.g., knowledge generated in the context of ongoing relationships and reflection on current practices, while making sense of our experiences). In a socially accountable initiative, there is an effective inclusion of both socially constructed knowledge and traditional scientific or clinical knowledge. Practice-based evidence is valued equally with evidence-based practice (Gabbay & LeMay, 2011).

Accordingly, a successful CE initiative brings all levels of skill, prior knowledge and experience, resources, and intellectual capital into the community to:

- Build everyone’s capacity, not just the capacity of one party or the other;
- Enrich and strengthen scholarship, research, and creative activity;
- Enhance curriculum, teaching, and learning; and
- Strengthen democratic values including civic responsibility.

## Emergent Evaluation Methodologies

Evaluation is not a task that is completed at the end of any initiative. Ideally, evaluation methodology is determined as part of the initial planning process of any initiative/project, and forms an integral part of the planning and execution processes. The evaluation process can inform the design and will undoubtedly, with an appropriate evaluation methodology, lead to changes throughout the implementation process.

Innovative initiatives are often constantly changing as they are developed and adapted in what might be a changing and unpredictable environment (Gamble, 2008). Because of the potentially very complex nature and contextual sensitivities of CE initiatives, the measurement of the effects of SA interventions is particularly challenging. Often, traditional formative and summative evaluation approaches are not appropriate for CE initiatives.

Two emerging methodologies that are identified as having potential for CE initiatives include Developmental Evaluation (DE) (Patton, 2004), and Realist Evaluation (RE) (Pawson et al., 2004). These two approaches:

- Consider the influence of contextual factors in the evaluation;
- Acknowledge that the path and destination are evolving and are flexible enough to work within this uncertainty;
- Seek to discover the implications of the evolving context for emergent design change processes;
- Are designed in a way that can surface needed policy reform.

With emergent evaluation methodologies, evaluation is not left to the end of an initiative i.e., focus on pre-determined goals or outcomes. Rather, emergent evaluation methodologies are part of the initiative design and process throughout and “support innovation development to guide adaptations to emergent and dynamic realities in complex environments” (Patton, 2004, p 1).

No literature was identified comparing these two approaches. The table on page 13 shows a brief comparison of traditional, developmental and realist evaluation based on the available literature describing these approaches.

## Comparison of Evaluation Approaches

Characteristic	Evaluation Approach		
	Traditional	Developmental	Realist
<b>Purpose</b>	Validate a model or hypothesis; accountability	Help develop and adapt the project (rather than validating the approach)	Answer “what works for whom in what circumstances and in what respects, and how?” Emphasis on understanding the interdependencies of content-mechanism-outcome (CMO)
<b>Situation</b>	Stable, goal oriented, predictable	Complex, dynamic, changing	Complex, dynamic, changing, start up
<b>Mind set</b>	Effectiveness, impact, compliance	Innovations in early stages, emergent situations, learning	Exploring unexplained outcomes and/or impacts on subpopulations
<b>Measurement</b>	Based on predetermined indicators	Based on emergent indicators	Examines the relationship between context, mechanisms and outcomes as an explanatory model
<b>Evaluation methods</b>	Emphasis on randomized controlled trials	Emphasis on how outcomes change	Emphasis on how outcomes change, for whom, under what circumstances, and in what respects
<b>Evaluator</b>	Typically outside the team	Is integrated into the team	Can be part of or outside the team
<b>Target of the change</b>	Depends on project	System	Individuals, individual mechanisms

*Source: Adapted from Patton, 2011 and expanded to include realist evaluation.*



## Developmental Evaluation

Development evaluation (DE), pioneered by Michael Quinn Patton, is defined as:

... evaluation processes and activities that support program, project, product, personnel and/or organizational development (usually the latter). The evaluator is part of a team whose members collaborate to conceptualize, design, and test new approaches in a long-term, on-going process of continuous improvement, adaptation, and intentional change. The evaluator's primary function in the team is to elucidate team discussions with evaluative data and logic, and to facilitate data-based decision-making in the developmental process.

*Source: Patton, 1994, p 317*

This emergent evaluation methodology is uniquely suited to articulating, implementing, and continuing to evaluate adaptations that emerge in response to ongoing changes in the environment. General principles that have been effective in one circumstance are adapted to suit the needs of another similar but, nevertheless, unique context, thus responding rapidly to sudden or unexpected change in the conditions of an initiative.

The DE approach has the following defining characteristics:

- **Adaptation and change.** The methodology recognizes that programs are changing, and these changing conditions create a complex environment in which linear evaluation methodologies are a poor fit. The purpose of development evaluation is more about assisting the partnerships to develop and adapt the project approach, not just validating the approach (Fagen, 2011). The emphasis is on adaptive learning rather than accounting to an external authority (Dozois, 2010);
- **Innovation and learning.** Ongoing, continuous improvement is a key focus of developmental evaluation (Fagen, 2011; Dozois, 2010). Development is about creative thinking (Gamble, 2008);
- **Context is considered.** In traditional evaluation methodologies, context can be treated as noise to be controlled or ignored. Development evaluation explicitly considers these contextual variables (Fagen, 2011);
- **Integrated evaluator role.** The evaluator, rather than being an outsider, is a "critical friend" who engages ongoing evaluation discussions with the project team (Fagen, 2011; Dozois, 2010; Gamble, 2008);
- **Flexibility.** New measures and monitoring mechanisms are developed as the understanding of the situation deepens (Dozois, 2010). Both the

path (how a CE initiative is unfolding) and the destination (what the partners want to achieve) are evolving (Gamble, 2008).

The J.W. McConnell Family Foundation, in collaboration with Patton and other partners, has been instrumental in creating and using DE to identify, test and share new approaches to addressing entrenched social challenges facing Canadians. Their work has generated the following key learnings:

- “‘Scaling’ innovations is not about growing programs or organizations, but about increasing their impact in ways that are appropriate to different contexts;
- Even successful projects can rarely be ‘duplicated’; what is required is a deep knowledge of what works - and why - so that the essence can be preserved while allowing for flexibility and adaptation to different circumstances;
- The notion of ‘best practices’ or templates for success stifles innovation. ‘Next practice’ better describes an approach based on continuous observation and adaptation;
- Conventional evaluation methods, which test outcomes against set objectives, can stifle innovation, which requires risk, experimentation, freedom to fail and the chance to learn from failure and the unexpected;
- The Foundation participated in the creation of Developmental Evaluation: balancing creative and critical thinking in guiding and assessing innovation;
- While the term ‘social innovation’ has spread quickly, along with notions of complex adaptive systems and related concepts, it is not clear that its use is leading to or associated with transformational change;
- The Foundation has learned that collaboration across sectors requires concerted effort to overcome differing organizational norms and values. It requires a commitment to social learning that includes the ability to adapt one’s own viewpoints and practices.”

*Source: J.W. McConnell Foundation website, 2014*

DE is particularly useful for the following types of initiatives:

- Innovations in early stages (Fagen, 2011; Patton, 2011), emergent situations (Dozois, 2010) early stage social innovations (Gamble, 2008);
- Changing or particularly complex environments (Fagen, 2011; Dozois, 2010; Gamble, 2008);
- Organizational learning is emphasized (Fagen, 2011; Dozois, 2010), often in real time (Dozois, 2010);

- Systems (not individuals) are the target of the change (Fagen, 2011) with multiple stakeholders (Patton, 2008). The project is socially complex (Dozois, 2010).

## Realist Evaluation

Realist synthesis is an approach to reviewing research evidence on complex social interventions, which provides an explanatory analysis of how and why they work (or don't work) in particular contexts or settings.

*Source: Pawson et al., 2004, p iv*

It seeks not to judge but to explain, and is driven by the question 'What works, for whom, in what circumstances, and in what respects?'

*Source: Pawson & Tilley, 2004, p 36*

While the realist emergent evaluation methodology is similar in many ways to DE, it has a unique emphasis on discovering the mechanism by which aspects of an initiative are successful, for whom and in what circumstances. Like the DE methodology, RE is initiated at the beginning of the planning process and concurrently informs ongoing adaptations. Realist evaluation is built on how the methodology views the nature of programs. Specifically, RE regards programs as sophisticated social interventions introduced into a complex social reality (Pawson et al., 2004). A socially complex program (or intervention) has the following characteristics in RE:

- **Programs are theories.** Programs are initiated when someone develops an idea (i.e., a theory) of how to create change in existing patterns (e.g., inequalities of social conditions, unhealthy lifestyles). The effectiveness of any given program depends on the efficacy of the underlying theories (Pawson & Tilley, 2004);
- **Programs are embedded.** Programs are delivered within social systems by the actions of people, and changes in behaviours, events, or social conditions are affected through the system of social relationships (Pawson & Tilley, 2004);
- **Programs are active.** The effects of any introduced program are generally dependent on the active engagement of individuals within the system. Accordingly, an understanding of the program participants is essential to the evaluation process (Pawson & Tilley, 2004);

- **Programs are open systems.** Programs are subject to unanticipated events and changes that will affect the program outcomes. Realist evaluation assumes that the interventions (e.g., programs) can change the initial conditions within the system (Pawson & Tilley, 2004). Programs can be changed during implementation as more is learned about the mechanisms and outcomes (Pawson et al., 2004).

The RE approach has the following defining characteristics:

- **Explanatory quest.** The realist evaluation asks not “What works?” but rather “What works for whom in what circumstances and in what respects, and how?” (Pawson & Tilley, 2004). It is an iterative process of building explanations for observed outcomes (Wong et al., 2012);
- **Tentative and fallible findings.** Findings tend to address individual mechanisms rather than whole programs (Pawson et al., 2004);
- **Importance of stakeholders.** Program development and delivery depend very much on the stakeholders (Pawson et al., 2004).

Wong et al. (2004) suggest the following situations where RE methodology might be best used in an academic situation e.g., medical education research:

- Randomized control trials have provided inconsistent results;
- There is a desire to target a particular subgroup with a broadly accepted intervention;
- Existing research provides rich qualitative data, but no data that lends itself well to statistical analysis;
- New interventions are being trialed to determine the impact on subpopulations;
- Changes are introduced that may alter the pattern of context, mechanism and outcomes; and
- Unexplained changes in outcomes are observed.

## Developmental and Realist Evaluation

Both developmental and realist evaluation methods are emerging approaches to the evaluation of complex interventions/programs in complex situations. These two approaches have much more than this in common, for example, both:

- Consider the influence of contextual factors in the evaluation;
- Acknowledge that the path and destination are evolving and are flexible enough to work within this uncertainty; and
- Seek to discover the implications of the evolving context for emergent design change processes.

## Concluding Comment

We end here, not because the subject has been covered exhaustively or to imply socially accountable community engagement begins with identifying needs, builds the collaborative mechanisms, finds and implements a solution, and evaluates the results. We end here because evaluation is where we need to start. We encourage the reader to incorporate evaluation in a developmental way – in a way that allows the early and ongoing evaluation of your engagement to inform, adjust, adapt, and initiate the journey forward. We end here, because the beginning, the middle and the end remain wrapped together in mutually beneficial, iterative, and collaborative processes that are sustained over time and make a difference – but of course not always the difference you set out to make or to expect.

Socially accountable, community-engaged initiatives are most important when the issues they are addressing are complex, relevant and meaningful to the interdependent partners engaged in seeking a better way forward. There will be near-misses and efforts that completely miss the mark, alongside achievements that no one would have dreamed possible. Learn from both and continue to seek to support communities where human dignity and compassion thrive and where all citizens enjoy the freedoms and privileges, the possible life that is too often denied to so many. It will take time – together we can make a difference.

## References

Full references for published articles and web addresses for web-based materials (where available) are provided below. The web addresses were valid as of March 31, 2014.

### Social Accountability

- Boelen, C. & Heck, J. (1995). Defining and measuring the social accountability of medical schools. Geneva: World Health Organization. Retrieved from [http://whqlibdoc.who.int/hq/1995/WHO\\_HRH\\_95.7.pdf](http://whqlibdoc.who.int/hq/1995/WHO_HRH_95.7.pdf)
- Boelen, C. & Woollard, R. (2011). Social accountability: The extra leap to excellence for educational institutions. *Medical Teacher*. 33. 614-619.
- Boelen, C. & Woollard, R. (2009). Social accountability and accreditation: A new frontier for educational institutions. *Medical Education*. 43. 887-894
- Bushe, G.R. (2011). Appreciative inquiry: Theory and critique. In Boje, D., Burnes, B. and Hassard, J. (eds). *The Routledge Companion to Organizational Change* (pp. 970-103). Oxford, UK: Routledge.)
- Lodenstein, E., Dieleman, M., Gerretsen, B., & Broerse, J. (2013). A realist synthesis of the effect of social accountability interventions on health service providers' and policymakers' responsiveness. *Systematic Reviews*. 2(98). Retrieved from <http://www.systematicreviewsjournal.com/content/2/1/98>
- Public Works and Government Services Canada (2001). *Social Accountability: A Vision for Canadian Medical Schools* (ISBN 0-662-66388-8). Ottawa: Health Canada. Retrieved from [http://www.afmc.ca/pdf/pdf\\_sa\\_vision\\_canadian\\_medical\\_schools\\_en.pdf](http://www.afmc.ca/pdf/pdf_sa_vision_canadian_medical_schools_en.pdf)
- Sandhu, G., Garcha, I., Sleeth, J., Yeates, K., & Walker, G.R. (2013). AIDER: A model for social accountability in medical education and practice. *Medical Teacher Web Paper*, 35, e1403–e1408. Retrieved from <http://informahealthcare.com/doi/abs/10.3109/0142159X.2013.770134>
- The Training for Health Equity Network. (2011). *THEnet's Social Accountability Evaluation Framework Version 1. Monograph I* (1<sup>st</sup> ed.). Belgium: The Training for Health Equity Network. Retrieved from <http://thenetcommunity.org/wp-content/uploads/2013/05/The-Monograph.pdf>
- World Bank. (2010). Social accountability in Africa: An introduction. In *Demanding good governance: Lessons from social accountability initiatives in Africa*. Washington, DC: McNeil, M. & Malena, C. (Eds.).
- The World Bank Group. (2013). *Mapping Context for Social Accountability, a resource paper*. Washington DC: O'Meally, S.C. Retrieved from [http://siteresources.worldbank.org/EXTSOCIALDEVELOPMENT/Resources/244362-1193949504055/Context\\_and\\_SAcc\\_RESOURCE\\_PAPER.pdf](http://siteresources.worldbank.org/EXTSOCIALDEVELOPMENT/Resources/244362-1193949504055/Context_and_SAcc_RESOURCE_PAPER.pdf)
- World Health Organization. (1995). *Defining and measuring the social accountability of medical schools*. Geneva: Boelen C, Heck, J.E. Retrieved from [http://whqlibdoc.who.int/hq/1995/WHO\\_HRH\\_95.7.pdf](http://whqlibdoc.who.int/hq/1995/WHO_HRH_95.7.pdf)

## Community Engagement

- The Carnegie Foundation for the Advancement of Teaching. (n.d.). *Classification Description: Community Engagement Elective Classification*. Retrieved from [http://classifications.carnegiefoundation.org/descriptions/community\\_engagement.php](http://classifications.carnegiefoundation.org/descriptions/community_engagement.php)
- Capital Health. (n.d.). *Involving patients and citizens in decision making: A guide to effective engagement*. Retrieved from <http://www.cdha.nshealth.ca/involving-patients-citizens>
- Centers for Disease Control/Agency for Toxic Substances and Disease Registry. (2011). *Principles of Community Engagement, Second Edition*. NA: No Author. Retrieved from [http://www.atsdr.cdc.gov/communityengagement/pdf/PCE\\_Report\\_508\\_FINAL.pdf](http://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf)
- Centers for Disease Control and Prevention. (1997). *Principles of Community Engagement* (1st ed). Atlanta: CDC/ATSDR Committee on Community Engagement. Retrieved from <http://www.cdc.gov/phppo/pce/>
- Cooperrider, D.L., & Srivastava, S. (1987). Appreciative inquiry in organizational life. In Woodman, R.W. & Passmore, W.A. (eds). *Research in organizational change and development Vol.1*(129-169). Champaign, IL: Stipes.
- EPIC. Engaging People. Improving Care. (2009). *Introduction to CE*. Retrieved from [http://www.epicontario.ca/Introduction\\_to\\_CE.aspx](http://www.epicontario.ca/Introduction_to_CE.aspx).
- Fawcett, S.B., Paine-Andrews, A., Francisco, V.T., Schultz, J.A., Richter, K.P., Lewis, R.K.,...Lopez, C.M. (1995). Using empowerment theory in collaborative partnership for community health and development. *American Journal of Community Psychology*, 23(5), 677-697. Retrieved from <http://link.springer.com/article/10.1007/BF02506987#page-1>
- Fawcett, S.B., Paine-Andrews, A., Francisco, V.T., & Vliet, M. (1993). Promoting health through community development. In D.S. Glenwick & L.A. Jason (Ed.). *Promoting health and mental health in children, youth and families*. New York: Springer Publishing Company.
- Fraser Health Authority (2009). *Community Engagement Framework*
- Gabbay, J., & Le May, A. (2011). *Practice-based evidence for healthcare: Clinical mindlines*. New York:Routledge.
- Government of Ontario. (2006). *Module 5: Community Engagement and Communication: The Health Planner's Toolkit*. Ontario: Government of Ontario. Retrieved from [http://www.health.gov.on.ca/transformation/providers/information/resources/health\\_planner/module\\_5.pdf](http://www.health.gov.on.ca/transformation/providers/information/resources/health_planner/module_5.pdf)
- Graeme S. (2011, March 21). *Sustaining Community Engagement*. [What is community engagement?] Retrieved from <http://sustainingcommunity.wordpress.com/2011/03/21/what-is-community-engagement/>
- Head, B.W. (2007) *Community Engagement: Participation on Whose Terms?* *Australian Journal of Political Science*, 42(3), 441-454. Retrieved from <http://www.tandfonline.com/doi/abs/10.1080/10361140701513570#.UzRXjfldXXo>
- The Health Planners Toolkit Module 5 Community Engagement and Communication: Government of Ontario/ Retrieved 4/20/2014 from

[http://www.health.gov.on.ca/transformation/providers/information/resources/health\\_planner/module\\_5.pdf](http://www.health.gov.on.ca/transformation/providers/information/resources/health_planner/module_5.pdf)

- Institute of Medicine & National Academy of Sciences. (1995). Assessing the social and behavioral science base for HIV/AIDS prevention and intervention: workshop summary and background papers. Washington DC: National Academy Press. Retrieved from [http://www.nap.edu/openbook.php?record\\_id=9207](http://www.nap.edu/openbook.php?record_id=9207)
- International Association for Public Participation. (2007). *IAP2 Spectrum of Public Participation*. Retrieved from [http://c.yimcdn.com/sites/www.iap2.org/resource/resmgr/imported/IAP2%20Spectrum\\_vertical.pdf](http://c.yimcdn.com/sites/www.iap2.org/resource/resmgr/imported/IAP2%20Spectrum_vertical.pdf)
- Jones, L., & Wells, K. (2007). Strategies for academic clinician engagement in community-participatory partnered research. *Journal of American Medical Association*, 297(4), 407-410.
- Jordan, C. (Ed.) (2007). *Community-Engaged Scholarship Review, Promotion & Tenure Package*. Peer Review Workgroup, Community-Engaged Scholarship for Health Collaborative, Community-Campus Partnerships for Health. Retrieved from [http://depts.washington.edu/ccph/pdf\\_files/CES\\_RPT\\_Package.pdf](http://depts.washington.edu/ccph/pdf_files/CES_RPT_Package.pdf) .
- Joshi, A., & Houtzager, P.(2012). Widgets or Watchdogs? Conceptual Explorations in Social Accountability. *Public Management Review, Special Issue: The Politics and Governance of Public Services in Developing Countries*, 14(2), 145–162. Retrieved from [http://www.tandfonline.com/doi/abs/10.1080/14719037.2012.657837#.UzRYK\\_IcXXQ](http://www.tandfonline.com/doi/abs/10.1080/14719037.2012.657837#.UzRYK_IcXXQ) .
- Local Health Integration Networks. (2011). *LHIN Community Engagement Guidelines and Tool Kit*. Ontario: Local Health Integration Networks. Retrieved from [http://www.torontocentrallhin.on.ca/uploadedFiles/Home\\_Page/Get\\_Involved/LHIN%20Community%20Engagement%20Guidelines%20and%20Toolkit%20-%20February%202011%20-%20FINAL\(1\).pdf](http://www.torontocentrallhin.on.ca/uploadedFiles/Home_Page/Get_Involved/LHIN%20Community%20Engagement%20Guidelines%20and%20Toolkit%20-%20February%202011%20-%20FINAL(1).pdf)
- Oxford Health Alliance Program. (n.d.). *Use of Community Coalitions to Drive Community Change*. Retrieved from [http://www.oxha.org/cih\\_manual/index.php/community-engagement-evidence](http://www.oxha.org/cih_manual/index.php/community-engagement-evidence)
- Queensland Department of Emergency Services. (2001). Department of Sustainability and Environment. [What is Community Engagement?]. Retrieved from <http://www.dse.vic.gov.au/effective-engagement/introduction-to-engagement/what-is-community-engagement#1> .
- Rifkin, S.B. (1986) Health planning and community participation. *World Health Forum*. 7(2): 156-62
- Sunderland, N., Muirhead, B., Parsons, R. and Holton, D. 2004. Foundation Paper. *The Australian Consortium on Higher Education, Community Engagement and Social Responsibility*. Downloaded 09 07 2014. [http://espace.library.uq.edu.au/eserv/UQ:10362/foundation\\_paper.pdf](http://espace.library.uq.edu.au/eserv/UQ:10362/foundation_paper.pdf)
- Taylor, J., Cheers, B., Wilkinson, D. (2008). *Working with Communities in Health and Human Services*. Oxford: Oxford University Press.
- Wallerstein, N., & Duran, B. (2010). Community-Based Participatory Research Contributions to Intervention Research: The Intersection of Science and Practice to



Improve Health Equity. *American Journal of Public Health*, 100(Suppl 1), S40–S46. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2837458/>.

## Collaborative Leadership

Canadian Interprofessional Health Leadership Collaborative. (2013). Environmental Scan Summary Report.

CDC/ATSDR Committee on Community Engagement; Centers for Disease Control and Prevention (U.S.); Public Health Practice Program Office. Principles of Community Engagement. Atlanta, Ga: Centers for Disease Control and Prevention, Public Health Practice Program Office; 1997.

Creede, C. (2013). Literature Review What informs the Topic of Collaborative Leadership for Healthcare System Change? (Revised)

Raelin, J. (2006). Does Action Learning Promote Collaborative Leadership? *The Academy of Management Learning and Education ARCHIVE*, 5(2), 152-168. Retrieved from <http://www.northeastern.edu/poe/Raelin%20AMLE.pdf>.

## Capacity Building

Fawcett, S., Paine-Andrews, A., Francisco, V., Schultz, J., Richter, K., Lewis, R. (1995). Using empowerment theory in collaborative partnerships for community health and development. *American Journal of Community Psychology*, 23(5), 677-697. Retrieved from <http://link.springer.com/article/10.1007%2FBF02506987#page-1>.

Kendall, E., Muenchberger, H., Sunderland, N., Harris, M., Cowan, D. (2012). Collaborative Capacity Building in Complex Community-Based Health Partnerships: A Model for Translating Knowledge Into Action. *Journal of Public Health Management Practice*, 18(5), E1–E13. Retrieved from [http://journals.lww.com/jphmp/Abstract/2012/09000/Collaborative\\_Capacity\\_Building\\_in\\_Complex.15.aspx](http://journals.lww.com/jphmp/Abstract/2012/09000/Collaborative_Capacity_Building_in_Complex.15.aspx).

LaFond, A., Brown, L., MacIntyre, K. (2002). Mapping capacity in the health sector: a conceptual framework. *International Journal of Health Planning Management*, 17(1),3-22. Retrieved from <http://onlinelibrary.wiley.com/doi/10.1002/hpm.649/abstract;jsessionid=41FDC2519FF94216D3AB1BE66D2D0793.f04t03?deniedAccessCustomisedMessage=&userIsAuthenticated=false>

Measure Evaluation. 2014. Retrieved from <http://www.cpc.unc.edu/measure>

## Developmental Evaluation

Fagen, M.C., Redman, S.D., Stacks, J., Barrett, V., Thullen, B., Altenor, S., Neiger, G.L. (2011). Developmental Evaluation: Building Innovations in Complex Environments. *Health Promotion Practice* 12(5), 645-650. Retrieved from <http://indigo.uic.edu/handle/10027/8489>

The J.W. McConnell Family Foundation. (2008). *A Developmental Evaluation Primer*. Montreal: Gamble, J.A.A. Retrieved from <http://www.mcconnellfoundation.ca/en/resources/publication/a-developmental-evaluation-primer>

- The J.W. McConnell Family Foundation & The International Institute for Child Rights and Development. (2010). *DE 201: A Practitioner's Guide to Developmental Evaluation*. Montreal: Dozois, E., Langlois, M., Blanchet-Cohen, N. Retrieved from [http://vibrantcanada.ca/files/development\\_evaluation\\_201\\_en.pdf](http://vibrantcanada.ca/files/development_evaluation_201_en.pdf)
- Patton, M.Q. (1994). Developmental evaluation. *American Journal of Evaluation*, 15(3), 311-319. Retrieved from <http://aje.sagepub.com/content/15/3/311.refs.html>
- Patton, M.Q. (2011). *Developmental evaluation: Applying complexity concepts to enhance innovation and use*. New York: The Guilford Press.
- Stepney, P., & Rostila, I. (2011). Towards an integrated model of practice evaluation balancing accountability, critical knowledge and developmental perspectives. *Health Sociology Review* 20(2), 133–146. Retrieved from <http://pubs.e-contentmanagement.com/doi/abs/10.5172/hesr.2011.20.2.133?journalCode=hesr>

## Realist Evaluation

- Lodenstein, E., Dieleman, M., Gerretsen, B., & Broerse, J. (2013). A realist synthesis of the effect of social accountability interventions on health service providers' and policymakers' responsiveness. *Systematic Reviews*. 2(98). Retrieved from <http://www.systematicreviewsjournal.com/content/2/1/98>
- Pawson, R., Greenhalgh, T., Harvey, G., Walshe, K. (2004). Realist synthesis: an introduction. ESRC Research Methods Programme. Retrieved from <http://www.ccsr.ac.uk/methods/publications/documents/RMPmethods2.pdf>
- Pawson, R., & Tilley, N. (2004). *Realist Evaluation*. British Cabinet Office. Retrieved from [http://www.communitymatters.com.au/RE\\_chapter.pdf](http://www.communitymatters.com.au/RE_chapter.pdf)
- Wong, G., Greenhalgh, T., Westhorp, G., Pawson, R. (2012). Realist methods in medical education research: what are they and what can they contribute? *Medical Education*, 46(1), 89-96. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/22150200>

## Appendix A: Additional Definitions

### Community Engagement

**Definition 1:** “the process of working collaboratively with groups of people who are affiliated by geographic proximity, special interests, or similar situations with respect to issues affecting their well-being” (CDC/ATSDR, 1997).

**Definition 2:** The CDC/ATSDR Committee for Community Engagement developed a working definition of community engagement. Loosely defined, community engagement is the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices (Fawcett et al., 1995).

**Definition 3:** ‘Community engagement’ is therefore a planned process with the specific purpose of working with identified groups of people, whether they are connected by geographic location, special interest, or affiliation or identify to address issues affecting their well-being (Queensland, 2001).

**Definition 4:** Community participation or engagement may be defined as the process of ‘working collaboratively with relevant partners who share common goals and interests’ or ‘working collaboratively with and for groups of people affiliated by geographical proximity, special interest, or similar situations to address issues affecting the well-being of those people’. Community engagement requires the development of partnerships with local stakeholders, involving them in assessing local health problems, determining the value of research, planning, conducting and overseeing research, and integrating research into the health care system” (Jones and Wells, 2007).

**Definition 5:** A planned process with the specific purpose of working with identified groups of people, whether they are connected by geographic location, special interest or affiliation, to address issues affecting their well-being. Linking the term ‘community’ to ‘engagement’ serves to broaden the scope, shifting the focus from the individual to the collective, with associated implications for inclusiveness, to ensure consideration is given to the diversity that exists within any community (State of Victoria, 2005).

