learning to work together, working to learn together
apprendre à collaborer, collaborer pour apprendre

Working Together on Research
La recherce concertée

November 26, 2006, Toronto

SUMMARY OF CIHC-EBRI WORKSHOP
COMPTE RENDU DE L'ATELIER CPIS-IRÉB

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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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CIP data will be made available

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LEAD EDITOR: Jamie Conklin. Jamie played a role in planning the workshop, he designed and compiled the research measures template, and skillfully facilitated the day-long *Working Together on Research* workshop.

CONTRIBUTING EDITORS: Members of the CIHC Secretariat (Andrea Burton, John Gilbert, Brenda Sawatzky-Girling) and CIHC Steering Committee (Ruby Grymonpre, Jennifer Medves, Judith McFetridge-Durdle, Hassan Soubhi and Esther Suter).

The *Working Together on Research* workshop was attended by a group of approximately 40 CIHC members identified as those leading the research components of the IECPCP projects across Canada (see Appendix A).

Susanna Gilbert of *Descriptions Design & Planning* formatted this document.

The views expressed in this report do not necessarily represent the views of the Canadian Interprofessional Health Collaborative.

Contents

Executive Summary 5

Sommaire exécutif 7

Working Together on Research Workshop 9

- Introduction to the Workshop 9
- The Policy Context 10
- The Research Project Template 10
- First Breakout and Plenary: *What Is Our Focus And How Well Are We Doing?* 13
- Panel Response to the Template Presentation 16
- Second Breakout and Plenary: *What is Missing?* 17
- Final Plenary Discussion 19

Conclusion 20

Appendix A Research Workshop Participants 21

Appendix B Detailed Notes from the Research Workshop Breakouts and Plenaries 23

- First Breakout and Plenary: *What Is Our Focus and How Well Are We Doing?* 23
- Second Breakout and Plenary: *What Is Missing?* 29

Appendix C Research Workshop Evaluation 33

Appendix D CIHC Inaugural Meeting 34

- CIHC Research Committee's Key Issues and Solutions: *What Have We Heard?* 34
- CIHC Evaluation Committee's Key Issues and Solutions: *What Have We Heard?* 36
- CIHC Inaugural Meeting Participants 37

Executive Summary

Working Together on Research was the key theme when approximately 40 researchers from across Canada gathered in Toronto on November 26, 2006 for a workshop co-sponsored by the Canadian Interprofessional Health Collaborative (CIHC) and the Élisabeth Bruyère Research Institute (EBRI). The workshop provided an opportunity for researchers to share ideas related to Interprofessional Education for Collaborative-Centred Practice (IECPCP), discuss effective collaboration and the ways in which collaborative practice can impact curricula and quality of care.

Following formal presentations, participants split into small groups to discuss their own research including results and some of the areas where research is falling short. A number of key themes emerged during these discussions. On some issues, researchers approached the subject with diverging perspectives. For example, some participants felt there should be a move towards achieving consensus on a model that defines the key features of interprofessional collaborative practice, while others questioned whether the concept can be expressed in a single model.

Recommendations resulting from the research workshop:

- Ensure the emerging research agenda draws on work already done (particularly the work of Way and Jones, and the Canadian Medical Education Directives for Specialists (CanMEDs) competency model).
- Continue to recognize IECPCP as a complex and various area of research, with research approaches tailored to specific contexts that employ mixed methods and longitudinal approaches.
- Develop a common terminology to facilitate communication among researchers.
- Continue to validate research instruments.
- Encourage researchers to augment their work by accessing external sources such as the organizational behaviour literature and the sociological literature.
- Continue to develop and build strong communication ties between members, both through electronic media and face-to-face meetings.
- Recognize the need for further discussion on specific topics such as knowledge translation and gaps in current practice.
- Share cases and collaboratively develop a shared model.
- Place a stronger emphasis on research design.
- Establish the CIHC as the hub for internal and external communication.

The discussions that began with the *Working Together on Research* workshop have provided some clarity about the current assets and gaps in IECPCP research approaches. These discussions and ensuing recommendations, in turn, fed into CIHC research and evaluation committee deliberations. Workshop participants can integrate the sharing, learning and recommendations from the workshop into their daily work while providing a collective voice into forward planning.

NEXT STEPS

The Canadian Interprofessional Health Collaborative (CIHC) **Inaugural Meeting** took place on November 27 and 28, 2006. Leads of the CIHC research and evaluation committee, along with the other CIHC priorities – partnerships, curricula and knowledge translation - built on the learning generated during the research workshop and facilitated a series of sessions with a larger and more varied group of participants. After the three days of CIHC meetings, the research and evaluation committees offered the following clarification between research and evaluation:

> **Research** studies must be conceptualized, designed and conducted in such a way that its findings can be generalized or extrapolated to circumstances outside of any particular project.
>
> The purpose of **evaluation** is to improve, not prove[1]. Evaluation is project specific, assessing the processes required to achieve a particular set of outcomes with the purpose of revising or refining the project (formative evaluation) and assessing whether or not a set of outcomes have been achieved (summative evaluation).

The research and evaluation committees are charged with moving the CIHC forward to extend the knowledge in research and evaluation of IECPCP. Read about their approach in Appendix D.

1 Stufflebeam DL. *Evaluation Models: A New Direction for Evaluation*. New York, NY: Jossey-Bass; 2001

Sommaire exécutif

La recherche concertée [Working Together on Research] était le thème central d'un atelier réunissant une quarantaine de chercheurs venus de toutes les régions du Canada qui s'est tenu à Toronto le 26 novembre 2006. Organisée conjointement par le Consortium pancanadien pour l'interprofessionnalisme en santé (CPIS) et l'Institut de recherche Élisabeth-Bruyère (IRÉB), cette rencontre a permis aux participants de partager leur vision concernant la formation interprofessionnelle pour une pratique en collaboration centrée sur le patient (FIPCCP), de discuter de moyens de collaboration efficaces ainsi que de l'impact de la pratique en collaboration sur les programmes de formation et sur la qualité des soins.

