



*Canadian Interprofessional Health Collaborative:  
activities, outputs and impacts evaluation*

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*Consortium pancanadien pour  
l'interprofessionnalisme en santé :  
évaluation des activités, des résultats obtenus et  
des impacts*

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INTERIM REPORT  
RAPPORT D'ÉTAPE



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The *Canadian Interprofessional Health Collaborative (CIHC)* is made up of health organizations, health educators, researchers, health professionals, and students from across Canada. We believe interprofessional education and collaborative patient-centred practice are key to building effective health care teams and improving the experience and outcomes of patients. The CIHC identifies and shares best practices and its extensive and growing knowledge in interprofessional education and collaborative practice.

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## Acknowledgements

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## A. SOMMAIRE

Le Consortium pancanadien pour l'interprofessionnalisme en santé (CPIS) est une initiative de deux ans financée par Santé Canada et dont l'objectif est de constituer un réseau canadien de partenaires afin de promouvoir la formation interprofessionnelle pour une pratique en collaboration centrée sur le patient (FIPCCP) et de faire progresser sa mise en œuvre. Une évaluation formative et sommative des activités, des résultats obtenus et des impacts des deux premières années d'opération du consortium a été commandée et ce document constitue un rapport d'étape de la composante formative de cette évaluation.

En janvier et février 2007, les membres du CPIS ont été invités à participer à un sondage en ligne pour exprimer leur point de vue concernant les activités du CPIS et leurs résultats à court terme. Un suivi par téléphone de février à avril 2007 a ensuite été effectué auprès d'un échantillon ciblé de membres couvrant un éventail assez vaste de contextes professionnels et de rôles au sein du CPIS afin d'approfondir l'évaluation de leur expérience. Cent cinquante-cinq personnes ont répondu au sondage et 21 ont ensuite été consultées par téléphone.

### Résultats préliminaires

Ce rapport décrit les résultats de l'évaluation des activités menées jusqu'au moment de cette évaluation et selon les principaux objectifs du CPIS : constitution du consortium, identification et partage des meilleures pratiques, et applications du savoir (la période couverte va des débuts du CPIS à avril 2007). Plusieurs retombées positives et plusieurs défis ont été identifiés comme le montre la liste qui suit :

- Partage des idées, des stratégies, des outils et des initiatives (surtout en ce qui concerne les projets reliés à la FIPCCP).
- Développement d'un réseau qui favorise l'interaction et une collaboration de grande envergure.
- Réalisation d'une conférence nationale ou d'un atelier de recherche de haut calibre.
- Les buts poursuivis par le projet et ses divers sous-comités, la participation à ces sous-comités et l'échéancier de communication du CPIS ont souffert de contraintes au niveau du temps et des ressources disponibles.
- Des membres de sous-comités se sont parfois sentis distants du groupe ou de l'organisme dans son ensemble, non familiers avec ses activités et un peu confus quant à leur rôle.
- La représentation des agences reliées à la santé, des sites cliniques, des patients et de leur famille, des organismes du secteur de la santé et du corps enseignant universitaire a paru insuffisante.

Ces divers aspects sont examinés plus en détail dans les sections suivantes du rapport : « organization and membership » [organisation et membres], « receptor communities » [milieux ciblés], « electronic communications » [communications électroniques], « national workshops » [ateliers d'envergure nationale], « knowledge translation » [applications du savoir], « goals and outputs » [buts et résultats] et « clarification and prioritization » [clarification et priorités].

### Conclusions provisoires

L'évaluation montre que les débuts du CPIS sont un succès et permet de cibler certaines questions pour la suite de ses travaux :

#### Succès initial

- Le CPIS a réussi à mettre en place une structure robuste qui consiste en un comité d'orientation, des sous-comités et des membres situés dans toutes les régions du Canada et couvrant un éventail d'expérience et d'expertise.
- Les sous-comités (évaluation, recherche, partenariats, programmes de formation, application du savoir, étudiants) se sont livrés à un important travail initial de définition des objectifs, d'examen des questions critiques et ont réalisé des progrès vers des résultats concrets.
- Malgré ses limites, la communication électronique a servi de manière efficace à faciliter le partage d'information et de ressources entre les membres du CPIS.
- Le site web du CPIS a joué un rôle très appréciable et a été consulté de manière régulière pour avoir accès à des données ciblées de grande qualité.
- Un cadre de mise en œuvre du savoir et certains outils connexes étaient en cours de développement au moment de l'évaluation.
- Les répondants se sont dits très enthousiastes par rapport à la mise en place d'une instance nationale vouée à la FIPCCP.

#### Questions à prendre en considération

- Les répondants ont souligné l'importance pour le CPIS d'être un véritable consortium fondé sur la collaboration et comprenant des représentants de toutes les instances concernées ainsi qu'un forum auquel tous les membres peuvent contribuer.
- L'importance pour le CPIS de maintenir une approche explicitement centrée sur le patient a été soulignée.
- De nombreux répondants ont souligné l'importance des rencontres en face à face pour atteindre les résultats visés par un réseau. Le CPIS doit donc examiner la manière d'utiliser au mieux ses ressources de manière à permettre de telles rencontres.
- Plusieurs avenues s'offrent au CPIS et, pour rester un organisme efficace et bien ciblé, le consortium pourrait devoir établir des priorités. L'établissement de grandes priorités doit être examiné pour pouvoir faire progresser la cause de la FIPCCP de manière efficace.

- Il faut également examiner la question des ressources pour assurer que le CPIS puisse être viable à long terme.

