


GSCF HIC EVALUATION – FINAL EVALUATION REPORT

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Submitted by the Social Research and Demonstration Corporation

SRDC SRSA
SOCIAL RESEARCH AND DEMONSTRATION CORPORATION | SOCIÉTÉ DE RECHERCHE SOCIALE APPLIQUÉE

Executive summary

What is the Green Shield HIC?

The Health Innovation Collaborative (HIC) was created in 2013 by Green Shield Canada Foundation (GSCF) to address inappropriate, fragmented, and costly care for seniors with complex chronic health conditions. The HIC brought together 5 Toronto-area healthcare organizations, each with a unique and innovative approach to improving care and quality of life for seniors with complex care needs, their families, and caregivers.

What does this document do?

This document is the final report of the evaluation of the HIC by the Social Research and Demonstration Corporation (SRDC). It compares the HIC at the end of its mandate with an earlier portrait created after roughly one year, and shows how the initiative has changed over time. SRDC worked collaboratively with HIC partners and developed evaluation findings based on interviews, surveys, documents, observations, and facilitated meetings.

What were the main findings?

Effectiveness of the HIC partnership: While the HIC was innovative in terms of design, some of these features made collaboration more challenging. Projects' diversity was a "double-edged sword" that brought challenges as well as benefits. On the whole, however, HIC partners were able to make substantial progress on many of the pre-conditions for collective impact.

Executive summary (cont'd)

What were the main findings?

Early impacts of the HIC: The HIC achieved all three collaboration goals – shared learning, networking and partnership; learning about cross-system perspectives was particularly appreciated by partners. The HIC also achieved its intermediate goal of building capacity among partner organizations to deliver better projects, meet organizational goals, and develop their work. Partners who were actively engaged throughout the initiative and had some degree of alignment with other partners tended to report more benefits from collaboration.

Why does this matter?

Improving the capacity of Ontario's healthcare system to meet the needs of the looming 'silver tsunami' is in all our interests, whether as current or future patients, family members, caregivers, or taxpayers. Providing better patient experiences and better outcomes for populations, and at lower costs, is the 'triple aim' of provincial governments across Canada, and better coordinated care is needed to achieve this goal. Collaboration across care settings, professions, organizations, and services is easier said than done, however, and the HIC – though not perfect – has produced important learning about how to structure and support collaboration in healthcare.

Table of contents

Report overview

This final report is the fourth major deliverable to GSCF for the HIC evaluation by SRDC, following the evaluation plan, an early collective case study, and a draft final report. This document includes an updated portrait of the HIC and assesses its overall effectiveness and potential to achieve the collective impact to which it aspires.

This report begins with background information on the development and operation of the HIC and an overview of SRDC's evaluation, including how data was collected and analyzed for the evaluation. It then provides the main findings of the evaluation, including how the HIC in its early stages compared to its current state, near the end of its mandate. The report makes conclusions about the HIC in relation to the initial evaluation questions about effectiveness and potential impact, and draws implications from the HIC experience for others supporting social innovation and collaboration in healthcare, in the form of lessons learned.

This case study is intended to be used as a learning tool for HIC partners, GSCF, and others undertaking similar work. As the evaluation partner in the HIC initiative, SRDC salutes the HIC partners for their achievements and willingness to take a risk with this experiment in collaboration. We very much appreciate the opportunity to have been part of your journey and learning.

OVERVIEW OF THE HIC

Overview of the HIC

This section provides an overview of the Health Innovation Collaborative (HIC), including:

- An introduction to the Green Shield Canada Foundation (GSCF), which provided funding and other supports to the HIC
- A brief outline of the problems in seniors' healthcare the HIC was designed to address
- An overview of the HIC's conception, structure and organization, vision and goals
- A summary of the component projects and partner organizations
- An overview of the inputs, activities and outputs of the collaboration, and its expected outcomes in the short, medium, and long-term

The Green Shield Canada Foundation (GSCF)

The Green Shield Canada Foundation (GSCF) was established in 1992 by Green Shield Canada, Canada's only national, non-profit health and dental benefits provider. GSCF was set up "to act as a catalyst supporting innovative ideas that pave the way for fundamental 'big picture' change in Canadian health care." Its strategy is designed to build community capacity, strengthen public policy, and advance knowledge in health care.

GSCF has three strategic directions:

- **Optimizing care** – exploring and promoting ways to improve the effective use of medications and increase the scope of pharmacists' practice to better address patient adherence and engage patients in more actively managing their conditions/health
- **Improving access** – Improving access to extended health coverage for uninsured and underinsured groups and individuals, including those with small employers, casual and part-time employees, seniors, early retirees, the unemployed, immigrants, students, individuals with pre-existing conditions and marginalized populations
- **Care coordination** – Coordinating care to support in-home care solutions in order to keep people living in their homes as long as possible

Tackling the challenge of seniors' care

Seniors have long been identified as a population of concern for GSCF, particularly the looming 'silver tsunami' that is expected to double the number of seniors in Canada in 20 years.

Several reports issued in the past five years – including *Ontario's Action Plan for Health Care*; Dr. Samir Sinha's *Living Longer, Living Well* report to inform Ontario's seniors' strategy; and the Drummond report from the Commission for the Reform of Ontario's Public Services – identified considerable shortcomings in Ontario's existing health care system. These shortcomings could compromise the system's ability to effectively address the needs of greater numbers of seniors who will live longer, but with more chronic conditions and greater disability. Particular concerns included:

- **Inappropriate care** – high numbers of patients occupying beds in hospitals that provide a level of care inappropriate to what is required (e.g., for mental health or rehabilitation needs). In 2012, older adults comprised 79% of these Alternate Levels of Care beds
- **Fragmented care** – through transitions from care settings (e.g., discharge from hospital to home care), and among providers; few protocols exist to share assessments, discharge or treatment plans, so seniors have to coordinate their own care with families and caregivers
- **Increasing costs** – aging is a key cost driver: nearly half of health care spending occurred on behalf of older adults (14.6% of Ontarians) in 2011

The situation is particularly concerning for seniors with multiple, complex, chronic health conditions, their caregivers and families, since these issues – and the associated costs – are magnified with the increased complexity of their health conditions and care needs.

The Health Innovation Collaborative (HIC)

As part of its strategic direction to support care coordination – and in direct response to the concerns identified in the healthcare reports – GSCF developed the Health Innovation Collaborative (HIC) in June 2012. GSCF invested three million dollars into five (and later, six) projects aimed at improving the quality and accessibility of care for seniors with multiple complex chronic health issues in the Greater Toronto area.

