STATEMENT OF COLLABORATION

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

Regarding the

Canadian Interprofessional Health Leadership Collaborative (CIHLC)

For the
IOM Board on Global Health

Global Forum on Innovation in Health Professional Education: Health Professional Education Innovation Collaborative

2012-2015
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1. **Purpose**

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

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

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

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

2. **Scope of the Collaboration**

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

**a) Objectives**

1. Develop a collaborative leadership model for health system change that can:
   a. identify collaborative leadership competencies required to build teamwork across health professions and health care workers in community, hospital and primary care settings;
   b. identify the collaborative leadership competencies that will be required for health system change;
   c. develop a collaborative leadership curriculum that is flexible and meets clinical, regional, local, cultural and global needs;
   d. ensure that the leadership curriculum will meet and inform common accreditation standards to be applied across all health professions; and
e. address the needs of educators and learners by identifying the resources, infrastructure and supports needed in order for them to become collaborative leaders.

2. Build and leverage existing partnerships within Canada and abroad that will be enhanced through the facilitation and implementation of collaborative leadership programs and knowledge translation.

3. Utilize existing IT mechanisms (e.g., videoconferencing, multi-disciplinary simulation, online resources) and social media to maximize cost-effective methods to effectively support communities in leadership training.

4. Develop new academic productivity and scholarship that will influence global policy reform.

5. Develop an evaluation framework that measures planned and emergent change at the educational, practice and system levels.

Appendix B provides additional information on CILHC’s objectives.

b) Implementation

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

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

a) Governance

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

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

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

b) Leadership

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

c) Roles and Responsibilities

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

d) Accountability/ Evaluation

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

4. Budget and Resources

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

5. Statement of Guiding Principles for the Collaboration

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

- Participants and their representatives share information transparently to enhance the work of the CIHLC.
- Participants and their representatives engage in communications that are open and collaborative.
- Participants will collaborate on public statements and communications with external groups.
- Responsibility for ensuring the success of CIHLC resides with all Participants.
- Participants and their representatives will engage in transparent, open and ongoing dialogue among Participants and external groups.
- Mutual respect will be practiced when exploring all ideas and issues.
- Participants will actively participate in addressing or leading certain components and/or activities of CIHLC’s work.
- Respect for the policies of the Participants and the rights of faculty, particularly with respect to academic freedom will be acknowledged.
- Intellectual property will be shared as appropriate, recognizing that rights will be governed by the applicable policies of the Participants and determined in accordance with those policies as projects are developed.
- Adherence to all applicable ethical standards.

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

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

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

7. **Conflict Resolution**

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

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

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

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

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

__________________________  ______________________________________
Renald Bergeron, MD  Richard F. Reznick, MD, MEd, FRCSC, FACS
Dean, Faculté de Medicine  Dean, Faculty of Health Sciences
Université Laval  Queen’s University

__________________________  ______________________________________
Roger Strasser, MD  Gavin C.E. Stuart, MD, FRCSC,
Dean and CEO  Vice-Provost Health, Dean, Faculty of Medicine
Northern Ontario School of Medicine  University of British Columbia

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

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

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

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

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

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

___________________________
Emmanuelle Careau, Ph.D.(c)
Université Laval Lead
Professor, Rehabilitation Department, Faculty of Medicine
APPENDICES
APPENDIX A: BACKGROUND

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

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

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

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

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

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

- **Phase 1** - engage the core Participants in establishing the CIHLC Secretariat and related infrastructure located at the University of Toronto. As this organizational implementation work is underway, the National Steering Committee will confirm levels of interest among Canadian, regional and international groups who wish to be involved in this initiative and the key informants to be invited to a consultation process in the next phase.

- **Phase 2** - conduct a comprehensive literature review of both peer-reviewed and grey literature to establish the level and rigour of evidence related to leadership, collaborative leadership and health system change. Secondly, conduct an environmental scan of collaborative leadership models that includes an international survey and a series of regional consultations with schools of medicine, nursing, public health, business and programs of IPE. The scan will identify any existing innovative and transformative programs of leadership training within and external to health care as well as identifying best practice examples at both entry and post licensure levels. Best practice models and evidence from the literature review will be triangulated with regional, national and international experiences of collaborative leadership. Results of the survey and consultations will assist in conducting a needs assessment. During this phase, the evaluation framework will also begin to emerge, identifying key indicators that can be measured over time in both the leadership and the system contexts.

- **Phase 3** - will focus on the development of a continuum of collaborative leadership modules, made up of the best practices identified in Phase 2 and new training modules that would be developed during this phase. New modules will be tested in a variety of contexts (i.e., academic, clinical and cultural) before finalization. Experiential learning, in both education and practice sectors, will be key to this training. Bringing students and educators together with practitioners and patients in clinical settings to develop a collaborative leadership model could enable the use of quality improvement as an anchor for collaborative leadership training in a relevant and real world setting. A community of practice will be used to link the students, educators, practitioners and patients to share the lessons learned and to provide individual and organizational support. Tools for learning collaborative leadership will be developed using complex systems. Co-creation of the models with international partners identified in Phase 1 will assure cultural verification of the educational continuum and learning approaches. Community engagement principles and processes will be embedded in all these phases and components.
In **Phase 4** the whole model will be rolled out through a number of local, regional and international partners. A comprehensive evaluation will be evident as part of Phase 4.

In the final **Phase 5**, the complete model, comprising a continuum of modules, will be packaged for use and adaptation in any context and any region. Evaluation indicators and tools will be included so that users can effectively assess the impact of the collaborative leadership training program on health systems globally. Refer to page 21 of this LOU for an in-depth logic model of the implementation approach.