Cette évaluation porte sur la première phase de cueillette de données (janvier à avril 2007). Les travaux du consortium se sont poursuivis depuis et la phase finale d'évaluation portera sur ces travaux et fera l'objet d'un autre rapport.

## A. SUMMARY

The Canadian Interprofessional Health Collaborative (CIHC) is a two-year Health Canada funded initiative aimed at building a pan-Canadian collaborative of partners to advance the field and implementation of Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP). An evaluation was commissioned to complete a formative and summative evaluation of the activities, outputs and impacts of the CIHC, undertaken within its first two years of operation. This is an interim report of the formative component of the evaluation.

In January/February 2007, CIHC members were invited to participate in an e-survey to elicit their perspectives about the activities and short-term outcomes of CIHC, and follow-up telephone interviews were then conducted between February and April 2007 with a purposive sample of members with varied professional backgrounds and CIHC roles to gain a more in-depth understanding of their experiences with CIHC. One hundred and fifty-five people responded to the e-survey and 21 people participated in telephone interviews.

### *Interim findings*

This report presents findings on the activities that have been undertaken by CIHC, and the outputs to date, in relation to its key objectives: building the collaborative; identifying and sharing best practices and translating knowledge (focusing on the period from CIHC inception until April 2007). A number of benefits and challenges have been identified, focused on:

- Sharing ideas, strategies, tools, initiatives (mostly related to IECPCP projects).
- Developing a network that increases connectedness and fosters wide ranging collaboration.
- Delivery of a highly valued national conference/research workshop.
- Limited time/resources to achieve project and sub-committee goals, attend sub-committee meetings, keep up with CIHC communications.
- Lack of attachment to the larger group/organization, unfamiliarity with activities, lack of clarity about role as subcommittee member.
- Insufficient representation and linkages with healthcare agencies, practice sites, patients and families, health care organizations and academic educators.

These issues are explored in more depth in the following sections: 'organization and membership', 'receptor communities', 'electronic communications', 'national workshops', 'knowledge translation', 'goals and outputs' and 'clarification and prioritization'.

## Interim Implications

The findings indicate early successes of CIHC and issues to consider as it continues its work:

### Early successes

- The CIHC has succeeded in establishing a strong organizational structure, consisting of a steering committee, sub-committees, and members from across Canada representing a range of experiences and expertise.
- The sub-committees (evaluation, research, partnerships, curriculum, knowledge translation, students) have undertaken significant initial work in defining their objectives, examining critical issues, and moving forward to achieving them.
- Electronic communication, although containing limitations, was being effectively utilized to foster sharing of information and resources amongst CIHC members.
- The CIHC website was a highly valued resource, and was regularly being used to access high quality and targeted information.
- A knowledge translation framework and tools were being developed.
- Respondents were very enthusiastic about a national organization committed to IECPCP.

### Issues to consider

- Respondents emphasized the need for CIHC to truly be a collaborative with representation of all stakeholders and a forum in which all members can contribute.
- It was stressed that CIHC should ensure that it maintains an explicitly patient-focused approach.
- Numerous respondents emphasized the importance of face-to-face meetings in networking and achieving outcomes, and thus CIHC might want to consider how to optimally invest resources into such meetings.
- There are many opportunities for CIHC, and as an organization, it might need to prioritize in order to be effective and focused. Consideration is needed to select key priorities, given the need to advance the IECPCP agenda in an efficacious manner.
- A focus on resources is also needed to ensure that CIHC is successful in sustaining itself in the longer-term.

This evaluation reports on the first stage of data collection (January to April 2007); work has been ongoing since this time, and the final stage of data collection will capture and report on this subsequent work.

## B. INTRODUCTION

The CIHC is a two-year Health Canada funded initiative aimed at building a pan-Canadian collaborative of partners to advance the field and implementation of IECPCP. Building upon the twenty IECPCP projects funded by Health Canada, its three main project components are: building the collaborative, best practice identification and sharing, and knowledge translation. The CIHC Logic Model (Appendix A) outlines these components, as well as the associated activities, outputs, short and medium term impacts and long-term impacts. It is expected that the establishment of linkages and sharing of information across the country will contribute to greater gains in knowledge, more efficient use of resources, more effective dissemination and uptake of evidence and best practices, and more generally, positive changes in research, policy, education and health care.

## C. EVALUATION

The purpose of the commissioned evaluation project is to complete a formative and summative evaluation of the activities, outputs and impacts of the CIHC, undertaken within its first two years of operation. Overall, the evaluation aims to allow early findings to be fed back to CIHC leaders/members in order to support future planning activities and the generation of information in relation to the Collaborative's overall efficacy in its first 2-years of operation.

The objectives are to:

1. Assess the extent to which the CIHC's stated goals and objectives have been addressed.
2. Determine the extent to which the CIHC's short-term outcomes and impacts, as stated in its logic model have been met.
3. Identify the successes and challenges of the CIHC's work in relation to its key project components (building the Collaborative, best practice identification and sharing, knowledge translation).
4. Understand how presage factors linked to the creation/implementation of the CIHC may have influenced its processes (activities) and its products (outcomes/impacts).

This report presents the findings from the formative phase of the evaluation project. As a result it will focus on emerging issues linked to objectives 1, 2 and 3 (objective 4 will be reported on in the final report when all data have been collected and the evaluation can provide a more informed assessment of presage, process and product factors).

## D. METHODS

The evaluation adopted a multi-method approach to data collection to generate broad descriptions as well detailed explanations of the CIHC's activities, outputs and impacts.

### *Ethics*

Ethical approval for this evaluation was received from the Research Ethics Board at the University of Toronto.