HIC projects were chosen based on their individual merit and alignment with the overall purpose of the HIC; priority was given to projects that addressed specific gaps or needs identified in the Drummond report, particularly for information technology, training, and integrated in-home care. Once projects were selected, GSCF introduced the idea of working within a collaborative to project partners, who agreed to experiment with this approach.

Additional funding was provided by the GSCF Board of Directors to support collaborative activities (see Resources provided, below). Over the past three years, HIC project partners have been working together with GSCF to share their knowledge, expertise, and resources, in order to identify and solve the unmet needs of seniors living with multiple chronic conditions. The HIC is about to wrap up its activities with a Learning Event in October 2015.

The HIC's vision and goals

The **overall vision** of the HIC was for older adults with complex chronic health conditions, their families, and caregivers to have:

- Increased access to services and information
- Increased quality of care, helping them to lead happy and healthy lives

The **primary goal** for the HIC was for projects to achieve increased efficiency and impact by working together through the collaborative. The HIC's specific objectives were to:

- **Improve the quality and accessibility of care** for seniors in the GTA region, aged 65+ with multiple complex chronic health issues
- **Expand opportunities for care at home**, improving the quality of life of seniors and their caregivers
- **Reduce emergency department visits**, hospital admissions/re-admissions, and admissions to long-term care facilities by improving community or at-home services and support
- **Increase the skills of personal support workers** who work directly with seniors in their homes
- **Increase the availability of online and mobile resources** that offer practical tools to connect seniors and their informal caregivers to local healthcare providers

Initial component projects of the HIC

PROJECT	PROJECT TYPE	ORGANIZATION
Health Gateway • A website of curated health information resources for people living with complex conditions and disabilities, and their families	Technology - Website development	**Bridgepoint Active Healthcare** • Teaching hospital aimed at delivering complex care
Health eConcierge • A web-based search and discovery platform that makes it easier for organizations to publish - and the public to find - health service information on the Internet	Technology – Platform development	**Centre for Global eHealth Innovation** • Research institute aimed at improving health through information and communication technologies
Online Dementia Care Training Program • An online training program for personal support workers in dementia care	Technology/ training – Online course development	**Alzheimer Society of Toronto (AST)** • Non-profit organization providing programs and services for people with dementia and their caregivers
House Calls • An interdisciplinary, home-based, primary healthcare program for frail and homebound seniors	Health Care services – Increasing capacity	**SPRINT (Senior People's Resources in North Toronto) Senior Care** • Non-profit organization providing services that enable seniors to live at home and thrive in the community
Virtual Ward • A short-term, interdisciplinary, home-based, primary healthcare program designed to improve health outcomes for patients who have been recently discharged from the hospital	Health Care services – Research	**St. Michael's Hospital** • Teaching and research hospital serving Toronto's inner city

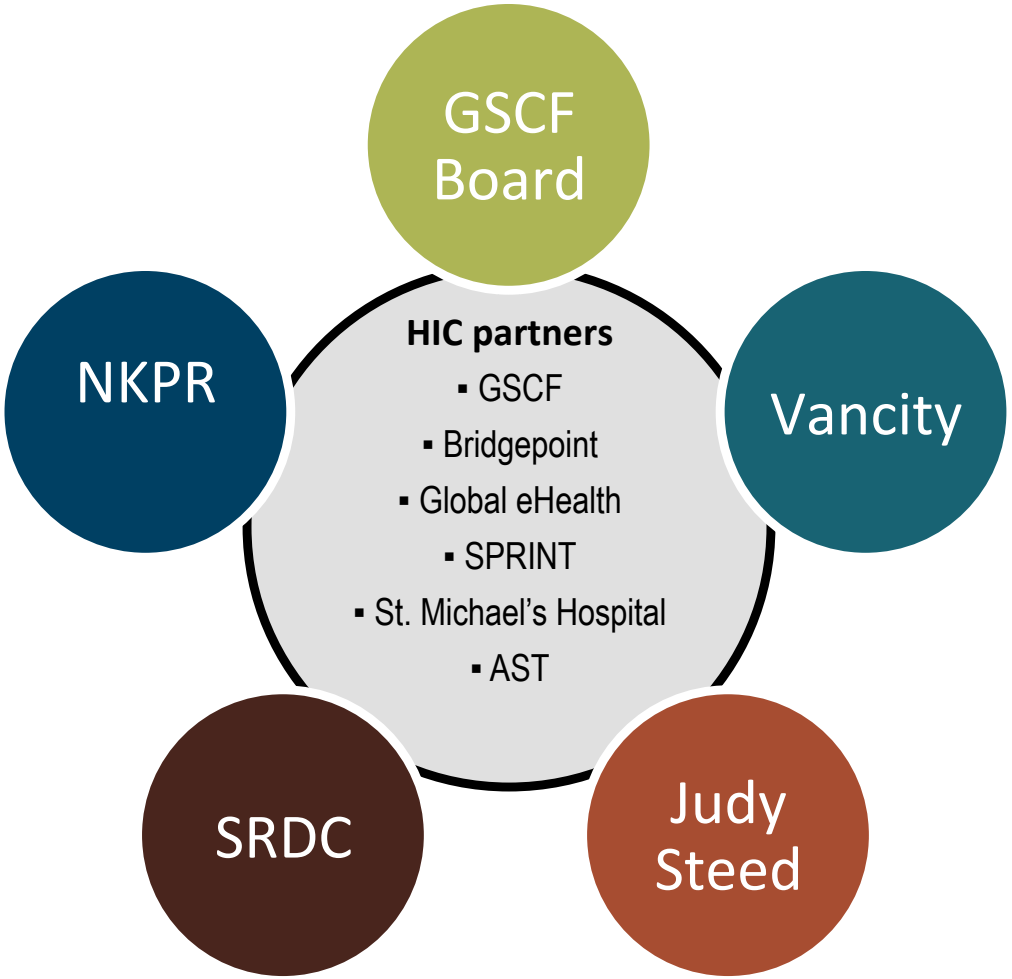
Changes to HIC projects over the course of the initiative

PROJECT	PROJECT TYPE	ORGANIZATION
Bridge2Health • A website of curated health information resources designed to **help patients, families and care providers make informed decisions** • Health Gateway was re-branded as Bridge2Health, with **more focus on clinical support**	Technology - Website development	Bridgepoint Active Healthcare
Health eConcierge • A web-based search and discovery platform that makes it easier for organizations to publish - and the public to find - health service information on the Internet	Technology – Platform development	Centre for Global eHealth Innovation
Online Dementia Care Training Program • Online training programs for PSWs and **other health professionals, as well as patients and families**, in dementia care	Technology/ training – Online course development	Alzheimer Society of Toronto (AST)
House Calls • An interdisciplinary, home-based, primary healthcare program for frail and homebound seniors	Health Care services – Increasing capacity	SPRINT (Senior People's Resources in North Toronto) Senior Care
GEMINI • A clinical registry designed to better characterize general medical inpatients and the care they receive • **Replaced Virtual Ward**, after the end of its research project	Health Care services – Research	St. Michael's Hospital

Resources provided to HIC projects

Reports on the HIC were provided to the GSCF Board twice a year. Documentation included annual progress reports from each project, quarterly status updates, and the work produced by several external organizations engaged by GSCF.