**Definition 6:** Community engagement is “collaboration between institutions of higher education and their larger communities (local, regional, national, global) for the mutually beneficial exchange of knowledge and resources in a context of partnership and reciprocity” (Carnegie Foundation, 2015 Classification).

**Definition 7:** Community-engaged scholarship integrates engagement with the community into research and teaching activities (broadly defined). Engagement is a feature of these scholarly activities, not a separate activity. Service implies offering one’s expertise and effort to the institution, the discipline or the community, but it lacks the core qualities of scholarship (Jordan, 2007).

**Definition 8:** “a revitalised emphasis on building institutional bridges between governmental leaders and citizenry, often termed ‘community engagement’ ” (Head, 2007).

**Definition 9:** “community engagement is a multi-level concept, ranging from engagement in policy development, through partnerships with agencies and consumers to plan and deliver local services, to individual engagement with programs” (Kilpatrick, 2009).

## Social Accountability

**Definition 1:** “Social accountability for medical schools is the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region and/or nation they have a mandate to serve” (Boelen & Heck, 1995).

**Definition 2:** An institutional responsibility to orient teaching, research and service activities to addressing priority health needs with a particular focus on the medically underserved (THEnet, 2011).

**Definition 3:** Social accountability (also called citizen-driven accountability or bottom-up accountability) refers to the strategies, processes or interventions whereby citizens voice their views on the quality of services or the performance of service providers or policy makers who, in turn, are asked to respond to citizens and account for their actions and decisions (Lodenstein et al., 2013).

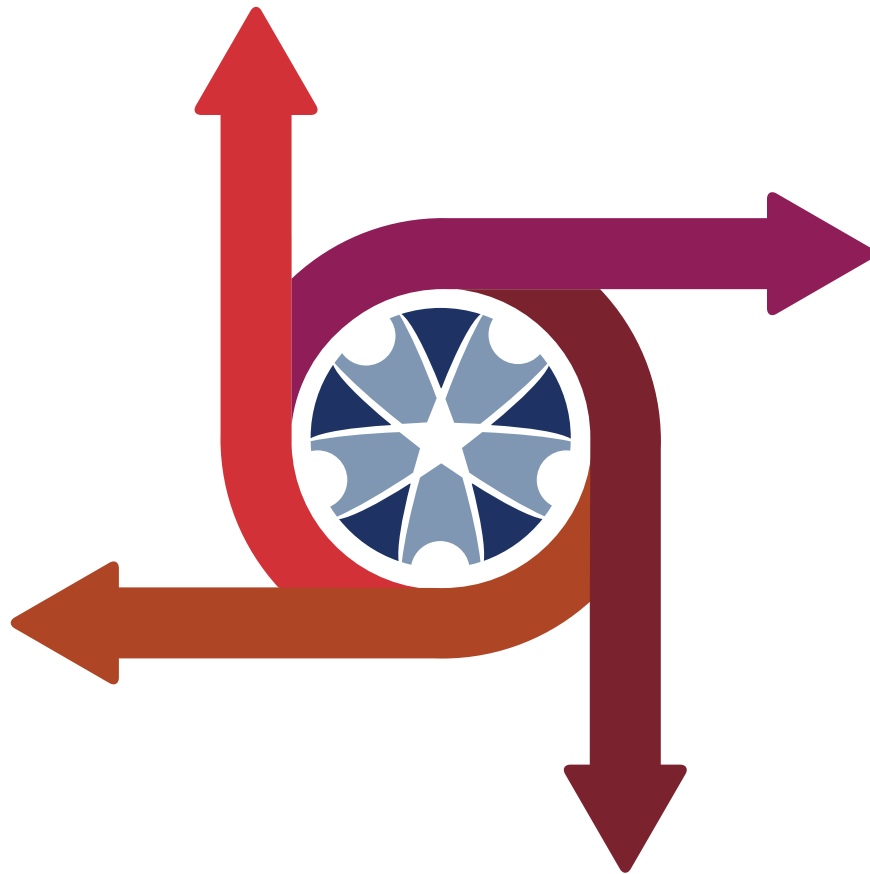
**Definition 4:** WHO has defined the Social Accountability of Medical Schools as “the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public” (Public Works and Government Services Canada, 2001).

**Definition 5:** Social Accountability is a contested concept, with no universally agreed definition of the range of actions that fall within its remit (see Joshi and Houtzager 2012). It is not this paper’s purpose to enter into this debate but instead to take a relatively broad view. Social accountability can be understood as an approach for improving public accountability that relies on the actions of citizens and non-state actors. One definition is:

“... the broad range of actions and mechanisms beyond voting that citizens can use to hold the state to account, as well as actions on the part of government, civil society, media and other societal actors that promote or facilitate these efforts.” (*Malena and McNeil 2010: 1*) (From O’Meally, 2013).

# Collaborative Change Leadership

A Certificate Program for Healthcare  
and Health Education Leaders



Five In-Class Sessions  
April 2014 – January 2015



Canadian  
Interprofessional Health  
Leadership Collaborative



Consortium Canadien  
sur le leadership en matière  
d'interprofessionnalisme en santé

## The CCL Program

The Collaborative Change Leadership (CCL) Program is an accredited, certificate program offered by the University Health Network (UHN) in collaboration with the University of Toronto (UofT) Centre for Interprofessional Education (IPE).

For the 2014/15 program, UHN is partnering with the Canadian Interprofessional Health Leadership Collaborative (CIHLC) in a unique opportunity to offer and evaluate an advanced program **aimed at senior and high potential leaders in healthcare and health education.**

The CIHLC is a pan-Canadian collaborative between the University of Toronto, the University of British Columbia, the Northern Ontario School of Medicine, Queen's University and Université Laval.

**The goal of the advanced CCL program is to develop people to lead health system transformation and enable socially accountable change in their community.**

Grounded in leadership, change and social accountability theories, processes and practices, this Program is designed for leaders who are driven to engage communities in a meaningful way and to create and sustain system changes that enhance the health of underserved populations.

Participants will co-create a Capstone Project with a community that has been identified as a priority population, which includes frail elderly, aboriginal peoples, mental health, non-communicable diseases/ chronic illness, youth and women, and lower-socioeconomic status. The focus is on, but is not limited to, interprofessional care and education, quality and safety, and patient/family/community-centered care.

## Prerequisites

**The candidate must meet the following prerequisites:**

- Five or more years of experience in a leadership role
- Support of their organization to participate in the Program
- An identified Capstone Project that engages the community

## Program Outcomes

**By the end of the program, we expect that participants will:**

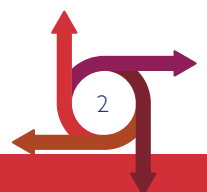
1. Model and exemplify collaborative change leadership in all facets of their professional work.
2. Advocate for socially accountable solutions to health inequities.
3. Be familiar with different theoretical change approaches, and be able to apply change theory in their own contexts.
4. Use appreciative inquiry principles to create a portrait of organizational strengths and change need, and where the capstone initiative naturally aligns to enable success.
5. Design and implement an emergent change strategy by stewarding a community-engaged capstone project.
6. Integrate and align complementary initiatives within their system.
7. Foster senior leadership and collaborative community engagement within and across systems.
8. Lead meaning-making processes to generate sustainable change.
9. Design and implement an evaluation strategy informed by developmental evaluation.
10. Reflect on, assess movement and adapt direction throughout change implementation.
11. Translate knowledge to improve health and health systems.

***“This program went well beyond any expectations I had. Having recently completed a Master’s program and comparing this program with some of those — I have been surprised that this program is hands down better than many of those programs.”***

*— Program Participant*

***“Teaching Collaborative Change Leadership is invaluable in transforming the health care system.”***

*— Program Participant*



## Program Structure

The CCL Program targets senior and high potential leaders across practice and education, who will register in teams. The program requires a minimum of two team members from each organization and/or community that represent different professions.

Structured to be context specific, the curriculum is adapted to the individuals, teams, organizations and communities participating. Participants will work on a Capstone Project during and between sessions in which they will develop, design, implement and evaluate a change initiative in their community or organization based on the principles of social accountability and community engagement. Participants from the same organization should either be working on the same initiative or be prepared to integrate, align or link different initiatives as part of working systemically.

This Program covers a ten-month period with five two-day face-to-face sessions and blends these intensive sessions with coaching from faculty within and between sessions. Additional coaching and learning will be promoted via an online platform and community of practice. Throughout and between these sessions, many instructional approaches are utilized including experiential learning, online learning, reflection, theory bursts, small and large group activities and peer learning.

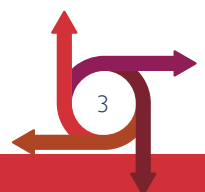
The commitment between sessions includes reading specified books and articles for the following session, participating in the online community of practice discussions, and applying learnings from the sessions to the Capstone Project.

Participants will also be involved in evaluating the Program, both within and between sessions and after the conclusion of the Program.

## Program Overview

Session	Dates & Times	Session Focus
Session 1 Discovering What Is	April 11-12, 2014 9:00-17:30	Exploring collaborative change leadership theories and practices; developing understanding of social accountability and community engagement in the context of setting up the capstone project and organizational inquiry; initiating community of practice.
Session 2 Imagining the Possibilities	May 30-31, 2014 9:00-17:30	Interpreting organizational inquiry results, deepening knowledge of emergent change and meaning making; begin designing change strategies and evaluation.
Session 3 Designing & Implementing	September 19-20, 2014 9:00-17:30	Navigating the tension between implementing a change plan and sensing system needs and adapting accordingly; leading meaning-making processes.
Session 4 Sensing, Evaluating and Adapting	December 5-6, 2014 9:00-17:30	Assessing movement, reflection and adapting strategies based on what is emerging as meaningful in the organization or community.
Session 5 Accomplishments, Reflection and Adaptation	January 30-31, 2015 9:00-17:30	Presenting and celebrating work and coaching each other; assessing movement, reflecting on and adapting strategies based on what is emerging as meaningful in the organization, community and system.
Capstone Project	Session 1 - Session 5	Developing, implementing and evaluating a capstone project that addresses the health/social needs of a specific community or vulnerable population.

***“For those who have an interest in learning how to stimulate change within their healthcare organizations, and who want to use a different approach to identifying and planning future initiatives that will make a difference in their organizations, this program provides all the necessary ingredients.” – Program Participant***



## Application Process

### Step 1: Program Abstract Submission

- Applicants must submit an abstract via email to [info@cihlc.ca](mailto:info@cihlc.ca) with the following:
- Names, email contacts and roles of colleagues from his/her organization and community expecting to attend the program (**a minimum of 2 participants per organization required**).
- A current curriculum vitae (CV) (experience & education).
- Candidate's motivation letter: a brief description of his/her leadership journey to date and how the advanced Collaborative Change Leadership program will help to enhance his/her leadership development.
- A one-page project outline that describes the: underlying rationale and scope for change in the proposed capstone project, the target population and/or community, and the organizational sponsor and partners that are willing to support this project.
- A letter of support from an organizational and/or community sponsor indicating support for the capstone project and the time needed to participate in and complete the Program.
- Application Deadline: Wednesday, January 15, 2014

### Step 2: Acceptance

- Applicants will be notified of acceptance into the program as the applications are reviewed, and no later than February 1, 2014.
- Written notification of acceptance will be issued along with registration information.

### Registration Fee: \$5,000 per participant\*

\*For every two registrants from a single organization, the third registration will be discounted by 50%. Registration includes: continental breakfasts, refreshment breaks and lunches and educational materials.

## For More Information

Jelena Kundacina, Program Coordinator: [info@cihlc.ca](mailto:info@cihlc.ca) or 416-603-5800 ext. 3854. Website: <http://cihlc.ca>

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## **Collaborative Change Leadership Project 2014-2015 - Capstone Initiative**

### **Descriptions**

<b>CIHLC Sponsored Teams</b>
To create a new and powerful partnership in which physicians, administrators/staff, and patients/caregivers experience shared accountability for the success and health of the communities that they serve to inquire into and create the relational shifts needed to transform the existing system.
To reduce pressures on the health care system through a fully implemented mature “shared”, inter-professional, collaborative care model in mental health for the rural and northern population of the Rural Kingston Health Link. The capstone involves systematically and consistently connecting primary care providers to specialty care.
To engage Aboriginal communities in discussions about senior’s health and wellness strategies.
To enhance the accessibility of collaborative leadership education for French-speaking health leaders to steward the translation and adaptation of a Francophone CCL program that would be culturally relevant (transcultural validation). The aim of the capstone initiative is to assess the relevance and adaptability of the CCL program for French-speaking health leaders.
<b>Other Teams</b>
To redesign the delivery of acute medical and psychiatric care in the Emergency Department for patients with mental health and addiction issues.
To develop an Ontario community of practice as a strategy to elevate the quality and quantity of simulation-based education and training in the field of pediatrics.
To develop a Trauma Centre of Excellence for the underserved and highly needy children, youth and families who have been exposed to complex developmental trauma; working very closely with community partners and several psychiatrists.
To ensure complimentary and synergistic work between portfolios, linking goals and objectives as appropriate to provide maximal impact and value across the organization.
To develop a project that supports success of students, staff, and patients within the practice learning environments (student-friendly practice environments).
To implement and evaluate an IP program of care for patients with head and neck cancers who have swallowing difficulties (dysphagia). The dysphagia program is delivered in an international health setting, which has previously not provided service to this population.
To develop a model that will provide culturally sensitive support to all international learners visiting, in addition to working collaboratively with clinical staff to develop customized learning curricula.

# Evaluation of the Integrated Collaborative Change Leadership Program 2014-15

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SUBMITTED TO THE CANADIAN INTERPROFESSIONAL HEALTH  
LEADERSHIP COLLABORATIVE AND THE UNIVERSITY HEALTH  
NETWORK - MAY 18, 2015

Marla Steinberg, PhD, Alison Govier, BA, Carina Bleuer, MPA, & Kate  
Powadiuk, MSW  
CONTRACTORS FOR THE UNIVERSITY OF BRITISH COLUMBIA

# Acknowledgements

This evaluation of the Integrated Collaborative Change Leadership (CCL) Program 2014-2015 was sponsored and informed by the Canadian Interprofessional Health Leadership Collaborative (CIHLC) evaluation team from the University of British Columbia – UBC (Lesley Bainbridge - Lead, Chris Lovato, Maura MacPhee), and Marla Steinberg who is an adjunct faculty member, consultant and program evaluation expert. Co-leadership and support were provided by the University Health Network – UHN evaluation team (Maria Tassone - lead, Kathryn Parker and Jill Shaver).

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We gratefully acknowledge everyone who participated in the evaluation by providing information and data, including the participants in the CCL Program, sponsors of capstone teams, engaged community members in the capstone teams, and CCL faculty.

The CIHLC project was funded by the Ontario Ministry of Health and Long Term Care and by individual contributions of the partner Universities. The views expressed herein do not necessarily reflect the views of the project funders.

# Executive Summary

## About CCL

This report presents the results of the evaluation of the Integrated Collaborative Change Leadership Program for the 2014-15 cohort. The Integrated Collaborative Change Leadership (CCL) Program is an accredited, certificate program offered by the University Health Network (UHN) in collaboration with the University of Toronto (U of T) Centre for Interprofessional Education (IPE). For the 2014-15 program, UHN partnered with the Canadian Interprofessional Health Leadership Collaborative (CIHLC) to offer and evaluate an integrated program grounded in social accountability (SA) and community engagement (CE). The CIHLC is a pan-Canadian collaborative involving the U of T, the University of British Columbia (UBC), the Northern Ontario School of Medicine (NOSM), Queen's University, and Université Laval. CCL attracted 31 participants (comprising 11 teams) from organizations across Canada. Most of the participants were managers or directors of health service organizations or academic institutions.

The purpose of the program is to develop people to lead health system transformation and enable socially accountable change in their community. The program is based around a set of core concepts that are activated and transmitted through a variety of pedagogical strategies. One of the course requirements is for teams to design, implement, and evaluate a capstone initiative within their organizations or communities. The program includes five in-person sessions, four intercessions, and faculty coaching during and between in-person sessions. The 2014-15 cohort lasted 10 months and took place between April 2014 and January 2015.

## About the Evaluation

The evaluation was designed to answer five questions:

1. What was valuable about the program?
2. What changes need to occur in the program to ensure its relevance/usefulness and support sustainability?
3. To what extent did the program achieve its program learning outcomes?
4. What else has changed/happened as a result of participating in the program? and
5. What value was created through the enhancements of social accountability and community engagement?

A developmental evaluation approach was used during the program to obtain information to adapt the program as it was being delivered. This report presents the information that was collected to address the five evaluation questions and demonstrate the value and impact of the program. A variety of data collection methods were used (surveys, interviews, focus groups, and document review), collecting both qualitative and quantitative data from multiple respondent groups (learners, capstone initiative teams, organizational sponsors, CCL faculty, and engaged community members).

Descriptive statistics were used to analyze the quantitative data. This involved the calculation of means and frequencies. Content analysis using MAXQDA (a qualitative software program) was used to analyze the qualitative data. Both planned and emergent coding was used by the four person analysis team.

### What was valuable about the program?

The program was rated as very high quality by the learners. Learners appreciated the overall design and content of the course and remarked favourably about most of the pedagogical elements. Of particular note, learners found the following elements to be valuable: experiential activities conducted during the in-person sessions, the concept and practices of social accountability and community engagement, the readings, the learning community, coaching by CCL faculty, the CCL faculty, the personal practical theory of CCL, Appreciative Inquiry, Alumni/Guest faculty, time spent with the team to work on capstone initiatives, and attending the program as a team.

### What changes need to occur in the program to ensure its relevance/usefulness and support sustainability?

While learners rated the program as very high quality, they were able to offer suggestions for how the program could be adapted. The most common suggestions participants mentioned were increasing experiential learning activities, limiting the time dedicated to reflection in large groups, shortening the length of the in-person sessions, providing the slides electronically before sessions, reducing the number and length of readings, and maintaining contact with program participants after the program ended. In response to feedback from participants, the CCL faculty routinely adjusted the program to better meet learner's needs. The faculty also identified additional areas where adaptations could be made, including adjustments to the readings and a requirement for a mandatory check-in with coaches.

### To what extent did the program achieve its program learning outcomes?

The learners rated the program as very successful in achieving its learning outcomes. Prior to the program, the majority of learners considered themselves to be within the "novice" to "intermediate" range of expertise on the core concepts. By the end of the program, the majority of learners rated themselves within the "expert" range. In addition, across all core concepts, learners self-reported an average increase of 84% in understanding. Limited data from engaged community members and sponsors also attest to the acquisition of the skills associated with the core concepts.

### What else has changed/happened as a result of participating in the program?

Learners reported experiencing a variety of positive transformations in the way they approach their work and relate to colleagues. They described themselves as more confident, authentic, and positive. They also reported being more focused on drawing on the collective intelligence of their teams through generative questioning and Appreciative Inquiry. This transformation helped learners and teams leverage their strengths when leading change initiatives as well as in their day-to-day work-related activities and within their personal lives. Some learners observed an increased interest in CCL from colleagues and managers. There appears to be some evidence that CCL concepts are spreading within learner organizations as learners apply the concepts to other projects. Through the use of the core concepts, changes were reported to internal organizational processes and to client services.

## What value was created through the enhancements of social accountability and community engagement?

It is clear that community engagement and social accountability were concepts that resonated with participants. There is ample evidence that all teams embraced the ideas of engaging with communities to co-create their initiatives. CCL faculty were also confident that learners successfully enacted the elements of community engagement. A few sponsors also noted the extensive and “unique” engagements undertaken by the learners. There was some uncertainty, however, as to the extent that the capstone initiatives were truly reflective of social accountability, as originally conceptualized and operationalized within medical education.

### Limitations

The main limitation of this evaluation is its heavy reliance on learner self-reports. While efforts were made to engage community members and organizational sponsors in the evaluation, the response rates from these groups were low. Nonetheless, the limited data that was available does begin to confirm that some learners were doing “something different” as they were taking on the concepts and practices of collaborative change leadership. The evaluation, because of its short-term nature, is also not able to speak to the sustainability of these changes for the learners or the impact of the program and the capstone initiatives on organizations and health systems.

### Suggestions for Further Evaluation

In order to further demonstrate the value of this program, it is recommended that longer-term follow up be conducted with the current cohort of learners and past cohorts.

### Conclusions

The evaluation of the program has shown that learners perceive the CCL program to be very high quality with many valuable concepts and pedagogical strategies. The data also show that learners report the program was highly successful in meeting its program or learning outcomes. Learners report a variety of impacts including being transformed, learning a common language, acquiring new knowledge and ways of being, increased confidence, and feeling energized.

Given that the majority of teams were in the Design or Destiny phases of their capstone initiatives, it is not surprising that fewer results were reported for communities, organizations, and systems. Most impacts beyond the learners centre on the spread of the concepts to other projects and increased interest within organizations and communities.

This program does appear to have set the learners on the right path for achieving transformative changes in health systems, as they report the skills, abilities, and motivations to carry on with their work, and the spread of these practices within and across organizations. The presentations given by program alumni during the in-person sessions revealed that some teams were able to achieve significant improvements within their health care systems (e.g., one team spoke to achieving a significant decrease in waiting times). Further evaluation will help to explore the extent to which the personal or individual level changes experienced by this cohort of learners will lead to further transformations in their health care systems and the extent to which past cohorts have been able to transform their systems.

## Table of Contents

<b>The Integrated Collaborative Change Leadership Program</b> .....	1
Program Metaphors: CCL Faculty .....	2
<b>Overview of the Evaluation</b> .....	3
Focus of the Evaluation.....	3
Evaluation Questions .....	4
Methodology.....	4
Analysis .....	5
<b>What was valuable about the program?</b> .....	5
Quality of the Program .....	5
Design and Pedagogical Elements .....	6
Capstone Initiatives.....	8
Blackboard .....	9
<b>What changes need to occur in the program to ensure its relevance/usefulness and support sustainability?</b> .....	11
<b>To what extent did the program achieve its program learning outcomes?</b> .....	13
<b>What else has changed/happened as a result of participating in the program?</b> .....	19
Impact on Learners .....	19
Increased knowledge .....	19
Common language .....	19
Changes to personal leadership practices .....	20
Impact on capstone teams.....	22
Impact on organizations .....	23
Increased interest and uptake/spread of CCL approaches.....	23
Changes to organizational processes.....	24
Using Appreciative Inquiry in Human Resources (HR) and strategic planning .....	24
Changes to governance structures .....	24
Emergent meeting agendas .....	24
Listening conferences .....	24
Changes to services.....	24
Dysphagia program of care .....	25
Shared care model in mental health.....	25
Emergency services for patients with mental health and addiction issues.....	25

<b>What value was created through the enhancements of social accountability and community engagement?</b> .....	26
<b>Limitations of the evaluation</b> .....	28
Limited ability to triangulate findings .....	28
Reduced response rates across data collection periods.....	28
Limited ability to speak to changes in health systems and sustainability .....	28
<b>Conclusions</b> .....	28
Recommendations for further evaluation .....	29
References .....	30
Appendix A: Overview of CCL Participants.....	31
Appendix B: Data Collection Methods and Sample Sizes .....	32
Appendix C: Valuable Elements of Program .....	33
Appendix D: Table of Selected Valued Elements and Illustrative Quotes .....	34
Appendix E: Overview of Capstone Initiatives .....	38
Appendix F: Suggestions for Adaptations .....	45
Appendix G: Session Objectives .....	56
Appendix H: Changes to Leadership Practices.....	57



## The Integrated Collaborative Change Leadership Program

The Integrated Collaborative Change Leadership (CCL) Program is an accredited, certificate program offered by the University Health Network (UHN) in collaboration with the University of Toronto (U of T) Centre for Interprofessional Education (IPE). For the 2014-15 program, UHN partnered with the Canadian Interprofessional Health Leadership Collaborative (CIHLC) to offer and evaluate an integrated program grounded in social accountability and community engagement. The CIHLC is a pan-Canadian collaborative involving the U of T, the University of British Columbia (UBC), the Northern Ontario School of Medicine (NOSM), Queen's University, and Université Laval.

The 2014-15 cohort of the program attracted 31 participants (comprising 11 teams) from organizations across Canada. Most of the participants were managers or directors of health service organizations or academic institutions. The largest team had five participants and one person attended the program on their own. A list of team members, sponsoring organizations, and locations can be found in Appendix A. Over the course of the program, four people withdrew and three participants joined existing teams after the first in-person session.

The purpose of the program is to develop people to lead health system transformation and enable socially accountable change in their community. The program is based around a set of core concepts (see Figure 1: CCL Core Concepts) that are activated and transmitted through a variety of pedagogical strategies including:

1. Five two-day in-person sessions;
2. Four intersessions;
3. An online learning platform;
4. Required readings;
5. The design, implementation, and evaluation of a capstone initiative;
6. A workbook; and
7. Team coaching by CCL faculty.

The first in-person session included an overview of the core concepts included in the program's integrated model of collaborative change leadership; theory bursts on several core concepts including collaboration, generativity, and reflection within the context of self-awareness; and an introduction to complex adaptive systems and organizational context.

A theory burst on Appreciative Inquiry (AI) as the core change model within the program (Whitney & Trosten-Bloom, 2010), included the "4-D's" or phases of AI: Discover (What do we know already that we will build on?), Dream (What do



Figure 1: CCL Core Concepts

we want to create? What difference do we want to make?), Design (How will we make this difference happen?), and Destiny (How do we adapt and re-adapt?). Teams began to apply their learning to their capstone initiatives by first describing their purpose and “passion” related to their initiatives.

In the second in-person session there was a continued focus on establishing a foundational understanding of collaboration, change and leadership concepts and theories; theory bursts on social accountability and emergence; and an introduction to sensing, developmental evaluation, and personal practical theory of CCL. Application of learning to the capstone initiative continued within the context of the Discover and Dream phases of AI.

The third in-person session included theory bursts on community engagement and the Design phase of AI, a deepening of the integration of emergence and developmental evaluation, and an exploration of CCL in a traditional healthcare system. Application of learning to the capstone initiative continued in teams and reflective experiences supported the continued evolution of the personal practical theories of CCL.

The fourth in-person session included theory bursts on the Destiny phase of AI, Theory U (Scharmer, 2007) and strengths; and experiential learning of collective intelligence and sensing. Peer sharing and coaching in teams, and a focus on sustaining collaborative change leadership in their system continued to expand and ground the application of learning to the capstone initiative, and to development of self as collaborative change leader.

The fifth in-person session focused on what was achieved with respect to the capstone initiatives, what was needed by the teams to take their work to the next level, the current state of their personal practical theory, and the continuation of the transformative journey of self as collaborative change leader. A final theory burst focused on mindfulness. “One-minute Wonders” were presented, the momentum and sustainability of capstone initiatives were explored, and collective portraits of CCL were created with team sponsor participation.

### Program Metaphors: CCL Faculty

The written descriptions of the program, lists of program elements and pedagogical strategies offer a partial understanding of what the program entails. When asked, the CCL faculty came up with three metaphors that furthered this understanding: a patchwork quilt, a spiraling plant, and a set of ingredients, as shown below:

*“The program is made up of different pieces and some, sometimes they don’t seem to fit but in the end it makes quite a beautiful whole. There are surprises, there are rough edges, different shapes and sizes, that make up the quilt and even so it seems to work very nicely as a cohesive whole. So patchwork quilt.”*

*“...some kind of spiraling plant where there’s a lot of pieces tucked in among itself ... they’re creating a sort of spiraling effect or a sort of growing in a world kind of effect.”*

*“.....the coming together of unique ingredients in a particular way to create something above and beyond what any ingredient could do on its own. And that if you tried to dismantle it and take it back to its original form of the individual ingredients, you can’t do it.”*

*“...you can adapt the individual ingredients and how they’re added and taken away and integrated based on the context so that whatever the product is, might look different in a different organization and a different context.”*

Together these metaphors evoke creativity, choice, adaptation, and transformation.