Après quelques présentations formelles, les participants se sont répartis en ateliers pour discuter de leurs travaux de recherche, des résultats obtenus et des domaines où ces résultats sont décevants. Plusieurs thèmes importants se sont dégagés de ces échanges. Dans certains cas, des approches différentes se sont manifestées. Par exemple, certains souhaitaient un consensus autour d'un modèle explicitant les principales caractéristiques d'une approche de collaboration interprofessionnelle alors que d'autres doutaient de la possibilité de condenser cette notion en un seul modèle.

Principales recommandations formulées lors de l'atelier :

- S'assurer que l'agenda de recherche en voie d'élaboration s'inspire des travaux déjà complétés (en particulier de ceux de Way et Jones, et du modèle de compétences CanMED [Canadian Medical Education Directives] destiné aux spécialistes).
- Continuer à traiter la FIPCCP comme un domaine de recherche complexe et diversifié dont les modalités doivent être adaptées au contexte et qui exige des méthodes variées et des approches longitudinales.
- Élaborer une terminologie commune pour faciliter la communication entre chercheurs.
- Continuer à valider des outils de recherche.
- Encourager les chercheurs à enrichir leurs travaux en ayant recours à des sources externes comme la documentation sur le comportement organisationnel et les publications portant sur la sociologie.
- Continuer à établir et à consolider des liens étroits au sein de la communauté des chercheurs, tant par le biais des médias électroniques que de rencontres des personnes.
- Reconnaître le besoin de poursuivre les discussions de certains sujets comme le partage du savoir et les lacunes dont souffre actuellement la pratique.
- Partager des histoires de cas et développer ensemble un modèle commun.
- Insister davantage sur la planification de la recherche.
- Faire du CPIS un pivot de communication interne et externe.

Les discussions amorcées lors de l'atelier sur *« La recherche concertée »* ont permis de clarifier les atouts et les lacunes des approches de recherche actuelles concernant la FIPCCP. Ces discussions et les recommandations qui en ont découlé ont aussi alimenté les délibérations du comité d'évaluation. Les participants à cet atelier peuvent intégrer les échanges, les enseignements et les recommandations qui en ont résulté à leurs activités quotidiennes et y puiser une contribution collective au processus de planification des activités à venir.

ÉTAPES SUIVANTES

La **toute première rencontre** du Consortium pour l'interprofessionnalisme en santé (CPIS) s'est tenue les 27 et 28 novembre 2006. Les leaders des comités d'évaluation et de recherche du CPIS, de concert avec les autres volets d'activité du CPIS –partenariats, programmes de formation et partage du savoir- ont élargi la base de savoir engendrée au cours de l'atelier en animant une série de sessions regroupant un cercle plus grand et plus varié de participants. Après les trois jours de rencontre du CPIS, les comités de recherche et d'évaluation ont formulé les clarifications qui suivent concernant la recherche et l'évaluation :

> Les travaux de **recherche** doivent être conçus, planifiés et exécutés de manière à ce que leurs résultats puissent être généralisés ou extrapolés à des circonstances ne relevant d'aucun projet spécifique.
>
> L'objet d'une **évaluation** est d'améliorer et non de prouver. Une évaluation dépend d'un projet particulier et consiste à estimer les procédures requises pour obtenir un ensemble spécifique d'effets dans le but de réviser ou de raffiner le projet (évaluation formative) et d'évaluer si un ensemble donné de résultats a été atteint (évaluation sommative). Les comités de recherche et d'évaluation ont le mandat d'aider le CPIS à améliorer le savoir en matière de recherche et d'évaluation concernant la FIPCCP. Leur approche est décrite à l'annexe D.

Working Together on Research Workshop

This section of the report presents a summary of the discussions that took place on November 26, 2006, at the Working Together on Research Workshop.

Attendees heard presentations from John Gilbert (Project Lead, CIHC), Sue Beardall of Health Canada, and Colla MacDonald of the University of Ottawa's Faculty of Education. Participants also heard from a panel moderated by Larry Chambers of EBRI, consisting of Lesley Bainbridge (University of BC), Teresa Broers (Queen's University), Scott Reeves (the CIHC Evaluation lead from the University of Toronto), and Dennis Sharpe (Memorial University of Newfoundland).

INTRODUCTION TO THE WORKSHOP

John Gilbert began the Working Together for Research workshop by welcoming the project representatives and other observers to the day. He described the events that led to the establishment of the Canadian Interprofessional Health Collaborative (CIHC), including the May 2006 meeting in Ottawa funded by Health Canada and hosted by the Élisabeth Bruyère Research Institute. As a result of that meeting, a process and team were put in place to hold a workshop on research before the end of 2006.

Research into Interprofessional Education for Collaborative Patient-Centered Practice (IECPCP) is essential to inform both policy and curricula related to interprofessional practice. Through the research carried out by the IECPCP and related projects, we will ultimately gain an understanding of the dynamics of effective collaboration, and of the ways in which collaborative practice can impact quality of care.

CIHC has established committees on research, evaluation, curricula, knowledge translation and partnerships which will help to shape the work of a broad network of stakeholders (including policy makers, researchers, educators, students, health system leaders, providers, patients, and families) interested in pursuing improvements to Canada's health system by changing the way that practitioners work together. The November 26 workshop is seen, in part, as a way of creating momentum in the work of these committees, particularly the research and evaluation.

THE POLICY CONTEXT

Sue Beardall of Health Canada placed the current research program into the broader context of the 2003 First Ministers Accord on Health Care Renewal, and the resulting Health Human Resource Strategy. One of the strategy's three key elements was Interprofessional Education for Collaborative Patient-Centered Practice (IECPCP), which is intended to help Canadians change the way we educate health providers so Canadians will have better and faster access to the health care provider they need when they need it, ultimately boosting the satisfaction of both patients and providers.

Ms Beardall described the overall framework of accountability for the 20 Cycle 1 (11 projects) and Cycle 2 (9 projects) IECPCP research projects. She explained the work that has been done so far to identify the data elements and data-gathering processes needed to assess the effectiveness of the overall research program, and she explained some of the features of the program logic model that has been adopted—which asks the 20 projects to provide data that will be used to assess immediate, short-term impacts.

She also announced that her team will be conducting site visits beginning this winter and concluding in the fall of 2007. These site visits will allow for the gathering of qualitative data about the progress of the various projects, which will be shared with project leaders in order to facilitate mid-course adjustments.