**Timelines**

<table>
<thead>
<tr>
<th>Phase</th>
<th>Timeline</th>
<th>Objective</th>
</tr>
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<tbody>
<tr>
<td>One: Set-Up</td>
<td>February – June 2012</td>
<td>- Secretariat in place&lt;br&gt;- Identify sources of funding and accountability with a comprehensive business plan to be approved by each university&lt;br&gt;- Develop detailed work plan for 3 years&lt;br&gt;- Set up coordinating committees – international, national and regional&lt;br&gt;- Stakeholder &amp; Community Engagement/Consultation (include informant interviews) - report&lt;br&gt;- Communication and knowledge translation strategy established including media relations&lt;br&gt;- Launch CIHLC website</td>
</tr>
<tr>
<td>Two: Reviews and Scans</td>
<td>July 2012 to November 2012</td>
<td>- Conduct literature review and environmental scan&lt;br&gt;Reports on findings of literature review and environmental scan&lt;br&gt;- Conduct needs assessment including with foreign partners&lt;br&gt;- Develop evaluation framework</td>
</tr>
<tr>
<td>Three: Creation, Development and Testing</td>
<td>2012-15</td>
<td>- Develop collaborative leadership model including a continuum of modules (existing and those to be piloted)&lt;br&gt;- Select pilot sites and develop template for pilot sites on reporting and evaluation</td>
</tr>
<tr>
<td>Four: Implementation and Evaluation</td>
<td>2012-15</td>
<td>- Execute pilot sites and monitor progress&lt;br&gt;- Create scholarship and dissemination track&lt;br&gt;- Conduct evaluation on all sites – issue a report&lt;br&gt;- Evaluate communication and knowledge translation strategy</td>
</tr>
<tr>
<td>Five: Production</td>
<td>2015</td>
<td>- Develop packaged education and training modules including evaluation indicators and tools</td>
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**Outcome: Transformative System Change**
APPENDIX D: LEADERSHIP

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

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

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

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

A) Role of National Steering Committee/Participants

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

B) Role of Co-Leads

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

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

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

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

a) Proposed Budget for Secretariat

**Personnel**

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

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

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

The administrative support will be required, on a full-time-time basis, to provide organizational and administrative support to resource staff. Specific responsibilities will include assisting in the
coordination of meetings, drafting agendas, maintaining documentation management system and preparing presentations. Budget management will come in-kind from the U of T’s Center for IPE.

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

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

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

Professional Services
Throughout the CIHLC project, the National Steering Committee will require the services of professionals and/or experts to assist on specific activities.
Costs of the CIHLC Infrastructure and Project Deliverables

**UBC**
Evaluation Framework and Toolkit $200,000

**Queen’s U**
Leadership Curriculum Programs $200,000

**NOSM**
Community Engagement Modules $200,000

**UofT**
Knowledge Development Lit. Review & Scan Consultations $200,000

**Laval**
Francophone Curriculum $200,000

**PROJECT DELIVERABLES**

**CIHLC Secretariat**
National Steering Committee & advisory groups
Program Development Coordination
Communications Administration and Operations
Oversight & Accountability $300,000

**Knowledge Sharing & Stakeholder Engagement**
- Consultations across North America
- Summit among affiliated networks
- General assembly of Global Forum (4) Collaboratives $35,000

**Knowledge Application**
- Abstracts Posters and Presentations at National and International Conferences Pilot testing
$50,000

**Knowledge Dissemination and Commercialization**
- Product Assembly and Marketing
- IT Modules and Social Media outputs
- CIHLC and Canadian brand export $50,000
Collaborative Leadership for Health System Change – Implementation Logic Model

**OUTPUTS**
- MOUs with key pilot sites
- List of key informants and participating organizations/professional schools
- Report of key literature review findings
- Report on needs assessment
- Package of education modules & training guides
- Technology enabled communication platform
- Framework with focus on ongoing improvement, key measurement indicators and tools

**INPUTS/ACTIVITIES**
- Organizations, professional schools and key informants supportive of collaborative education and practice
- Leadership Training Modules and Best Practices
- E-Community of Practice
- Developmental evaluation\(^1\) Framework examining emergent change

**RESULTS/OUTCOMES**
- Employee changes in attitudes, knowledge & behaviours related to leadership competencies
- High functioning teams leading transformative changes in their organization’s processes and structures that support collaborative practice

**CURRENT CHALLENGE**
Traditional leadership training in silos creates duplication, increases costs, and prevents the best health outcomes.

**Program Mechanisms**
(Communities of Practice, Social Support, Communication Theory, Organizational Change Theory)

**Context Specific Factors/Characteistic**
(e.g., previous history of collaborative practice, policy environment, level of organizational readiness, resources available)

1 Health Canada. Interdisciplinary Education For Collaborative, Patient-Centred Practice
2 Blueprint for Action in Ontario.
3 http://www.healthforceontario.ca/WhatIsHFO/AboutInterprofessionalCare/ProjectResources.aspx
4 http://www.chd.ubc.ca/
6 CIHC A National Interprofessional Competency Framework.
   http://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210r.pdf
7 Transforming Care for Canadians with Chronic Health Conditions. Canadian Academy of Health Sciences
   http://www.cahs-acss.ca/reports/ences.
8 Accelerating Primary Care. Series of Papers sponsored by Public Health Agency of Canada.
   http://www.buksa.com/APCC/sessions.asp
9 The Pan-Canadian Health Leadership Capability Framework Project. Canadian Health Services Research