## Learner Descriptions of the Program

Themes of transformation also surfaced in learner descriptions of the program which were offered in the post-program survey:

*“An excellent opportunity for both personal and professional growth. The program provides you with an opportunity to learn about yourself as a leader, the impact that your style has on those with whom you work, and it introduces you to the skills too that you need to begin your process along a path to lead change in way that is transformational, socially accountable and sustainable.”* (CCL Participant)

*“This program not only transforms your thinking about leadership, it also transforms your thinking about yourself. The program inconspicuously brings you on a journey of self-growth that simultaneously provides a foundation for leadership practice that is collaborative and impactful.”* (CCL Participant)

*“This program is an integrated leadership course that supports and encourages personal and professional change. The CCL works towards developing understanding across systems (individual, team, community) through core concepts of Appreciative Inquiry, mindfulness practice, and developmental evaluation in attempt to allow complex systems to adapt and co-create in ways both seen and potentially in ‘unseen’ ways.”* (CCL Participant)

## Overview of the Evaluation

As a CIHLC partner, UBC, along with the UHN, were responsible for the evaluation of CCL which was co-lead by Marla Steinberg and a CCL faculty member, Kathryn Parker. An evaluation working group was established to guide the evaluation. The working group was composed of the following members from UBC (Lesley Bainbridge, Maura MacPhee, and Chris Lovato) and from UHN/CCL (Kathryn Parker, Jill Shaver, and Maria Tassone). A participatory process was used involving all CIHLC members, UHN members, and CCL faculty, to determine the purpose of the evaluation, develop the evaluation questions, and review the evaluation plan and the evaluation report.

### Focus of the Evaluation

In a partnership meeting in January 2013, UHN and CIHLC partners agreed that the evaluation should provide information to serve three main purposes:

1. To improve the delivery of the program and future offerings of the program.
2. To demonstrate the value, impact, or return on investment of the program.
3. To support sustainability (through marketing and transferability).

## Evaluation Questions

The evaluation was designed to answer five questions:

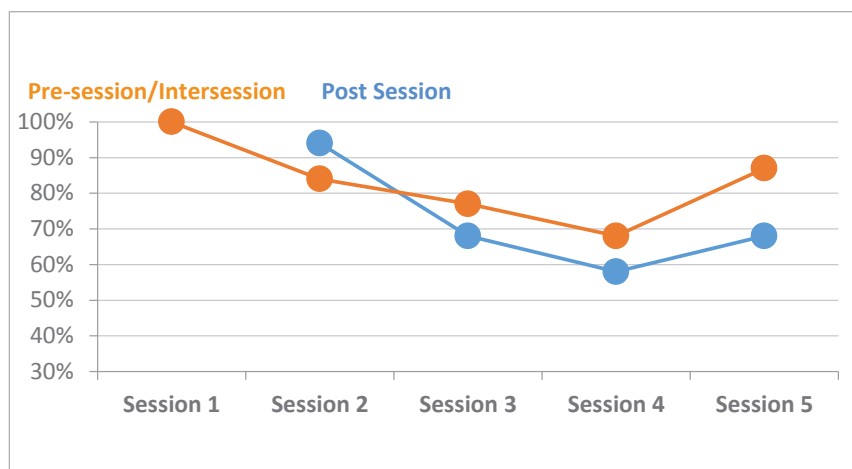
1. What was valuable about the program?
2. What changes need to occur in the program to ensure its relevance/usefulness and support sustainability?
3. To what extent did the program achieve its program learning outcomes?
4. What else has changed/happened as a result of participating in the program? and
5. What value was created through the enhancements of social accountability and community engagement?

## Methodology

A developmental evaluation approach (Patton, 2011) was used during the program to obtain and review information that could be used to adapt the program as it was being delivered. This report presents the information that was collected to address the five evaluation questions and to demonstrate the value and impact of the program. Ethics approval was received from the U of T.

The evaluation involved a mixed method design, collecting both qualitative and quantitative data from multiple respondent groups (learners, capstone initiative teams, organizational sponsors, CCL faculty, and engaged community members). A variety of data collection tools were developed. All tools were either adapted from tools developed by CCL faculty, used in previous cohorts, or newly developed for this evaluation. None of the tools were standardized or validated. The data collection methods and sample sizes are presented in Appendix B. It should be noted that the majority of data is based on learner self-reports, as there was limited participation from organizational sponsors (30% of sponsors) and engaged community members (45% of the teams). The response rates shown in Figure 2 indicate that the data reflects the majority of learners, with survey response rates ranging from 58% to 100%. Data was collected before each in-person session, at the end of each intersession, at the end of each in-person session, and at the end of the program.

Figure 2: Response Rates



## Analysis

Descriptive statistics (means and frequencies) were used to analyze the quantitative data. Content analysis using MAXQDA (a qualitative software program) was used to analyze the qualitative data. Both planned and emergent coding was used to identify themes within and across evaluation questions. A first level of coding was used to sort the data into the relevant evaluation questions (description of the CCL program, capstone initiatives, valuable elements of the program, impact, and areas for adaptations). Second and third levels of coding were generated to further reduce the data. Codes within each of the main evaluation questions were created by one analyst, and reviewed by the three other team members until an agreement was reached on the most appropriate name and content.

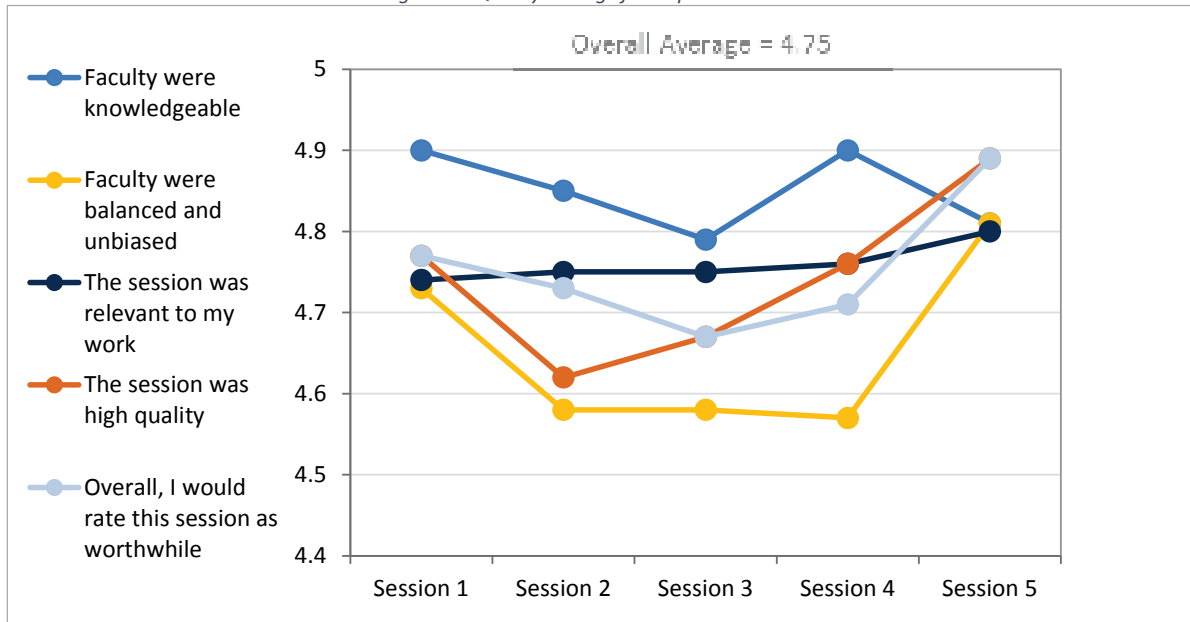
While the qualitative software program does produce frequencies of responses, this information is not consistently presented in this report, as it could not always be considered reliable. Within and across some of the data collection tools, several questions elicited the same responses and several questions were asked multiple times. This meant we were not always able to distinguish whether or not a high frequency response was the result of a question being asked several times, several questions eliciting the same responses, or a frequently offered response to one question. In this report, we present the full breadth of responses, point out when a response was mentioned by just a few learners, and when possible, include the frequencies of responses.

## What was valuable about the program?

### Quality of the Program

The program received very high quality ratings from the learners. This was seen in the ratings of the five in-person sessions and overall quality ratings for the program. Figure 3 shows the average quality ratings across the five in-person sessions. Respondents were asked to rate their level of agreement with a series of statements on a five point scale that ranged from “strongly disagree” to “strongly agree.” The quality ratings had a very small range (from 4.5 and 5) with an average of 4.75 across the five sessions. All elements of the program received very high quality ratings (above 4.5) with minor variations. Session 5 received the highest ratings across four of the five items.

Figure 3: Quality Ratings for In-person Sessions



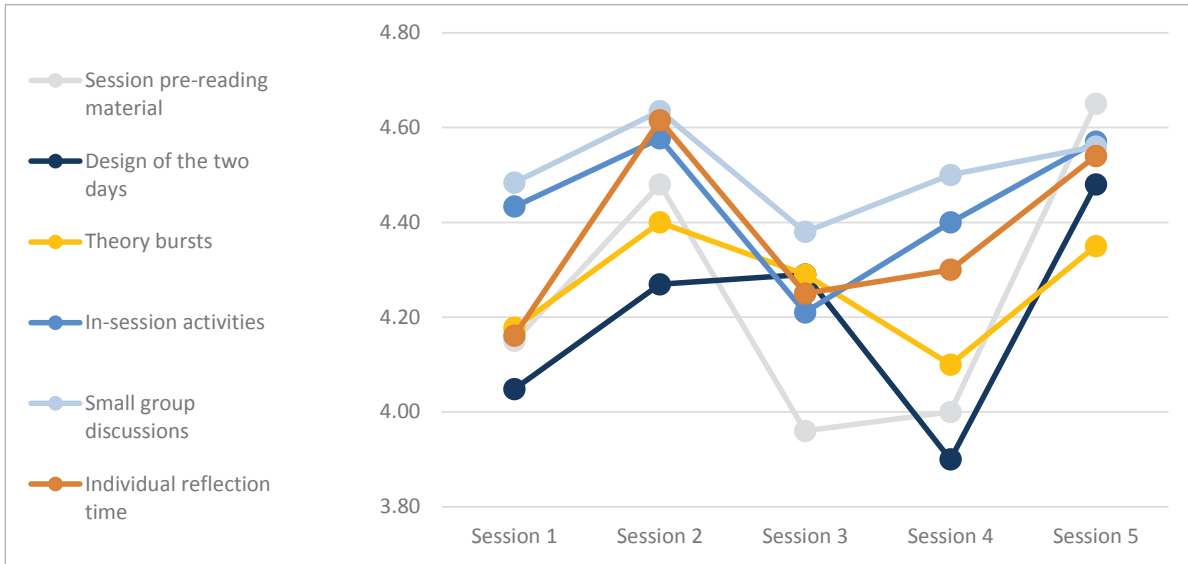
Equally high ratings were received for the program as a whole. Respondents strongly agreed to the following statements:

Statement	Average Rating (scale of 1 to 5)
The program was relevant to my work.	4.8
The program was high quality.	4.8
Overall, I would rate this program as worthwhile.	4.8
I would recommend this program to others.	4.9

### Design and Pedagogical Elements

Learners found all of the pedagogical and design elements of the program to significantly contribute to their learning and to be of value (see Figure 4).

Figure 4: Average Rating of Pedagogy across Sessions



As can be seen in Figure 4, all the major elements of the pedagogy were very highly rated (on a scale of 1 to 5 with 1 presenting “not at all” and 5 representing “a great deal”). The range of ratings was quite small with a low of 3.9 and a high of 4.63. As shown below, in rank order, session 5 received the highest ratings and session 4 received the “lowest” rating:

Session	Average Rating Across Elements
5	4.53
2	4.50
1	4.24
3	4.23
4	4.20

Participants appreciated the “whole package” of the program as shown below:

*“Without learning the CCL core concepts, doing the readings, experiencing the intensives and activities, being coached and leading a capstone project, I would not have changed as a leader or had the tools and strategies that I now have. Exposing these concepts to our core team and having their support and understanding that the answers are not yet in front of us has also been important.” (CCL Participant)*

*“This is tough to articulate because there are so many components to collaborative change leadership and each is an important ingredient. I think the main learning comes from applying the concepts to our work in the project. Our lives and our work became a living lab for collaborative change leadership. Each time we tried something we’d debrief... test new thoughts with each other... give each other feedback... reassure each other that it was okay to change directions, be emergent, act on what we were sensing etc.” (CCL Participant)*

*“I think the entire program was amazing.” (CCL Participant)*

In the open-ended responses, most of the design and pedagogical elements were mentioned (see list of codes generated in Appendix C: Valuable Elements of Program). The most frequently reported valued elements included:

- Experiential activities conducted in the in-person sessions.
- The concept and practices of social accountability.
- The concept and practices of community engagement.
- The readings.
- The learning community.
- Coaching by CCL faculty.
- The CCL faculty.
- Personal practical theory of CCL.
- Appreciative Inquiry.
- Alumni/Guest faculty who attended in-person sessions and shared their CCL journeys.
- Time with team/time to work on capstone/attending with team.

A table showing these elements and illustrative quotes is presented in Appendix D: Table of Selected Valued Elements and Illustrative Quotes.

The occurrence of social accountability and community engagement in the most valued aspects of the program reflects the fact that learners were both directly asked about the value of these elements (in order to specifically capture the import of these enhancements), and they spontaneously mentioned them in response to other evaluation questions.

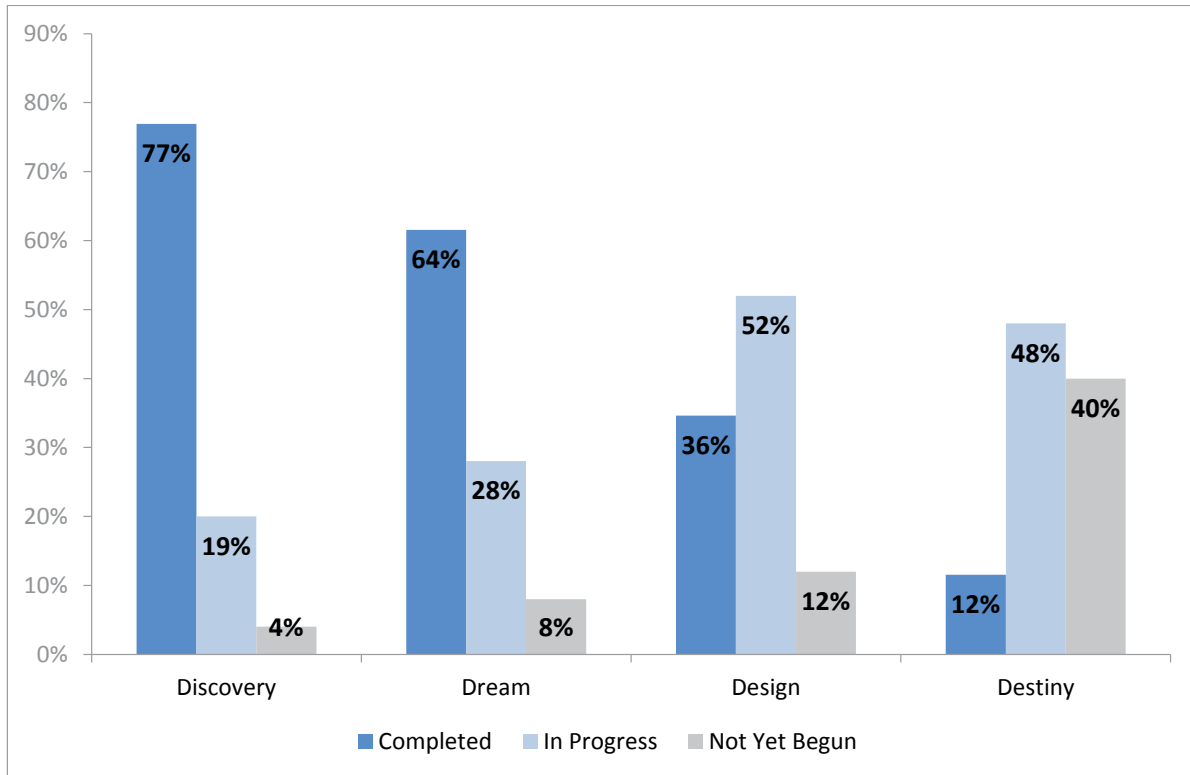
### Capstone Initiatives

One of the requirements of the program was for learners to co-create a capstone initiative with a community that had been identified as a priority population, which included frail elderly, aboriginal peoples, mental health, non-communicable diseases / chronic illness, youth and women, and lower socioeconomic status. The focus was intended to be on, but was not limited to, interprofessional care and education, quality and safety, and patient/family/community-centered care. Descriptions of the capstones initiatives undertaken by the present cohort can be found in Appendix E: Overview of Capstone Initiatives. The capstones provided the learners the opportunity to practice the core CCL concepts.

We were able to assess the progress made by teams in their capstone initiatives by asking participants to indicate where they were in their Appreciative Inquiry phases.



Figure 5: Progress in Appreciative Inquiry Stages within Capstone Initiatives N=25



As can be seen in Figure 5, by the end of the CCL program, the teams were at different places in the change process of their capstone initiatives. Across all respondents, 77% had completed the Discovery stage (where the focus is on “what do we know already that we will build on?”), 64% had completed the Dream stage (which focuses on “what do we want to create?”), 36% had completed the Design stage (where teams address “how will we make this difference happen?”), and only 12% had completed the final Destiny stage (where the focus is on “how do we adapt and re-adapt?”). This means that by the end of the course, about half the participants indicated they were either in the Design phase (meaning they were in the process of implementing their initiatives) or in the Destiny phase.

One of the teams sought ethics approval for their initiative but had not yet received ethics approval by the end of the program. As a result, they were unable to complete the discovery stage, but did apply the core concepts and started the inquiry process with a smaller “core” team.

### Blackboard

An online learning platform (Blackboard), was used in this cohort. The learning platform served a variety of purposes including:

- Document storage;

- Collaboration space (separate forums were set up for each capstone team to communicate with each other);
- Deployment of evaluation surveys;
- Learner journals; and
- Discussion forums for posting reflections on readings.

While the majority of learners reported that they did not use the platform as often as they had intended (based on responses to a question asked in the intersession 2 survey), it was still mentioned as a valuable element of the CCL program. In particular, the benefits derived from Blackboard included the following:

Figure 6. Benefits of using Blackboard for the CCL program

Benefit	Illustrative Excerpts
Increased understanding or insight.	<p><i>I also feel that I gained a deeper understanding of some of the abstract concepts by reading the posts of others on the discussion forum.</i></p> <p><i>Gained a clearer understanding of the concepts presented by the readings by reviewing discussion posts from others.</i></p> <p><i>The discussion from the reading helped me to consolidate the themes/learning principles.</i></p>
Offered validation.	<p><i>I made time to read the discussion board as it assured me that I was not the only one thinking a certain way or wondering how to be that CCL on a consistent basis.</i></p>
Provided access to other's thinking.	<p><i>I liked the discussion board and liked having the opportunity to read and reflect on other participant's learning.</i></p> <p><i>Hearing feedback about the readings from other classmates. Stories from others about how they were implementing the concepts into real life situations was very inspiring.</i></p> <p><i>The opportunity to learn from others and to stimulate my thinking in relation to the readings.</i></p> <p><i>Being able to read some of the other posts was interesting and allowed you to relate and consider others thoughts.</i></p>
Solidified learning.	<p><i>Posting materials on Blackboard was useful to be able to review and refresh the content after each intensive.</i></p> <p><i>Reviewing the posts of others greatly enhanced the depth of my understanding of the concepts we learned during the intensive and opened my thinking to new ways of understanding situations.</i></p>

Benefit	Illustrative Excerpts
<p>Provided opportunity to reflect.</p>	<p><i>Reading the discussion and experiences of my colleagues in the program...this allowed me to be reflective on my own practices, reactions to the readings, etc.</i></p> <p><i>An opportunity to express the thoughts, ideas that I had from reading the resources that were presented to us. The readings provided great thought and reflective thinking. It really is an opportunity to think, reflect, share ideas and go forward to help each of us become better leaders.</i></p> <p><i>Honestly I encountered a moment of surprise when I saw how personal people's reflections were. I did mine early and while they were authentic they were not quite so 'naked'. Reading other people's posts have made me reflect on whether I need to be more forthcoming or more vulnerable to optimize my learning and the learning of others. I will struggle with this and have not reached an answer but I think this was a standout moment... and linked to some of the course readings about 'building the bridge.'</i></p> <p><i>The insights and related discussions from others supported my own reflection.</i></p>
<p>Provided access to information.</p>	<p><i>The learning platform made accessing information easy and the requirements for posting kept me on track with the readings.</i></p> <p><i>Access to the resources in one central location on blackboard. Knowing and having access to multiple avenues for support as needed.</i></p> <p><i>I LOVE that our materials are available in one location.</i></p>
<p>Facilitated practice.</p>	<p><i>The reading and discussion boards also helps to shape our work in our "day jobs" on our team.</i></p>

## What changes need to occur in the program to ensure its relevance/usefulness and support sustainability?

Participants provided suggestions for adaptations in 10 areas:

- Course content;
- Core concepts;
- Session activities;
- Reflections;
- Faculty;
- Logistics;

- Online platform;
- Program resources;
- Evaluations; and
- Post program activities.

The most common suggestions participants mentioned were increasing experiential learning activities, limiting the time dedicated to reflection in large groups, shortening the length of the in-person sessions, providing the slides electronically before sessions, reducing the number of lengthy readings, and maintaining contact with program participants after the program ended. A list of all suggestions and illustrative quotes can be found in Appendix F: Suggestions for Adaptations.

As mentioned, in keeping with a developmental evaluation approach, the faculty adapted the program during and between in-person sessions based on learner feedback and faculty observations. The faculty also engaged in structured debriefs after each in-person session to surface areas that they felt were in need of modifications. During a final program debrief, the faculty agreed to examine or commit to a number of changes, shown below in Figure 7.

*Figure 7: Areas for Adaptation Suggested by CCL Faculty*

<b>Program Element</b>	<b>Adaptations Under Consideration</b>
Program Eligibility.	<ul style="list-style-type: none"> <li>• Continue to encourage enrolment of teams, however accept individuals on a case-by-case basis.</li> <li>• Teams can include members from the same organizations (intra-organizational teams) or members from different organizations (inter-organizational teams).</li> <li>• Ensure leaders have the appropriate level of accountability over the changes envisioned for their capstone initiatives.</li> <li>• Continue to market to organizations across Canada.</li> <li>• Recognize the challenges non-English speakers will experience.</li> </ul>
Sponsors.	<ul style="list-style-type: none"> <li>• Add a requirement for an “Executive Sponsor.”</li> <li>• Upon acceptance into the program, ensure sponsors “Save the date” for Session 5, Day 2.</li> </ul>
Marketing.	<ul style="list-style-type: none"> <li>• Ensure program materials reflect the purpose of the program: leading change collaboratively, not learning how to lead change (change management).</li> </ul>
Capstone Initiatives.	<ul style="list-style-type: none"> <li>• Ensure language around the capstone initiatives is clear – the projects should be manageable, a scale that provides the opportunity for participants to apply their learnings and concepts. One of the critical success factors of the program is the application of the core concepts of the program. Consider the words we use to reflect a manageable (or “smaller”) project – e.g. scale, accountability.</li> <li>• Include timelines (e.g. capstones to be at “design” or “implementation” by the end of the program).</li> </ul>
Coaching.	<ul style="list-style-type: none"> <li>• Include mandatory meetings with coaches.</li> <li>• Continue to include peer coaching during in-person sessions.</li> </ul>
Online Learning Platform.	<ul style="list-style-type: none"> <li>• Maintain as a requirement; ensure clarity on the purpose of the online learning environment.</li> </ul>

Program Element	Adaptations Under Consideration
Guest Faculty/Alumni.	<ul style="list-style-type: none"> <li>Request guest faculty contact information available for participants.</li> </ul>

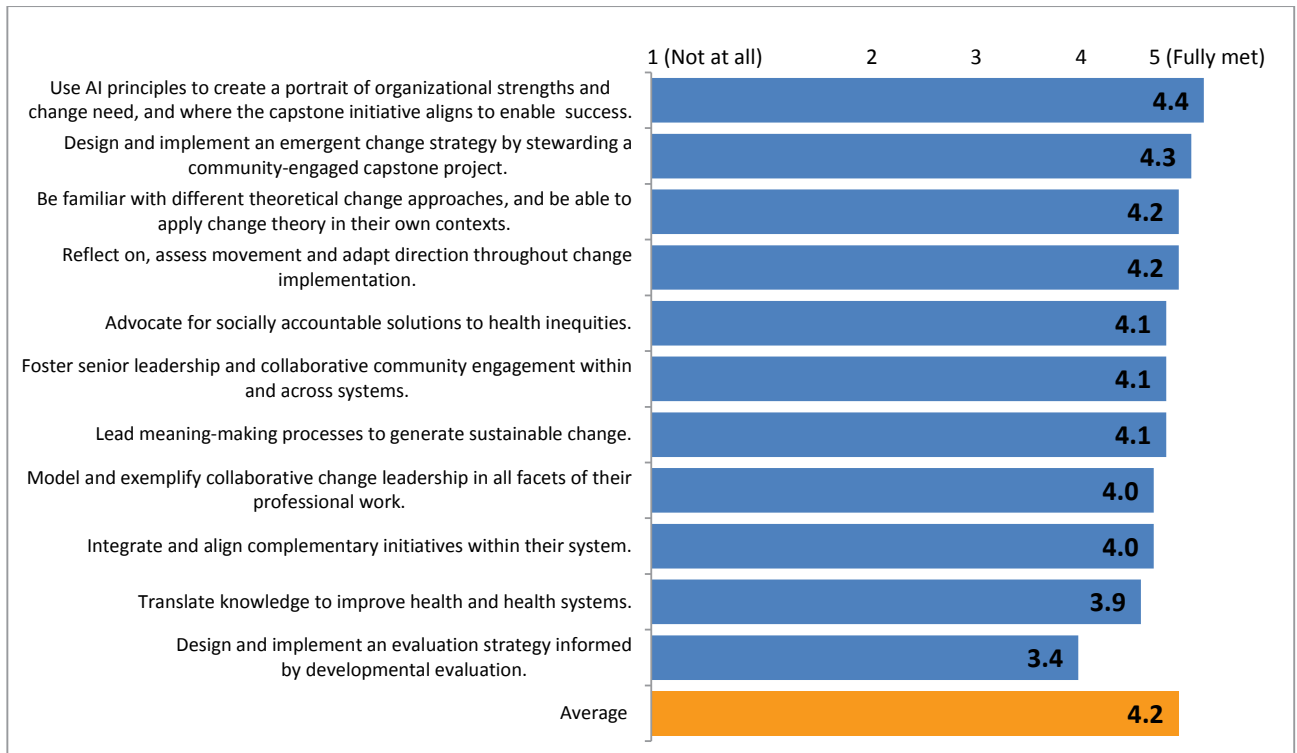
## To what extent did the program achieve its program learning outcomes?

The learning outcomes, as indicated on the program brochure, include:

1. Model and exemplify collaborative change leadership in all facets of their professional work.
2. Advocate for socially accountable solutions to health inequities.
3. Be familiar with different theoretical change approaches, and be able to apply change theory in their own contexts.
4. Use Appreciative Inquiry principles to create a portrait of organizational strengths and change need, and where the capstone initiative naturally aligns to enable success.
5. Design and implement an emergent change strategy by stewarding a community-engaged capstone project.
6. Integrate and align complementary initiatives within their system.
7. Foster senior leadership and collaborative community engagement within and across systems.
8. Lead meaning-making processes to generate sustainable change.
9. Design and implement an evaluation strategy informed by developmental evaluation.
10. Reflect on, assess movement, and adapt direction throughout change implementation.
11. Translate knowledge to improve health and health systems.

As can be seen in Figure 8, data from the post-program survey show that learners felt the program’s learning outcomes were achieved. Learners were asked to rate the achievement of the program outcome on a scale that ranged from 1 to 5, with 1 representing “not at all” and 5 representing “fully met.” Overall, an average of 4.1 was achieved across all program outcomes.