The overall program evaluation workplan will be complete by March 30, 2007. Pilot data collection will take place in the spring of 2007, and an interim evaluation will take place in the summer/fall of 2007. The final IECPCP evaluation will be carried out in the summer of 2008.

THE RESEARCH PROJECT TEMPLATE

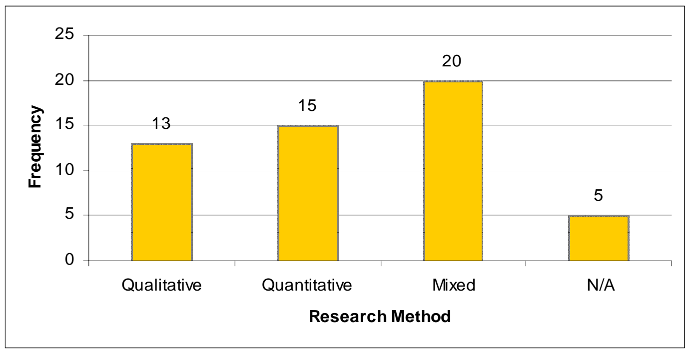
In the weeks leading up to the Working Together for Research workshop, a template was circulated to the IECPCP projects across Canada to gather information about the research measures currently in use[1]. Colla MacDonald of the University of Ottawa's Faculty of Education made a presentation about the data gathered in the research template, and about possible models for conducting research into IECPCP.

Dr. MacDonald's presentation included the following points about the 21 projects (the 20 Health Canada-funded IECPCP projects as well as the Working Together project at the Élisabeth Bruyère Research Institute and University of Ottawa) represented in the template data:

- The purpose of all projects was to design, deliver and evaluate interprofessional collaborative practice learning resources
- The terms 'collaboration' and 'team work' were used interchangeably
- There was no clear definition of interprofessional practice
- There was no consistency in what good interprofessional training looks like

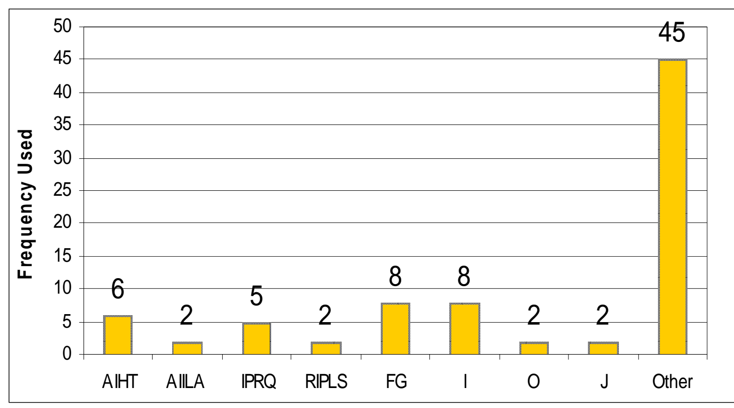
[1] A summary of these research templates is available on www.cihc.ca *Workshop Prepackage #1: IECPCP Research Measures*

Dr. MacDonald also noted that the projects used 53 different instruments to measure the same phenomenon. The 53 instruments represented the following methods:



Approximately 31 of the instruments have been used in other, non-IECPCP projects. Only 12 of these instruments have undergone psychometric testing.

Eight instruments or methods were used in more than one of the IECPCP projects:



- AIHT--Attitudes towards interprofessional health care teams (6 projects)
- AIILA--Attitudes towards interprofessional health care teams (2 projects)
- IPRQ--Interprofessional reciprocity questionnaire—this includes: the Attitudes to Health Professional Questionnaire (AHPQ), Interdisciplinary Education Perception Scale (IEPS), and the Entry Level Interprofessional Questionnaire (ELIQ) (5 projects)
- RIPLS--Readiness for Interprofessional Learning Scale (2 projects)
- FG--Focus group (8 projects)
- I--Interviews (8 projects)
- O--Observation (2 projects)
- J--Journals/diaries (2 projects)

Dr. MacDonald suggested that there were several things that IECPCP researchers might consider:

- The need for quality standards:
  - An agreed-to curriculum or conceptual model for interprofessional training that can be used as a quality standard to design, develop, deliver and evaluate education in interprofessional practice
  - An agreed-to model that can be adopted in or adapted to various situations (pre-service; in-service; face-to-face training, online and blended education programs)
- A definition of quality IECPCP
- Identification of the variables that define quality IECPCP

Dr. MacDonald suggested that the immediate need is to develop an educational model and assessment tool for interprofessional practice. She offered her own DDLM-IP model as an example of a model that is grounded in both an interprofessional paradigm and a constructivist educational theory.

FIRST BREAKOUT AND PLENARY:
What Is Our Focus And How Well Are We Doing?

During the first breakout, the four breakout groups considered three questions about research in IECPCP:

- What characteristics, competencies, and abilities do we seek to measure?
- What instruments will measure these factors and help us to improve curricula and practice?
- How can existing approaches be strengthened & what alternative approaches could be used?

After completing their discussions, the groups re-assembled in a plenary session to listen to brief report outs and to discuss the implications of their discussions.

The following subsections present a synthesis of these discussions. Appendix A contains the complete facilitator notes from the breakouts and plenary.

1. What characteristics, competencies, and abilities do we seek to measure?

Five key themes emerge from the discussion of the first question:

- We need to achieve consensus on a model that defines the key features of inter-professional collaborative practice.
- Some of the possible components of this model could include:
  - Attitudes toward collaboration
  - Trust, respect, flexibility
  - Conflict management and negotiation skills
  - Communications competence
  - Awareness of scope of practice
  - Organizational competence
  - Leadership
  - Clarity of the task
  - Power relations
- However, some of us believe that the phenomenon of inter-professional collaboration may not be capable of expression in a single model—the phenomenon may be distinctly different in different organizational contexts.
- An effective model or approach to collaboration should consider the impact of the temporal dimension: collaboration may change as a patient moves along the continuum of care, and the intensity of collaboration may vary from relationships to partnerships depending on the duration of the work.