### *Participants*

All 336 members of CIHC at the time of data collection were invited to participate in the evaluation.

### *Data collection*

#### **Electronic surveys**

Quantitative data in the form of an e-survey were gathered to generate a broad understanding of CIHC members' initial views of the Collaborative. In January/February 2007, an individualized e-mail was sent to the 336 members of CIHC providing them with information about this evaluation study and inviting them to complete an on-line survey about the activities and short-term outcomes of CIHC. A follow-up reminder was sent approximately two weeks after the initial message. At the end of the survey, respondents were asked to identify if they would be willing to participate in a follow-up telephone interview.

#### **Telephone interviews**

Telephone interviews, using a semi-structured interview schedule were conducted to gather an in-depth understanding of members' views of the CIHC. The sample of members was constructed to elicit information from a broad mix of members in terms of geographic location, profession and organization, and role in CIHC. Interviews were conducted between February and April 2007. The interviews took between 15-30 minutes to complete, were tape-recorded and transcribed verbatim.

#### **Data analysis**

Survey data were analyzed by the use of descriptive statistics to describe quantitatively key aspects of the CIHC's work. Qualitative data were analyzed by employing an inductive thematic approach. These generated a number of major and minor themes which reflected key issues from the data. The survey and interview data were examined together to identify common and discrepant findings, and how they could be integrated to provide a more comprehensive evaluation.

## E. INTERIM FINDINGS

The survey and interview results have been integrated to provide both a broader understanding of issues as illuminated through the survey, and more in-depth insights gathered through the interviews. This section first describes the survey and interview participants, and then reports on the activities that have been undertaken by CIHC at the time of the evaluation, and the outputs to date, in relation to its key objectives: building the collaborative; identifying and sharing best practices and translating knowledge

### Participation

One hundred and fifty-five people completed the survey. This represents a 46% response rate. Forty-four people also agreed to participate in a telephone interview. From this list, a smaller sub-group of 20 people was selected to maximize representation from a range of provinces and organizations, and professional backgrounds and roles within CIHC. Nineteen people agreed to be interviewed, and an additional two people who had not initially volunteered were approached to enhance the range of backgrounds of interview participants, for a total of 21 interviews.

Table 1 provides characteristics of the survey and interview respondents' roles in CIHC.

*Table 1: Participants' roles in CIHC*

Role in CIHC	Survey participants	Interview participants
IECPCP project member	138	8
Health care provider	18	2
Student representative	14	2
Expert advisor/international observer	8	2
Government representative	6	2
Community representative	5	1
Other	15	4
<b><i>CIHC sub-committee representation</i></b>		
Curricula	21	1
Partnerships	13	3
Evaluation	12	3
Knowledge translation	11	2
Students	10	1
Research	7	2

## F. KEY EMERGING ISSUES

The key issues that emerged from the data analysis have been categorized into the following sections, discussed below: ‘organization and membership’, ‘receptor communities’, ‘electronic communications’, ‘national workshops’, ‘knowledge translation’, ‘goals and outputs’ and ‘clarification and prioritization’.

### I. ORGANIZATION AND MEMBERSHIP

A key initial activity was to establish the organizational structure of CIHC. This involved the creation of a steering committee and sub-committees to guide the initiative, and the recruitment of members from across Canada with relevant experience and expertise.

#### Steering committee and sub-committees

A CIHC steering committee with members from each of the provinces involved in IECPCP was established to guide the efforts of the Collaborative. At the time of this evaluation, the steering committee had had two face-to-face meetings and had monthly teleconferences. Interview participants who are members of the steering committee spoke positively about the effectiveness of the committee and its collaborative nature. The steering committee established six sub-committees (research, evaluation, partnership, curriculum, knowledge translation, students) to guide the work of CIHC, with steering committee members acting as co-chairs. Co-chairs invited people with relevant expertise and experience to join the sub-committees and IECPCP project leaders were told to ask project members if they were interested in joining the sub-committees. Steering committee survey and interview participants expressed enthusiasm about the steering committee and sub-committees, yet some noted the challenge of doing this work in addition to many other responsibilities:

*“I think the only piece I’m perhaps a little bit challenged with is there is a fairly significant expectation of steering committee members and maybe sub-committee...co-chairs as far as the commitment [...] It’s certainly not because of lack of passion or interest, but I think all of us, just like everything else, that we’re doing this in addition to our other responsibilities” (Interviewee 8).*

The sub-committees are working together with students, consultants, and the CIHC secretariat to develop and address their objectives. Survey participants were asked to rate the degree to which they think the sub-committee is working towards or has met its goals on a scale of 1 to 5. Based on 58 responses to this question, 10.3% (n=6) replied ‘has not met goal’, 55.2% (n=32) replied ‘is starting to meet goal’, 20.7% (n=12) replied ‘unsure’, 8.6% (n=5) replied ‘has nearly met goal’, and 5.2% (n=3) replied ‘has fully met goal’.

The majority of survey and interview participants who discussed their involvement in sub-committees commented that their sub-committee was making good progress, had clarified its function and goals, had solicited help to support its activities, and that the teleconferences were good opportunities for dialogue and knowledge exchange. Some participants said that it is too early to comment on the progress of the sub-committees, and a smaller number of people were

concerned that the progress of their sub-committees was slow. Respondents commented on the essential and valuable support being provided by the CIHC secretariat.