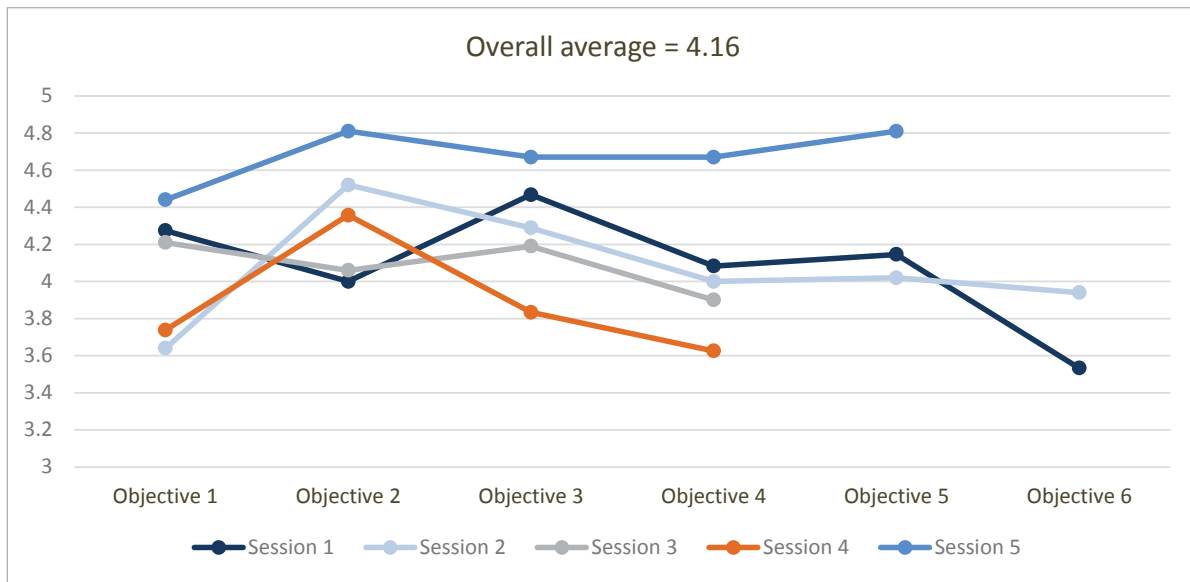
Figure 8: Average Rating of Program Outcomes



As can be seen in Figure 8, most of the average ratings of the program outcomes clustered around the overall average of 4.1. The only exception is the average rating for the achievement of the developmental evaluation outcome. This received an average rating of 3.4. This lower rating may reflect the progress on capstone initiatives. Recall that about one quarter of the teams were in the Dream phase of their capstone initiatives and about half were in the Design phase, and may not yet have had a chance to implement their developmental evaluations.

Learners also reported that the session objectives were well met, as can be seen in Figure 9. A list of the session objectives can be found in Appendix G: Session Objectives. The average ratings ranged from 3.53 to 4.81. The average rating of achievement of objectives across all sessions and objectives was 4.16. This suggests that learners believe the sessions were successful in meeting their objectives.

Figure 9: Average Rating of Achievement of Session Objectives



Using the pre and post ratings, we were able to calculate the level of change from pre to post. On average, as can be seen in Figure 11, learners reported increases in understanding between the ranges of 48% for mindfulness and 144% for generativity. Across all core concepts, an average of an 84% increase in understanding was reported.

Figure 11 shows the average rating of the participants' understanding of the core concepts prior to the program (pre) and at the end of the program (post). Level of understanding was rated on a 10 point scale with 1 representing "novice" and 10 representing "expert" (see sidebar).

As can be seen in Figure 10, the average pre-program level of understanding ranged from a low of 3.3 (for the generativity core concept) to a high of 5.5 (for Appreciative Inquiry and mindfulness). Across all core concepts, the average pre-program rating of understanding was 4.4, which could be considered high novice or low intermediate. The average rating of understanding across core concepts post program was 7.9, squarely in the expert range.

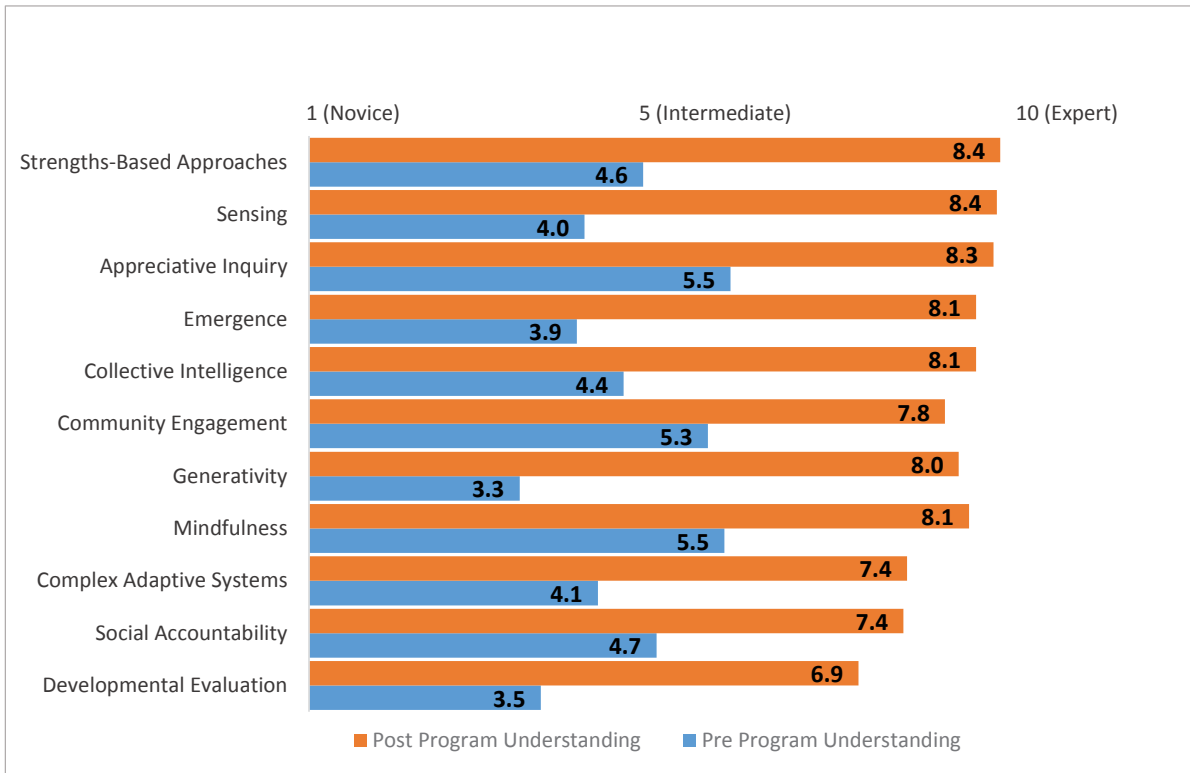
**Novice** – You have limited (a) understanding or (b) ability to apply this core concept of CCL. As a change leader, you would find it very difficult to speak about and apply this core concept.

**Intermediate** – You have some (a) understanding or (b) ability to apply this core concept of CCL, but still have more to learn. As a change leader, you could speak about this core concept and feel somewhat comfortable with its application.

**Expert** – You have mastered this core concept of CCL. As a change leader, you can speak about many issues related to this core concept and have used it frequently in your work or will use it frequently; others would consider you a resource.

\*Adapted with permission from the U of T, Centre for Interprofessional Education, *ehpic*™ Needs Assessment.

Figure 10: Average Ratings of Understanding of Core Concepts Pre and Post Program



Using the pre and post ratings, we were able to calculate the level of change from pre to post. On average, as can be seen in Figure 11, learners reported increases in understanding between the ranges of 48% for mindfulness and 144% for generativity. Across all core concepts, an average of an 84% increase in understanding was reported.

Figure 11: Average Percentage Increase in Understanding of Core Concepts Pre to Post

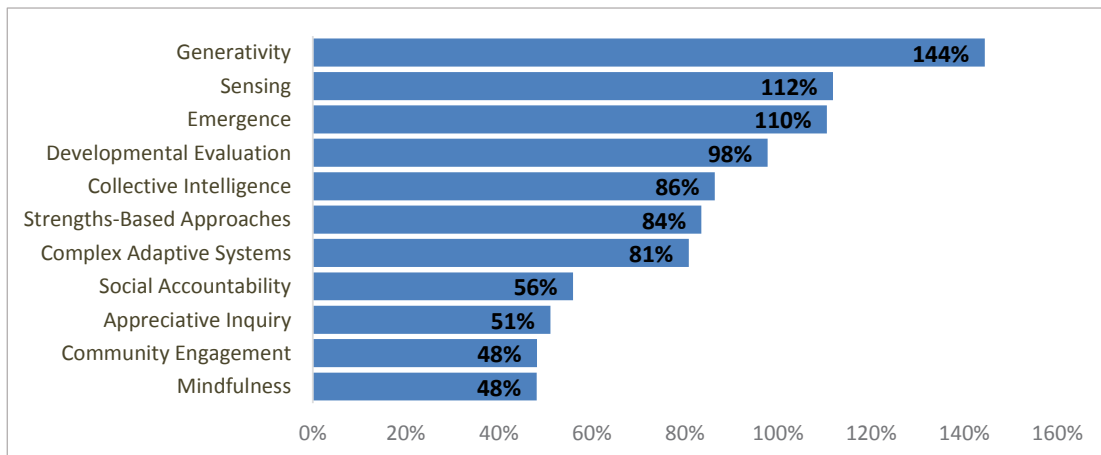


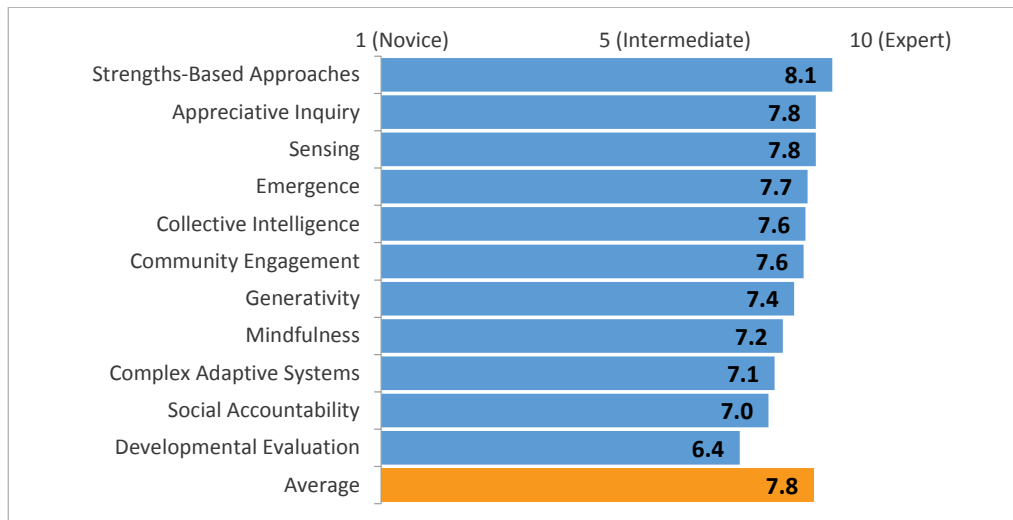


Figure 12: Pre-Program Ratings of Experience

Growth in the acquisition of the core concepts can also be seen in learner’s ratings of their own prior experience before the program and their self-rated ability to apply the concepts after the program. Prior to the program, the average level of experience was 4.0. This can be considered high novice or low intermediate. The ratings ranged from a low of 3.1 for generativity to a high of 5 for Appreciative Inquiry (see Figure 12). As can be seen in Figure 13, after the program, learners rated their ability to apply the core concepts quite high with an average of 7.4 on the same 10-point scale. On average, they would consider themselves to be “high intermediate” or “low expert” ability.

Appreciative Inquiry	5.00
Community Engagement	4.74
Mindfulness	4.60
Strength-Based Approaches	4.24
Social Accountability	4.15
Collective Intelligence	3.98
Complex Adaptive Systems	3.67
Sensing	3.63
Emergence	3.34
Developmental Evaluation	3.16
Generativity	3.06

Figure 13: Average Ratings of Learner’s Ability to Apply Core Concepts Post-Program

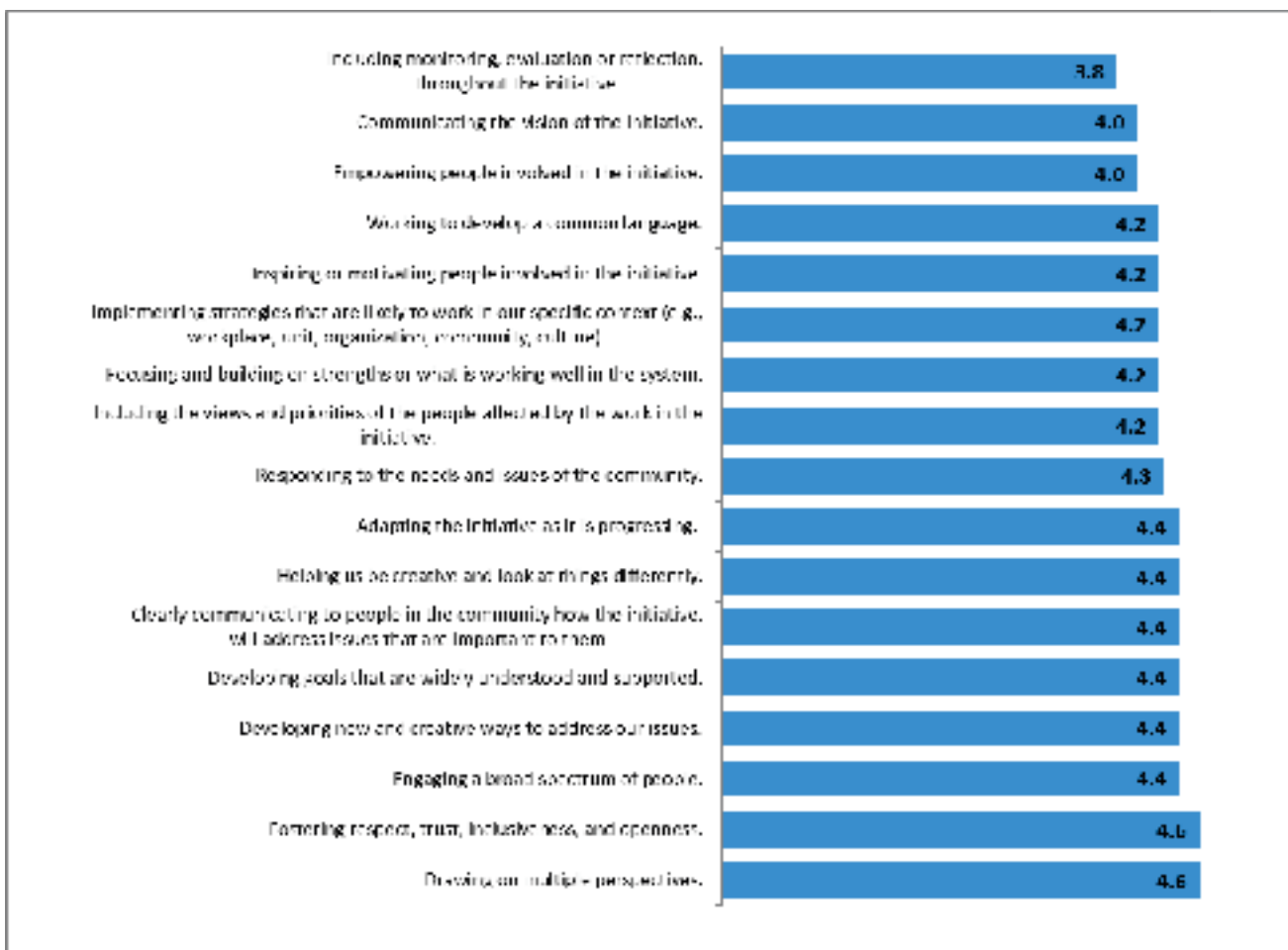


The acquisition of the core concepts by the learners is also supported by the engaged community members who participated in the online survey. Engaged community members are the people within the learner’s systems who were engaged through the Appreciative Inquiry change process to co-create, implement, and evaluate the capstone initiative. They were asked to indicate the extent to which they experienced the core concepts. While data is available for only three teams (involving five engaged community members), there was remarkable consistency among this small group. As can be seen in Figure 14, across all the descriptors of the core concepts, engaged community members reported experiencing the core concepts an average of 4.3 (rated on a 5 point scale, see side bar), meaning they experienced it slightly more than “most of the time.”

Rating Scale Used with Engaged Community members:

- 1 = Not at all
- 2 = Occasionally
- 3 = Some of the time
- 4 = Most of the time
- 5 = All the time
- Don’t Know

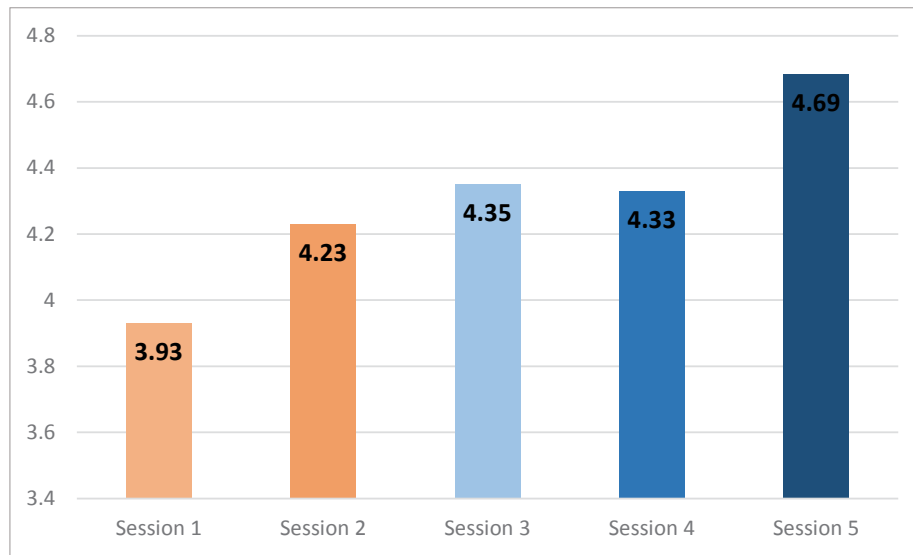
Figure 14: Average Ratings of Experiencing Core Concepts by Engaged Community Members, n=5



The interviews with engaged community members also revealed examples of how the engaged community members experienced the various core concepts. One person spoke to experiencing emergence and mentioned “a greater openness,” while a second person noticed community engagement and commented that “the breadth of staff involved is broader, encompassing whole teams in the organization and across organizations in (the) planning change.”

A final view of the achievements of the program outcomes centres on how prepared the learners felt to move forward with their capstone initiatives. This question was asked after each in-person session and at the end of the program in the post-program survey. As can be seen in Figure 15, learners reported increasing feelings of preparedness from session to session (rated on a five point scale with one representing “not at all” and five representing “fully prepared”). By the end of session 5, learners reported feeling very confident that they will be able to move forward with their capstone initiatives to achieve their transformative changes.

Figure 15: Average Feelings of Preparedness to Move Forward with Capstone Initiatives



## What else has changed/happened as a result of participating in the program?

### Impact on Learners

#### Increased knowledge

Learners noted that the course helped increase their knowledge of concepts such as positive psychology, complex adaptive systems, Theory U, social accountability, change strategies, and developmental evaluation. For some learners, these concepts provided a new framework and perspective to understand their existing work environment and lead change:

*“The model of collaborative change leadership provides a methodology, framework and language that allows me to lead in a different way.” (CCL Participant)*

*“The combination of the readings, discussion, my own fieldwork, and ongoing exposure to various leadership concepts has supported my personal leadership growth and development through providing me with a framework from which to act/do.” (CCL Participant)*

#### Common language

The CCL concepts also provided a common and unifying language for teams:

*“My team is now more aware of our respective strengths and speaks a common leadership language. It has made it much easier to move forward now that we are on the same page.” (CCL Participant)*

*“We now as a capstone team speak a common language and our leadership practice comes from a common source.” (CCL Participant)*

### Changes to personal leadership practices

A variety of impacts were reported on the learners' personal leadership practices. These included:

- Increased confidence;
- Asking generative questions;
- Seeking ideas, perspectives, and opinions of colleagues from a place of non-judgment;
- Leading from a place of authenticity;
- Being open to what is emerging;
- Sensing;
- Taking time to reflect; and
- Taking an appreciative approach.

### A table showing the changed practices, their impact, and illustrative quotes can be found in Appendix G: Session Objectives

#### Session 1:

1. Interpret and apply the Collaborative Change Leadership model.
2. Explore and articulate the purpose of the capstone initiative grounded in social accountability.
3. Begin to apply awareness of self and self in relationship within the context of collaborative change leadership and the intended change.
4. Identify and engage champions, collaborators and partners, including sponsor and mentor.
5. Design interview questions for understanding organizational context using Appreciative Inquiry methodology.
6. Conduct interviews.

#### Session 2:

1. Interpret organizational inquiry results to create a portrait of organizational strengths and change need.
2. Refine the purpose of the capstone initiative and ground in social accountability principles.
3. Begin to describe a personal practical theory of collaborative change leadership.
4. Choose and apply leadership practices for what is emerging in the organization and/or community context.
5. Identify appropriate communication and engagement approaches for the design of the change strategy.
6. Begin designing the integrated emergent change and evaluation strategy.

#### Session 3:

1. Lead and engage in meaning-making processes to design the change.
2. Navigate the tension between implementing a change strategy and sensing system needs and what is emerging, and adapting accordingly.
3. Continue to refine the integrated emergent change and evaluation strategy with a focus on design and implementation.
4. Describe how the personal practical theory of collaborative change leadership is shifting and evolving.

#### Session 4:

1. Lead the interpretation and synthesis of what is emerging in the organization and/or community through sensing methods.
2. Interpret and maximize the impact of individual, team, organization/community, and system strengths.

3. Lead self, team, organization/community, and system adaptation according to what is emerging.
4. Explore and evaluate intended and unintended outcomes, and continue to evolve the evaluation according to what is emerging.

Session 5:

1. Assess movement and adapt strategies based on what is emerging as meaningful in the organization.
2. Use storytelling to inspire and engage.
3. Identify and apply personal practices that enable the sustainability of collaborative change leadership for self, team, organization/community, and system.
4. Enact and model their personal practical theory of collaborative change leadership.
5. Create a collective portrait of collaborative change leadership, including its value and impact.

## Appendix H: Changes to Leadership Practices.

These leadership practices were also observed by engaged community members:

*“Being front-line I think we are inundated with ‘ta-da this is the new initiative and this is how we are going to roll it out.’ Whereas this time it was ‘think about it, this is what it might look like’.... It’s been different because they’ve been involving everyone from the get go. We were there from the beginning. They walked us through the entire process...It’s been an organic process that way.” (Engaged Community Member)*

*“I like how they disseminated the questions. They asked us to ask different types of people in different positions...questions like ‘where do you see IPE ideally in the organization’ or ‘what does IPE mean to you?’ They asked us to ask our team members, students and frontline staff. This really opened the sphere of communication...Keeps the perspectives real. Nice to get a real barometer rating.” (Engaged Community Member)*

*“She’s doing an excellent job, not sure what elements she puts into practice that are so successful, but does it fluidly. In general in the organization one of her successful approaches, she involves different members of different professions and mobilizes their energy towards a particular cause around patient care. Invitations of different stakeholders. Knowing who to call.... She is very open and very sensible. She’s not married to her own ideas. She very much comes at the project with a ‘how can we make this better’ attitude. That goes over very well because everybody wants this to work. But if you didn’t have someone like [name of learner] driving it you could have quite a different result.” (Engaged Community Member)*

### Impact on capstone teams

Through the CCL program, learners gained a better understanding of teammates’ strengths and complementary skills, which helped the capstone teams:

- Match team members to roles and tasks that drew on their unique strengths;
- Harness the collective wisdom of the team;
- Challenge one another to further develop their skills; and
- Be more effective and engaged in their work.

*“Throughout the process, it seemed that someone would step in as required, when required and deliver what was required. We believe we made room for each of us to bring forward the best of ourselves and for each voice to be heard and each style to shine as we worked on our capstone initiative.” (CCL Participant)*

Learners reported that over the course of the CCL program, they built strong, trusting relationships with team members. They felt more comfortable sharing vulnerabilities and exploring each other’s strengths. The course also equipped them with a common language and framework for approaching their work. As a result, teams became more unified, collaborative, creative, focused, and effective. Some teams continue to look for opportunities to collaborate within their organizations.

## Impact on organizations

### Increased interest and uptake/spread of CCL approaches

Not only are learners modeling CCL in their workplaces, some reported they are also being asked by managers to share their knowledge with colleagues. As a result, some learners have given presentations about the CCL program to colleagues, while other learners have started book clubs or simply shared CCL resources. This is contributing to increased interest and uptake of CCL approaches within organizations.

Three examples were provided of learners using CCL approaches in other projects:

*“I was asked for input on the development of a video and brochure for patients on the inpatient amputee program. I learned that the team was planning to develop some tools to help patients understand the various roles of the team members they would encounter during their admission. I was asked to provide my input from an interprofessional perspective, but quickly found myself referring to broader CCL concepts in my reply. I started asking questions that would help me understand what their hopes were, in an appreciative way, and asked about the role of the patient and family in the development process. This led to others in the team asking questions themselves, and considering a slightly different approach in the planning. As a result, they decided to survey some patients and have a focus group discussion, to inform next steps, before they start the filming stage. I asked about the strengths of the various team members and who might be best suited to take on various roles in the process. I could sense that the team had put a lot of work into this project already, and needed some reassurance that it could still move forward in some way. I suggested that we see what emerges after the stakeholder discussion and use that input to take all their great work to the next level.” (CCL Participant)*

*“Social accountability and community engagement have been key in another initiative I am working on in the Emergency Department. In transforming the patient flow journey in the ED, we brought a patient/family advisor who was supported in ensuring the needs of patients presenting with medical emergencies drove our process re-design. We have also engaged multiple internal stakeholders in the hospital to assist with the process change - community engagement is not about a location but about all those who need to have a say or who may impact or be impacted by the work being done. Engaging IT, patient/family advisor, access & flow, physicians, nurses, admin support, lab/DI, registration etc. has ensured that we are recognizing issues early and ensuring all voices and perspectives are integrated into the new design.” (CCL Participant)*

*“I am bringing these concepts into many other areas outside of the capstone. I am part of a policy integration process at work, merging policies from 2 organizations that have merged. In the process of one review, I suggested to the group that we bring the patient perspective to the review process. We thought creatively about how to do that, and in doing so, found examples from patients that significantly shifted the direction of the corporate policy. I felt like the stars had started to align!” (CCL Participant)*

Some learners noted challenges in implementing CCL approaches within their organizations:

*“The organization is still not appreciating this approach to change, but I intend to make it my mission to add this to any leadership and project discussion.” (CCL Participant)*

*“Although there is a bit of upheaval within my organization due to individuals not fully understanding or supporting collaborative change, many are eager and ready to embrace it and I feel I can assist them.” (CCL Participant)*

*“I am actually feeling a bit more discouraged with my organization in the sense that I now feel I have a better understanding of collaborative change leadership and I see it not being implemented within areas of our institution. This is a bit disheartening especially given our institution is currently undergoing a large collaborative change leadership process.” (CCL Participant)*

### Changes to organizational processes

Changes were also noted by learners in organizational processes as a result of their involvement in the CCL program. These are presented below.

#### Using Appreciative Inquiry in Human Resources (HR) and strategic planning

One organization incorporated Appreciative Inquiry (AI) techniques into their HR practices. According to the CCL learner, using AI helped staff feel that “they have a voice.” Another organization used AI in the development of their strategic plan:

*“I think that our [X] Strategic Plan would have looked completely different if we had not come together as a team in the CCL program. Our AI approach encouraged the people we consulted to dream big and not to be held back by our current state.” (CCL Participant)*

#### Changes to governance structures

One organization’s capstone initiative helped foster stronger connections between two interprofessional education committees, which resulted in merging the committees into one.

#### Emergent meeting agendas

One organization changed the way they run community meetings. Instead of guiding the meeting with a traditional agenda and a determination to address each item, the team simply identified the main topic of discussion and allowed ideas to emerge.

#### Listening conferences

One organization changed the way they collected feedback from clients:

*“We are hosting ‘listening conferences’ with our clients and families rather than just depending on client surveys. We have a light supper with them and at round tables; we ask them when they last accessed our services, what worked for them? What did not work? And what can we do differently in order to make their experiences better? We are getting some very great insight and new knowledge that we never expected and have a new found appreciation for the clients we serve. It is our honour to work with them!” (CCL Participant)*

### Changes to services

Learners also noted changes to services as a result of their capstone initiatives. These changes are summarized below.