- We should be sure to consider the work that has already been done—particularly the work of Way and Jones, and the Canadian Medical Education Directives for Specialists (CanMEDs) competency model which includes:
  - Medical expert
  - Communicator
  - Collaborator
  - Manager
  - Health advocate
  - Scholar
  - Professional

2. What instruments will measure these factors and help us to improve curricula and practice?

Four themes emerge from the discussion of the second question:

- Until we make more headway on the previous question, we will be unable to suggest firm or definitive answers to this question.
- The research subject is complex and various, and for now research approaches should be tailored to the specific characteristics of the context, and should employ mixed methods and longitudinal approaches.
- We should consider developing a standardized case study method that includes such things as an observational methodology, a common approach to relationship mapping, standardized questions, and a way of generating quantitative data.
- We should consider identifying specific components of collaboration, and devise or identify measures suitable for those components.

3. How can existing approaches be strengthened & what alternative approaches could be used?

Four themes emerge from the discussion of the third question:

NEXT STEPS

During the CIHC Inaugural Meeting, the CIHC research and evaluation committees clarified the difference between research and evaluation:

CIHC's working definition of research:

> **Research** studies must be conceptualized, designed and conducted in such a way that its findings can be generalized or extrapolated to circumstances outside of any particular project.

CIHC's working definition of evaluation:

> The purpose of **evaluation** is to improve, not prove[1]. Evaluation is project specific, assessing the processes required to achieve a particular set of outcomes with the purpose of revising or refining the project (formative evaluation) and assessing whether or not a set of outcomes have been achieved (summative evaluation).

Read more in Appendix D.

- We need to develop a common vocabulary and common terminology, so we can be sure that we are talking about the same things
- Several specific suggestions were made, including:
  - We must win the sympathy and support of healthcare workers
  - We must allow the research questions to drive the measures
  - Our results will be perceived to be weak unless we make use of comparison groups in our research designs
  - We need more rigorous research designs
- We need to bring about more integration within this field of research, by:
  - Developing research approaches that recognize the linkages between education, practice, and policy
  - Ensuring that the various projects and provincial bodies are collaborating in this endeavor
  - Strengthening the links between accreditation / regulation and the scope of practice bodies
- We must continue to validate the instruments that we are creating and using.

Plenary Discussion

Three broad themes were evident in the plenary discussion:

- We must recognize and build on existing evidence that supports the importance of collaboration, and we must be clear about the type of new evidence that we must create. To what extent are we seeking to motivate practitioners, and to what extent are we looking for cost-benefit analysis to convince policy makers?
- We must be clear on the overall purpose of the IECPCP research program, and on the needs of our audiences. If policy makers are currently interested in wait times, HR shortages, length of stay, readmission, and patient satisfaction, then our research should speak to these issues. We should also remember that some professional associations are skeptical of collaboration, so our results must be persuasive.
- Currently there is significant variety evident in our own assumptions and approaches. It will take time for us to negotiate common ground.

PANEL RESPONSE TO THE TEMPLATE PRESENTATION

After the first breakout and plenary, a panel was convened to respond to the presentation by Colla MacDonald. The panel included the following participants:

MODERATOR: Larry Chambers, President, Élisabeth Bruyère Research Institute

PANELISTS:

Lesley Bainbridge, In-BC Project, University of British Columbia
Teresa Broers, QUIPPED Project, Queen's University
Scott Reeves, CIHC Evaluation, University of Toronto
Dennis Sharpe, Collaborating for Education and Practice Project, Memorial University of Newfoundland

Panelists and the audience made the following points:

- This meeting is in itself an important achievement. In at least some other jurisdictions that are considering collaborative practice, research teams have not been able to come together for face-to-face discussion.
- The DDLM-IP model is too much for the present time. We need parsimony in a model. We may also need more than one model.
- The project teams need to have time to discuss our respective measures and approaches.
- Perhaps we could consider forming communities of practice based on specific instruments or methods.
- One person expressed concern that the projects are all over the map and suggested that it may be premature to publish findings.
- On the other hand, the diversity may allow for triangulation of the data, which would be a positive outcome.
- This is our first meeting, and nobody else has done this sort of thing. We are at the beginning. CIHC committees will create links between people who may wish to collaborate. Over the next two days we will discuss whether we want to ask Health Canada for support in getting together again before October 25-26, 2007 (when *Collaborating Across Borders*, a Canada-USA meeting is scheduled in Minneapolis).
- Disasters and failures can sometimes establish the need for collaboration. This sort of thing has happened in the UK, and also in Ontario.
- The scan of instruments afforded by the template is useful. However, we also need to understand how the template fits into an overall research design.
- This is a good start, but in eight months some of the Cycle 1 IECPCP projects are finished. Perhaps the CIHC website could allow us, for example, to share how we are framing and using focus groups. The qualitative data is proving to be the richest source for revealing process issues in ways that allow us to reflect on curricula change.
- Patient safety is a key issue that could be helped through interprofessional collaborative practice.
- Perhaps we could report to each other on lessons learned from Cycle 1.
- We might look upon the template as an evolving inventory of what we are doing. Perhaps we should think more about facilitating our own collaboration, to advance the overall field.

SECOND BREAKOUT AND PLENARY:
What is Missing?

1. What are the gaps in our tools and approaches?

Seven themes are evident in the discussion of this question:

- The four groups suggested that specific tools and approaches may be needed for a variety of purposes, including:
  - Cost-benefit analyses
  - Measuring patient satisfaction and outcomes
  - Measuring family satisfaction and outcomes
  - Measuring quality of care
  - Assessing commitment to change
  - Identifying and measuring causal relationships
  - Focusing on processes
  - System outcomes
  - Non-observable outcomes
- Some members of the groups continued to emphasize the importance of creating broader models or theories to account for collaborative practice: people specifically pointed to the need to view collaboration in terms of a system of interdependent factors, the need to develop a conceptual basis for the tools that are used, the need to develop a model (along the lines of Jones and Way), and the need for a longitudinal focus.
- However, other members of the groups continued to stress that diversity and variety may be a strength of this research program, that IPE may be a complex and diverse phenomenon that would benefit from multiple views and approaches.
- Some people pointed out that the research program should be open to external sources of knowledge, such as the organizational behaviour literature, the sociological literature (including the sociology of occupations).
- Some suggested that we should identify and then create linkages with existing centres of expertise, including: OISE, the University of Washington in Seattle, the UBC Health Care Collaborative (with its numerous case studies), the University of Texas at Houston, the national organization in the UK (CAIPE).
- Some stressed the need for us to achieve a better understanding of the overall stakeholder environment, specifically mentioning existing knowledge brokers, the faculty members who will be expected to lead new IPE endeavours, and the clinical team members and patients who comprise the CPCP component.
- Some argued that we should view IECPCP as part of a program to promote cultural and organizational change within universities and health care institutions, and we thus need to understand the dynamics of change in culture, attitude, knowledge, skill, behaviour at both individual and system levels.