These outside resources included an ongoing chronicle of the HIC compiled by a journalist and Atkinson Fellow specializing in aging (Judy Steed); stakeholder communications work by a public relations firm (NKPR); training and support to develop Demonstrating Value snapshots by a charitable organization dedicated to community development (Vancity); and the work of an external evaluator (SRDC).



Organization of the HIC

Original Committees

Project Leads: Shared information on project development within the HIC	**Evaluation:** Contributed to learning and achievement of outcomes at the project level (e.g., peer reviews) and guided the evaluation of the HIC	**Communications/ Outreach:** Developed press releases and published reports, newsletters, events, brochures, website content and other marketing materials	**Technology:** Addressed technical matters of the projects, including linkage of resources to a website or infrastructure from technology-related projects

Representatives from GSCF and each of the five projects met together on a regular basis, participating in committees to support action on HIC goals. Mid-way through the project, the number of committees was reduced to reflect the changing demands of the collaboration and time constraints of partner organizations. After that point, meetings of designated project representatives – usually project leads – were held every two months, with additional meetings scheduled as required to address specific issues.

The following slide was developed by the Evaluation Committee and GSCF to illustrate how HIC resources and activities were seen to connect to project goals.

The Health Innovation Collaborative

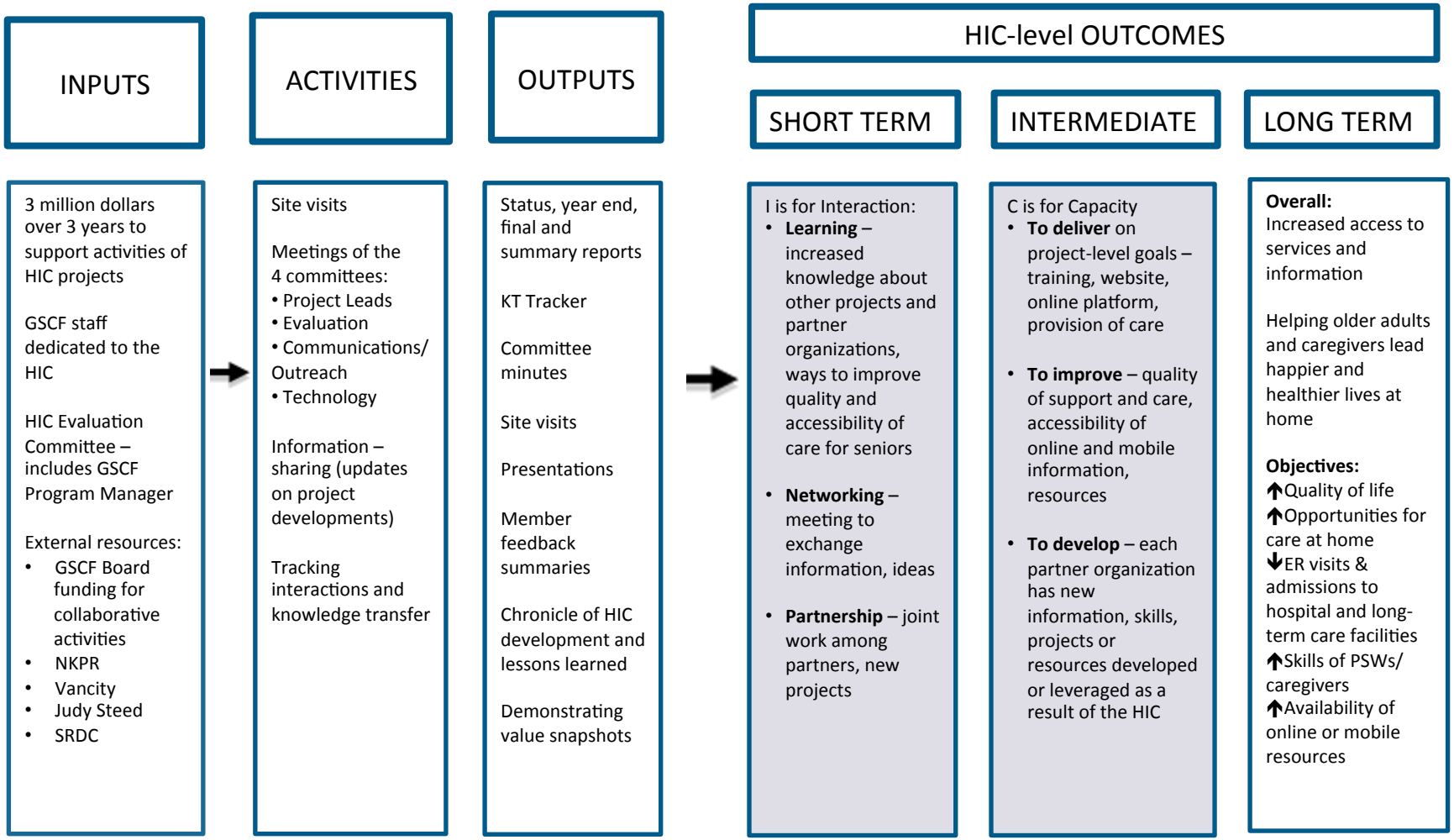
Goals	Objectives	Activities	Means of Verification	Outputs*	Person Responsible
Is there value in working as a collaborative? Should the model be replicated?	Increase learning between HIC members	-share knowledge / learning -share documents / reports -site visits -status and year end reports -status meetings (discussion)	- Data collected in Knowledge Management (KM) tracker - Status /Committee Meetings - Site Visits - Member feedback (interviews, surveys and anecdotal evidence)	1. Statistics in KM tracker 2. Summary Reports from KM tracker 3. Meeting Notes 4. Site Visit Presentations 5. Organization Profiles 6. Member Feedback Summary	1. HIC Member Orgs 2. Evaluation Committee 3. GSCF / Judy Steed 4. HIC Member Orgs 5. Judy Steed 6. GSCF / Judy Steed
HIC Increased efficiency and impact of working through the collaborative	Increase networking opportunities within and outside of HIC	-share contacts -connect people to people -connect people to resources	- Data collected in Knowledge Management (KM) tracker - Status Meetings - Member feedback (interviews, surveys and anecdotal evidence)	1. Statistics in KM tracker 2. Summary Reports from KM tracker 3. Meeting Notes 6. Member Feedback Summary	1. HIC Member Orgs 2. Evaluation Committee 3. GSCF / Judy Steed 6. GSCF / Judy Steed
"I is for Interaction"	Increase opportunities for HIC members to work with new partners	-new partnerships established via HIC members with outside organizations -new initiatives developed between HIC members but outside actual HIC	- Data collected in Knowledge Management (KM) tracker -Status Meetings -Member feedback (interviews, surveys and anecdotal evidence)	1. Statistics in KM tracker 2. Summary Reports from KM tracker 3. Meeting Notes 6. Member Feedback Summary	1. HIC Member Orgs 2. Evaluation Committee 3. GSCF / Judy Steed 6. GSCF / Judy Steed
Did we help people better navigate the system?	Expand opportunities for care at home	-project level deliverables (as applicable, not all members to report)	-both quantitative and qualitative indicators	7. Status reports 8. Year end and final reports	7. HIC Member Orgs 8. HIC Member Orgs
SERVICES & INFO Older adults and caregivers have increased access to services and information	Increase availability of online or mobile resources	-project level deliverables (as applicable, not all members to report)	-both quantitative and qualitative indicators	7. Status reports 8. Year end and final reports	7. HIC Member Orgs 8. HIC Member Orgs
Did we provide people with better care / improve their experience?	Increase quality and accessibility of care for seniors and caregivers	-project level deliverables (as applicable, not all members to report)	-both quantitative and qualitative indicators	7. Status reports 8. Year end and final reports	7. HIC Member Orgs 8. HIC Member Orgs
CARE Increased quality of care, helping older adults and caregivers lead happy and healthy lives	Decrease # of ED visits/hospital & LTCH admissions/ re-admissions	-project level deliverables (as applicable, not all members to report)	-both quantitative and qualitative indicators	7. Status reports 8. Year end and final reports	7. HIC Member Orgs 8. HIC Member Orgs
	Increase skills of PSWs and caregivers	-project level deliverables (as applicable, not all members to report)	-both quantitative and qualitative indicators	7. Status reports 8. Year end and final reports	7. HIC Member Orgs 8. HIC Member Orgs