### Dysphagia program of care

Through their capstone initiative, one CCL team designed and implemented an interprofessional program of care for patients with head and neck cancers who have swallowing difficulties (dysphagia). The dysphagia program is delivered in an international health setting which has previously not provided service to this population.

Changes to patient care included:

- Staff now routinely screen for dysphagia. Patients identified with dysphagia are assessed and treated.
- A geriatric assessment screening instrument is now used in the Emergency Department.
- Increased collaboration between dietitians and the speech language pathologist in the assessment, diagnosis, and management of patients with dysphagia.
- Speech language pathologists conduct weekly hospital visits to work with patients.
- Dietitians and physicians work collaboratively to ensure that patients are given the appropriate diet orders.
- Frail older patients on this care pathway experience no further decline in function while at hospital.
- Patient data is collected and used for developmental evaluation of the program.

### Shared care model in mental health

Through their capstone initiative one team enabled two organizations to develop a shared care, interprofessional model in mental health for rural and northern populations.

The capstone team, along with community partners, has changed the patient experience by:

- Engaging patients, families, and community members in educational presentations about mental health. Participants learned about local mental health services and interprofessional practices, and are now encouraged to share their experiences with the mental health system. Patients walk away with a new understanding of how providers work together, and clinicians walk away with new insights about how to provide care that meets the needs of the community.
- Successfully completing 10 care plans under the new shared care model.

### Emergency services for patients with mental health and addiction issues

- Changes to how a department provides emergency services to patients who are experiencing a behavioural crisis. The learner noted that *“When the unit is functioning optimally, the quality of care and the level of patient and provider satisfaction is much higher than it has ever been in the past.”* No information was provided on how the learner knew that satisfaction had increased.

## What value was created through the enhancements of social accountability and community engagement?

While the concepts of social accountability and community engagement were an explicit enhancement to the CCL program brought about by the partnership with the CIHLC, they were integrated with existing core concepts into the program through readings and other instructional methods. In addition, the CCL faculty was expanded to include expertise in the concepts of social accountability (SA) and community engagement (CE).

It is important to recognize that elements of both concepts, particularly CE, were already present in the some of the core concepts (i.e. co-creation). One of the benefits of this explicit focus, however, was in providing learners with a language to explicitly embed these concepts in their practice. In this section, we specifically address how the integrated concepts and practices of CE and SA were experienced by the learners.

As mentioned, CE and SA were concepts that certainly resonated with participants. Earlier we presented a few quotes that illustrated how the learners embraced and applied the concepts. Here are a few more of the many, many examples that were offered:

*“In the work I am doing to more effectively collaborate with caregivers, we are planning a number of focus groups to meaningfully engage families/caregivers. We are being attentive to barriers to participation such as geography, poverty, lack of transportation and are taking accountability to mitigate these barriers. We have intentionally adopted a ‘nothing about us without us’ principle and will engage families/caregivers as partners in co-creating. I am co-leading a group that is tasked with eliminating stigma that is displayed toward people we serve who are living with mental illness, severe physical disability and seniors. We are moving forward based on values of respect, dignity, compassion and social justice. Given the complexity of the initiative, we have engaged researchers to assist us with the process. The research will systematically monitor our community engagement such that the feedback informs the project.” (CCL Participant)*

*“I find myself naturally thinking of asking questions as to how we can make this organization more responsive and reflective of our staff and community members.” (CCL Participant)*

*“Social Accountability – I realize that it is important to consider everyone who might be impacted or who may have historically overlooked and purposefully ensuring that their needs are equitable met.” (CCL Participant).*

*“A particularly new aspect of learning for me through CCL has been in the areas of social accountability and community engagement. Throughout the course, I have become aware how much these areas are more of an espoused theory for me as opposed to a theory-in-use. While many of the other concepts were familiar to me and concepts I have applied in different forms over time, I see myself more of a novice/beginner in the areas of social accountability and community engagement. I am challenging myself to integrate these areas intentionally going forward by asking – who is at the table? Who does this change*

*impact? How can I widen the circle of involvement in order to adequately engage those who are most impacted in the emerging solution?” (CCL Participant)*

*“In particular, our component on social accountability as a core concept has been a new learning for me. I love the connection to purpose, and to making a difference in the world, that this focus has created within me. The opportunity to design and lead collaborative change in order to address priority health concerns of the people and region we serve is rewarding and inspiring in its connection to my own personal purpose.” (CCL Participant)*

*“I have always been sensitive to seeking the viewpoints of the under-represented, and now feel even more committed and empowered to continue, with a framework of social accountability to guide me in the process.” (CCL Participant)*

CCL faculty were confident that learners successfully enacted the elements of CE. There was some uncertainty, however, as to the extent that the capstone initiatives were truly reflective of SA as it was originally conceptualized and operationalized within medical education. SA within the health system was first championed and developed in medical education to ensure that medical education was grounded in the needs of marginalized populations. While elements of SA are present in other CCL core concepts, an explicit focus on marginalized populations is new to the CCL program. Further, its application to geographically based health service organizations has not yet been fully developed within the SA literature, and the teams proposed their capstone initiatives when first applying to the program, that is, before being exposed to the full concept of SA. It is clear that the capstone initiatives did include a broader range of engagements than what was typically practiced in health service organizations, as shown in the following quote:

*“Social accountability? (Not sure I am labeling this one correctly and I am still thinking about this concept) – Moving forward I am most inspired about how I can honour and serve the ‘voices in the system’ – or how I can be a champion to ensure that more voices in the system are heard more regularly. One of the most powerful stories I heard during the interviews related to our project came from someone in an administrative role who was ignored by her clinical colleagues even though she knew important information about a patient. Power, hierarchy and stereotypes happen easily in organizations and I feel compelled by the idea that organizations can become better places by allowing more people the space to speak.” (CCL Participant)*

However, it is not clear whether or not these engagements included marginalized groups as originally articulated in the SA literature. It appears that some learners engaged with people whose voices had traditionally been excluded (one definition of marginalization) while others engaged with marginalized groups, as defined in the original thinking around SA. Unfortunately, the full enactment of all aspects of SA, as originally developed, across all projects, is not known.

## Limitations of the evaluation

### Limited ability to triangulate findings

The evaluation findings are based largely on self-reports of program participants. The use of learner self-report was strengthened by collecting data over multiple time periods. While some confirmation of learner self-reports was provided by a limited number of engaged community members, organizational sponsors, and the full CCL faculty, the extent to which the changes reported by respondents are evident to others in their organizations and communities, and the extent to which these changes have led to changes in practices and ways of being, are not known.

### Reduced response rates across data collection periods

Learners were asked to respond to paper and pencil surveys at the end of each in-person session and online surveys at the end of each intersession. While there was some variation in the questions asked at the different survey administrations, the bulk of the questions remained the same across survey administrations. As we saw earlier in this report, it is clear that respondents did experience “survey fatigue” with each subsequent data collection period (with a rallying of engagement for the final post-program online survey). This resulted in fewer respondents with each subsequent survey administration and fewer responses to individual questions. The data collected towards the end of the program, because it is based on fewer respondents and responses, may not represent the full picture of the program.

### Limited ability to speak to changes in health systems and sustainability

As mentioned, because of the variability in the progress made on capstone initiatives, the evaluation was limited in its ability to speak to outcomes beyond the individual and team level. Further, without longer term follow up, we are unable to offer insights into the sustainability of the changes, adaption and spread, and impacts on communities, systems, and organizations.

## Conclusions

The evaluation of CCL has shown that learners perceive the CCL program to be a very high quality program with many valuable concepts and pedagogical strategies. The data also show that learners report the program was highly successful in meeting its program or learning outcomes.

Learners report a variety of impacts including being transformed, learning a common language, acquiring new knowledge, increased confidence, and feeling energized. In addition to individual transformation, learners reported increased cohesiveness within their capstone teams and a greater ability to work effectively together.

Given that the majority of teams were either in the Design or Destiny phase of their capstone initiatives, it is not surprising that fewer results were reported for communities, organizations, and systems. Most of the impacts that went beyond the learners centred on the spread of the concepts and increased interest of “the collaborative ways” within their organizations and communities.

At this point, we are unable to say if these learners will go on to complete their capstone initiatives and create the demonstrable changes in their health care systems and communities that they intend. This program does appear to have set the learners on the right path for achieving transformative changes in

health systems, as they report the skills, abilities, and motivations to carry on with their work, and the spread of these practices within their organizations. The presentations given by program alumni during the in-person sessions revealed that some teams from past CCL cohorts were able to achieve significant transformations within their health care systems (e.g., one team spoke of achieving a significant decrease in waiting times). Further evaluation will tell to what extent the personal or individual level changes experienced by this cohort of learners will lead to further transformations in their health care systems, and the extent to which past cohorts have been able to transform their systems.

## Recommendations for further evaluation

The following are offered as recommendations to support future evaluations of the CCL program:

1. Conduct longer term follow up of previous cohorts and the present cohort. For example, check in with the present cohort at six months to one year post-program.
2. Continue to collect information from respondents that can corroborate learner self-reports, like organizational sponsors and engaged community members. Consider 360 degree type feedback from staff, co-workers, and managers of the learners.
3. Streamline data collection tools to reduce redundancy (e.g., on the post session survey, the question that asked for “highlights of the session” yielded the same responses as the question that asked about “valuable elements of the program.” In addition, there was redundancy between the post-program survey, the Capstone Final Report, and Learner Final Reflections).
4. Ask more focused questions in the data collection tools (e.g., the Capstone Final Report and Learner Final Reflections included vaguely worded questions like “describe your learning” which did not provide useful data nor trigger respondents to talk about what was learned. Suggest changing the question to something like: “what was the most valuable learning and how have you applied it in your work or personal life?”).
5. Collect data to enable the linking of respondents across data collection tools and administrations in order to more easily assess change.
6. Reduce the number of data collection periods to deal with respondent fatigue.
7. Deploy post-session surveys through an online survey platform after the in-person sessions rather than administering paper versions at the end of the long two day in-person sessions.

## References

- Patton, M.Q. (2011). *Developmental Evaluation. Applying Complexity Concepts to Support Innovation and Use*. Thousand Oaks, CA: Sage.
- Scharmer, C. O. (2007). *Theory U: Leading from the Future as It Emerges*. Cambridge, MA: The Society for Organizational Learning.
- Whitney, D. and Trosten-Bloom, A. (2010). *The Power of Appreciative Inquiry: A Practical Guide to Positive Change, Second Edition*. San Francisco, CA: Berrett-Koehler Publishers, Inc.

## Appendix A: Overview of CCL Participants

Organization	# Team Members	Position Titles	Location
St. Joseph's Health Centre	2	Administrative Director	Ontario
		Medical Director	
Hospital for Sick Children	2	Advanced Nursing Practice Educator	Ontario
		Manager	
Sunnybrook Health Sciences Centre	5	Director	Ontario
		Director	
		Manager	
		Professional and Education Leader	
		Professional Practice Leader	
Lethbridge College	3	Dean	Alberta
		Chair	
		Chair	
University Health Network (UHN) - Collaborative Academic Practice (CAP)	4	Research Scientist	Ontario
		Practice Leader	
		Practice Leader	
		Clinical Coordinator	
UHN - International Centre for Education (ICE)	3	Manager	Ontario
		Coordinator	
		Manager	
Casa Services	1	Director	Alberta
Northern Ontario School of Medicine	3	Professor and Chair	Ontario
		Director	
		Officer & Aboriginal Lead	
Queen's University – Providence Care	2	Administrative Director	Ontario
		Director	
Université Laval - Centre de santé et de services sociaux de la Vieille-Capitale	2	Psychologist	Quebec
		Professionnel de recherche (Research Professional)	
UBC - Fraser Health Authority	3	Director	British Columbia
		Managing Consultant	
		Managing Consultant	

## Appendix B: Data Collection Methods and Sample Sizes

Method	N	Response Rate
Pre-Program Surveys	31	100%
Post Session Surveys (x 5)	Average 26 (range 21 to 31)	Average of 84%
Intersession and Pre-Session Surveys (X4)	Average 22 (range 18 to 29)	Average of 72%
Post Program Survey	27	90%
Engaged Community Member Survey	5 respondents from 3 teams	27% of teams
Engaged Community Member Interviews	7 respondents from 5 teams	45% of teams
Sponsor Survey	7	30%
Capstone Final Reports	11	100%
Learner Final Reflections	30	100%
CCL Faculty Focus Group	5	100%



## Appendix C: Valuable Elements of Program

This list shows the codes that were generated from the responses that spoke to valuable elements of the program.

- Adaptation
- All
- Application
- Attending as a Team
- Blackboard
- Capstone Initiative
- Coaching
- Concepts
  - Appreciative Inquiry
  - Collective intelligence
  - Community Engagement
  - Complex Adaptive Systems
  - Developmental Evaluation
  - Emergence
  - Generativity
  - Mindfulness
  - Other
  - Personal Practical Theory of CCL
  - Sensing
  - Social Accountability
  - Strength based approaches
  - Theory U
- Faculty
- In-person sessions
  - Agenda/how the day was organized/designed
  - Alumni/Guest Faculty
  - Consolidation of all concepts
  - Deep Dives
  - Experiential Activities
  - Interactivity
  - One Minute Wonders
  - Peer Coaching
  - Reflection
  - Theory Bursts
  - Time with sponsors in last session
  - Time with Team/time to work on capstone
- Intersession
- Journals
- Learning Community
- Relationships Formed/Networking
- Resources
  - Workbook
  - Readings
  - Videos
  - Session PPTs
- Self-Awareness
- Sharing Ideas
- Having sponsors

## Appendix D: Table of Selected Valued Elements and Illustrative Quotes<sup>1</sup>

Valuable Element	Illustrative Quotes from Participants
<p>Experiential activities conducted in the in-person sessions.</p>	<p><i>"I also enjoyed the hands on learning or active learning practices particularly the ones that focussed on self-awareness and growth."</i></p> <p><i>"Some of the exercises especially the collage helped me to reflect deeply during the process of creating my visual display."</i></p> <p><i>"Some of the exercises that we did were very interesting which I have used with another team meeting which worked out very well. How to pose questions, to dream, to let go and respect other opinions."</i></p>
<p>The concept and practices of social accountability.</p>	<p><i>"I appreciate learning more about social accountability. This is now the lens that I look through when I am evaluating if an initiative/project is worthwhile"</i></p> <p><i>"I am becoming ever more aware of my responsibility, our responsibility, to attend to health and have an awareness of how we are and how we are not accountable to folks on the fringes and certain populations.... I don't have direct hands on work around this and often hosting conversations with groups of folk who do."</i></p> <p><i>"We have changed the focus of our emergency department to one of an access centre that considers the wider determinants of health. It is our goal to accept and help all those who come to us in a non-judgemental way, listen to them and try to meet their medical and non-medical needs. This is now part of our hospital's strategic plan."</i></p>
<p>The concept and practices of community engagement.</p>	<p><i>"Engagement of stakeholders is a big part of my work and even at my team level we are noticing much more who we are including/excluding in our conversations, decisions and programs.... Also the impact of not being included ourselves and how that is impacting our willingness to partner in initiatives that we had no voice in or no part in creating.... that has been quite useful."</i></p> <p><i>"Our Managers met together and prepared a plan to learn from the community members and clients and their families, who access our services, what was working, what needed to be changed and what other services did they want from our agency. We knew we were not reaching all the community members who needed health care services. We thought of a Community Engagement strategy that we called a "Community Conversation and Supper". We prepared a tag line to our promotional activities that said "if it is about you, it should be with you". We heard from over 200 people about our services. We just listened, We did not defend our programs or correct anyone. We just asked questions as they gave us answers. We sat in round tables and talked over dessert</i></p>

<sup>1</sup> As mentioned, we are not able to report the frequencies with which the valuable elements were reported as these numbers are unreliable due to question repetition and redundancy.

Valuable Element	Illustrative Quotes from Participants
	<p><i>and tea. We also asked how we could reach their family members or neighbours who did not access our services. The feedback was phenomenal. We prepared a report from the meeting and will be sending out a copy to each person who attended the meeting.”</i></p> <p><i>“Historically non-patient care service providers have not been considered when education plans have been developed. We acknowledged that this group contributes significantly to our patient care teams in ways we had not previously thought of. Therefore, when we did our stakeholder engagement interviews, we made sure that these voices were heard. We learned a lot about how they felt about their contributions to the care of our patients and things they would like to see incorporated into an IPE strategy.”</i></p> <p><i>“More intentional about who to include when. For example we used to ask ‘who else needs to be at the table?’ Now we ask this question but with an added layer about ‘how can we best involve them?’ e.g., our work helped us realize that we need to not only include patient care managers but to bring them into our work earlier as co-creators – not just consult with them.”</i></p>
The readings.	<p><i>“Also, all the readings were important in helping support the content of the program.”</i></p> <p><i>“A few key readings: Strengths Finder, Mindful Leadership, Change Your Questions Change Your Life. I will likely go back and read these again!”</i></p> <p><i>“Really enjoyed some of the readings.”</i></p> <p><i>“Readings were exceptional and exciting.”</i></p> <p><i>“I have copied the Choice Map and placed it in a prominent spot in my office so I can be constantly reminded of the Learner path and the Judger Pits. Actually we have gained many valuable resources in the form of our required reading, and I will refer to them frequently, rereading sections and gaining deeper understanding of the material. I find even now that I appreciate the content of some our earlier readings more than I did when I first read them.”</i></p>
The learning community.	<p><i>“The variety of backgrounds of participants in the program was extremely valuable.”</i></p> <p><i>“Being safe to be vulnerable and to have the supportive learning environment was key.”</i></p> <p><i>“Feeling a part of a community where you have read the same books, received the same questions to reflect on and are growing in the same area of leadership.”</i></p>

Valuable Element	Illustrative Quotes from Participants
	<p><i>"I loved the community building among participants!"</i></p> <p><i>"The richness and real-life experiences brought to the sessions by my colleagues in this cohort helped to make the CCL paradigm more tangible and real."</i></p> <p><i>"Standout for me is the remarkable people -&gt; time to see each other and be in this journey of work together."</i></p>
Coaching by CCL faculty.	<p><i>"The coaching was an essential component and I do not think we would have been as successful without it."</i></p> <p><i>"The personal coaching helped to really clarify points specific to our capstone project that we were still unclear about during the teaching sessions."</i></p> <p><i>"I appreciated the opportunity to work directly with a CCL coach. This was most helpful in moving our project forward"</i></p> <p><i>"Coaching is a gift!"</i></p>
The CCL faculty.	<p><i>"An exceptionally talented and experienced faculty who were available for conversation, dialogue and mentorship."</i></p> <p><i>"The depth of knowledge held by the faculty."</i></p> <p><i>"The team of teachers was excellent and that type of program is built on that essential ingredient. The team was acting as a role model for the participants. The members were applying the core concepts of the CCL program all the way through. It was obvious and very inspiring for me."</i></p>
Personal practical theory of CCL.	<p><i>"I found the creation of a visual depiction of our personal practical theory very helpful. It provided me with insight not only on what I had absorbed of the course material but also allowed me to embrace my creative side."</i></p> <p><i>"Personal practical theory – provides a touchstone to guide work."</i></p> <p><i>"Discovering our personal practical theory was a highlight of my learning. The exercise helped me to achieve this goal."</i></p>
Appreciative Inquiry.	<p><i>"I used the concepts in appreciative leadership in planning a retreat for a committee I chair. Using Appreciative Inquiry we were able to ground ourselves in what we do best and is most engaging, and aligned this with the key priorities."</i></p> <p><i>"I used AI principles in the design and delivery of educational sessions that I was providing and to nurses in an intensive care setting. Nurses became engaged and openly discussed issues."</i></p>

Valuable Element	Illustrative Quotes from Participants
	<p><i>“The concept of Appreciative Inquiry was brought to life in the early stages of my capstone initiative. We used the 4 stages of Appreciative Inquiry to move from a custodial care model to a recovery based and trauma informed philosophy of care in our new service. Concepts of co-creation and emergence were essential to the engagement of our team. They took over the design and they became fully accountable for and the key drivers for change. Their excitement and enthusiasm for better patient care was palpable throughout our organization. They owned the improvement and continue to drive its success!”</i></p> <p><i>“Appreciative Inquiry - This has become a mainstay in my leadership “arsenal”. I consider how I ask my questions and how I get people engaged.”</i></p>
<p>Alumni/Guest faculty who attended in-person sessions and shared their CCL journeys.</p>	<p><i>“I really enjoyed the presentation of the different CCL participants, particularly the CAMH group. Their presentation really exemplified the powerfulness of CCL core concepts. Brian Hodge's visit was also a highlight.”</i></p> <p><i>“Visit by past participants of CCL/leaders - this really helped to ground the concepts and demonstrated the value of the CCL core concepts.”</i></p>
<p>Time with team/time to work on capstone/ attending with team.</p>	<p><i>“I really appreciated the breakout sessions to be able to work with my team members because unlike many of the other teams, none of us work together in our daily work life.”</i></p> <p><i>“Engaging in this course as a team gave me a comfort zone in which to questions, reflect and seek feedback during the learning process without feeling judge. This helped to solidify my understanding of the material, clarify my understanding and provide others feedback which enriched my own personal learning.”</i></p> <p><i>“Time to work on capstone projects during the sessions was also greatly appreciated.”</i></p> <p><i>“Connecting with my group between sessions to discuss implementation of the concepts reinforces the learning during the sessions.”</i></p>

## Appendix E: Overview of Capstone Initiatives

<b>Team 1</b>	
Description	The creation of a new and powerful partnership in which physicians, administrators/staff, and patients/caregivers experience shared accountability for the success and health of the communities that they serve to inquire into and create the relational shifts needed to transform the existing system.
Passionate Purpose	To have valued, engaged clinical teams delivering exceptional patient care within the organization.
What was Achieved	<p>The team is midstream in the Appreciative Inquiry change process with three additional communities to engage.</p> <p>Through this process the team has found some inspiring themes coming up within the organization such as “We want to foster a culture of WE,” “the word patient deeply resonates with me,” “patient care is almost a holy word,” “I think of patients as our cherished loved ones,” and most inspiring to the team, “I want to put the caring back into health care.”</p>
Lessons Learned	<p>During the capstone initiative the team was reminded of the value of building relationships before diving into content. While working with a community group, the team assumed that the group members knew each other well and moved directly into the workshop content without taking time to do introductions. However, the group members did not know each other and the workshop was not as fruitful as a result. The team has now realized putting the agenda aside and deeply listening to what mattered to participants would have been a useful intervention and has now renewed their commitment to starting every conversation, interaction, and meeting with purposeful connection.</p> <p>Another important lesson for the team was in the core concept of emergence. The team has learned to personally and collectively be mindful and patient, watching for what needs to occur and finding balance between this and action.</p>
Going Forward	The next steps will be to bring the inquiry themes back to the Core Team for a Summit. This will form an excellent foundation for the Physician Partnership work going forward.

<b>Team 2</b>	
Description	To redesign the delivery of acute medical and psychiatric care in an emergency department for patients with mental health and addiction issues.
Passionate Purpose	To provide the best possible care to patients who present themselves at the emergency department at a time of crisis.
What was Achieved	The team has reached the Destiny phase in the Appreciative Inquiry change model. According to the team, the capstone initiative has significantly changed how emergency services are delivered to patients who are experiencing a behavioural crisis. The team reported that when the unit is functioning optimally, the quality of care and the level of patient and provider satisfaction is much higher than it has ever been in the past.
Lessons Learned	The team learned the importance of collaboration and including multiple voices

<b>Team 2</b>	
	when they ran into challenges with the design and implementation of their capstone initiative. The team felt they were not sufficiently inclusive of emergency physicians during the Discovery phase of the Appreciative Inquiry change model. However, they plan to start a new round of discovery in which they will be more inclusive.
Going Forward	The team is now evaluating their project to see how to move forward to create and implement their vision more effectively. They will continue to refine their capstone initiative using the principles of collaborative change leadership. They will continue to cycle through the four Appreciative Inquiry phases using developmental evaluation along the way. The team also plans to continue modeling the principles of collaborative change leadership throughout the organization and the wider community with many projects in mind.

<b>Team 3</b>	
Description	To develop a community of practice as a strategy to elevate the quality and quantity of simulation-based education and training in the field of pediatrics.
Passionate Purpose	We believe that education is the bridge between research and safe patient care. The ability to develop, implement, and evaluate education to a collective standard requires experts to collaborate, mentor, and share knowledge thereby creating an organizational network where high quality education is timely and accessible for all staff.
What was Achieved	The team is nearing the end of the Dream phase in the Appreciative Inquiry change model.
Lessons Learned	The team learned that highlighting individual strengths is energizing for team members and makes them more engaged and effective. The team members discovered their core strengths differed and this resulted in a very effective partnership. For example, one team member was strong in communication. The second team member recognizing this as a strength allowed that individual to be the primary communicator without feeling devalued. With this new lens, the team can better coach their staff to recognize and celebrate the strengths of their peers.
Going Forward	The team's next steps are to: <ul style="list-style-type: none"> <li>• Create a report on what they sensed from the community members information with recommendations for a Vision and Design workshop (Summit).</li> <li>• Deliver a presentation of the community insights.</li> <li>• Host a Design workshop to complete the Dream phase and enter into the Design phase of the Appreciative Inquiry change model.</li> </ul>

<b>Team 4</b>	
Description	To develop a Trauma Centre of Excellence for the underserved and highly needy children, youth, and families who have been exposed to complex developmental trauma, working very closely with community partners and several psychiatrists.
Passionate Purpose	The development of a Trauma Centre of Excellence for Children and Family Mental Health.
What was Achieved	The capstone is between the Design phase and the Destiny phase. Among the achievements there have been significant improvements in the organization with

<b>Team 4</b>	
	regard to accountability, performance management, and program development, as well as within the larger systems (collaboration and joint initiatives across Human and Health Services, changes with interdisciplinary team work and joint initiatives, shared management agendas across systems, etc.).
Lessons Learned	This one-member team has embraced “co-creating new ways of doing and being.” In addition, collaborative change has begun to take root for her in the sense that she has committed both personally and professionally to meaningfully live through a process of being open to feedback, mindfully considering, and adapting.
Going Forward	Going forward there will be a continuation of building partnerships across systems both internally and externally.

<b>Team 5</b>	
Description	To ensure complimentary and synergistic work between portfolios, linking goals and objectives as appropriate to provide maximal impact and value across the organization.
Passionate Purpose	To be a system-wide leader in creating a culture of interprofessional (IP) collaboration which fosters the highest quality person-centered care.
What was achieved	The team has created an IP education strategy that synergistically co-exists within the IP care strategy. They have created action items for future work and are now prioritizing them to create a timeline for their strategic plan. They have incorporated not only student education, but education for staff (of all roles and professions), patients, and families as part of the IP team.
Lessons Learned	The team learned to apply many of the core concepts such as emergence, generativity, developmental evaluation, and sensing by being adaptable and flexible, becoming more attuned to understanding what they were seeing, hearing and listening to, challenging their thinking, and being open to creativity.
Going Forward	As the team moves forward from the Design phase to the Destiny phase of the Appreciative Inquiry process they plan to engage their newly expanded team to prioritize the activities within an integrated IP Collaboration strategy design plan. This will allow them to create a timeline with activities mapped out over the next three years and beyond. This timeline will also include a plan for evaluation of the strategy as it unfolds.

<b>Team 6</b>	
Description	To develop a project that supports success of students, staff, and patients within the practice learning environments (student-friendly practice environments).
Passionate Purpose	To create a student friendly practice environment which ensures the safety of students and patients.
What was Achieved	The team is currently at the end of the Discovery phase, moving into the Dream phase of the Appreciative Inquiry process.
Lessons Learned	Through developmental evaluation the team learned to identify a “path” that they know and expect will change as the voices they engage identify what is important to them and what they value related to the project. They have come to realize that this adaptation is part of the process and is essential in their dynamic complex system of



Team 6	
	education and practice.
Going Forward	As the team moves into the Dream phase, they will generate the design which may include processes, professional development, roles, support etc. Following this, in the Destiny phase, the team will bring their passionate purpose to life, implementing their Dream and Design to support student friendly practice environments that are innovative, support student learning, and ensure student and patient safety.