2. How can we collaborate in the coming weeks?

Three themes are evident in the discussion of this question:

- We must continue to communicate with each other, using a variety of media (print, the Internet, chat rooms, a virtual blackboard, and face-to-face).
- This communication might focus on a variety of specific topics or collaborative projects, including:
  - Knowledge translation (perhaps using CHSRF's *Mythbusters* as a model)
  - Continuing to identify the gaps in curricula, research, and evaluation
  - Sharing cases from different parts of the country
  - Working collaboratively on the development of a model
- We must continue to build on CIHC and continue to organize ourselves, perhaps by viewing ourselves as a set of linked and evolving Communities of Practice with specific interests, perhaps by organizing new subgroups in relation to domains such as pre-licensure, post-licensure, research designs, methods, outcomes, etc.

NEXT STEPS

Following the CIHC Inaugural Meeting, November 27-28, 2006, the CIHC Research and Evaluation committees agreed that their work in relation to moving the CIHC forward is distinct.

The **research committee** will be looking at how IECPCP works or would work based on *testable theories and models*. They will be doing this to improve understanding of the processes involved in IECPCP and how they are linked to specific outcomes defined at the level of the patient, the health care team, or the organizational level. The CIHC research committee will: catalogue conceptual frameworks, theories and methodologies; create a rubric/matrix of current projects, identify interprofessional components; identify gaps and develop a national research agenda; platform for communities of interest.

The **evaluation committee** will be looking at the evidence that IECPCP works to *improve those outcomes*. This implies the need to look at how evaluation is organized and conducted to provide that evidence, and to weigh the evidence provided in terms of designs and methodologies. The CIHC evaluation committee will provide leadership in the development and implementation of an overall strategy to support and promote collaboration and knowledge transferring concerning evaluation across Health Canada funded IECPCP projects.

3. Funding ideas

Participants were invited to discuss possible funding sources in the small groups. Not all of the groups reported back on this subject, and some of the discussion was more a commentary on how funds are being directed rather than on potential sources of funding. Here are the main ideas that emerged related to possible sources of funding:

- Health Canada
- Provincial government research funds
- Provincial health authorities
- Research institutes
- CHSRF – in terms of service delivery

FINAL PLENARY DISCUSSION

The following main points emerged from the plenary discussion:

- Health Canada will be carrying out site visits and will be gathering qualitative data during these visits. This data could potentially be used as an informal formative evaluation, to help distribute lessons learned and strengthen the overall research program.
- It may be helpful to look upon the IECPCP effort underway across the country as a network of researchers, with CIHC as the hub of the network. There is a need to identify the specific people within the network who are acting as boundary spanners and knowledge brokers, who may be able to better ensure that information is circulating to the benefit of the overall program.
- The discussions during the day have highlighted a need for the research teams to place more emphasis on research design. Perhaps we could collaboratively categorize the possible types of design that are appropriate for research into IECPCP, and then identify four or five "best" designs. We may be able to look at research designs in relation to the ongoing evolution of research into IECPCP, beginning with developmental, then field tests, then comparisons of the results of field tests, then quality of evidence, and finally designs to bring about policy change. We could share this information via the CIHC website.
- We must remember that our funders are ultimately interested in the major issues of the federal and provincial governments, and today that means people are interested in wait lists. Collaboration is a possible solution to the wait list problem. Our communications and our research may need to focus on the creation of evidence that collaboration, and education about collaboration, can alleviate wait lists.

Conclusion

The *Working Together on Research* workshop provided an opportunity for researchers to share ideas related to Interprofessional Education for Collaborative-Centred Practice and to discuss effective collaboration and the ways in which collaborative practice can impact curricula and quality of care. The discussions that began with the *Working Together on Research* workshop have provided some clarity about the current assets and gaps in IECPCP research approaches.

Working Together on Research discussions and ensuing recommendations, in turn, fed into CIHC research and evaluation committee deliberations. Workshop participants can integrate the sharing, learning and recommendations from the workshop into their daily work while providing a collective voice into forward planning. The next steps following *Working Together on Research* are clear: the CIHC research and evaluation committees are confirming their terms of reference and membership, and implementing a workplan to further the knowledge in research and evaluation of Interprofessional Education for Collaborative Patient-Centered Practice throughout the two-year funding period of the CIHC (until June 2008) and beyond.

Appendix A
Research Workshop Participants

Participants in the November 26 Working Together for Research Workshop

This one-day workshop was attended by a group of approximately 40 individuals primarily representing the research components of the IECPCP projects across Canada.

NAME	AFFILIATION
Lesley Bainbridge	In-BC, UBC
Sue Beardall	Office of Nursing Policy, Health Canada
Teresa Broers	QUIPPED, Queen's University
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Appendix B
Detailed Notes from the Research Workshop Breakouts and Plenaries

FIRST BREAKOUT AND PLENARY:
What Is Our Focus and How Well Are We Doing?

Red Group

What characteristics, competencies, and abilities do we seek to measure?

- Transcending tools
- Measures should relate to a model, whatever model
- There are levels of competences:
  - Individual
  - Team
  - System
  - Organization
- Blending of tools
- Attitudes toward collaboration
- Trust, respect (Jones & Way)
- Beliefs of individuals
- Organizational competence / capability
- Keep questions general

What instruments will measure these factors and help us to improve curricula and practice?

- Mixed methods
- Longitudinal data
- Understand the process
- Context

How can existing approaches be strengthened & what alternative approaches could be used?

- Buy-in from health care staff
- Questions should drive the measures, not vice versa
- Instrument approach is too static; be more pliable, dynamic, and patient

Brown Group

Initial conversation:

- Research is designed to answer a question
- Research and evaluation lie on a continuum
- We need more funding sources to get monies for program development (if framed as research)
- Evaluation does not necessarily start with a question that needs an answer. Evaluation can be seen as a set of activities designed to evaluate outcomes.
- IECPCP evaluation agenda is being supported by having researchers involved
- There are program evaluator professionals who will see this as their turf

What characteristics, competencies, and abilities do we seek to measure?