## Membership

To date, CIHC has been successful in recruiting members from across Canada who represent a range of organizations, interests and perspectives. In response to the survey question about whether there are individuals, groups, or organizations that are not currently but should be CIHC members, 16.4% (n=24) respondents said 'yes', 6.2% (n=9) said 'no' and 77.4% (n=113) said 'not sure'. The thirty-one survey respondents who provided suggestions for who should be members of CIHC mentioned the following groups: health care professional associations, accrediting bodies, patient/consumer groups, health administrators, government decision-makers, collaborative practice worksites and health care professionals.

The interview data offered a number of comments about ensuring that the Collaborative should not be seen as an organization that caters only for academia:

*"This can't be seen as another academic exercise. And I think that's really important because I know that a lot of the people that I've been dealing with they have a hard time with it [...] you kind of feel second rate and you're a sort of second sub class to the academics and I'm not quite sure why that is [...] and that there's opportunity here to make this a true collaborative rather than it being said that it is a collaborative"* (Interviewee 19).

The three groups of people most commonly discussed during the interviews as requiring attention in relation to their membership in CIHC were: patients/public, practice-based health care professionals, and policymakers. The following quotes reflect the first concern that the CIHC has a focus on patients' needs:

*"It's got the term patient-centred in it for a reason and I think that the Collaborative so far has not really figured out how to put the patient-centred back in the equation. So that patient voice [...] the issue of how do they experience collaborative practice? What do they want to get out of collaborative practice? How does it feel? How could it be improved upon? I think there's room to try to work on how to ask those questions and get effective answers and then communicate that across to projects. So I think the patient role really needs some work"* (Interviewee 9).

Some interview respondents felt that the CIHC has an acceptable practice-based representation because IECPCP members involved a number health care professional groups. In contrast, other respondents were more uncertain about a broad practice-based membership:

*"If we're looking at 'interprofessional' we need to look at not just the university trained professional but all people within health care in a hospital, in the system, if it's going to work"* (Interviewee 18).

*"I also think the representation needs to be looked at carefully because there's a heavy emphasis towards the academic side and a very thin emphasis toward the community side. And unless we have both of those represented well, I think we lose the connection between what we do as educators and researchers, and what happens on the ground floor, and in the practice"* (Interviewee 1).

One health care professional interviewee emphasized the importance of having people who work in the delivery of health care, as members of the Collaborative, although stressed the challenges of engaging in and balancing such work with clinical responsibilities.

Similarly, there were comments about how to optimally engage policymakers. A few people noted that, “it’s never too early to start doing the political advocacy thing” (*Interviewee 7*), and that it is important to connect with policy makers, including people from various health care programs (e.g. regional strategies such as the stroke strategy) and ensuring that high-level decision makers are engaged with CIHC.

The partnership sub-committee is reviewing these critical issues concerning membership/partnership, including a review of who are current members and whether there are gaps in the membership profile, what might be the obligations and responsibilities of CIHC members in the future, and what types of partnerships are necessary and should be prioritized.

## 2. RECEPTOR COMMUNITIES

CIHC aims to identify its receptor communities and the most effective way to deliver information to these groups. CIHC has defined receptor communities as the relevant health care stakeholders and decision makers in Canada including government, health care organizations (health facilities/agencies operating in all settings across the continuum of care – general medicine, mental health, palliative care, public health, etc.), health care providers and professional associations.

To address the Collaborative’s goal of ensuring that all receptor communities have been identified, survey respondents were asked to record the importance of particular receptor communities for their IECPCP projects (see Table 2).

*Table 2: Respondents’ perceptions of important receptor communities for their IECPCP project*

	Not important	Somewhat important	Unsure	Important	Very important
Educators	1% (1)	1% (1)	3% (4)	23% (28)	73% (90)
Health care provider	2% (2)	1% (1)	3% (4)	21% (26)	73% (91)
Federal government	2% (3)	6% (7)	8% (10)	29% (36)	55% (68)
Provincial/territories	2% (3)	1% (1)	6% (7)	28% (35)	63% (78)
Regulatory bodies	4% (5)	2% (2)	7% (9)	33% (41)	54% (67)
Researchers	2% (2)	3% (4)	8% (10)	38% (47)	49% (61)
Patients	2% (2)	9% (11)	9% (11)	37% (46)	44% (54)
Students	1% (1)	2% (3)	4% (5)	27% (33)	66% (82)
NGOs	3% (4)	7% (9)	26% (32)	39% (48)	25% (31)

As Table 2 indicates, the majority of respondents rated all previously identified receptor communities as 'important' or 'very important' to include in the CIHC's work. When asked whether there were any additional receptor communities not listed which should be included, 22.6% (n=28) respondents said yes, and 77.4% (n=96) said no. Thirty-one respondents suggested the following as additional receptor communities (see Table 3).

*Table 3: Respondents' perceptions of additional receptor communities*

Receptor community	N
Senior administrators (universities, health service organizations, post secondary institutions, health authorities)	9
General public/families of patients	7
Professional associations/accrediting bodies	4
International health care educators, researchers, and practitioners	3
Media and opinion leaders	3
Health authorities	2
Communities (non-health professionals)	1
Student organizations	1
Health care staff (e.g. ward clerks)	1
NGOs	1
Community agencies with already established networks (e.g. Canadian association of pediatric health centres)	1

### 3. ELECTRONIC COMMUNICATIONS

Table 4 reports on CIHC members' initial usage of communication mechanisms utilized to support the achievement of its outcomes. As Table 4 indicates, the most common methods of electronic communication are teleconferences, e-mails and/or use of the CIHC website.