Additional Evaluation Outputs**

3rd Party Evaluation***

HIC logic model

Building on the previous model, SRDC developed the logic model below to strengthen the connection of HIC activities to intended short, medium, and long-term outcomes. Together with the Evaluation Committee, SRDC identified the short-term and intermediate outcomes as most relevant for the HIC evaluation.



EVALUATION OVERVIEW

Evaluation Questions

The evaluation of the HIC aimed to answer three main questions:

1. How well has the HIC worked as a collaborative partnership?
2. What are the perceived early impacts of the HIC, if any?
3. What key lessons have been learned?

The following section outlines how SRDC approached answering these questions, including:

- The evaluation's framework and design
- Sources of information
- Analysis plan

The section ends with reflections on the evaluation process, and how these should be considered alongside the findings, conclusions and lessons learned.

Evaluation approach

SRDC evaluated the implementation and impact of the HIC initiative by taking a ***developmental evaluation approach***. This approach places greater emphasis than traditional evaluation on integrating evaluation feedback into ongoing program development from the outset, with the evaluator providing rapid feedback in the role of a "critical friend." The developmental evaluation approach is flexible, future-oriented, and focused more on performance improvement than on narrow definitions of merit and accountability. SRDC considered the developmental evaluation approach to be most appropriate for the HIC, given its focus on innovation and collaboration.

SRDC also took a ***participatory approach*** to the HIC evaluation, working closely with the HIC Evaluation Committee and GSCF throughout the two-year period of the contract to support effective oversight of the evaluation. This approach helped ensure the HIC evaluation was flexible and iterative, and focused on matters of greatest priority to the HIC partners and GSCF.

Evaluation framework

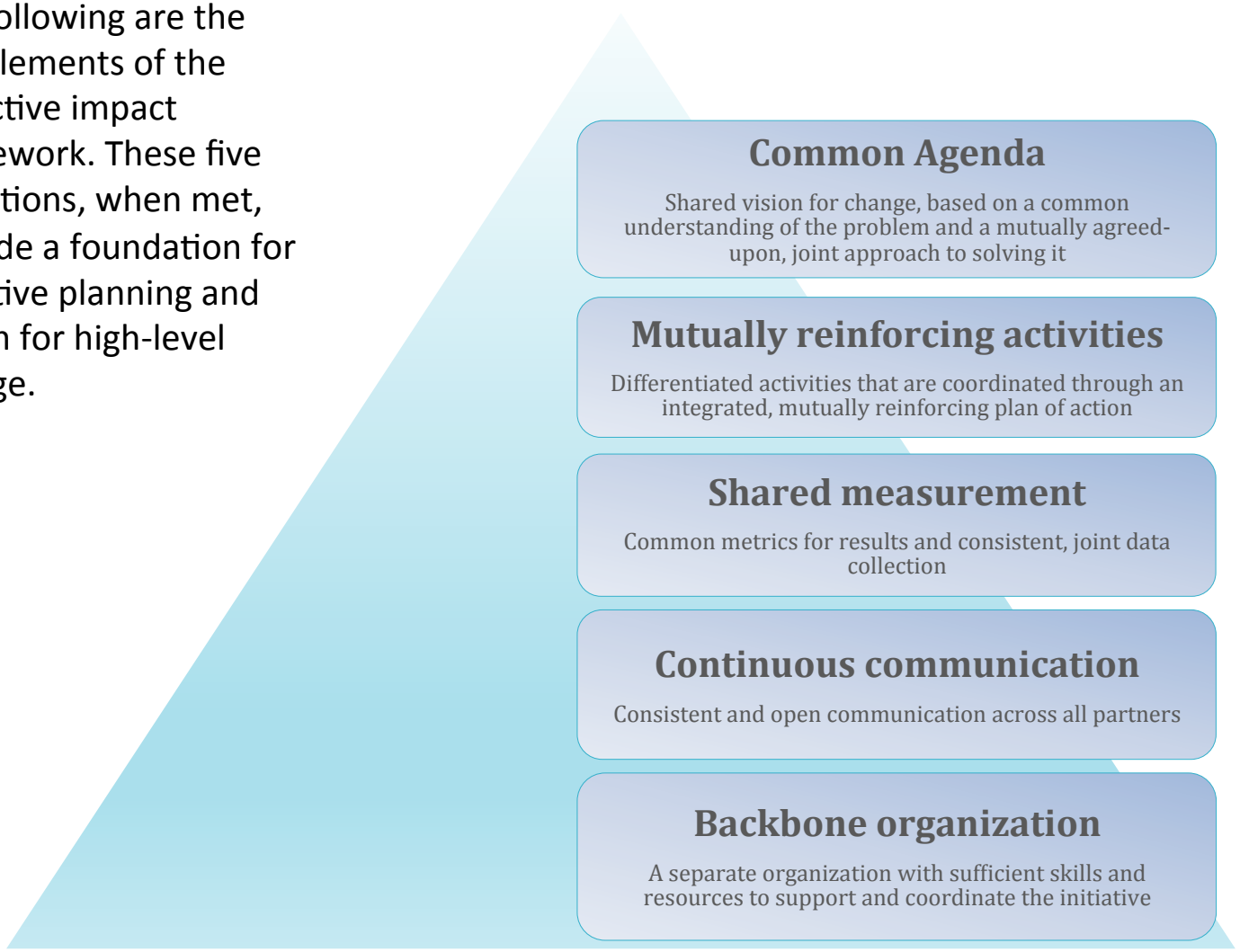
SRDC used the concept of ***Collective Impact*** as the framework for the HIC evaluation. Collective impact is "the commitment of a group of actors from different sectors to a common agenda for solving a complex social problem."* This is a structured approach that focuses systematically on developing certain elements or aspects of the collaborative process (see next page). SRDC assessed the *potential* for the HIC to achieve collective impact, insofar as it met these preconditions. Our rationale for adopting the Collective Impact framework is found in the Appendix.