Team 7	
Description	Implement and evaluate an IP program of care for patients with head and neck cancers who have swallowing difficulties (dysphagia). The dysphagia program is delivered in an international health setting, which has previously not provided service to this population.
Passionate Purpose	Not available.
What was Achieved	<p>Among some of the capstone achievements are:</p> <ul style="list-style-type: none"> <li>• Staff now routinely screen for dysphagia.</li> <li>• Patients identified with dysphagia are assessed.</li> <li>• Utilization data is collected and care is documented in the patient chart (which previously was not).</li> <li>• Since the team’s intervention the core team reported “asking different types of questions of patients and within their interprofessional teams.”</li> <li>• The health professionals believe they have “elevated the service of the professions and have committed to ongoing learning and working as an interprofessional team.”</li> </ul>
Lessons Learned	<p>The team relied on human capital and relationships already established with stakeholders, Canadian staff working with local staff, and information technology, such as video conferencing to deal with the challenges posed by geographic distance, international context, and cultural factors.</p> <p>They learned how transferable and flexible the AI method is and were enlightened by the results achieved.</p>
Going Forward	Going forward the team hopes that lessons learned from this process can be applied locally to improve the much needed care for this previously underserved and marginalized population. They are also hoping that the appropriate resources and training have been put in place for the clinicians so that the dysphagia program of care is sustainable and that the new model of evidence based care will be provided to this population, especially once the formal arrangement between the two organizations has expired.

Team 8	
Description	To develop a model that will provide culturally sensitive support to all international learners visiting the organization (e.g., fellows and observers), in addition to working collaboratively with clinical staff to develop customized learning curricula.
Passionate	Leveraging the organization’s thinking to make the organization the institution of

<b>Team 8</b>	
Purpose	choice for the internationally educated learner, and to develop the unit into a rich organizational resource in the practice of international education.
Lessons Learned	One main lesson the team learned is that collaborative change leadership can have significant impact in “traditional systems.” The team found that although they operated in structures that are seemingly top-down, their experience with many stakeholders has shown them that creating opportunities to learn from one another fosters relationship building. In addition the team has embraced core concepts such as Appreciative Inquiry, strengths-based, and mindfulness, among others.
Going Forward	Going forward toward the Destiny phase of the AI process, the team envisions the unit as a Centre of excellence in international education, and a key resource to the organization broadly. The hope is to continue working closely with the broader community, and to engage a wider range of system voices as appropriate to further develop, refine and/or expand what the unit is, and what it does.

<b>Team 9</b>	
Description	To engage Aboriginal communities in discussions about senior’s health and wellness strategies.
Passionate Purpose	To support healthy aging and encourage aging with vitality, dignity, and wellness within Aboriginal communities by building leadership capacity using Aboriginal culture as the foundation to demonstrate collaborative change leadership theory.
What was Achieved	The team has facilitated two workshops with Aboriginal health leaders to enhance leadership capacity within their organizations, as well as to engage the participants to provide advice and input for the capstone project.
Lessons Learned	<p>After holding a community engagement session it became clear that in order to achieve the type of change the team had originally envisioned they should enhance leadership capacity within First Nation communities using the CCL concepts and tying in Aboriginal culture. This led the team to their current passionate purpose: to engage Aboriginal communities in discussions about senior’s health and wellness strategies.</p> <p>The team, working with a small First Nation community, also learned how similar the CCL theory is to Aboriginal culture.</p>
Going Forward	Using a strengths-based approach in keeping with Aboriginal culture, the team is developing further workshops with the ultimate goal of creating Aboriginal change leaders that will transform health care and health status of Aboriginal people.

<b>Team 10</b>	
Description	To reduce pressures on the health care system through a fully implemented mature “shared,” interprofessional, collaborative care model in mental health for rural and northern populations. The capstone involves systematically and consistently connecting primary care providers to specialty care.
Passionate Purpose	For people to be treated as a whole person through the integration of primary care and mental health services in their local community.
What was	The team has developed and is piloting a mental health addition to the Coordinated

<b>Team 10</b>	
Achieved	Care Plans used by the one of the organizations. Other organizations have also invited the team to participate with them and the team is currently planning community education and engagement sessions. The team has also submitted a grant for funding to further work in the area of compassionate care though capacity enhancement and knowledge translation.
Lessons Learned	<p>Restructuring at one organization led to the capstone team to encounter many unforeseen changes. Integral team members left the organization and new members were introduced, such as a new corporate lead for the project after the Vice President of the organization retired. The team has learned that the only thing that is certain is change itself; and more importantly, with change comes opportunity.</p> <p>For example, the psychiatrist, with whom the team partnered to help identify complex mental health clients for the capstone, had decided to retire. This provided the team with an opportunity to propose that the psychiatrist work in a co-located fashion in the rural practice as opposed to at the hospital, thereby moving closer to a more collaborative model of care.</p> <p>Throughout the process the team honed their engagement and emergence skills. They found that building relationships has been one of the keys to their success.</p>
Going Forward	Moving forward the team will work to implement the capstone in five more rural communities.

<b>Team 11</b>	
Description	Enhancing the accessibility of collaborative change leadership education for French-speaking health leaders to steward the translation and adaptation of a Francophone CCL program that would be culturally relevant (transcultural validation). The aim of the capstone initiative is to assess the relevance and adaptability of the CCL program for French-speaking health leaders.
Passionate Purpose	Bring forward collaborative change leadership to enable healthcare changes in French-speaking communities.
What was Achieved	The team was able to make recommendations to project sponsors for a future training program designed for French-speaking leaders in the healthcare system who wished to develop their collaborative change leadership abilities to bring about changes in their complex systems. These project sponsors found the collaborative process extremely fruitful and deemed the recommendations very relevant. They wished to continue the CCL program adaptation process.
Lessons Learned	<p>The team learned to work as a team based on their individual strengths and realized they had three complementary essential competencies for their initiative: the ability to lead, the ability to learn, and the ability to innovate.</p> <p>The team has also learned to incorporate the core CCL concepts into their everyday work such as the concept of emergence. They have also learned and practiced generative listening during the interviews with stakeholders and community members. Finally the team has been equipped to use Appreciative Inquiry and developmental evaluation, and found ways to apply it in their current work.</p>

<b>Team 11</b>	
Going Forward	The team is looking at a strategy for a pilot project that would help document the learning and benefits of a CCL program adapted to French-speaking leaders using evaluative data. The results of the pilot would be used to inform a decision of whether to launch the program on a larger scale.

## Appendix F: Suggestions for Adaptations

### 1. Recommendations for Course Content

Recommendation	Explanation	Quotes	# of mentions <sup>2</sup>	Session					
				1	2	3	4	5	Post
Increase experiential learning.	Participants would have appreciated more time learning how to apply the theories and core concepts learned during the program to real life, and for the program to incorporate more experiential learning.	<p>"[I was hoping for] more application of the core concepts in design from [the] 1<sup>st</sup> moment. Be the work."</p> <p>"Continu[ing] with activities that allow the application of core concepts in unique and interesting ways [would take Session 5 to the next level of value]."</p> <p>"More experiential experiencing and embodying the concepts in way that ground them in personal experiences."</p>	10	✓	✓	✓	✓		
Share learnings related to the capstone.	Participants want to learn about other participants capstones.	<p>"Updates on capstone projects and processes and tools used by various project teams and why they chose [the] project and the process used [Would take Session 3 to the next level of value for participants]."</p> <p>"Get different groups to talk more about what they are doing for their projects and perhaps get feedback from other groups..."</p>	6	✓					
Focusing on "readiness" to implement capstone initiatives.	One participant felt the program could focus on "readiness" to implement capstone initiatives.	"Not sure that our capstone project was mature enough to conduct interviews and would want to have some part of the program that focused on readiness. This is	1	✓					

<sup>2</sup> This count represents the number of times something was mentioned and not the number of individuals mentioning it.

Recommendation	Explanation	Quotes	# of mentions <sup>2</sup>	Session						
				1	2	3	4	5	Post	
		much easier within an organization (where the project and the champion has been identified) than it is in the community setting."								

## 2. Recommendations for Core Concepts

Recommendation	Explanation	Quotes	# of mentions	Session						
				1	2	3	4	5	Post	
Dedicate more time to mindfulness.	Participants would have liked to see the concept of mindfulness be introduced earlier on in the program and for mindfulness practice to be part of each session.	<p>"Maybe it would be interesting to present mindfulness earlier than at the end of the program. That would bring the opportunity to insert some exercises in the face to face sessions."</p> <p>"I would have mindfulness practice be part of each day."</p>	5	✓		✓				✓
Dedicate more time to developmental evaluation.	Participants would have appreciated spending more time learning about Developmental Evaluation.	"The developmental evaluation process could be more present in the sessions. For me, I had a glance of it, but I can't say that I will be able to apply it without a lot of thinking."	3		✓					✓
Core concepts: other suggestions.	<p>Some participants also suggested:</p> <ul style="list-style-type: none"> <li>• Providing short videos on each of the core concepts.</li> <li>• Challenging participants to implement a concept within a certain time-frame, and reporting on how it went.</li> <li>• Providing opportunities to practice theory bursts.</li> <li>• Spending more time learning</li> </ul>	<p>"I would appreciate that the concept and idea of social accountability be embedded more clearly and deeply in the program."</p> <p>"Maybe, focus more in leadership theories and practices (through face-to-face sessions) will be useful. I also noted that at the end of program, some participants have difficulties to see the difference between leadership and management as well as between</p>	8	✓			✓			✓

Recommendation	Explanation	Quotes	# of mentions	Session						
				1	2	3	4	5	Post	
	about complex change management situations, social accountability, Leadership theories, and practice.	different styles of leadership...."								

### 3. Recommendations for Session Activities

Recommendation	Explanation	Quotes	# of mentions	Session						
				1	2	3	4	5	Post	
Provide more time for participants to get to know each other.	Participants would have liked more time to spend working, socializing, and getting to know their fellow learners.	"I think that perhaps out of town/city/province learners might be afforded intentional opportunities to meet each other and socialize during evenings. I could not remember all the delegate names and where they were from until closer to the end of the course. We would have been able to socialize more and share and support one another during challenging times such as travel time, leaving families, etc."	6	✓						✓
Encourage more movement.	Participants would have appreciated more opportunities for "movement" and outdoor exercises.	"I found the opportunities to go outside were greatly appreciated. It would be nice to incorporate more exercises that took us out of the indoor space."	4	✓						✓
Have more time with mentors.	Participants want to increase the time spent working with their mentor.		3		✓		✓			
Reduce repetitive discussion.	Two participants felt that the discussion and material could be covered in less time. That said, at least one of the participants could not think of how to present the	"I often felt that there was too much discussion but always ended up reflecting on the value of the discussion - ironically. I think the material could absolutely be covered in less time, but I don't think the spirit of the	2	✓						✓

Recommendation	Explanation	Quotes	# of mentions	Session						
				1	2	3	4	5	Post	
	material in a different way.	course learnings could happen in a different format. Being present is really what was transformational about this course."								
Increase interaction with alumni.	Participants expressed a desire to learn from and connect with past cohorts. One participant suggested offering participants a mentorship session by CCL graduates.	"Moving forward, learning from other past cohorts...this would add to the experience and wisdom but would also allow for building more cross-Canada perspectives."	3		✓					✓
Session activities: other suggestions.	Individual participants also mentioned cutting out: <ul style="list-style-type: none"> <li>The proprioceptive writing exercise.</li> <li>The workbook exercises and Group work not related to the capstone initiative.</li> </ul>	"Group work outside of capstone group was not productive in my opinion." "I didn't find the workbook exercises useful."	3	✓						✓

#### 4. Recommendations for Reflection

Recommendation	Explanation	Quotes	# of mentions	Session						
				1	2	3	4	5	Post	
Reduce time spent on large group reflections.	Participants found time spent reflecting in large groups was too long.	"I believe that the returns to plenary aren't always necessary. I understand the objective of making the collective learning emerge, but this sometimes weighs down the process. It would be interesting to give precedence to individual reflection and to share this with our team members." "I value the reflective elements of the course and yet I did feel like the some of the large group reviews at the beginning of the day	8	✓		✓	✓			✓



Recommendation	Explanation	Quotes	# of mentions	Session					
				1	2	3	4	5	Post
Reflection: other suggestions.	<p>Some participants suggested more:</p> <ul style="list-style-type: none"> <li>• Sharing in sessions.</li> <li>• Designed self-reflection and mindfulness.</li> <li>• Discussion on how the program has impacted participants personal and work lives in small group sessions.</li> <li>• Focused reflections questions (less repetitive questions).</li> </ul> <p>And less:</p> <ul style="list-style-type: none"> <li>• Time spent on recapping group members comments expressed during the intersession.</li> </ul>	<p>may have taken a bit long sometimes. I wonder if sometimes it might be enough to debrief at group level without doing paired, table, whole group.”</p> <p>“The recap of group members’ comments expressed during the intersession could be a lot shorter. You could present what has been adjusted as a result of the received comments. That may be sufficient.”</p> <p>“Some of the reflection questions I did find a bit repetitive so perhaps reviewing these to avoid duplication, or asking more focused reflection questions.”</p>	7	✓	✓	✓			✓

#### 5. Recommendations for Faculty

Recommendation	Explanation	Quotes	# of mentions	Session						
				1	2	3	4	5	Post	
Encourage more engagement.	Participants felt the faculty could have solicited the engagement of a wider variety of participants.	“For the large group sessions, I would have appreciated it if the faculty did more to engage the whole group. I found that it was the same people over and over again who expressed their opinions and a missed opportunity for others to develop leadership skills in a large group setting.”	2				✓			✓

Recommendation	Explanation	Quotes	# of mentions	Session						
				1	2	3	4	5	Post	
Have fewer faculty voices.	One participant felt there were too many faculty perspectives.	"...I find I am experiencing a disconnect with faculty because there are too many faculty voices... experience in the room does not feel cohesive somewhat disjointed... less faculty in the future?"	1			✓				
Spread faculty across the teams.	One participant recommended that faculty staff be sitting at the tables with the teams during sessions.		1		✓					

## 6. Recommendations for Program Logistics

Recommendation	Explanation	Quotes	# of mentions	Session						
				1	2	3	4	5	Post	
Shorten session days.	Participants found the in-person sessions long, making it difficult to absorb all the information and remain attentive.	"Shorter days – There was a great deal of information to take in and I found it difficult, after a point, to absorb anything new. I think 3 shorter days would be better than 2 long days."  "Shorter days, maybe adding a third day."  "Shorter class day. End at 4:30."	10		✓					✓
Do not run program over the summer.	Participants would have preferred if the program did not run over the summer.	"Perhaps changing the time frame. The course started in April to January. Starting the course in April and competing readings during the summer was a challenge..."  "Timing over the summer made participation very difficult."	5		✓					✓
Shorten program length overall.	Two participants mentioned the course could have been shorter	"I am wondering if overall the length of the program could have been shortened. It was	2							✓

Recommendation	Explanation	Quotes	# of mentions	Session						
				1	2	3	4	5	Post	
	and material could have been covered in less time.	a huge time commitment and at the outset I was not clear on the intensity of the program.”								
Program logistics: other suggestions.	<p>Participants also suggested:</p> <ul style="list-style-type: none"> <li>Changing the days the program was offered to avoid Saturdays.</li> <li>More variety in the food offered.</li> <li>(E)valuations to be anonymous.</li> </ul>	<p>“You may want to think about changing the days the program is offered - e.g. not on Saturdays.”</p> <p>“Although the food offered was very good (for the most part) it would have been nice to offer more variety on a session by session basis (not the exact same two days of food each time).”</p> <p>“This is the first part of this evaluation form that has invited suggestions for improvement. Given that this is clearly not an anonymous evaluation of the program, I don't feel that I can be candid in my remarks.”</p>	2							✓

## 7. Recommendations for Online Platform

Recommendation	Explanation	Quotes	# of mentions	Session						
				1	2	3	4	5	Post	
Make online platform easier to use.	Participants found the online platform could be more user-friendly or facilitative. They found it difficult to navigate and challenging to find the right password.	“The online learning platform has potential but the actual technology could be more facilitative. I know that it would be riddled with issues - but if it felt more like Facebook or LinkedIn or something I'd check as part of my regular routine that would be awesome! Trying to find the random character	5		✓					✓

Recommendation	Explanation	Quotes	# of mentions	Session						
				1	2	3	4	5	Post	
Limit formal expectations of online conversations.	Participants suggested that their participation on the online platform be optional as opposed to required.	password I could not change and locate the right page to post remarks always felt like a bit of a chore in spite of the fact that I loved the people and the materials." "I thrive in face to face connections and environments and only tend to use online platforms as needed. I haven't used Blackboard much more than what was required and don't want to have it as a forced choice of the learning in this program."	4		✓		✓			
Set up live chat on online platform.	Two participants mentioned setting aside times for all participants to interact online at the same time.	"Discussion forums were not very active online - perhaps consider a way to allow for live/synchronous chatting during intersessions."	2		✓					✓
Pose discussion questions on online platform.	Two participants mentioned it would be helpful to have discussion questions posed regularly.	"Personally, due to competing demands, I work very well with timelines. However, I am aware that sometimes this is not conducive to the best interactive blackboard responses/participation. I think for me it would be more collaborative to have ongoing questions/discussions posed (i.e., weekly or bi-weekly) rather than a deadline for everyone's responses."	2		✓					
Online platform: other suggestions.	Participants also suggested: <ul style="list-style-type: none"> <li>• Providing an introduction to the online platform for participants.</li> <li>• Continuing with the use of friendly reminders to go participate online.</li> <li>• Placing more structured</li> </ul>	"Although the face to face aspect was very valuable, it was also difficult to get away from work and home for several days at a time as our team had to travel to Toronto. Perhaps having some sessions online (i.e. webinar, Skype in etc.) as a way to engage using technology as technology is being used more to engage multiple stakeholders	4		✓					✓

Recommendation	Explanation	Quotes	# of mentions	Session				
				1	2	3	4	5
	<p>requirements on participants.</p> <ul style="list-style-type: none"> <li>• Hosting a session via the online platform for out of town participants.</li> </ul>	<p>especially when meetings are difficult to schedule.”</p>						

**8. Recommendations for Program Resources: Readings, PPT Slides, Workbook, and Assignments**

Recommendation	Explanation	Quotes	# of mentions	Session					
				1	2	3	4	5	Post
<p>Make slides available electronically before sessions.</p>	<p>Participants would have liked the slides to be available electronically before the sessions (in order to type notes during the session).</p>	<p>“Would like the slides provided electronically and we can each bring them with us to the sessions or print them out.”</p> <p>“I would like to be able to download all the PowerPoint presentations off the website in order to be able to refer to them in the future.”</p>	<p>11</p>		✓				✓
<p>Make reading materials available for purchase / part of course fees.</p>	<p>Participants found it challenging to acquire the readings materials before the program.</p> <p>Some suggestions included:</p> <ul style="list-style-type: none"> <li>• Sending the readings to participants upon acceptance into the program.</li> <li>• Having the reading materials available for purchase from the program.</li> </ul>	<p>“Having the books/readings packaged and sent to me upon acceptance, rather than individually ordering the required materials.”</p> <p>“Having pre-readings available for purchase.”</p> <p>“When sending out the initial communications re: readings, warn the participants that it might be challenging to find them – should order early on in order to receive &amp; read them prior to the first session.”</p> <p>“It would be nice if the final report is in a</p>	<p>3</p>	✓					
<p>Program</p>	<p>Participants also suggested</p>		<p>3</p>			✓			✓

Recommendation	Explanation	Quotes	# of mentions	Session				
				1	2	3	4	5
resources: other suggestions.	changes relating to the format of the final report, the homework assignment to make up for missed intersessions, and handouts/workbook.	format that could be shared with others in the organization or could be used in a presentation to sponsors or affected committees.”  “The “homework” assignment that I am to complete to make up for the intersession does not support my learning as anywhere near as much as the face to face sessions. I am a very hands on visual learner and I can absolutely notice the difference trying to complete the homework vs being at the sessions.”  “We get a lot of handouts but not sure what purpose they have; maybe overview of what’s excluded in package +/- or for reflecting to session +/- or continuation with project.”						

**9. Recommendations for Post-program Activities**

Recommendation	Explanation	Quotes	# of mentions	Session					
				1	2	3	4	5	Post
Facilitate opportunities to be in contact with participants after the program.	Participants expressed a desire to remain in contact with their fellow CCL classmates after the program ended.  Suggestions included:	“I am also hoping to stay connected with our fellow capstone students, so that we can continue to support and mentor one another, even after the completion of the course.”	10					✓	✓

Recommendation	Explanation	Quotes	# of mentions	Session				
				1	2	3	4	5
<ul style="list-style-type: none"> <li>• A community of practice.</li> <li>• A one-day symposium.</li> <li>• A booster session.</li> <li>• Website/online community.</li> <li>• Email-address circulation.</li> </ul>	<p>"I think there should be some way to sustain the network created in this session. It is my experience that even after great experiences such as we had, participants drift apart and lose contact unless there is some formal way to reconnect and maintain linkages."</p>							
<p>Provide opportunities to remain in contact with mentors and faculty.</p> <p>Participants expressed desire to remain in contact with faculty and mentors after the program ended for guidance and to share their work.</p>	<p>"Ideally, it would have been great if my team could have taken our capstone into design and destiny still under the guidance and access of our coach and course resources. We changed our passionate purpose at the end of the second intensive, which I think is actually part of the process, sometimes your passionate purpose changes through discovery and dream. I wonder if there is a way to help support beyond the course, even if it is just one more coaching session."</p>	3				✓		✓

#### 10. Recommendations for Evaluation

Recommendation	Explanation	Quotes	# of mentions	Session					
				1	2	3	4	5	Post
<p>Limit the evaluation questions.</p>	<p>Participants felt the evaluation questions repetitive and that there were too many of them.</p>	<p>"I think that some of the (e)valuations ask the same question. These could be shortened and perhaps eliminated in some cases. In some cases, I felt like I was answering the same question over and over."</p>	2					✓	✓

## Appendix G: Session Objectives

### Session 1:

7. Interpret and apply the Collaborative Change Leadership model.
8. Explore and articulate the purpose of the capstone initiative grounded in social accountability.
9. Begin to apply awareness of self and self in relationship within the context of collaborative change leadership and the intended change.
10. Identify and engage champions, collaborators and partners, including sponsor and mentor.
11. Design interview questions for understanding organizational context using Appreciative Inquiry methodology.
12. Conduct interviews.

### Session 2:

7. Interpret organizational inquiry results to create a portrait of organizational strengths and change need.
8. Refine the purpose of the capstone initiative and ground in social accountability principles.
9. Begin to describe a personal practical theory of collaborative change leadership.
10. Choose and apply leadership practices for what is emerging in the organization and/or community context.
11. Identify appropriate communication and engagement approaches for the design of the change strategy.
12. Begin designing the integrated emergent change and evaluation strategy.

### Session 3:

5. Lead and engage in meaning-making processes to design the change.
6. Navigate the tension between implementing a change strategy and sensing system needs and what is emerging, and adapting accordingly.
7. Continue to refine the integrated emergent change and evaluation strategy with a focus on design and implementation.
8. Describe how the personal practical theory of collaborative change leadership is shifting and evolving.

### Session 4:

5. Lead the interpretation and synthesis of what is emerging in the organization and/or community through sensing methods.
6. Interpret and maximize the impact of individual, team, organization/community, and system strengths.
7. Lead self, team, organization/community, and system adaptation according to what is emerging.
8. Explore and evaluate intended and unintended outcomes, and continue to evolve the evaluation according to what is emerging.

### Session 5:

6. Assess movement and adapt strategies based on what is emerging as meaningful in the organization.
7. Use storytelling to inspire and engage.
8. Identify and apply personal practices that enable the sustainability of collaborative change leadership for self, team, organization/community, and system.
9. Enact and model their personal practical theory of collaborative change leadership.
10. Create a collective portrait of collaborative change leadership, including its value and impact.



## Appendix H: Changes to Leadership Practices

Practice	Description	Impact	Illustrative Excerpts
Increased confidence.	<p>Learners reported an increased confidence in:</p> <ul style="list-style-type: none"> <li>• Their ability to lead;</li> <li>• Their colleagues; and</li> <li>• The system and how to move forward.</li> </ul>	<p>Increased confidence helped learners:</p> <ul style="list-style-type: none"> <li>• Effectively perform and model change leadership.</li> <li>• Be a more productive team member.</li> <li>• Face complex change.</li> <li>• Facilitate conversation on contentious issues.</li> <li>• Accept more responsibility.</li> <li>• Recognize and use their strengths.</li> <li>• Recognize strengths in colleagues.</li> </ul>	<p><i>“I was having difficulty in recognizing my strengths, judging myself critically, thinking I couldn’t be a CCL. This session allowed me to evolve. See, I can do this. I have been doing this.”</i></p> <p><i>“This intersession also enabled me to reflect on my own strengths to identify areas where I could maximize these strengths in my day to day practice”</i></p> <p><i>“I look at [team members] strengths and work with them”</i></p>
Asking generative questions.	<p>Learners noted that they are asking more questions and asking questions in a different way. For example, questions are grounded in Appreciative Inquiry or in their passionate purpose.</p>	<p>Being more generative helped learners:</p> <ul style="list-style-type: none"> <li>• Engage the contribution of colleagues.</li> <li>• Engage richer interactions.</li> <li>• Develop the project and solve problems as ideas emerge.</li> <li>• Approach and facilitate discussions around contentious issues.</li> </ul>	<p><i>“My presence has shifted from being an information provider to an information seeker, from a solution driver to a solution inquirer.”</i></p> <p><i>“I do not have to have all of the answers but I recognize that I am a key support and hold a position of power and privilege that makes it essential for me to listen carefully and with respect and actively encourage contributions from everyone. I also see that asking questions is often more powerful than providing answers, even if I think I have the answers since I can trust others to create relevant practices that are meaningful to them as we work together towards shared</i></p>

Practice	Description	Impact	Illustrative Excerpts
			<i>goals."</i>
Seeking ideas, perspectives, and opinions of colleagues from a place of non-judgment.	Learners noted that they actively engage colleagues, listen more, and are less inclined to bring their own biases to a discussion. Many learners discovered that they don't need to have all the answers and can instead rely on the collective intelligence of the group.	Valuing the contributions of colleagues helped learners: <ul style="list-style-type: none"> <li>• Build relationships with colleagues and stakeholders.</li> <li>• Feel more comfortable delegating to team members.</li> <li>• Empower colleagues to take leadership roles.</li> <li>• Stay focused on the purpose.</li> <li>• Find opportunities for colleagues to use their strengths.</li> </ul>	<p><i>"During all the fieldwork activities I saw how the wisdom of the team allows us co-creating and developing the capstone initiative as ideas emerge. I learned that I don't need to have all the answers. I just advocated for the help of others and left others use their strengths. This was a big transformation for me".</i></p> <p><i>"When I stepped back and really took the learner road and really focused that on individual with whom I found I was always on the judger path with, I was able to connect with them and get past some of our 'issues' and create a more positive relationship."</i></p>
Leading from a place of authenticity.	Learners reported that their participation in the program helped them become more self-aware. This allows them to lead from a place of authenticity.	Leading from a place of authenticity helps learners: <ul style="list-style-type: none"> <li>• "Speak from the heart and mind more frequently."</li> <li>• Trust their instincts.</li> <li>• Act from their core values.</li> <li>• Use their strengths.</li> <li>• Avoid over-thinking.</li> </ul>	<p><i>"I feel that I am engaging with myself differently. I am really trying to centre myself, to act from my core and my values, and this is translating into how I work with others, and how I make meaning at work."</i></p> <p><i>"For me the value is just about being able to be 'me' and finding the space to lead from an authentic place within myself."</i></p> <p><i>"The program transformed me as a leader, by allowing</i></p>

Practice	Description	Impact	Illustrative Excerpts
			<p><i>me to be authentic. This is beneficial to me but also my team as they get to see an authentic person every day."</i></p> <p><i>"The CCL program has enabled me to become more self-aware through an emerging self-growth over the months of the program. This self-growth has allowed me to accept my true authentic self. I am more trusting of my instincts."</i></p>
Being open to what is emerging.	Learners reported an increased comfort with ambiguity and willingness to welcome what emerges.	<p>Working with emergence helps learners:</p> <ul style="list-style-type: none"> <li>• Adapt and switch directions as information emerges.</li> <li>• Save time by avoiding unnecessary work.</li> <li>• Manage uncertainty and change.</li> <li>• Approach system level problems with a sense of calm.</li> <li>• Attune to adjacent work and pause to invite more players to the table before making decisions.</li> </ul>	<p><i>"Much more comfortable with emergence. Sometimes in the past I would work so far ahead that conditions would change before implementation. I am now more focused on sensing, attuning to adjacent work and intersections, pausing to invite more players to the table before making decisions etc."</i></p>

Practice	Description	Impact	Illustrative Excerpts
Sensing.	Learners reported that they pay more attention to what is happening in their environment by listening and observing subtle cues.	<p>Sensing helps learners:</p> <ul style="list-style-type: none"> <li>• Better understand organizational norms and culture.</li> <li>• Capture the unspoken feelings in conversations.</li> <li>• Identify what might need to shift given the energy in the room and the feedback received from colleagues.</li> <li>• Stay in touch with the issues that are evolving.</li> <li>• Suspend their voice of judgment and stay open to new ideas</li> </ul>	<p><i>“All of our project team commented that during the interviews that they conducted, they really utilized sensing to capture the unspoken feelings that were present. We noted body language, tone of voice, enthusiasm – all of which spoke to the level of engagement of our interviewees.”</i></p>
Taking time to reflect.	Learners reported taking more time to slow down, pause, and reflect.	<p>Reflection helps learners:</p> <ul style="list-style-type: none"> <li>• Be more intentional about who to engage and when.</li> <li>• Consider the implications of their decisions to the broader system.</li> <li>• Lead with calmness and greater spaciousness.</li> </ul>	<p><i>“I have also created a five question prompt that I am reading before each meeting I attend with the following questions: Am I present? Am I on the judge path or learner path? Am I coming from a voice of judgment or fear? Am I listening with an open heart, open mind and open will? Am I focusing on problems rather than solutions? These prompts are helping to ground me in the CCL Core Concepts as I continue to do my work as a transformative change agent of the health care system.”</i></p> <p><i>“I would often find myself thinking about the literature I read or conversations I had in the sessions when I was dealing with a difficult situation and thinking ‘what would a CCL do in this instance.’ I seem to always reflect on any discussions I have with team members</i></p>

Practice	Description	Impact	Illustrative Excerpts
			<p><i>when dealing with changes."</i></p> <p><i>"I have a deeper appreciation of reflection and the value of it. I did not utilize the exercise of reflection truly in the past, and now have been seeing the value of it. I feel the opportunity of taking this course has been very valuable."</i></p>
Taking an appreciative approach.	Many learners reported bringing an Appreciative Inquiry approach to their work by focusing on possibilities rather than obstacles.	<p>Appreciative Inquiry helps learners:</p> <ul style="list-style-type: none"> <li>• Avoid making judgments about colleagues or ideas.</li> <li>• Understand colleagues' concerns.</li> <li>• Build on people's strengths to facilitate change.</li> <li>• Inspire big picture thinking.</li> </ul>	<p><i>"With consideration of the concepts of Appreciative Inquiry, I am now looking at things as possibilities, not impossibilities and searching for ways to make them reality."</i></p>

## Collaborative Change Leadership Program 2014-2015: Reflective Themes from Participant Feedback - Faculty Synthesis

Upon completion of the final in-person session, participants submitted papers describing their total experience. The faculty prepared a synopsis of these reflections.