*Table 4: Respondents' usage of communication mechanisms for CIHC*

	0 times	1-5 times/	6-10	11-15	16-20	More than 21	Total
Teleconferences	42% (53)	56% (70)	1% (1)	1% (1)	0% (0)	0% (0)	125
CIHC website	23% (28)	64% (78)	9% (11)	2% (3)	0% (0)	1% (1)	121
Blog <sup>1</sup>	96% (109)	0% (0)	0% (0)	0% (0)	0% (0)	4% (4)	113
E-mails	15% (19)	50% (66)	18% (24)	7% (9)	5% (6)	5% (7)	131
Listserv <sup>2</sup>	80% (91)	15% (17)	2% (2)	0% (0)	1% (1)	3% (3)	114

<sup>1</sup> Blogs had not been developed at the time of data collection.

In addition to these forms of communication, a CIHC newsletter had been developed and distributed, and a website discussion forum was being developed in collaboration with NaHSSA.

Table 5 indicates that most members saw teleconferences, website and emails as ‘useful’ or ‘very useful’ mechanisms for communicating with other CIHC members.

*Table 5: Respondents’ evaluations of usefulness of communication mechanisms for CIHC*

	Not at all	Not very	Unsure	Useful	Very useful	N/A
Teleconferences	4% (5)	0% (0)	6% (8)	28% (35)	29% (37)	33% (41)
Website	2% (3)	6% (7)	14% (17)	40% (49)	18% (22)	20% (24)
Blog	8% (9)	2% (2)	14% (16)	0% (0)	0% (0)	77% (90)
E-mails	2% (2)	1% (1)	4% (5)	37% (47)	46% (59)	11% (14)
Listserv	6% (7)	2% (2)	9% (11)	12% (14)	6% (7)	65% (76)

Each of these methods of communication are discussed below.

### Teleconferences

Teleconferences were cited as a key method of communication for sub-committee members. For these respondents, the necessity of teleconferences given the geographical distances and their low cost, and the need for regular sub-committee contact teleconferences were an important electronic form of communication. However, respondents identified the challenges of coordinating the timing of meetings and having people participate, and in sustaining people’s interest and commitment between meetings. Some individuals suggested that brief descriptions of sub-committee members’ backgrounds and their pictures might help since it is difficult to connect on the telephone with people that you do not know. One commented that one-hour teleconferences may not be the most effective strategy for sub-committees, and a face-to-face meeting could also be valuable to their progress.

### Website

The CIHC website was developed to act as an important channel for sharing promising and best practices. At the time of the evaluation, the website was being used to share information with CIHC members and as a communication tool for sub-committees (e.g. posting meeting materials, notifying about meetings). A discussion forum was being set up but was not yet in use. Twenty-three percent (n=28) of survey respondents stated that they did not access the CIHC website at all, while 64% (n=78) accessed the website on average 1-5 times/month.

<sup>2</sup> A listserv had not been developed at the time of data collection.

Interview data indicated that people involved in sub-committees or looking for particular information were more likely to use the website:

Most survey and interview respondents spoke positively about the website, noting that it was “useful, well organized, easy to use” (Interviewee 11), and that, “it’s been quite useful in keeping me up to date on interprofessional activities and programs” (Interviewee 20). For example, many respondents had accessed research workshop summaries and had become aware of conferences through it. Respondents also valued the comprehensiveness of the CIHC website:

*“What it [CIHC website] has done is it’s given me a one-stop shopping kind of place to go and look through who’s doing what, to remind myself who I should connect with” (Interviewee 1).*

One interviewee made a suggestion to develop a section of the website catered to patients/public:

*“I think there needs to be a shift, in patient thinking as well as that they belong to a clinic or team of practitioners that provides them with the best care [...] the one thing that I can think of is the patient education strategy and maybe that is web linked for access and making it coast to coast” (Interviewee 20).*

Some survey respondents noted that they had had technological difficulties with the website, and felt that the site could be more user-friendly and informative if for example it had less text, more iconic direction and clearer wording. Other suggestions included having a website discussion room by subgroup and sending out e-mails to inform members of website updates. At the time of this evaluation, limitations of the website had been recognized, and a consultant was working with CIHC to improve it.

### **E-mails**

E-mails were, understandably, the most common form of communication (see Table 5), and were instrumental to communication amongst CIHC members. The CIHC secretariat was particularly mindful of sending focused e-mails, being cautious not to overwhelm people.

### **Blogs and listserv**

Although some survey respondents indicated usage of a blog and listserv, these had not yet been formally established by CIHC at the time of this evaluation.

### **Newsletter**

The first CIHC newsletter had been electronically distributed to CIHC members. One respondent suggested having electronic newsletters outlining the IECPCP project work to date, and another respondent suggested having simple, regular communications, for example, ‘new lessons learned’.

#### 4. NATIONAL WORKSHOPS

The first of two national workshops, consisting of a research workshop and an inaugural meeting, took place in November 2006. The goals of the inaugural meeting were to network the Canadian IECPCP community and begin the work of establishing a formal national organization to advance IECPCP. The goals of the research workshop were to bring together researchers/evaluators and other interested parties to examine current research activities and approaches and make recommendations on future research related to IECPCP.

The majority of survey and interview respondents who participated in the research workshop and/or inaugural meeting found them to be ‘useful’ or ‘very useful’, as indicated in Table 6.