- If we carry on thinking we know how to do it, we will keep getting exactly what we have now
- Team versus collaboration
- We need to move to a consensus on the components of collaboration
- Collaboration as a concept is embedded within regulated health profession competencies. What about unregulated health workers?
- Approaches to teaching collaboration in education settings are different from health practice settings.
- Is there consensus on what we should be measuring?
- Effective team function: there is a general, "soft" consensus
- "Teams" in IECPCP may be different. We need to deconstruct the term IP Teams. The phenomenon is complex and may be difficult to specify tightly.
- What is going on in IPC?
- Should it be analyzed in relation to specific settings and sectors?
- There are meta challenges for IPC across sectors and settings: trust, longevity, interpersonal relations, clarity of the task
- Implicit and explicit power relations are important
- Implicit and explicit task assignment and ownership is important
- What are the characteristics of collaborative practice? We need to be able to say upfront what the key components are.
- Willingness to collaborate and communicate.
- CanMEDs core competency:
  - Expert
  - Communicator
  - Collaboration
  - Manager
  - Scholar
  - Professional

- We started all of this because of ideals. We must be careful not to oversimplify. We need to measure sociological constructs, i.e. power relationships / differential ("negotiated power")
- Other professions have core competencies in their standards / code of ethics, with different language and nuances of meaning in the terms. They do talk about collaboration in how they practice with others.
- Across the regulated health professions there needs to be more consensus on what collaboration is
- What constitutes collaborative practice? How do we teach this?
- Will teams produce better outcomes?
- There is very little scientific research and evidence on teams and their defining characteristics.
- Teamwork is complex and changes as the patient moves along the continuum of care.
- Communication, coordination, collaboration
- Knowledge exchange: how people learn together, through networks and brokers. Collaborative, education, overlay. COL / COP.

What instruments will measure these factors and help us to improve curricula and practice?

- We need to be able to measure complexity.
- Power relations in teams
- Need to measure things differently in different settings, recognizing the complexity and differences
- Huge challenges for developing instruments and think about generalizability

How can existing approaches be strengthened & what alternative approaches could be used?

- Evaluation is weak unless we have a comparison group.
- We need more rigorous research designs.
- New knowledge is necessary because of the complexity – collaborative practice is complex

Orange Group

What characteristics, competencies, and abilities do we seek to measure?

- We need to build on what is available
- There is not one instrument or model
- There are tools in the UK which may support our work
- Define our terms clearly and within the context
- Use and pool data in different contexts and stage of learning
- Collectively rather than individually
- Different and better (collecting whole)

- How do we perceive patient care (different)
- Look for new definition from WHO
- Collaborative
- Respectful person for others and for self
- Understanding (skills and ability)
- Critique of others and self
- Scope of practice knowledge
- (RCC) Relationship centered care
- Mutual trust
- Educators
- Foster
- Model
- Competencies and abilities
  - Communication
  - Collaboration
  - Expert practice
  - Manager
  - Scholar
  - Advocate
  - Professional (attitude)

What instruments will measure these factors and help us to improve curricula and practice?

- We must seek to measure…

What…	How…
Communication Decision making Introduction, role and sharing Physician centrality scale CUILU Combined Universities IP Learning Unit	Simulation Lab Role Play Real people SBAR IRS (through observation) NOQ subscale Patient satisfaction Validity (needs to be done) CMMS Audit Tool

Time Together	
Southern Alberta	SW SLP 0T PT

How can existing approaches be strengthened & what alternative approaches could be used?

- We don't have terminology definitions that are consistent
- Are we changing the team's work or collaboration
- In UK they have a continuum:
  - Level
  - Scope of practice
  - Context
  - Needs to lifelong
  - Workplace change
- For, with, and about CAIPE. Don't have practice definitions.
- Attitudes

Yellow Group

What characteristics, competencies, and abilities do we seek to measure?

- The domains are not linear
- Goal directedness
- Flexibility
- Disciplinary articulation
- Communication: respect, listening
- Conflict management, resolution, negotiation skills
- Leadership
- Team dynamics
- Relationship (short term) & partnerships (long term)
- Derive from CanMEDs and should include unique competencies (meso, macro, micro)
- 7 elements / abilities

What instruments will measure these factors and help us to improve curricula and practice?

- Case Study:
  - Standardized

- "variable real life"
- Key features
- Methodology
- Relationship mapping
- We need numbers
- We need standardized questions for this process (recommendation for CIHC)
- Observational methodology
- Knowledge tests

- Attitude
  - Toward teaming and collaboration
  - Soft skill / personality
  - What are soft skills?
- Behaviour
- Is this for scholarship or for policy?

How can existing approaches be strengthened & what alternative approaches could be used?

- Keeping the flame alive
- Connect the dots between
  - Education
  - Practice
  - Policy
- Collaborate between projects and provinces
- Links (strengthen them) between accreditation / regulation and scope of practice bodies
- Validate the instruments

Plenary Discussion

- Need for more sophisticated designs. And methods.
- Process. People ask where is the evidence for collaboration? We have a short window of time to find the answer.
- The evidence is there. We need to build on it.
- The UK has created an evidence database. The Canadian research effort needs to create a way to pull the evidence together.
- When is this research program about scholarship and when is it about policy? We need to be clear on this distinction.
- We must have a theory to test. We need to discuss theories, which can then be the basis for models.
- Can you even answer scholarship and policy questions in the same breath? The criteria may differ in the two instances.
- Models come before theory, contrary to what an earlier person said.
- What should we measure? Currently we are looking in different directions.