One of the most striking observations about the final papers from participants in CCL 3.0 is how deep and resonant the reflections were, with highly passionate, personal language. One participant captured the essence of CCL as *“finding silence in the beautiful chaos.”* Almost every person described their CCL experience as **transformative and life-changing** in some way. *“I have found that the model of collaborative change leadership reinforced many of the things that I believed to be right about leadership but in some ways never had the courage to espouse.... As I began to understand and embrace the principles of collaborative change leadership, I began to change. I began to see results in those around me and noticed their enthusiasm.”*

For many, this included having their sense of **authenticity, confidence and deep purpose** in their work unleashed for the first time. *“This journey has allowed me to give myself permission to let go, to go with the flow, and to be true to my authentic self. Although CCL has ended, my journey has just begun.”*

Equally striking was the **depth of integration of all strands of the Collaborative Change Leadership concepts**. Almost every paper called out multiple aspects of the conceptual frame as significant aspects of their learning, and every aspect of CCL was mentioned by many participants. Many described the **multi-faceted nature of CCL as what makes it so powerful**. One participant’s description of CCL beautifully illustrated this: *“to mindfully support concepts of appreciative inquiry, sensing, emergence, and generativity through a strengths-based approach, a position of connecting to the core of my spirit base of knowingness, and even when knowing may not exist, that I can trust in what might be.”* Another described the program as an *“integration and accumulation for me of core concepts, models and theories that have informed my change leadership practice over time from my prior knowledge, background and experience.”* Some recognized its power as *“based on basic human needs... to be in community.”*

Almost every participant expressed their evolving leadership as requiring **pausing, self-awareness, mindfulness and reflection**. While learners commented comprehensively on some of the more “doing” aspects of collaborative change leadership, the predominant theme of personal and professional transformation spoke to deep listening, presence and awareness as absolutely necessary to enable any other action. Almost every participant referenced **mindfulness**, often as the overlay to all other aspects of CCL. *“Allowing myself to create time and space for purposeful pauses and reflection is the entry point through which I can explore the other core concepts of collaborative change leadership. Mindfulness is what allows me to transition into the learner path, and what gives me the*

*comfort, confidence and self-permission to explore my relationship with being 'at the bottom of the U.'*"

The recognition of the integral nature of the different elements of CCL was accompanied by many reflections about how the program had enabled **movement on significant initiatives focused on improving health and education**, but more important, had included an **unexpected personal transformation of tremendous depth**, frequently framed as **the beginning of a transformative journey**.

*"I initially approached this course with the primary intention of completing a capstone project with my colleagues...the real learning for me would have an impact far beyond the capstone itself... I find myself showing up at work differently."... "I feel that I have learned a lot and yet my journey of transformation as a collaborative change leader has just begun."*

For some, CCL represented an **articulation of perspectives or approaches that people had intuitively known or already embraced**. *"The way I had typically worked for years was validated"..."I felt validated about something that deeply inspires me."* For many, the program enabled them to recognize that they had **great untapped capacity for this way of being and working**. *"The most important lesson I learned is that these concepts are already within me – I only have to listen and trust my inner self and let them emerge..." "I have realized that these are skills I already have but was not really aware of as they show themselves in a very narrow context"..."The new concepts that seemed so complicated at first now had a beautiful simplicity to them, like they were in me all along and I just had to look inwards to tap into them."*

Another dominant theme related to the powerful and necessary impact of **adopting a learner stance and being able to suspend judgment**. *"Change your questions, change your life"* was frequently cited as a pivotal book, with many describing the different ways they had integrated a learning perspective into their lives. *"The most challenging is seeing from a compassionate lens – this will require that purposeful pause and deep thinking – the movement from judger to learner"..."When I stepped back and really took the learner road and really focused that on individual with whom I found I was always on the judger path with, I was able to connect with them and get past some of our "issues" and create a more positive relationship."* Many mentioned **generative questions** as critical, linked closely with **engaging with multiple points of view**. *"Opt for the path of choice rather than judgment as often as possible – looking for diverse points of view."*

Many learners found the concepts and language of **collective intelligence** critical to bringing collaborative change leadership to life, embedded in **a shifting notion of leadership away from having all the answers toward generative engagement and emergence**. *"I learned I don't need to have all the answers – I advocated for the help of others and let others use their strengths – this was a big transformation for me"..."The meaning of leadership has shifted, leading does not imply always starting, jumping ahead, and having all the answers. I feel more satisfaction in resting back, co-creating and*

*encouraging the collective intelligence of the team”... ..“I am relying on the wholeness of my being to guide my decision making, and am seeking answers to questions by harnessing the collective wisdom of those around me”... ..“I cannot lead collaboratively from my cubicle.”*

For many, there was a deepened understanding that **there may not even be a “right” answer** – that many paths create workable possibilities.... *“there is no right answer or perfect path (or perfect leader)... organizations are many layered and the voices in the system need to influence future directions.”.....“Bring your full awareness and presence to this moment – practice seeing that whatever comes up is workable if you are willing to trust your intuition.”*

The **experience of CCL itself had mirrored and modeled this embracing of collective wisdom**, with many people acknowledging the value of the learning community and the way knowledge built over time. *“I was able to see myself both uniquely and as part of a great whole, which made for a very rich and transformative learning experience”... ..“The 10 months, intensives, and coaching are really needed to be able to reflect and experience each concept and tool.”*

The final – and for many, most significant -- learning cited by multiple participants was a new **foregrounding of social accountability**, linked closely to a deepened understanding of the need to be continually in touch with the purpose and impact of one’s work. *“I have always been sensitive to seeking the viewpoints of the under-represented, and now feel even more committed and empowered to continue, with a framework of social accountability to guide me in the process.” ...“I find myself quite consciously considering the notion of social accountability at the onset of any initiative now” ... “I love the connection to purpose, and to making a difference in the world that this focus has created within me”... ..“CCL begins with viewing potential ideas/initiatives/change through a lens of social accountability to determine if it is worthwhile.”*



Canadian  
Interprofessional Health  
Leadership Collaborative



Consortium Canadien  
sur le leadership en matière  
d'interprofessionnalisme en santé

## Conference Posters of the

*Canadian Interprofessional Health Leadership Collaborative (CIHLC)*



UNIVERSITY OF TORONTO  
FACULTY OF MEDICINE



a place of mind  
THE UNIVERSITY OF BRITISH COLUMBIA



Northern Ontario  
School of Medicine  
École de médecine  
du Nord de l'Ontario  
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UNIVERSITÉ  
LAVAL



## The Canadian Interprofessional Health Leadership Collaborative

Margo Paterson [1], Lesley Bainbridge [2], Serge Dumont [3], Sue Berry [4], David Marsh [4], Sarita Verma [5], Maria Tassone [5,6]

1. Queen's University 2. University of British Columbia 3. Université Laval 4. Northern Ontario School of Medicine 5. University of Toronto 6. University Health Network

### BACKGROUND

The **Canadian Interprofessional Health Leadership Collaborative (CIHLC)** has been chosen by the U.S. Institute of Medicine's (IOM) Board on Global Health as one of four innovation collaboratives around the world. The collaboratives are intended to incubate and pilot ideas for reforming health professional education called for in the Lancet Commission report, and are part of the IOM's new Global Forum on Innovation in Health Professional Education launched in March 2012.

### VISION

Collaborative leadership for health system change to globally transform education and health.



### GOAL

To co-create, develop, implement and evaluate a global collaborative leadership model, through the pan-Canadian collaborative and engagement of the global community.

### OBJECTIVES

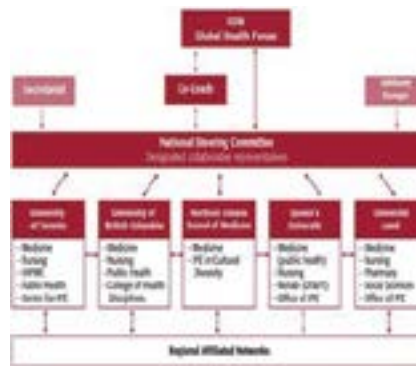
1. Develop a collaborative leadership model for health system change.
2. Build and leverage existing partnerships within Canada to facilitate and implement collaborative leadership programs.
3. Utilize IT and social media to support communities in leadership training.
4. Develop new academic productivity and scholarship to influence global policy reform.
5. Develop an evaluation framework that measures planned and emergent change at the educational, practice and system levels.

### CIHLC MEMBERS

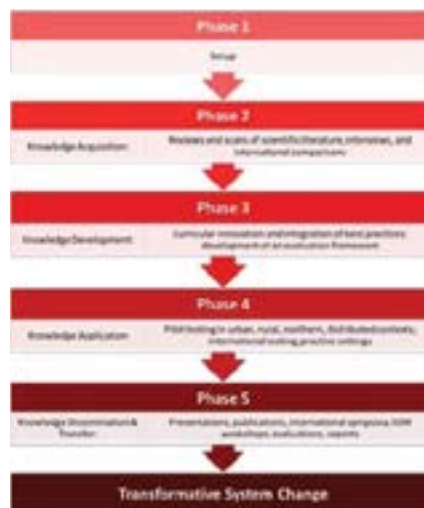
The CIHLC, led by the University of Toronto, consists of the University of British Columbia, the Northern Ontario School of Medicine, Queen's University and Université Laval as partners.



### CIHLC STRUCTURE



### PROCESS



### WHERE WE ARE NOW

#### Completed (Phase 1):

- ✓ Established the National Steering Committee (NSC) with representation from all five universities to lead the project
- ✓ Early engagement of stakeholders
- ✓ Developed a business plan
- ✓ Fundraising efforts with over 20 contacts
- ✓ Statement of collaboration between partners
- ✓ Presentations at national, provincial, regional and local meetings
- ✓ Dissemination of scholarship in Kobe, Japan; Thunder Bay, Canada; Washington DC, USA
- ✓ Attended two IOM Global Health Forums on Innovation in Health Professional Education
- ✓ Highlighted in Global Commission ([www.healthprofessionals21.org](http://www.healthprofessionals21.org)) and IOM websites ([www.iom.edu](http://www.iom.edu))

#### In progress (Phase 2):

- Conducting reviews of peer reviewed and grey literature. The **literature reviews** are leading the evolution of the program and its key components, namely:
  - The definition and impact of **collaborative leadership for health system change**
  - The existing evidence base for collaborative leadership **education and curricula**
  - The principles of **community engagement and social accountability**
  - Validity of potential **evaluation frameworks**
- **Qualitative research** through **key informant** interviews for further refining "**collaborative leadership**"
- Developing an **evaluation framework** for **systematic implementation** and to support pilot testing of the collaborative leadership curriculum

### DELIVERABLES & OUTCOMES

- Collaborative leadership competencies
- Collaborative leadership curriculum for health care students, practitioners and leaders
- Evidence-based products anchored in the principles of social accountability
- Evaluation framework for systematic implementation
- Global education and practice partnerships
- Health reform with improved health outcomes



## Building Community in Generating a Canadian Interprofessional Health Leadership Collaborative

Sarita Verma [1], Maria Tassone [1, 2], Lesley Bainbridge [3], Margo Paterson [4], Sue Berry [5], David Marsh [5], Serge Dumont [6]

1. University of Toronto 2. University Health Network 3. University of British Columbia 4. Queen's University 5. Northern Ontario School of Medicine 6. Université Laval

### BACKGROUND

The **Canadian Interprofessional Health Leadership Collaborative (CIHLC)** has been chosen by the U.S. Institute of Medicine's (IOM) Board on Global Health as one of four innovation collaboratives around the world. The collaboratives are intended to incubate and pilot ideas for reforming health professional education called for in the Lancet Commission report, and are part of the IOM's new Global Forum on Innovation in Health Professional Education launched in March 2012.

### VISION

Collaborative leadership for health system change to globally transform education and health.



### GOAL

To co-create, develop, implement and evaluate a global collaborative leadership model, through the pan-Canadian collaborative and engagement of the global community.

### OBJECTIVES

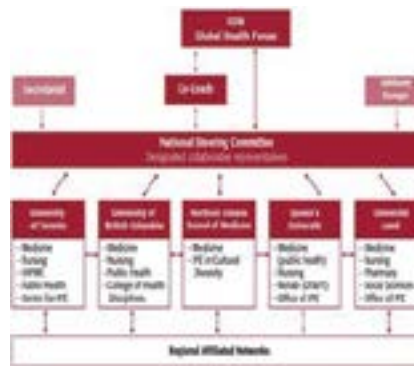
1. Develop a collaborative leadership model for health system change.
2. Build and leverage existing partnerships within Canada to facilitate and implement collaborative leadership programs.
3. Utilize IT and social media to support communities in leadership training.
4. Develop new academic productivity and scholarship to influence global policy reform.
5. Develop an evaluation framework that measures planned and emergent change at the educational, practice and system levels.

### CIHLC MEMBERS

The CIHLC, led by the University of Toronto, consists of the University of British Columbia, the Northern Ontario School of Medicine, Queen's University and Université Laval as partners.



### CIHLC STRUCTURE



### PROCESS



### WHERE WE ARE NOW

#### Completed (Phase 1):

- ✓ Established the National Steering Committee (NSC) with representation from all five universities to lead the project
- ✓ Early engagement of stakeholders
- ✓ Developed a business plan
- ✓ Fundraising efforts with over 20 contacts
- ✓ Statement of collaboration between partners
- ✓ Presentations at national, provincial, regional and local meetings
- ✓ Dissemination of scholarship in Kobe, Japan; Thunder Bay, Canada; Washington DC, USA
- ✓ Attended two IOM Global Health Forums on Innovation in Health Professional Education
- ✓ Highlighted in Global Commission ([www.healthprofessionals21.org](http://www.healthprofessionals21.org)) and IOM websites ([www.iom.edu](http://www.iom.edu))

#### In progress (Phase 2):

- Conducting reviews of peer reviewed and grey literature. The **literature reviews** are leading the evolution of the program and its key components, namely:
  - The definition and impact of **collaborative leadership for health system change**
  - The existing evidence base for collaborative leadership **education and curricula**
  - The principles of **community engagement and social accountability**
  - Validity of potential **evaluation frameworks**
- **Qualitative research** through **key informant** interviews for further refining "**collaborative leadership**"
- Developing an **evaluation framework** for **systematic implementation** and to support pilot testing of the collaborative leadership curriculum

### DELIVERABLES & OUTCOMES

- Collaborative leadership competencies
- Collaborative leadership curriculum for health care students, practitioners and leaders
- Evidence-based products anchored in the principles of social accountability
- Evaluation framework for systematic implementation
- Global education and practice partnerships
- Health reform with improved health outcomes



# Fostering Interprofessional Learning and Practice through the Development of Collaborative Leadership Program

Margo Paterson<sup>1</sup>, Lesley Bainbridge<sup>2</sup>, Emmanuelle Careau<sup>3</sup>, Janice Van Dijk<sup>1</sup>, David Marsh<sup>4</sup>, Sue Berry<sup>4</sup>, Karim Remtulla<sup>4</sup>, Maria Tassone<sup>5</sup>, Sarita Verma<sup>5</sup>

<sup>1</sup>. Queen's University <sup>2</sup>. University of British Columbia <sup>3</sup>. Université Laval <sup>4</sup>. Northern Ontario School of Medicine <sup>5</sup>. University of Toronto

## BACKGROUND

The **Canadian Interprofessional Health Leadership Collaborative (CIHLC)** has been chosen by the U.S. Institute of Medicine's (IOM) Board on Global Health as one of four innovation collaboratives around the world. The collaboratives are intended to incubate and pilot ideas for reforming health professional education called for in the Lancet report, *Education of Health Professionals for the 21<sup>st</sup> Century: A Global Independent Commission*, and are part of the IOM's Global Forum on Innovation in Health Professional Education launched in March 2012.

**Vision** - Collaborative leadership for health system change to globally transform education and health



From limited innovative capacity To dramatically increased innovative capacity

**Goal** - To develop, implement, evaluate and disseminate an evidence-based program in collaborative leadership (CL) that builds capacity for health systems transformation

CIHLC will be grounded in the principles of social accountability and community engagement and is embedded in a context of interprofessional and relationship-centred care.

## OBJECTIVES

1. Develop a collaborative leadership model for health system change
2. Build and leverage existing partnerships within Canada to facilitate and implement collaborative leadership programs
3. Utilize IT and social media to support communities in leadership training
4. Develop new academic productivity and scholarship to influence global policy reform
5. Develop and implement an evaluation framework that measures planned and emergent change at the educational, practice and system levels



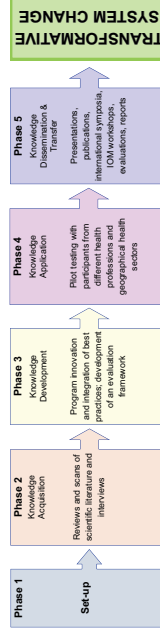
## CIHLC MEMBERS & STRUCTURE

- University of Toronto (lead)
- University of British Columbia
- Northern Ontario School of Medicine
- Queen's University
- Université Laval



The National Steering Committee (NSC), with representation from the five universities, leads the project and reports to the IOM.

## PROCESS



## PHASE 1

- ✓ Early engagement of stakeholders
- ✓ Successfully procured funding from the Ontario Ministry of Health and Long-term Care
- ✓ Dissemination of scholarship in Japan, Australia, US, and Canada
- ✓ Participation at IOM Global Health Forums on Innovation in Health Professional Education
- ✓ CIHLC highlighted in Global Commission ([www.healthprofessionals21.org](http://www.healthprofessionals21.org)) and IOM ([www.iom.edu](http://www.iom.edu)) websites

## PHASE 2

- ✓ **Environmental scans to define "collaborative leadership"**
- ✓ Conducted qualitative research through key informant interviews (n=34 participants) for further refining of the term, "collaborative leadership" (CL)
- ✓ Transcribed and analyzed interviews through iterative coding
- ✓ Conducted reviews of peer-reviewed and grey literature on CL for health system change
- ✓ Reviewed 183 journal articles/reports and 24 theoretical books

## PHASE 2

### Curriculum Literature Review

- ✓ Conducted systematic reviews of peer-reviewed and grey literature on CL curricula, including inventory of existing programs
- ✓ Reviewed 250 scientific articles and 349 health leadership courses
- ✓ Performed descriptive statistics, correlational tests and a cluster analysis to inform the development of the CIHLC program

### Main results from environmental scans and literature reviews

- ✓ There is no single shared understanding of how CL should be defined
- ✓ Key elements of collaborative leaders = humility, excellence in communication, co-creating a shared vision, self-awareness, and ability to influence/engage others and effectively use group processes
- ✓ Definition of CL program: *To develop people to lead systems and enable socially accountable change in their community*
- ✓ Five themes emerged describing leadership in health:
  - 1) innovation & system change
  - 2) tools to transform service delivery
  - 3) collaboration
  - 4) teambuilding/partnerships
  - 5) personal/interpersonal competencies
- ✓ Identified knowledge, skills and attitudes for CL program
- ✓ Produced guidelines for CL program development and community engagement

## PHASES 2 & 3

- Developing the **Evaluation Framework** using a developmental evaluation approach
- Creating the design for a collaborative leadership education program for "Emerging leaders in health", including practice leaders and middle managers
- Integrating community engagement and social accountability into curriculum design
- Creating a model pilot CL program



- ### DELIVERABLES & OUTCOMES
- Collaborative leadership evidence-based education program for emerging leaders
  - Program will be anchored in the principles of social accountability, community engagement, and interprofessional care
  - Evaluation framework for implementation
  - Global education and practice partnerships
  - Health, system sustainability and patient engagement outcomes

# Collaborative Leadership for Health System Change to Globally Transform Education and Health

Maria Tassone<sup>1</sup>, Sarita Verma<sup>1</sup>, Lesley Bainbridge<sup>2</sup>, Sue Berry<sup>3</sup>, Emmanuelle Careau<sup>4</sup>, Chris Lovato<sup>2</sup>, David Marsh<sup>3</sup>, Margo Paterson<sup>5</sup>, Janice Van Dijk<sup>5</sup>

<sup>1</sup>University of Toronto, <sup>2</sup>University of British Columbia, <sup>3</sup>Northern Ontario School of Medicine, <sup>4</sup>Université Laval, <sup>5</sup>Queen's University

## BACKGROUND

The **Canadian Interprofessional Health Leadership Collaborative (CIHLC)** has been chosen by the U.S. Institute of Medicine's (IOM) Board on Global Health as one of four innovation collaboratives around the world.



The collaboratives are intended to incubate and pilot ideas for reforming health professional education called for in the Lancel report, *Education of Health Professionals for the 21<sup>st</sup> Century: A Global Independent Commission*, and are part of the IOM's Global Forum on Innovation in Health Professional Education launched in March 2012.

**Goal** - To develop, implement, evaluate and disseminate an evidence-based program in collaborative leadership that builds capacity for health systems transformation

## OBJECTIVES

1. Develop a collaborative leadership model for health system change
2. Build and leverage existing partnerships within Canada to facilitate and implement collaborative leadership programs
3. Utilize IT and social media to support communities in leadership training
4. Develop new academic productivity and scholarship to influence global policy reform
5. Develop and implement an evaluation framework that measures planned and emergent change at the educational, practice and system levels

## PHASE 1: SET-UP

- ✓ Early engagement of stakeholders
- ✓ Successfully procured funding from the Ontario Ministry of Health and Long-Term Care
- ✓ Dissemination of scholarship in Japan, Australia, US, and Canada
- ✓ Participation at IOM Global Health Forums on Innovation in Health Professional Education
- ✓ CIHLC highlighted in Global Commission (www.healthprofessionals21.org) and IOM (www.iom.edu) websites

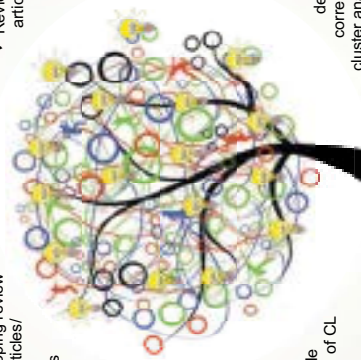
## PHASE 2: KNOWLEDGE ACQUISITION

### Environmental Scan to Define "Collaborative Leadership"

- ✓ Conducted qualitative research through key informant interviews (n=34 participants) for further refining of the term, "collaborative leadership" (CL)
- ✓ Conducted a scoping review of 183 journal articles/reports and 24 theoretical books

### Curriculum Literature Review

- ✓ Conducted systematic reviews of peer-reviewed and grey literature on CL curricula, including inventory of existing programs
- ✓ Reviewed 250 scientific articles and 349 health leadership courses
- ✓ Administered online survey to target audience



### RESULTS: Key Elements of Collaborative Leaders

- ✓ There is no single shared definition of CL
- Humility and self-awareness
- Influencing / engaging others
- Co-creating a shared vision with others
- Effectively using group processes to bring in diverse perspectives

### Analysis of Curriculum Literature

- ✓ Performed descriptive statistics, correlational tests and a cluster analysis to inform the development of the CIHLC program

**Results:** ✓ Identified knowledge, skills and attitudes for CL program

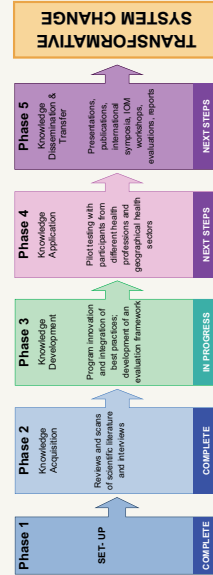
*CIHLC will be grounded in the principles of social accountability and community engagement and is embedded in a context of interprofessional and relationship-centred care.*

## PHASE 3: KNOWLEDGE DEVELOPMENT

1. Based on findings, there is a need and value for a unique focus on CL in health care
2. Currently creating the design and pilot for a collaborative leadership education program for emerging leaders
3. Mandate of CL program will be developing people to lead systems and enable socially accountable change with their community
4. Employing a modular and longitudinal approach
5. Innovative action learning project based on community engagement principles
6. Developing the **Evaluation Framework** using a developmental evaluation approach

**VISION** - Collaborative leadership for health system change to globally transform education and health

## NEXT STEPS



**BETTER CARE, BETTER HEALTH, BETTER VALUE**

# Collaborative Leadership for Relationship-Centred Health System Transformation

Sarita Verma<sup>1</sup>, Maria Tassone<sup>1</sup>, Lesley Bainbridge<sup>2</sup>, Sue Berry<sup>3</sup>, Emmanuelle Careau<sup>4</sup>, David Marsh<sup>3</sup>, Margo Paterson<sup>5</sup>, Deanna Wu<sup>1</sup>, Janice Van Dijk<sup>5</sup>  
 1. University of Toronto, 2. University of British Columbia, 3. Northern Ontario School of Medicine, 4. University Laval, 5. Queen's University

## BACKGROUND

The **Canadian Interprofessional Health Leadership Collaborative (CIHLC)** has been chosen by the U.S. Institute of Medicine's (IOM) Board on Global Health as one of four innovation collaboratives around the world. The collaboratives are intended to incubate and pilot ideas for reforming health professional education called for in the Lancet report, *Education of Health Professionals for the 21<sup>st</sup> Century: A Global Independent Commission*, and are part of the IOM's Global Forum on Innovation in Health Professional Education launched in March 2012.