*Table 6: Respondents’ evaluations of usefulness of national workshops*

	Not at all	Not very	Unsure	Useful	Very	N/A
Research workshop 2006	3% (4)	0% (0)	5% (6)	6% (7)	20% (23)	66% (77)
Inaugural meeting 2006	3% (3)	1% (1)	5% (6)	7% (8)	42% (49)	42% (49)

Both meetings were seen as instrumental in fostering the exchange of information amongst IECPCP learning projects and associated stakeholders. Many survey and interview participants noted the benefits of various stakeholders coming together to network through face-to-face interactions:

*“One of the things that events like the inaugural meeting had, one of the benefits of those is that it’s not just university people getting together, it’s university researchers, policy makers, practitioners; there is some increased networking in that sense in terms of a broader array of individuals involved” (Interviewee 5).*

IECPCP project members were particularly appreciative of the opportunity to meet and exchange information, share resources/expertise and *“to just to get to know each other and to find out [...] about each others challenges and strategies” (Interviewee 16)*. Some members noted how the meetings enabled them to take advantage of the informal networking opportunities:

*“The most useful part of the conference that I found was there was sort of an impromptu meeting of the project managers over lunch. I found that really useful to be able to connect with my peers” (Interviewee 11).*

Indeed, it was pointed out that this initial networking process enabled members to connect at a later point in time, and to share resources and instruments. The meeting also provided opportunities for CIHC sub-committees to engage conference participants in defining their objectives and activities:

*“I found it quite helpful in regards to ensuring at least a better understanding of where all the committees were [...] it really helped me see, because each of the sub-committees did a report, so it really helped me to face-to-face have better understanding of what everybody was doing at one time, one place [...] we actually used that time very effectively to seek feedback” (Interviewee 8).*

While electronic forms of communication was considered helpful, as noted above, survey and interview respondents stressed the importance for regular face-to-face meetings. Although the expense of such meetings was acknowledged, it was felt that face-to-face meetings were critical in developing relationships, sharing ideas, and moving the Collaborative's agenda forward. As one respondent stated:

*“A teleconference is fine. I think it's good to get some work done but there is value in meeting and you get richer dialogue and richer sharing when you actually can meet and have a conversation with somebody at the table because you can show them stuff and everything”*  
(Interviewee 19).

The importance of face-to-face meetings was seen as particularly useful for people with similar backgrounds and interests. A number of respondents recommended that small groups (e.g. principal investigators, research managers, community colleges, health care practitioners) should have the opportunity for regular meetings. Others suggested having workshops/conferences based on themes, regional meetings, web-casts and videoconferences.

Respondents identified two main challenges connected to the meetings. In relation to the inaugural meeting, some respondents commented that there was insufficient amount of time for this sharing of information with other IECPCP projects:

*“The only thing that didn't work as well as I think it could have was a poster presentation [...] It was probably the most valuable thing that the different projects across the country needed [...] but we were really, really rushed”* (Interviewee 9).

In relation to the research meeting, it was noted that there was not enough time dedicated for discussing relative strengths/weaknesses of different IECPCP project evaluation designs, or assessing how their evaluation findings could contribute to the goals of the CIHC and Health Canada.

## 5. KNOWLEDGE TRANSLATION AND DISSEMINATION

Another key element of the CIHC's work is to engage in efforts that ensure that information gained is shared appropriately translated to the various receptor communities. Survey respondents were asked to note whether CIHC has been effective in sharing information with receptor communities. While most respondents (54.8%; n=68) responded 'not sure', 34.7% (n=43) responded 'partially', 7.3% (n=9) responded 'no' and 3.2% (n=4) responded 'yes'. Table 7 provides a summary of additional comments concerning this question.

**Table 7: Perceived effectiveness of CIHC in sharing information with receptor communities**

No access to/unsure of information shared with receptor communities	19
Doubt receptor communities know about CIHC/current focus is on CIHC and IECPCP projects/have not yet received communication	10
Need to continue existing efforts and introduce new ones/too early to judge/hard to explain effectiveness	14
Need greater interaction between education and health departments	1
Have been invited to participate in inaugural meeting and research meeting	1
There is international awareness of CIHC	1
Workshop was effective	1
Individual projects probably better suited to connect with some of the receptor communities	1

These findings indicate that respondents were unaware of what activities were occurring. In fact, the knowledge translation sub-committee was actively working on developing a knowledge translation plan, which included initially identifying different receptor communities and then devising communication approaches that would be most effective with those specific communities. A key part of this process for the knowledge translation sub-committee was building a connection with other sub-committees, such as partnership to assist the knowledge translation plan:

*“We recognized early on that we needed to link with a partnership sub-committee because obviously they were setting some priorities around who we should be trying to build partnerships with and we thought that we needed to know what their priorities were in order to focus our attention appropriately as well [...] Out of those meetings we identified that a real priority was to connect with a practice settings so in other words, making sure that this whole initiative isn’t stuck in academia” (Interviewee 13).*

One interview respondent described the knowledge translation sub-committee’s current activities, which included a series of documents that is like quick information of CIHC. A one page fact sheet, PowerPoint slides and an information briefing document for policy makers and decision makers.

## 6. INITIAL GOALS AND OUTPUTS

Table 8 provides an indication of members’ perceptions relating to how well they think the CIHC was progressing in meeting its stated goals.