- Can we move to common measures? Are there common metrics?
- We are after long-term outcomes. The projects must also consider sustainability of results.
- The design of an evaluation always depends on who is asking the questions. Since our funders are policy makers who are interested in things like wait times and the imminent shortage of professionals (doctors and nurses), we should try to communicate how IECPCP will help to solve these problems.
- Collaboration takes time, and the only evident outcome may end up being quality of care.
- What about scope of practice? Do we also need to look at this?
- We need metrics that speak to the current issues. Patient satisfaction, length of stay, readmission – we need to look at these. But even if we establish these links, will this be sufficient to change pre-licensure attitudes to collaboration? And does attitude change lead to behaviour change and ultimately to the quality of care outcomes that we are interested in?
- We need to provide evidence to show more efficient health care delivery. It is critical that we show IECPCP in relation to efficiency. We must prove the cost/benefit ratio of IECPCP.
- But keep in mind that professional associations are actually skeptical about collaboration. They espouse support, but they are actually keen to see the cost/benefit of collaboration (in terms of both dollars and time).
- Perhaps we should begin with pre-licensure and then move downstream. It may be difficult to demonstrate efficiency. However, we could start on the pre-licensure side and then show the cost/benefit.

SECOND BREAKOUT AND PLENARY:
What Is Missing?

Group I

What are the gaps in our tools and approaches?

- Organizational: how does a complex organization move towards change?
- Patient and family centered satisfaction and outcomes, process
- What are some of the theories that can inform our questions?
- Translation of attitude, knowledge, skills into behaviour and environmental system change

How can we collaborate in the coming weeks?

- Clusters to make us talk across Canada to address these issues

Group 2

What are the gaps in our tools and approaches?

- The current number of instruments may reflect various components of IPE (53 is not necessarily a bad thing)
- Concept needs to precede the tool
- Battery of tools (coordinated approach to measurement) across multiple learners and context
- “Natural selection” of tools
- How tied to theory do our educational interventions need to be?
- How do we move from model to intervention?
- Applaud Health Canada for the openness of the grant
- Learning how to do RCT with complex interventions
- Longitudinal focus
- Non-observable outcomes
- Practice-based education
- Patient health outcomes
- Patient satisfaction
- System outcomes
- How is the patient incorporated into IECPCP?

How can we collaborate in the coming weeks?

- Greater knowledge of projects. How are they interconnected?
- How can we integrate? Face to face discussion.
- Link projects with a model.

Plenary Discussion

- Patience: these are complex projects. We need to be patient for the outcomes to emerge and to be translated into policy.
- We should be interested in networks—how they work. Hubs, spokes. Networks need boundary spanners and knowledge brokers. We need to identify our hubs and brokers.
- How are our activity reports used by Health Canada? Could this data be used in a formative way, could HC synthesize and disseminate the results?
- At the moment, the activity reports are used as an accountability tool, and this is not likely to change in the near term. However, the site visits could yield qualitative data that offer lessons learned that could be shared through CIHC.
- CIHC is the hub of this network.
- There is a need for us to better understand research design. How can we share this information? Via the CIHC website?
- We should indeed use technology to leverage the work of our groups. Use software to enhance our own interaction. And perhaps look at holding regional meetings.

- Maybe we could try to categorize the best designs for this sort of work, and come up with four or five. Perhaps we could show the work being done in phases, starting with developmental, then field tests, then comparisons, then quality of evidence, then designs related to policy changes.
- We are trying to speak the language of government. It is useful to recall that wait lists is a big issue. Collaboration is a possible solution, and for collaboration to take hold we need education and evidence.

Group 3

What are the gaps in our tools and approaches?

- Cost benefit analysis tools
- Patient tools
- Facilitator competencies for IPE. Self efficacy.
- Collaborative practice (Jones & Way)
- Organizational behaviour literature applied to health care
- Michael West translation to CH Care (Ashton)
- Questionnaires: use sociology expertise.
- We need good probes and then we can use qualitative data
- Standard lexicon
- Behaviour collaboration, maintain (?) schemes, OSIE – U of Washington, Seattle
  U of S or U of M
- UBC Health Care Collaborative with ten years of case studies
- U of Texas at Houston: case studies, IP and multi
- Quality of Care
- KT – who are the knowledge brokers
- Commitment of change tools
- Behaviour of faculty to lead IPE
- Patients: who are they?
  patient as teacher
  When do they stop being a patient?
- KT: who do we want to influence? CEOs, public, educators, health care.

How can we collaborate in the coming weeks?

- The answer is CIHC. But what is the question?
- Do not always communicate in print. Web, graphics, chat rooms around a topic. Use something like Blackboard.
- There are 1000 involved.
- Patients and patient outcomes
- Knowledge translation (like mythbusters)
- Competencies: how to measure change and behaviour
- Enabling identification of gaps

- Measure faculty changes
- There is lots of literature in other disciplines. Translation to IP required.
- Share cases across the country
- Use technology to continue to communicate.

Group 4

What are the gaps in our tools and approaches?

- Individual competencies are ok, but team and organizational levels need some work
- Area of cost-effectiveness and causality (can seem overwhelming and complex). But it is possible to do.
- For example, the UK is using a national framework:
  - Unity through our national organization
  - Key service priorities led to development of measurement
- Systems approach
- Process data – to answer the question "why?"
- Useful and appropriate links to organization literature
- Sociology of professions. E.g. emerging roles and trends e.g. nurse practitioner, physical therapy practitioner, support workers.
- Link to population health, e.g. needs
- Integration versus add on. Culture shift.

How can we collaborate in the coming weeks?

- Apply community of practice concept to existing sub-committees of CIHC and new ones with a more specific focus.
- Use current synthesis of EICPCP as a working document.
- Create ways of dialogue.
- Define subgroups by domains (e.g. matrix). For example:
  - Pre-licensure
  - Research design
  - Research methods
  - Outcomes

Funding ideas

- Lack of focus on teams
- Lack of education research dollars
- Barriers: who holds the funds
- Health Canada (only national)
- Provincial government and research funds
- Provincial health authorities
- Research institutes
- CHSRF – service delivery

Appendix C
Research Workshop Evaluation

Following the Working Together on Research Workshop, participants completed an evaluation form describing their experience. A series of questions scored on a 5 point scale were posed to determine how the symposium was received, and if its objectives were met. A score of 4 was given if the respondent agreed with a given statement, and a score of 5 for agreed strongly. A summary of the results of this survey are presented below.