**Vision** - Collaborative leadership for health system change to globally transform education and health



**Goal** - To develop, implement, evaluate and disseminate an evidence-based program in collaborative leadership (CL) that builds capacity for health systems transformation

CIHLC will be grounded in the principles of social accountability and community engagement and is embedded in a context of interprofessional and relationship-centred care.

## OBJECTIVES

1. Develop a collaborative leadership model for health system change
2. Build and leverage existing partnerships within Canada to facilitate and implement collaborative leadership programs
3. Utilize IT and social media to support communities in leadership training
4. Develop new academic productivity and scholarship to influence global policy reform
5. Develop and implement an evaluation framework that measures planned and emergent change at the educational, practice and system levels



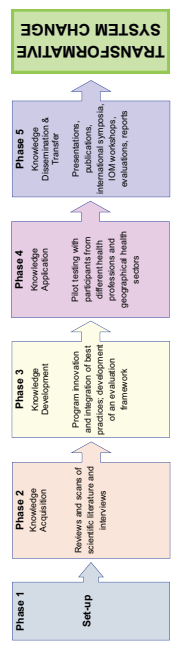
## CIHLC MEMBERS & STRUCTURE

- University of Toronto (lead)
- University of British Columbia
- Northern Ontario School of Medicine
- Queen's University
- Université Laval



The National Steering Committee (NSC), with representation from the five universities, leads the project and reports to the IOM.

## PROCESS



## PHASE 1

- ✓ Early engagement of stakeholders
- ✓ Successfully procured funding from the Ontario Ministry of Health and Long-term Care
- ✓ Dissemination of scholarship in Japan, Australia, US, and Canada
- ✓ Participation at IOM Global Health Forums on Innovation in Health Professional Education
- ✓ CIHLC highlighted in Global Commission ([www.healthprofessionals21.org](http://www.healthprofessionals21.org)) and IOM ([www.iom.edu](http://www.iom.edu)) websites

## PHASE 2

### Curriculum Literature Review

- ✓ Conducted systematic reviews of peer-reviewed and grey literature on CL curricula, including inventory of existing programs
- ✓ Reviewed 250 scientific articles and 349 health leadership courses
- ✓ Performed descriptive statistics, correlational tests and a cluster analysis to inform the development of the CIHLC program

### Main results from environmental scans and literature reviews

- ✓ There is no single shared understanding of how CL should be defined
- ✓ Key elements of collaborative leaders = humility, excellence in communication, co-creating a shared vision, self-awareness, and ability to influence/engage others and effectively use group practices
- ✓ Definition of CL program: *To develop people to lead systems and enable socially accountable change in their community*
- ✓ Five themes emerged describing leadership in health:
  - 1) innovation & system change
  - 2) tools to transform service delivery
  - 3) collaboration
  - 4) teambuilding/partnerships
  - 5) personal/interpersonal competencies
- ✓ Identified knowledge, skills and attitudes for CL program
- ✓ Produced guidelines for CL program development and community engagement

## PHASES 2 & 3

- Developing the **Evaluation Framework** using a developmental evaluation approach
- Creating the design for a collaborative leadership education program for "Emerging leaders in health", including practice leaders and middle managers
- Integrating community engagement and social accountability into curriculum design
- Creating a model pilot CL program



- ### DELIVERABLES & OUTCOMES
- Collaborative leadership evidence-based education program for emerging leaders
  - Program will be anchored in the principles of social accountability, community engagement, and interprofessional care
  - Evaluation framework for implementation
  - Global education and practice partnerships
  - Health, system sustainability and patient engagement outcomes

# Evaluating the CIHLC Collaborative Leadership Education Program

Maria Steinberg<sup>1</sup>, Lesley Bainbridge<sup>1</sup>, Sarita Verma<sup>2</sup>, Maria Tassone<sup>2</sup>, Sue Berry<sup>3</sup>, Rosemary Brander<sup>4</sup>, Emmanuelle Careau<sup>5</sup>, Maura Macphee<sup>1</sup>, David Marsh<sup>3</sup>, Margo Paterson<sup>4</sup>, Chris Lovato<sup>1</sup>, Benita Tam<sup>1</sup>  
 1. University of British Columbia 2. University of Toronto 3. Northern Ontario School of Medicine 4. Queen's University 5. Université Laval

## CIHLC BACKGROUND

### CIHLC's VISION

Collaborative leadership for health system change to globally transform education and health



From limited innovative capacity To increased innovative capacity

## CIHLC OBJECTIVES

1. Develop a collaborative leadership model for health system change
2. Build and leverage existing partnerships within Canada to facilitate and implement collaborative leadership programs
3. Utilize IT and social media to support communities in leadership training
4. Develop new academic productivity and scholarship to influence global policy reform
5. Develop and implement an evaluation framework that measures planned and emergent change at the educational, practice and system levels

## CIHLC'S PROGRESS



**BETTER CARE, BETTER HEALTH, BETTER VALUE**

## CIHLC EDUCATION PROGRAM MODEL

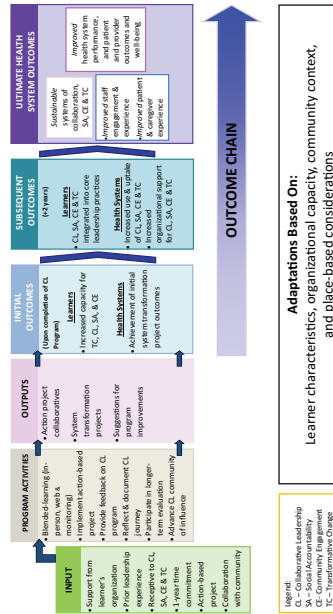
### Program encompasses

- Collaborative leadership competencies
- Principles of enactment (social accountability and community engagement)
- State of the art pedagogical strategies (blended-learning and service learning project)



## CIHLC LOGIC MODEL

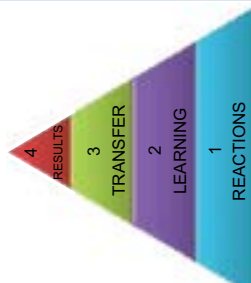
*Emerging Leaders will develop the capacity for system transformation for context-adaptable, community-engaged, socially accountable improvements in health*



*CIHLC is grounded in the principles of social accountability and community engagement and is embedded in a context of inter-professional and relationship-centred care*

## GUIDING FRAMEWORKS & FOCUS

- CIHLC Model for CL based on knowledge acquisition phase
- THEnet's Evaluation Framework for Socially Accountable Health Professional Education
- Framework for Promoting and Assessing Value Creation in Communities and Networks
- Framework for Evaluating System Thinking Interventions
- Developmental Evaluation



KIRKPATRICK'S LEVELS OF EVALUATION

## CIHLC Evaluation Focus

1. Quality, relevance and usefulness
2. Progress of action project
3. Effectiveness of education program
4. Successes, lessons learned and future directions



## EVALUATION COMPONENTS

**Mixed methods, key stakeholders, and multiple lines of evidence including:**

- Evaluation coach check-ins
- Post-module surveys (learners and faculty)
- Post-intercession focus groups (learners and mentors)
- Post-program interviews
- Web analytics
- Reflective journaling
- Community engagement survey
- Sponsor interviews

### TIME FRAME

- Pilot begins January 2014
- Final evaluation reports available March 2015

# We are all teachers and we are all learners: Program design for teaching collaborative leadership

Emmanuelle Careau<sup>1</sup>, Margo Paterson<sup>2</sup>, Sarita Verma<sup>3</sup>, Janice Van Dijk<sup>2</sup>, Gjin Biba<sup>1</sup>, Lesley Bainbridge<sup>4</sup>, Sue Berry<sup>5</sup>, David Marsh<sup>5</sup>, and Maria Tassone<sup>5</sup>  
 1. Université Laval 2. Queen's University 3. University of Toronto 4. University of British Columbia 5. Northern Ontario School of Medicine

## CIHLC BACKGROUND

**The Canadian Interprofessional Health Leadership Collaborative (CIHLC)** has been chosen by the U.S. Institute of Medicine's (IOM) Board on Global Health as one of four innovation collaboratives around the world tasked to incubate and pilot ideas for reforming health professional education.

**Vision: Collaborative leadership for health system change to globally transform education and health**



## CIHLC OBJECTIVES

1. Develop a collaborative leadership model for health system change
2. Build and leverage existing partnerships within Canada to facilitate and implement collaborative leadership programs
3. Utilize IT and social media to support communities in leadership training
4. Develop new academic productivity and scholarship to influence global policy reform
5. Develop and implement an evaluation framework that measures planned and emergent change at the educational, practice and system levels

## SET-UP

- ✓ Early engagement of stakeholders
- ✓ Successfully procured funding from the Ontario Ministry of Health and Long-Term Care
- ✓ Dissemination of scholarship in Japan, Australia, US, and Canada (www.healthprofessionals21.org) and IOM (www.iom.edu) websites

## KNOWLEDGE ACQUISITION

**Environmental scans to define "collaborative leadership"**

- ✓ Conducted qualitative research through key informant interviews (n=34 participants) for further refining of the term, "collaborative leadership" (CL)
- ✓ Conducted a scoping review of 183 journal articles/reports and 24 theoretical books

**Results: Key Elements of Collaborative Leaders**

- Humility and self-awareness
- Influencing / engaging others
- Co-creating a shared vision with others
- Effectively using group processes to bring in diverse perspectives

- ✓ There is no single shared definition of CL

**Curriculum Literature Review**

- ✓ Conducted systematic reviews of peer-reviewed and grey literature on CL curricula, including inventory of existing programs
- ✓ Reviewed 250 scientific articles and 349 health leadership courses
- ✓ Administered online survey to target audience

**Analysis of Curriculum Literature**

- ✓ Performed descriptive statistics, correlational tests and a cluster analysis to inform the development of the CIHLC program
- Results:** ✓ Identified knowledge, skills and attitudes for CL program

## CIHLC EDUCATION PROGRAM MODEL

**Program encompasses**

- Collaborative leadership competencies
- Principles of enactment (social accountability and community engagement)
- State of the art pedagogical strategies (blended-learning and service-learning project)



**CIHLC is grounded in the principles of social accountability and community engagement and is embedded in a context of interprofessional and relationship-centred care**

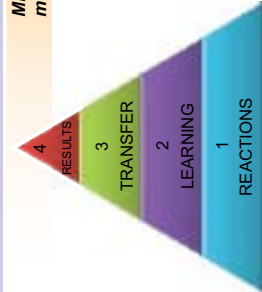
## KNOWLEDGE DEVELOPMENT

1. Based on findings, there is a need and value for a unique focus on CL in health care
2. Currently creating the design and pilot for a collaborative leadership education program for emerging leaders
3. Mandate of CL program will be developing people to lead systems and enable socially accountable change within their community
4. Employing a modular and longitudinal approach
5. Innovative action learning project based on community engagement principles
6. Developing the **Evaluation Framework** using a developmental evaluation approach

## EVALUATION COMPONENTS

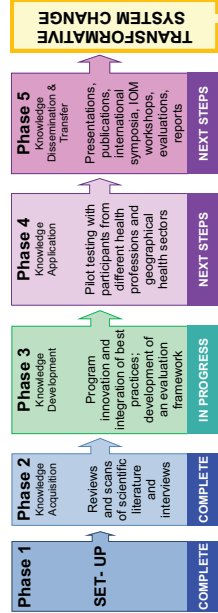
**Mixed methods, key stakeholders, and multiple lines of evidence including:**

- Evaluation coach check-ins
- Post-module surveys (learners and faculty)
- Post-intercession focus groups (learners and mentors)
- Post-program interviews
- Web analytics
- Reflective journaling
- Community engagement survey
- Sponsor interviews



KIRKPATRICK'S LEVELS OF EVALUATION

## NEXT STEPS



**BETTER CARE, BETTER HEALTH, BETTER VALUE**



## Inventory of Canadian leadership education programs

Matthew Gertler<sup>1</sup>, Sarika Verma<sup>1</sup>, Maria Tassone<sup>1</sup>, Jane Seltzer<sup>1</sup>, Emmanuelle Carreau<sup>2</sup>  
<sup>1</sup>University of Toronto <sup>2</sup>Université Laval

### Introduction

The development of leadership attributes for health professionals has been identified as an important enabler to address systematic healthcare inequalities and improve health outcomes.<sup>1</sup> Physicians are often ideally positioned to take on leadership roles and need the leadership skills to do so. This is reflected in the upcoming *Draft CanMEDS 2015 Physician Competency Framework* that identifies leadership as one of seven major competencies for physicians to develop. Within this competency, collaborative leadership has been identified as a key concept.<sup>2</sup>

The Canadian Interprofessional Health Leadership Collaborative (CIHLC) is a partnership between five Canadian universities supported by the Institute of Medicine (IOM) to develop collaborative leadership education to create health system change.

The inventory is part of the foundational research conducted for evidence about collaborative leadership education. This inventory also breaks new ground by identifying Canadian courses and programs available to health professionals that contain a leadership component, but would have been missed by traditional literature reviews.

### Methods

#### Search Methodology

Programs and courses were found through systematically searching university and national health association websites. Schools and departments searched included medical schools, schools of nursing, public health, health administration and schools of business. Some leadership courses that were not from a university or association were included on the recommendation of CIHLC members.

#### Information Captured

Each program or course captured in the inventory was recorded with attributes in an excel spread sheet. Examples of these attributes are:

- **Education level**—Undergraduate, Graduate, Continuing Education
- **Target Professions**—Generic (available to 2 or more professions), Physicians, Nurses, Public Health Professionals, Other Professions (includes specific professions with small percentage of the total courses)

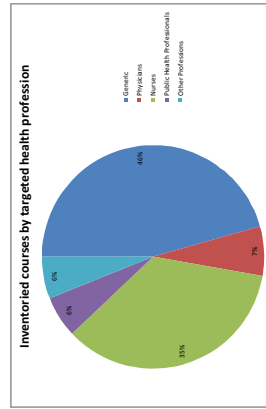
#### Analysis

The programs and courses were categorized by presence of collaborative elements. This was established based on the inclusion of terms such as 'interprofessional team building'. Programs and courses were aggregated by profession and education level in order to make comparisons across the groups.

### Results

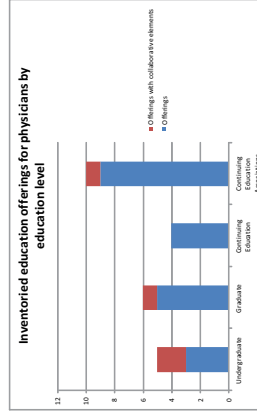
#### Total Leadership Offerings

This inventory found 349 programs and courses that were related to health leadership. 25 of these were found to be targeted directly at physicians.



#### Leadership Offerings for Physicians

Of the 25 courses targeted at physicians more than half of the courses were aimed at post licensure professionals. Only a small number of the courses were categorized as having elements of collaborative leadership.



#### Descriptions of Courses

The courses offered to medical students vary in structure and length. There are one week courses and those that cover the duration of medical school and are taken simultaneously with undergraduate medical education. None of the courses or programs identified collaborative leadership as part of the content, however two of the undergraduate programs contained collaborative elements such as interprofessional teamwork.

### Discussion

#### When Leadership Education is Available

The inventory found a small number of courses available to pre-licensure medical students and the majority of courses available for practicing physicians in the form of continuing education. This can be contrasted with nursing where 72 of the 123 courses targeted at this profession were taught at the undergraduate stage. In addition when looking at the medical undergraduate course offerings they are often not mandatory or of a short duration.

Potential access points for early leadership education for future physicians could be through the generic courses and programs aimed at more than one health profession, seminars offered to all health professions by interprofessional education departments, and through health administration programs.

#### Collaborative Leadership Education

Only a few programs and courses exhibited the criteria we set out as collaborative leadership elements. More research could be conducted to see if collaborative leadership is represented in medical curriculum.

### Conclusion

With health leadership education in Canada most available for practicing physicians through continuing education, there may be an opportunity to introduce collaborative leadership education to medical students and residents. More research could be conducted to gain further insight to when, if, and how leadership and specifically collaborative leadership could be taught to this cohort.

### References

1. Frenk J, Chen L, Bhutta ZA, et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *The Lancet*. 2010; 376(9756): 1923-1958. doi: 10.1016/S0140-6736(10)61854-5.
2. Frank JR, Snell LS, Sherbino J, et al. *Draft CanMEDS 2015 Physician Competency Framework – Series II*. Ottawa: The Royal College of Physicians and Surgeons of Canada; 2014 May.

## Canadian Interprofessional Health Leadership Collaborative - Publications, Posters, Workshops and Presentations

### Publications

MacPhee, M., Paterson, M., Tassone, M., Marsh, D., Bainbridge, L., Steinberg, M., Careau, E., and Verma, S. (2013). "Transforming health systems through collaborative leadership: Making change happen!" *5th International Service Learning Symposium Paper Series*.

Careau, E., Biba, G., Brander, R., Van Dijk, J., Verma, S., Paterson, M. and Tassone, M. (2014). ["Health Leadership Education Programs, Best Practices and Impact on Learners' Knowledge, Skills, Attitudes & Behaviors and System Change: A Literature Review"](#). *Journal of Health Leadership*.

MacPhee, M., Berry, S., Brander R., Van Dijk, J., Bainbridge, L. and Paterson, M. (2014). "A hybrid approach to service learning via a new leadership development program". P. L. Lin, M. R. Wiegand, & A. R. Smith-Tolken, (Ed). *Service-Learning in Higher Education: Building Community Across the Globe*. Indianapolis, Indiana: University of Indianapolis Press.

Brander, R., MacPhee, M., Careau, E., Tassone, M., Verma, S., Paterson, M. and Berry, S. (2015). "Collaborative Leadership for the Transformation of Health Systems". In D. Forman, M. Jones, & J. Thistlethwaite (Eds.) *Leadership and Collaboration: Further Developments for Interprofessional Education*. New York, NY: Palgrave, Macmillan.

Gertler, M., Verma, S., Tassone, M., Seltzer, J. and Careau, E. (in press). "Navigating the Leadership Landscape: Creating an inventory to identify leadership education programs for health professionals". *Health Care Quarterly*.

Brander, R., Bainbridge, L., Van Dijk, J., and Paterson, M. Transformative Interprofessional Continuing Education and Professional Development to Meet Patient Care Needs: A Synthesis of Best Practices. In C. Orchard, C. and L. Bainbridge (Eds.) *Interprofessional client-centred collaborative practice: What does it look like? How can it be achieved?* Hauppauge, NY: Nova (due 2016).

### Posters

Paterson, M., Bainbridge, L., Dumont, S., Berry, S., Marsh, D., Verma, S., and Tassone, M. (2012). *The Canadian Interprofessional Health Leadership Collaborative*. ATBH (All Together Better Health) VI – 6th Annual International for IPECP. Kobe, Japan. October 5-8 2012.

Verma, S., Tassone, M., Bainbridge, L., Paterson, M., Berry, S., Marsh, D., and Dumont, S. (2012) *Building Community in Generating A Canadian Interprofessional Health Leadership Collaborative*. Rendez-Vous 2012. Thunder Bay, Ontario. October 9-14 2012.

Paterson, M., Bainbridge, L., Careau, E., Van Dijk, J., Marsh, D., Berry, S., Remtulla, K., Tassone, M., and Verma, S. (2013). *Fostering interprofessional learning and practice through the development of collaborative leadership curricula*. Canadian Association of Occupational Therapists (CAOT). Victoria, British Columbia. May 29-June 1, 2013.

Verma, S., Tassone, M., Bainbridge, L., Berry, S., Careau, E., Marsh, D., Paterson, M., Wu, D., and Van Dijk, J. (2013). *Collaborative Leadership for Relationship-Centred Health System Transformation*. 2013 National Health Leadership Conference. Niagara, Ontario. June 10-11, 2013.

Tassone, M., Verma, S., Bainbridge, L., Berry, S., Careau, E., Lovato, C., Marsh, D., Paterson, M., and Van Dijk, J. (2013). *Collaborative leadership for health system change to globally transform education and health. Collaborating Across Borders (CAB) IV*. Vancouver, British Columbia. June 12-14 2013.

Steinberg, M., Bainbridge, L., Verma, S., Tassone, M., Berry, S., Brander, R., Careau, E., MacPhee, M., Marsh, D., Paterson, M., Lovato, C., and Tam, B. (2013). *Evaluating the CIHLC Collaborative Leadership Education Program*. Assessing Health Professional Education: A Workshop. Institute of Medicine, Washington, DC. October 9-10, 2013.

Careau, E., Paterson, M., Verma, S., Van Dijk, J., Biba, G., Bainbridge, L., Berry, S., Marsh, D., and Tassone, M. (2013). *We are all teachers and we are all learners”: Program Design for Teaching Collaborative Leadership*. 5th International Symposium on Service Learning (ISSL). Stellenbosch, South Africa. November 20-22, 2013.

Gertler, M., Verma, S., Tassone, M., Seltzer, J., Careau, E. (2014). *Inventory of Canadian leadership education programs*. International Conference on Residency Education (ICRE), Toronto, Ontario. Oct 24, 2014.

### **Workshops and Panel Discussions**

Careau, E., Berry, S., Paterson, M., Van Dijk, J., Remtulla, K., Bainbridge, L., Marsh, D., Tassone, M. and Verma, S. (2013). *Fostering interprofessional learning and practice through the development of collaborative leadership competencies*. Canadian Conference on Medical Education (CCME). Quebec City, Quebec. April 20-23 2013.

Verma, S., Careau, E., Tassone, M., Negandhi, H., Zodpey, S., de Villiers, M., and Bezuidenhout, J. (2013). [Roundtable] – Innovations in Teaching Leadership through Professionalism. Establishing Transdisciplinary Professionalism for Health: *A Public Workshop of the Global Forum on Innovation in Health Professional Education*. Institute of Medicine. Washington, DC. May 14-15, 2013.

Bainbridge, L., Verma, S. and Tassone, M. (2014). *Transforming health systems through collaborative leadership: Catalyzing change!* ATBH (All Together Better Health VII), Pittsburgh, PA. June 6-8, 2014.

Tassone, M., and Verma, S. (2014). “Progress Report for the Institute of Medicine”. In [Assessing Health Professional Education: Workshop Summary](#). Ed. Patricia A. Cuff. Washington, DC: The National Academies Press.

Brander, R., MacPhee, M., Careau, E., Paterson, M. and Van Dijk, J. (2014). *Collaborative Leadership for Health Systems Transformation for the Scholarship of Teaching & Learning*. International Society for The Scholarship of Teaching & Learning. Quebec City, Quebec. Oct 22-25, 2014.

Tassone, M. and Rosenfeld, J. (2014). *Crafting the future of IPE Linked Practice: Next Steps*. Reaching the Summit: Leading the Way from Interprofessional Education to Practice. Toronto, Ontario. Dec 2, 2014.

Bainbridge, L and Austin, Z. (2014). *Evaluating the success of IPE linked to IPP*. Reaching the Summit: Leading the Way from Interprofessional Education to Practice. Toronto, Ontario. Dec 2, 2014.

Careau, E. and Paterson, M. (2014). *Enabling the leadership to transform interprofessional practice*. Reaching the Summit: Leading the Way from Interprofessional Education to Practice. Toronto, Ontario. Dec 2, 2014.

Briggs, M. and Creede, C. (2014). *Enabling the leadership to transform interprofessional practice*. Reaching the Summit: Leading the Way from Interprofessional Education to Practice. Toronto, Ontario. Dec 2, 2014.

### **Presentations and Keynote Speeches**

Verma, S. (2011). *The CHSES Inaugural Retreat*. The Council of Health Sciences Education Subcommittee (CHSES) – Inaugural Retreat, Toronto, December 7, 2011.

Verma, S. (2012). *Innovation and Boundless Directions: Health Professions Education Reform*. The Council of Health Sciences Education Subcommittee (CHSES) – 2012 Retreat. Toronto, December 20, 2012.

Tassone, M. (2012). *Emerging Directions in Interprofessional Education*. Council of Health Sciences Education Subcommittee 2012 Retreat. Toronto, December 20, 2012.

Verma, S., and Tassone, M. (2012) [Linking Health Professions Education to Practice Canadian Successes & Lessons Learned](#). Educating for Practice: Improving Health by Linking Education to Practice Using Interprofessional Education – A Public Workshop of the Global Forum on Innovation in Health Professional Education. Global Forum on Innovation in Health Professional Education. Institute of Medicine. Keck Center of the National Academies, Washington, DC. August 29-30, 2012.

Verma, S., and Tassone, M. (2012) [Educating for Practice – Using collaborative leadership to improve health education and practice](#). Workshop II: Educating for Practice Learning how to improve health from interprofessional models across the continuum of education to practice. Global Forum on Innovation in Health Professional Education. Institute of Medicine. Keck Center of the National Academies, Washington, DC. November 29-30, 2012.

Verma, S. (2013). *The Role of Health Professions Education in Transforming Healthcare in Academic Health Systems*. Association of Academic Health Centers International – 1st Middle East & North Africa Regional Meeting. Doha, Qatar, March 18, 2013.

Verma, S. (2013) *Leadership in Integrative Health for the 21st Century: Qualities, Intention, Outcomes*. Academic Consortium for Complementary and Alternative Health Care (ACCAHC). Portland, Oregon. June 26-28, 2013.

Verma, S. (2013). *International Trends in Health Professions Education Reform and Renewal*. AACHI Inaugural Central and Eastern European Regional Meeting: Collaborative Health Care - Changing Paradigms in Education, Health Care and Research. Budapest, Hungary. November 7 - 8, 2013.

Careau, E., Paterson, M., Brander, R., Van Dijk, J. and Verma, S. (2014). *Transforming health systems through collaborative leadership: Curriculum development*. World Federation of Occupational Therapists. Yokohama, Japan. June 20, 2014.

Brander, R., MacPhee, M., Careau, E., Paterson, M. and Van Dijk, J. (2014). *Collaborative Leadership for Health Systems Transformation*. International Society for The Scholarship of Teaching & Learning (issotl 14). Oct 22-25, Quebec City, Quebec, Oct 22-25. 2014.

Careau, E. (2014). <To train or not to train collaborative leaders> *Is that the question?* The Health Professional Educator Network Annual Meeting. Quebec City, Quebec. Nov 14, 2014.

## IOM Global Forum on Innovation in Health Professional Education Workshop Summary Reports

### Summary reports featuring CIHLC presentations and workshops

Institute of Medicine. (2014). "Assessment as an Agent for Change [World Café]." In Patricia A. Cuff Ed. [\*Assessing Health Professional Education – Workshop Summary\*](#). (pp. 41-54). Washington, DC: The National Academies Press.

Institute of Medicine. (2013). "Innovations in Teaching Leadership through Professionalism [Roundtable]". In Patricia A. Cuff Ed. [\*Establishing Transdisciplinary Professionalism for Improving Health Outcomes – Workshop Summary\*](#). (pp. 30-34). Washington, DC: The National Academies Press.

Institute of Medicine. (2014). "Debate Number 1: Admission Versus Training". In Patricia A. Cuff Ed. [\*Building Health Workforce Capacity Through Community-based Health Professional Education - Workshop Summary\*](#). (pp. 43-44). Washington, DC: The National Academies Press.

### Summary reports featuring CIHLC progress notes

Tassone, M., and Verma, S. (2013). "Canada: The Canadian Interprofessional Leadership Collaborative". In Patricia A. Cuff Ed. [\*Interprofessional Education for Collaboration: Learning How to Improve Health from Interprofessional Models across the Continuum of Education to Practice – Workshop Summary\*](#). (pp. 154-156). Washington, DC: The National Academies Press.

Tassone, M., and Verma, S. (2013). "Canada: The Canadian Interprofessional Leadership Collaborative". In Patricia A. Cuff Ed. [\*Establishing Transdisciplinary Professionalism for Improving Health Outcomes – Workshop Summary\*](#). (pp. 146-149). Washington, DC: The National Academies Press.

Tassone, M., and Verma, S. (2014). "Canada: Progress Report for the Institute of Medicine". In Patricia A. Cuff Ed. [\*Assessing Health Professional Education – Workshop Summary\*](#). (pp. 126-130). Washington, DC: The National Academies Press.

Tassone, M., and Verma, S. (2014). "Canada: Progress Report for the Institute of Medicine". In Patricia A. Cuff Ed. [\*Building Health Workforce Capacity Through Community-based Health Professional Education - Workshop Summary\*](#). (pp. 154-156). Washington, DC: The National Academies Press.