SRDC also considered the HIC as an intervention operating within the larger public health system. This means the evaluation tried to consider not only the internal workings of the HIC, but as much as possible, the influence of the macro context as well.

*Source: FSG. See http://www.fsg.org/OurApproach/WhatIsCollectiveImpact.aspx

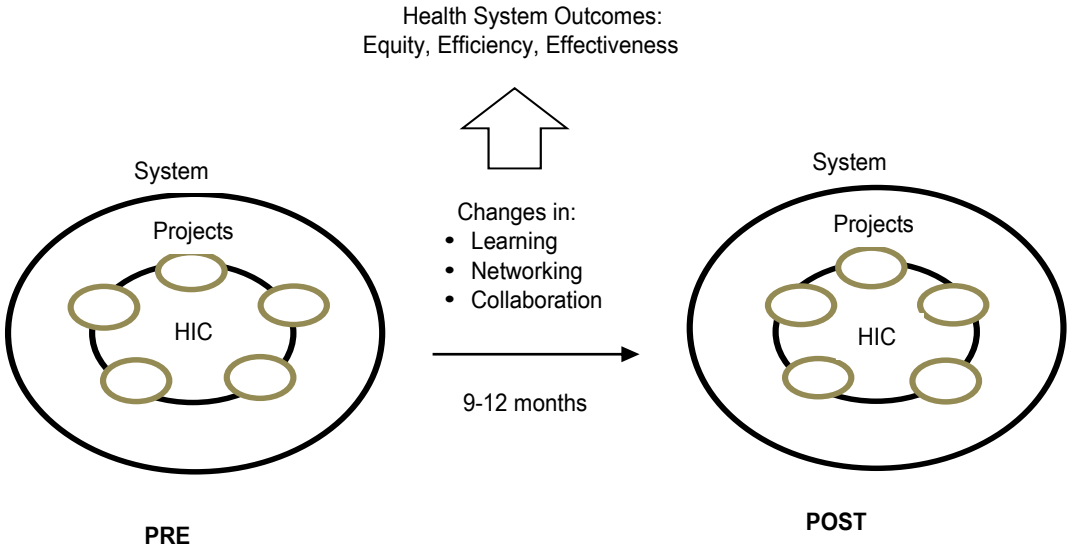
Framework for Collective Impact

The following are the five elements of the collective impact framework. These five conditions, when met, provide a foundation for effective planning and action for high-level change.



Source: HanleyBrown, Kania, and Kramer (2012). *Channeling change: making collective impact work.*

Evaluation design



- **A collective case study design** allowed us to capture information about the implementation and short-term outcomes of the HIC, and its *potential* to achieve broader, systems-level impacts. While our focus was on the HIC, we reference project achievements where relevant.
- The **retrospective pre/post design** allowed for a longitudinal perspective on the development of the HIC, to assess changes over time. The first case study covered the period from September 2013 to early February 2014. The second assessment looked particularly at the period from February 2014 to September 2015.
- This report summarizes SRDC's assessment of the maturity of the HIC partnership at this later stage, including insights into the strengths of the collaborative, challenges and areas for improvement, the development of the collaboration over time, and implications of the findings within the broader health care landscape.

Sources of information

We have primarily used qualitative methods to gain an in-depth understanding of the operation of the HIC, its effectiveness and potential impacts. Both the early and later case studies have been informed by:

- A review of HIC documents, such as projects' quarterly and annual progress reports
- Analysis of information on partners' learning, networking, and partnership activities, as captured from reports and collated in the Knowledge Transfer (KT) Tracker
- SRDC's participation at many HIC Evaluation and Project Leads meetings
- Site visits to each project in the fall of 2013
- Two rounds of interviews with Project Leads and team members as well as GSCF representatives, conducted from November 2013 to January 2014, and in the summer of 2015
- Self-assessment activities and discussion with the Evaluation Committee and in two facilitated sessions with partners in February 2014 and June 2015
- An Organizational Capacity Questionnaire completed by each Project Lead in February 2014 and a more comprehensive version completed in July 2015
- Ongoing communication with GSCF staff

Analysis of information

Our analysis of the information included:

- Review of the grey and peer-reviewed literature on the needs of seniors with complex health conditions, healthcare innovation, and the evaluation of collaborative partnerships
- Iterative reviews of all sources of information to identify emerging themes, their prevalence and nuance, and relevance to the collective impact framework, as well as contradictory information
- Verbatim quotes from interviews, reports, and facilitated sessions to illustrate key findings
- Descriptive interpretation of survey results and content of the Knowledge Transfer (KT) Tracker, including frequency and proportion of survey responses and KT Tracker categories (e.g., organization, type and specifics of each activity, initiators and recipients of collaborative interactions)
- Use of social network software (Kumu) to analyze and illustrate the information presented in the KT tracker, and identify trends
- Verification of all findings by two SRDC researchers, and detailed feedback on the report from HIC partners

KT Tracker analysis

The KT Tracker included information compiled from partners' progress reports on their learning, networking and partnership activities until June 2015. This data was analyzed with the aid of Kumu, a new data visualization tool for understanding relationships.