*Table 8: Respondents' perceptions of CIHC's progress on meeting goals*

	Has not met goal	Is starting to meet goal	Unsure	Has nearly met goal	Has fully met goal
Promote and demonstrate the benefits of IECPCP	11% (14)	53% (66)	22% (27)	11% (14)	2% (3)
Stimulate networking and the sharing of the best approaches to IECPCP	4% (5)	58% (72)	17% (21)	17% (21)	4% (5)
Facilitate interprofessional collaboration in education	9% (11)	52% (64)	20% (25)	16% (20)	3% (4)
Facilitate interprofessional collaboration in practice	19% (23)	45% (56)	29% (36)	7% (9)	0% (0)
Articulate and facilitate an IECPCP research agenda	10% (12)	49% (61)	30% (37)	8% (10)	3% (4)
Facilitate the knowledge transfer into the appropriate receptor communities	18% (22)	44% (55)	34% (42)	3% (4)	1% (1)
Facilitate and support sustainable change in IECPCP	23% (28)	39% (48)	32% (40)	6% (7)	1% (1)
Be an information hub to link key stakeholders	6% (7)	55% (68)	26% (32)	14% (17)	0% (0)
Strengthen IECPCP evidence-based approaches for key stakeholders	15% (19)	47% (58)	33% (41)	4% (5)	1% (1)

As Table 8 shows, most members felt that the CIHC had begun to meet all nine of its goals. These data were supported by the interviews. Indeed, most interviewees indicated that the CIHC's initial success in meeting its goals was due to the varied activities described above (organization of CIHC membership, steering committee, sub-committees, communication strategies, national workshops, knowledge translation activities).

The goals to stimulate networking and the sharing of best approaches to IECPCP and to be an information hub to link key stakeholders were particularly apparent:

*"One of the things I was always missing through the IECPCP projects was the opportunity to link [...] this is the start of being able to stop reinventing the wheel and to using each other's expertise across the country to get further ahead faster [...] having access to other projects and having the CIHC web site, I think is really valuable" (Interviewee 1).*

Participants described different instances of where the sharing of resources and expertise was occurring due to CIHC. For example, representatives from one university had been sent to participate in a course provided at another university, speakers from other parts of the country were invited to present at a workshop. It was felt that the sub-committees, in particular, were key in helping the CIHC meet its goals:

“The federal action research or the Kirkpatrick model for evaluation, things like that, which before maybe I’d heard about, I became a little more aware of. The conversations that I have [with other CIHC members] it’s just really been quite amazing [...] It sort of opened up way more doors that I would not have known” (Interviewee 10).

Survey respondents were asked to estimate the number of outputs that have been influenced by their involvement in CIHC, the results of which are reported in Table 9.

**Table 9: Estimation of outputs produced/influenced due to CIHC involvement**

	0	1-5	6-10	11-15	16-20	More than 20
Published research	80% (99)	19% (24)	1% (1)	0% (0)	0% (0)	0% (0)
Unpublished research reports	69% (86)	28% (35)	1% (1)	1% (1)	1% (1)	0% (0)
IECPCP centred meetings	31% (38)	50% (62)	11% (14)	2% (2)	2% (2)	5% (6)
Presentations	28% (35)	57% (71)	10% (12)	1% (1)	3% (4)	1% (1)
Educational programs	54% (67)	41% (51)	5% (6)	0% (0)	0% (0)	0% (0)
Educational materials	49% (61)	44% (55)	5% (6)	0% (0)	0% (0)	2% (2)
Health care policy	81% (101)	16% (20)	2% (3)	0% (0)	0% (0)	0% (0)

The results in Table 9 indicate that members report CIHC is having an impact on published and unpublished research, meetings, presentations, programs, materials, and policy. When asked to indicate additional outputs, survey respondents reported the following: faculty development workshops, journal club meetings, grant application, conference abstracts and information for agencies.

Respondents also noted that they had used materials from the CIHC national meeting to develop their own local educational materials. In addition, one member noted that his involvement in CIHC had helped him to develop a provincial network which was working towards affecting provincial policy making.

## 7. CLARIFICATION AND PRIORITIZATION

The data contained several references to the need for further clarification and prioritization of CIHC goals and activities. While many members expressed satisfaction, some were uncertain about CIHC goals, as they had not been well communicated to them. Others noted the need for improved communication links between steering committee, sub-committees and CIHC membership regarding dissemination information concerning key activities and goals:

*“No, I don’t know a lot of what you guys [CIHC] are doing. Like I said I enjoy the website. I don’t know what you guys are doing to connect with the other groups, I don’t know what your goals are, your long range plans [...] I want to get information and it doesn’t feel there’s a lot of them connecting with us” (Interviewee 11).*

*“I think they [CIHC steering committee] need to work on their communication [...] I didn’t go in November because I wasn’t exactly aware of it” (Interviewee 20).*

The interviews also provided respondents an opportunity to discuss their future ideas of what type of organization CIHC should be and what range of activities it should be focused on undertaking in the next few years, as the following data extracts illustrate:

*“I think it [the CIHC] is positive in raising interest in the field. I think it would be even more helpful if that was a critical interest and a self-questioning one [...] the first step would be acknowledging that the effectiveness of IPE is an important question, that it hasn’t yet been answered, and that it needs to be answered before, or at least alongside at the very worst, alongside a series of other activities to promote IPE [...] if you think of any of the disease groups like the Canadian Diabetes Association, it has a significant body of its members involved in groups evaluating or developing guidelines, and that includes often getting other people to work on the effectiveness of those interventions. So, these national organizations dealing with diseases frequently are a definitive source of information on what works and I think that it would also be the case with the CIHC” (Interviewee 3).*

*“While there’s benefit to being sort of a bigger system and yet let’s have all these people involved, how is this actually going to relate to the people that I work with and what does that look like to them to actually bring it down to a practical application level” (Interviewee 19).*