Statement	**% Agreement**
Before the Session	
1. The purpose of this workshop was clearly defined.	92%
2. The materials provided in advance of the workshop were useful.	92%
During the Session	
1. The morning presentation and panel were useful.	70%
2. The first breakout and plenary sessions were useful.	88%
3. The summary of IECPCP projects and conceptual model was useful.	50%
4. The second breakout and plenary sessions were useful.	100%
5. The workshop summary and closing was useful.	94%
6. The facilitator kept things on track.	100%
7. Overall, I was satisfied with today's workshop.	100%
Session Objectives	
1. The workshop met its objective of defining the theories/models being used by IECPCP projects, and understanding how they relate to IECPCP issues.	35%
2. The workshop met its objective of determining the appropriateness and effectiveness of the theories, measurement approaches, and tools that are being used in current IECPCP projects.	35%
3. The workshop met its objective of identifying the gaps in the current portfolio of measurements and instruments, and developing a strategy for filling those gaps.	96%
4. I would be interested in attending the next CIHC research workshop.	100%
Overall	
1. The workshop provided a useful opportunity to share knowledge of IECPCP with colleagues.	96%
2. The workshop offered a helpful opportunity to network with CIHC colleagues.	96%
3. The workshop was useful in allowing me to work collaboratively with CIHC colleagues.	91%

24 evaluation forms were returned.

Appendix D
CIHC Inaugural Meeting

To provide some continuity in terms of next steps following the November 26, 2006 *Working Together for Research* workshop, Appendix D connects the workshop with the Inaugural Meeting of the CIHC, held November 27 and 28. Much of the activity during the inaugural meeting was focused on the CIHC's five sub-committees – partnerships, research, evaluation, curricula and knowledge translation.

During the inaugural meeting, CIHC research and evaluation committee leads built on learning generated during the research workshop and facilitated a series of sessions with a larger group of participants. After the three days of CIHC meetings, the research and evaluation committees agreed that their work in relation to moving the CIHC forward is distinct, and offered the following clarification between research and evaluation:

CIHC's working definition of research:

> **Research** studies must be conceptualized, designed and conducted in such a way that its findings can be generalized or extrapolated to circumstances outside of any particular project.

CIHC's working definition of evaluation:

> The purpose of **evaluation** is to improve, not prove[2]. Evaluation is project specific, assessing the processes required to achieve a particular set of outcomes with the purpose of revising or refining the project (formative evaluation) and assessing whether or not a set of outcomes have been achieved (summative evaluation).

The following pages summarize what participants advised the research and evaluation leads in terms of how to proceed in furthering the research and evaluation of Interprofessional Education for Collaborative Patient-Centered Practice.

CIHC RESEARCH COMMITTEE'S KEY ISSUES AND SOLUTIONS:
What Have We Heard?

CIHC Research Committee leads Jennifer Medves, Hassan Soubhi and Esther Suter summarized the conversations during the inaugural meeting to identify key issues and solutions and develop the CIHC Research Committee's mandate. The **research committee** will be looking at how IECPCP works or would work based on *testable theories and models*. They will be doing this to improve understanding of the processes involved in IECPCP and how they are linked to specific outcomes defined at the level of the patient, the health care team, or the organizational level.

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[2] Stufflebeam DL. Evaluation Models: A New Direction for Evaluation. New York, NY: Jossey-Bass; 2001

Key themes in the research committee's terms of reference:

- Catalogue conceptual frameworks, theories, methodologies
- Create a rubric/matrix of current projects, identify IP components
- Identify gaps and develop a national research agenda
- Platform for communities of interest

A summary of the conversations during the inaugural meeting:

Issues that were raised

- Ethics
  - Multi-site research project requiring multiple approvals
  - How do research ethics boards view IPE research?
  - Need to inform funding agencies

Literature that may be useful

- Drawing on other theories/conceptual frameworks for researching IP education and practice
  - Psychology
  - Sociology of health professionals
  - Organizational behaviour
  - Organizational theory
  - Social constructivist theory
  - Situational learning
  - Pedagogy theory

Faculty development

- We know a lot about the students
- We do not know how to help faculty to teach IP

Reporting the negatives

- Flip side of collaboration also needs to be documented

The research committee's role

- Matchmaking of researchers
- Workshops – ethics, funding partners
- Promote dialogue between practice and faculty
- Mapping research activities
- Identify gaps

CIHC EVALUATION COMMITTEE'S KEY ISSUES AND SOLUTIONS:
What Have We Heard?

CIHC Evaluation Committee leads Ruby Grymonpre and Judith McFetridge-Durdle summarized the conversations during the inaugural meeting to identify key issues and solutions and develop the CIHC Evaluation Committee's mandate. The **evaluation committee** will be looking at the evidence that IECPCP works to *improve those outcomes*. This implies the need to look at how evaluation is organized and conducted to provide that evidence, and to weigh the evidence provided in terms of designs and methodologies.

The Evaluation Committee's mandate:

- The CIHC Evaluation Committee will provide leadership in the development and implementation of an overall strategy to support and promote collaboration and knowledge transferring concerning evaluation across Health Canada funded IECPCP projects.

A summary of the conversations during the inaugural meeting:

What did we hear?

- Benefits to evaluation are well recognized (effectiveness, efficiency, impact, communication, sustainability)
- Projects use different frameworks
  - Logic model, 3P, Kirkpatrick, Guskey

What are the issues?

- Lack of clarity regarding similarities and differences between evaluation and research
- The Health Canada logic model- how can we use this?
- Inequitable access to expertise in evaluation
- Lack of systematic standardized approach to evaluation in IPE
- Lack of specific strategies to evaluate the impact of IPE at the meso & macro levels.
- Traditional research funding agencies will not fund the infrastructure to continue this work
- Lack of evidence of what works in evaluation IPE – need systematic reviews
- Research capacity development – mentoring/educating/training new scientists

What can CIHC do?

- Resources on evaluation
  - Core questions, core methodologies, core process and outcome measures
  - Web-posting of evaluation logic models (including Health Canada's)
- Mechanism for linking with experts
- FAQ's – ask the expert
  - Discussion groups – ask each other
- Initiate conversations with granting agencies re funding possibilities

CIHC Evaluation Committee mandate

- Will provide leadership in the development and implementation of an overall strategy to support and promote collaboration and knowledge transfer concerning evaluation across HC funded IECPCP projects.

CIHC INAUGURAL MEETING PARTICIPANTS

Participants in the November 27-28 Canadian Interprofessional Health Collaborative Inaugural Meeting

This two-day meeting was attended by a group of 93 individuals representing the IECPCP projects across Canada and related stakeholders.

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