It is important to note that Kumu provides a *visual impression* of the collaborative interactions among HIC partners, rather than specific data points. In particular:

- Lines in the Kumu diagrams do not represent all HIC interactions. The Kumu program condenses multiple activities between partners into a single, darker line for clarity.
- New colours are created when there are numerous instances of different types of interactions between partners.
- Arrows on Kumu diagrams represent the *direction* of the activity – arrows point from the initiating partner to the receiving partner. This does not accurately reflect activities initiated by two or more partners at once.
- Kumu does not allow for a single activity to be directed towards all partners, such as site visits. We had to separate out these joint activities into single interactions, which likely increased activity counts. However, we believe this was probably balanced by a general under-reporting of interactions over the course of the initiative.
- The Kumu platform is still in development, and certain functions (e.g., sorting by date) are not yet available.

As a result, the Kumu images should be interpreted as *impressionistic,* and in conjunction with the descriptive information provided.

Reflections on the evaluation

- Conducting the evaluation over two years has been useful to assess how the HIC has evolved over time, but it has also been challenging for SRDC to accurately reflect the perspectives of all project partners, especially with multiple people representing a single project, project changes, and many personnel changes. In addition, project partners often participated in certain evaluation activities but not others (e.g., interviews but not surveys or vice versa). In this report, we define project partners as key personnel (usually Project Leads), and identify the type of data source for findings. While at any given time there were five HIC projects, this report incorporates data from all six HIC projects. Given the small number and unique nature of the HIC projects, we have chosen not to attribute quotations – even in a general way – to preserve confidentiality.
- Likewise, project partner representatives sometimes struggled with how to convey their experiences of the HIC, especially those who had not been involved for a long period of time, or who were involved more in project operations than as a HIC champion within their organizations. In these cases, answering survey questions about partnership, organizational, or community outcomes was difficult, as was reflecting on changes in the HIC over time. It was not always possible for SRDC to find appropriate evaluation methods and tools that could capture this diversity of role and experience, but we trust the variety of methods used in the evaluation – including partner verification of results – has helped in this regard.

Reflections on the evaluation

- We are conscious there are gaps in our perspective, partly as a result of becoming involved almost a year after the HIC got underway. This meant we weren't able to meet some of the project personnel initially involved, or to observe group dynamics during the critical formative stage, when partner engagement is usually high. We have tried to remedy this gap by reviewing documents and getting partners' opinions on HIC development over time, but it is still possible we have underestimated the achievements of the early days in terms of collaboration and capacity development.
- Our evaluation was definitely able to build on the considerable early work of HIC partners, especially by the Evaluation Committee, to clarify the goals and purpose of the HIC (such as the initial logic model), and the evaluation.

FINDINGS

Findings

The findings section begins by providing an overview of the HIC in its early stages, in terms of the findings and conclusions of the first collective case study and evaluation report prepared in June 2014. This is intended to provide readers with a point of comparison and context for the later portrait.

The Findings section then outlines how the HIC has developed since the early collective case study, and the main themes that characterize the HIC near the end of its mandate. Each theme or evaluation finding is presented separately and illustrated with supporting information. Data sources are identified, and quotes from project partner interviews, facilitated sessions, and reports are highlighted in text boxes. Kumu-generated diagrams based on data from the KT Tracker are also included where relevant.

What did the HIC look like early on?

Based on interviews with project partners, as well as site visits, observations, survey responses, and a review of HIC documents, SRDC developed a collective case study or portrait of the HIC after a little more than one year of activity. The following were the key themes we identified for the early evaluation findings in June 2014:

- GSCF was regarded as a very supportive funder
- The HIC provided an opportunity to share cross-system perspectives
- A foundation of trust was being built
- Opportunities were being developed for sharing and learning across projects
- There were signs of increases in organizational capacities
- There was potential for multiple benefits of collaboration beyond core projects
- There was a collective lack of clarity/understanding about *how* to achieve HIC goals
- HIC partners struggled to define collaboration operationally
- Structural issues continued to pose challenges
- Resource and capacity constraints affected engagement

What were the conclusions of the early portrait of the HIC?

Based on these themes, SRDC concluded that just over one year in, the HIC was still at a relatively early stage of collaboration maturity – not surprising, given that most collective impact initiatives have long-term mandates of a decade or more. With the help of GSCF as the backbone organization, considerable progress had already been made to establish good working relationships and mechanisms for communication among the partners, most of whom had not known each other at the outset.

However, partners struggled to understand how they could work together to achieve the HIC's vision, and how to measure and achieve its goals. As a result, there was some concern about the HIC's ability to succeed, even as partners were committed to finding ways to do so. Partners' difficulty envisioning how the HIC should work towards achieving its collective goals was in part the result of the innovative structure of the collaborative, particularly the fact that the collaborative structure emerged *after* projects were selected. We found few examples of similar collaborations that could provide guidance and direction towards actions and outcomes.

SRDC made a series of recommendations to address these concerns, including examining structural barriers in each of the preconditions for collective impact. We suggested using shorter-term goals to define success, developing a plan of 2-3 key tasks for joint work, considering ways to measure progress, and discussing plans for sustainability. We felt these recommendations would better position the HIC to have the *potential* for collective impact, if it continued beyond its three-year mandate.

What took place in the interim?

Since the early assessment was done, the HIC has evolved and developed. SRDC has continued to work closely with HIC partners, who have taken action on most of our early recommendations. In addition to ongoing work on each of their individual projects, HIC partners have:

- Attended regular meetings of the various HIC Committees
- Adopted SRDC's proposed logic model for the initiative (see page 17), identifying Learning, Networking, and Partnership as the key outcomes of interest for the evaluation
- Participated in two facilitated sessions about collaboration (February 2014, and April 2015)
- Revised quarterly updates and meeting agendas to focus more explicitly on reciprocity ('Gives and Gets'), joint problem-solving, and opportunities for collaboration
- Established and implemented a joint work plan that included the production of videos on individual projects, interviews with beneficiaries of each project, and plans for a Learning Event in the fall of 2015
- Conducted a second round of site visits to each partner organization
- Undertaken training in demonstrating value, and developed Value Snapshots through the Vancity Community Foundation Demonstrating Value Tool
- Presented lessons learned to date from the HIC in an interactive workshop at the 2014 conference of the Philanthropic Foundations of Canada

What does the HIC look like now?

Using similar data sources as for the early portrait of the HIC, SRDC has conducted a second round of data collection and analysis to examine how the HIC has developed over its three-year lifespan, and what has been achieved.

As a result of the activities HIC partners have undertaken together, there has been progress in several areas of the collaborative partnership. Of course, some limitations remain – due in part to how the HIC was formed and structured – that mean some partners derived more benefit from the collaboration than others.

However, project partners were generally pleased with their experience with the HIC, and when considered along with the achievements of their individual projects, all feel GSCF's HIC initiative has been a success overall.

What does the HIC look like now?