*“I occasionally struggle a little bit with where CIHC will land after the two years of funding and I would not want to see CIHC become the only voice for IECPCP in the country. I think the individual provinces need to have the space to have their, to do their thing and to contribute nationally wherever possible. But they need to have a voice provincially themselves. So, if CIHC continues after the two years, I’m still not clear what that might look like. I’m not sure that a society or an association actually fits the bill, but I do think that some means of keeping in touch with people and keeping in touch with what’s going on, is important” (Interviewee 1).*

Given the wide range of stakeholders involved in the CIHC and the variety of activities they are currently undertaking, respondents also noted that was need in the next year or so to prioritize and focus:

*“A concern I have is how to manage such a snowball, we want it to snowball but we have to manage that in a realistic manner [...] since we are so new and there are so many potential activities and relationships that we can foster, I see it as a challenge. So I guess we do have to identify the priorities like what is CIHC actually going to do and how can CIHC manage to slot these other really great activities somewhere else. Even though they might make more sense to be with CIHC we can’t actually do everything that we want to do, or maybe we can” (Interviewee 16).*

*“It is an organization that I think really is emphasizing flexibility and innovation, not rigid at all, so that’s really exciting. I guess a bit of the challenge is that there might be lots of different approaches, and so we have to be cautious when we describe to people what CIHC is that we*

*can't be everything to everybody at one time. I do believe that the Collaborative is attempting to address that. For example, the partnership sub-committee is attempting to determine who the priorities are of our audiences, our primary participant membership. Now everybody could be a member, but given the time, the limited resources, etc., where are your priorities, and I think the collaborative recognizes that they have to make some decisions about priority" (Interviewee 8).*

Despite issues around clarification and prioritization, respondents expressed a keen desire for the CIHC to continue well beyond the two years of its initial funding, as it was engaged in a range of innovative and creative activities. As a result, respondents agreed that an important aspect of the CIHC work in the next year was to work on ensuring its longer term viability and sustainability.

## G. INTERIM IMPLICATIONS

This interim report aimed to provide an insight into the initial work of the CIHC.<sup>3</sup> Findings from this stage of the evaluation indicate that the main objectives, as set out in the CIHC logical model (building the collaborative, best practice identification and sharing, and knowledge translation), are being addressed through the activities, as well as the early outcomes, as outlined in the model. In providing useful feedback for the steering committee's on-going work, this section provides a summary of early key successes and also highlights some issues for them to consider in the future.

### *Early successes*

A number of key early successes emerged from the survey and interview data sets. These focused on the following areas:

- The CIHC has succeeded in building upon the IECPCP projects, and establishing a strong organizational structure, consisting of a steering committee, sub-committees, and members. It has strived to involve people from across the country with varied backgrounds and expertise, and to be as inclusive as possible.
- The strong leadership in the CIHC is apparent by the wide range of activities that have been undertaken in the initial stages of CIHC and the fact that members are investing tremendous time from their already busy schedules.
- All of the sub-committees were engaged in defining and moving their agendas forward. Issues raised by survey respondents, for example in relation to CIHC partners, membership, and receptor communities are being addressed in these sub-committees. The findings from this interim report may nevertheless provide some further helpful attention to issues concerning these groups of people.
- There is effective communication between CIHC members, mostly via e-mails, teleconferences and the newsletter. Although geographical distance meant that face-to-face contact was limited, this type of interaction was still valued by respondents.
- The CIHC website is a key resource. It is regularly used by the members to learn about IECPCP projects and to access information.
- The November 2006 national workshops were considered highly successful. They were instrumental in fostering relationships and networking, and supporting the exchange of information and resources, which appeared to be still continuing to occur after these gatherings.

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<sup>3</sup> This evaluation reflects the activities of CIHC up until the early part of the year 2007. Work that has been conducted since that period of time will be captured in the final evaluation (June 2008).

- Despite some uncertainty about information sharing activities with receptor communities, the knowledge translation framework (which most respondents were unaware of) had identified relevant receptor communities and had devised a number of effective communication strategies for each, meant that these concerns were understood and were being addressed.
- Respondents were very enthusiastic about the CIHC. They particularly valued its commitment to advance IECPCP, network with a wide range of stakeholders, share information and knowledge in an open and inclusive manner. Respondents were therefore keen to ensure the Collaborative's longer term success

### *Issues to consider*

The data generated a number of issues that should be considered in the next stages of the development of the CIHC.

- Respondents emphasized the need for CIHC to truly be a collaborative, whereby all members can contribute, it was emphasized that CIHC should ensure that it has an explicitly patient-focused approach and be inclusive to all types of health care workers.
- Numerous respondents emphasized the importance of face-to-face meetings in networking and achieving outcomes, and thus CIHC might want to consider how to optimally invest resources into such meetings.
- CIHC has undertaken an ambitious two-year plan aiming to achieve a range of important objectives and goals. The findings indicated that there are many opportunities for CIHC, and as an organization, it might need to prioritize in order to be effective and focused (i.e. developing the evidence-base for IECPCP to ensure that changes in health care, education, and policy, are based on what we know to be effective, engaging key decision-makers).
- CIHC was in an early stage of development when the data for this report were gathered, and thus not all respondents were clear on what type of organization CIHC was aiming to be or what its key goals were. Given this uncertainty, it may be worthwhile to focus on this issue over time as CIHC becomes more focused and developed.
- The issue of resources also needs some consideration, given the large number of activities the CIHC are currently undertaking within a relatively small (and time-limited) budget. At the moment, the CIHC are dependent on the voluntary contributions from an extensive network of members from across the country. Respondents placed a high value on the work of the CIHC. To build on these early successes, attention needs to be placed on ensuring the long-term financial sustainability of the CIHC.

Appendix A



August 16, 2006

PROGRAM LOGIC MODEL