The following are key themes or characteristics that represent the HIC in its current state as of September 2015, including achievements and areas for growth or change:

- The HIC is **an innovative model** for collaboration
- GSCF is still seen as **an extremely supportive and flexible funder**
- Projects' **diversity made collaboration challenging** at first
- **Diversity has also been an advantage** – most projects benefitted from other partners' input
- Resource and capacity constraints – especially **staff turnover – affected engagement**
- HIC partners were generally able to develop **trust and effective communication**
- **Better understanding developed on HIC goals and a joint action plan**, but more work was needed
- Shared **measurement continued to be a challenge**
- **A key benefit has been sharing and learning** about cross-system perspectives
- Most partners **valued opportunities for networking**
- **Partnerships and joint work developed**, though this was limited
- There were **many project-level achievements**

The HIC is an innovative model for collaboration

To answer this question, we reviewed some of the research literature on health innovation. We found many definitions, but most refer to:

- the *creation* of a new idea, process, or product, as well as its *implementation*
- the *dynamic process of learning* and exploring a response to a given problem

Health innovations typically include new services, new ways of working, and/or new technologies that *transform collective practices* in health systems or settings. Successful innovations are often viewed as having built on existing structures to meet objectives, and focusing on *increasing access* to services.

Several common themes relevant to the HIC emerged from the literature on innovation:

- **Unintended outcomes and setbacks are common, and criteria for success may change**
  Given the unpredictable nature of innovation, it may be difficult to identify meaningful objectives and targets in advance. 'Double-loop learning' entails frequent, often considerable changes in direction
- **Communication within/between organizations encourages innovation**
  Measuring the vitality of networks for learning and support among projects can be equally as important as measuring the success of individual projects
- **A collaborative and supportive team is consistently identified as vital to innovation**
  Innovation is rarely achieved in isolation, but more often through collaboration
- **Innovation is fostered in environments with substantial support, leadership, and organizational policies** that align with the proposed innovation

The HIC is an innovative model for collaboration

With these definitions in mind, we identified the following HIC features as innovative:

- The **selection of project partners by the funding organization**, rather than by partners themselves. Usually, partners in a collaborative self-select on the basis of pre-existing or preferred partnerships.
- The deliberate selection of **very diverse projects**, focused on technology and information/ research, training, and direct service. Again, partners in health collaboratives usually have commonalities in terms of focus area and operations.
- The involvement of hospitals, a university/hospital-based research unit, primary care, and community organizations. While **cross-sectoral initiatives** are common in health promotion and case management on a single health issue, those that focus on multiple chronic diseases are fairly rare.
- **Extra funding** to support collaborative activities. The GSCF Board of Directors increased the overall HIC budget by an additional 15% (5% more than was requested) to facilitate the HIC collaboration, and for GSCF staff to engage outside help with evaluation, communications, training, and project documentation.
- The atypical **role of the funder** – whereas most funders take a fairly passive role vis-à-vis their projects, GSCF staff were actively engaged throughout the duration of the HIC, first in a consultation process at the "idea stage" and then as a project partner.
- The **focus on experimentation and learning** – From the outset, the GSCF Board and staff recognized there was no guarantee of success for the HIC, but were willing to embrace the risk of failure that is inherent in innovation, provided it resulted in learning.

GSCF is still seen as an extremely supportive and flexible funder

- HIC partners were generally very happy with the leadership provided by GSCF. All partners who completed the 2015 survey responded affirmatively to questions about their satisfaction with the leadership and management of the HIC, its leadership structure, and the processes that supported collaboration among members in the partnership.*
- GSCF was very involved in HIC activities and regularly sought ways to support partners. Partners who completed the 2015 survey all agreed or strongly agreed that GSCF provided resources for the partnership and facilitated their use, including:
  - Dedicated staff responsible for the management and coordination of the partnership
  - Tangible (e.g., funding) as well as intangible (e.g., expertise) resources for its work
  - A structure that allowed the partnership to receive resources
  - Resources (e.g., space, materials, expertise, funds) for the partnership that came from multiple sources
  - Resources that all partners were able to use

*response options were 'yes', 'somewhat', or 'no'

> *"I think Green Shield has been wonderful. Green Shield is not a typical funder. Most funders are not like this. They're not as involved, they're not as engaged, they're not as responsive. This collaborative would not have worked with your typical funder."* [Project partner interview]

GSCF is still seen as an extremely supportive and flexible funder

- GSCF was very open to and supportive of changes to funded projects as they developed. Examples included:
  - Allowing funding to the St. Michael's Hospital to transition from the Virtual Ward to the GEMINI project
  - Being open to AST developing additional family-focused online training courses, in addition to those for personal support workers

> *"Green Shield's approach to this – they were flexible throughout the process. Sometimes funders can be very rigid… but being able to talk to them about how things are going, maybe things need to shift a little bit in order to help the overall greater good of the project."* [Project partner interview]

> *"One of the things I liked about the HIC is that you don't have to fall in. If it didn't work, it didn't work."* [Project partner interview]

> *"This is a really neat way of facilitating five unique projects. There was this very loose and supportive environment that allowed for that to happen, and allowed for a lot of fluctuation and variation over the years."* [Project partner interview]

Projects' diversity made collaboration challenging at first

- Diversity among HIC projects was apparent in many ways – in the types of projects, their focus areas, and their stages of development, the types of partner organizations, partners' prior experience with collaboration, etc.
- The diversity of projects and organizations made it difficult for HIC partners to find ways to collaborate, and to develop a collective identity, especially at first.

> *"We're just…five people that can communicate, but how are we going to leverage each other's expertise? And those realms of expertise may be so far apart that all we're going to be able to do is look at each other from a distance and think, 'I would never possibly be able to do that.'"* [Project partner interview]

> *"Speaking of the HIC as an organization doesn't necessarily feel like what it meant to be part of the HIC. It didn't feel like it was one organization; it felt like five groups that were sharing their experiences sometimes, and had some commonalities."* [Project partner interview]

Diversity was also an advantage – most projects benefitted from other partners' input

- **HIC partners helped each other develop and improve their projects**, using their knowledge, experience, and professional networks. Partners provided each other with input and advice; staff, client, and organizational contacts; and opportunities. Examples include:
  - AST social workers met with both Health eConcierge and GEMINI to provide input into their projects
  - Bridgepoint's interprofessional educator discussed options for e-learning with AST
  - HouseCalls' manager of adult day services worked with AST to provide insight into case scenarios that could be used in the Dementia Care Training online module
  - Bridgepoint linked the Health eConcierge team to collaborative work being undertaken with the Inclusive Design Research Institute at the Ontario College of Art and Design University (OCADU), and the project teams met to discuss the user-centred design data and recommendations
  - Partners from St. Michael's Hospital provided information to AST regarding potential evaluation methods for AST's online Dementia Care Training

Diversity was also an advantage – most projects benefitted from other partners' input

> *"I found all of the team leads meetings – those were the opportunities where we really had an opportunity to try to figure out how to help each other – I saw them as really working leads meetings, and a lot of the intricacies and problems and solutions were identified and discussed as a group. It was almost as if they were sort of the advisory group… which was very, very useful."* [Project partner interview]

- In the 2015 Survey, **all partners agreed the HIC has been a benefit to their organization,** and has…
  - Enhanced their organization's ability to fulfill its goals and objectives
  - Helped their organization acquire knowledge about services, programs or people in the community
  - Improved their organization's capacity and/or skills to meet the needs of the people they serve

Resource and capacity constraints – especially staff turnover – affected engagement

- With only one exception, every organization associated with the HIC – even SRDC and GSCF – experienced staff changes. This **turnover made the process of relationship-building challenging** for all partners, and sometimes limited the capacity of newer partner representatives to contribute fully to HIC.

> *"To be perfectly frank, I think because of the turnover in our project, we haven't contributed to the HIC as much as we should have."* [Project partner interview]

- In interviews, a few of the newer partner representatives said they had difficulty integrating into the collaborative, and on the survey, responses differed as to whether the HIC had sufficient orientation for new partners as they joined the partnership [2015 Survey].

> *"Consistency in people is a big thing… I think if someone is coming into the project, into the end of Year 1, or the end of Year 2, I just think that it would be very difficult to drop in on this group that has built this relationship."* [Project partner interview]

Resource and capacity constraints – especially staff turnover – affected engagement

- While HIC partners generally felt the reporting and accountability requirements were less onerous than with other funding they'd received, **HIC activities required a considerable commitment of time and resources,** on top of that required for their individual projects. While most partners either agreed or strongly agreed that the partnership's benefits outweighed the costs (i.e., time), this was not true of everyone [2015 Survey].

> *"One of the big struggles we had was with the resources, with all of the meetings and who goes to what meeting – that was a real strain."* [Project partner interview]

- To SRDC, partners' engagement and momentum on HIC activities seemed to diminish in the last few months of the project. We suspect this is partly because HIC demands on partners increased toward the end of the project – for the evaluation, video production, project stories, and planning the Learning Event – even as partners tried to wrap up their projects and funding came to an end. A few partners also needed to focus on finding other sources of funding to sustain their projects.

Partners were generally able to develop trust and effective communication

- HIC partners were able to build on the time, energy, and mechanisms in which they'd invested early on to develop **regular, open communication and trusting relationships**. In any group, this an ongoing process, and for the HIC, it appears to have only improved with time.

> *"Collaborative work is easier in theory than in practice. It requires time and effort to build relationships, trust, a shared vision and a common way of working."* [Project partner final report]

- According to the July 2015 survey, all partners agreed or strongly agreed that:
  - The HIC facilitated communication among partners, particularly during meetings
  - The HIC had well-coordinated activities and meetings
  - The HIC had clear and open communication among partners
  - The HIC offered an environment where differences of opinion could be voiced
  - The environment fostered respect, trust, inclusiveness and openness
  - Processes were in place that allowed partners to discuss how they were working together

Partners were generally able to develop trust and effective communication

- Interviews were more nuanced than survey responses about communication, however. For instance, a minority of partners said they felt communication among HIC partners was at times influenced by the power dynamics inherent in any funding relationship.

> *"There was this asymmetry, in that Green Shield was giving us money, and of course, when someone is giving you money, you want to please them. So, generally, when they suggest something, you go along with that."* [Project partner interview]

- A couple of partner representatives said they had concerns they did not feel comfortable raising or felt had not been addressed. As in the earlier report, these concerns were primarily related to not having a good understanding of some of the other projects, and not seeing sufficient commonality among projects for the HIC to achieve meaningful success.

- While we often heard from partners about the energy and engagement of partners at early HIC meetings, we also heard that later meetings were more effective, where there was more of a focus on joint work rather than reporting project activities.

> *"… Getting people on board and really understanding what their expectations are and what their timelines are and what's possible [is important]. And unfortunately, a lot of that discussion is hard to get to until you do relationship-building. You need to get to that level where you trust each other and you're on board."* [Project partner interview]

Better understanding developed on HIC goals and joint action

- HIC partners shared a high-level vision regarding improving access to information and quality of care for seniors with complex chronic health conditions.

> *"[It was] great to meet people with similar overall goals."* [2015 Facilitated session]

- **But initially, partners struggled to understand how the HIC's success could be measured** when HIC goals did not apply to all projects. The vision of 'Bob' – a description of the care trajectory of a fictitious senior with complex needs – had been used to envision success, but eventually, partners decided it was not realistic to expect that Bob, his family, and caregivers would encounter each of the HIC projects. Partners eventually agreed that the HIC's long-term goals were more likely to be achieved by single projects rather than the collaborative.
- **Partners also agreed to focus the evaluation on learning, networking and partnership as short-term HIC goals** that would help develop the capacity and quality of each project; longer-term system outcomes/impacts were expected to flow from this enhanced capacity. Once partners agreed that the focus of the HIC evaluation would be on *process* goals instead of system impacts, the purpose of the HIC became clearer, albeit not to everyone.
- Mid-way through the HIC mandate, **partners developed a work plan with joint tasks**. Though much of the work of implementing this joint work plan fell to GSCF as the backbone organization, by the time of the survey in June 2015, all partners agreed there were processes in place to establish common goals and objectives that were supported by all the partners.

But more work needed on goal-setting and work planning

- As noted earlier, not all partners were clear what could be accomplished by the HIC, even late into the initiative. This could have affected – and been affected by – the degree of engagement these partners had in collaborative activities, and staff turnover.

> *"I think I have struggled off and on with what the purpose of the HIC was. I never really knew, to be honest, if that was because I hadn't been involved from the beginning."* [Project partner interview]

- However, it also reflects how challenging it was to have HIC goals that did not apply to all projects. In their 2015 survey responses, partners expressed a wide diversity of opinions on whether or not there was:
  - A process in place to support the implementation of common goals and objectives
  - A common vision for the partnership and a strategic plan for achieving it

> *"[There's a need to] refine down to a few limited goals that apply to all. Sometimes we run into a 'square peg in a round hole' problem."* [2015 Facilitated session]

> *"For the collaborative to truly produce something more than the individual projects, we needed to be more aligned, either geographically, or topically, or methodologically."* [Project partner interview]

Shared measurement continued to be a challenge

- The KT Tracker was the only source of shared data on HIC-level activities and outcomes. Since partners did not *systematically* report their learning, networking and partnership activities until mid-way through the initiative, these data are likely under-estimates.

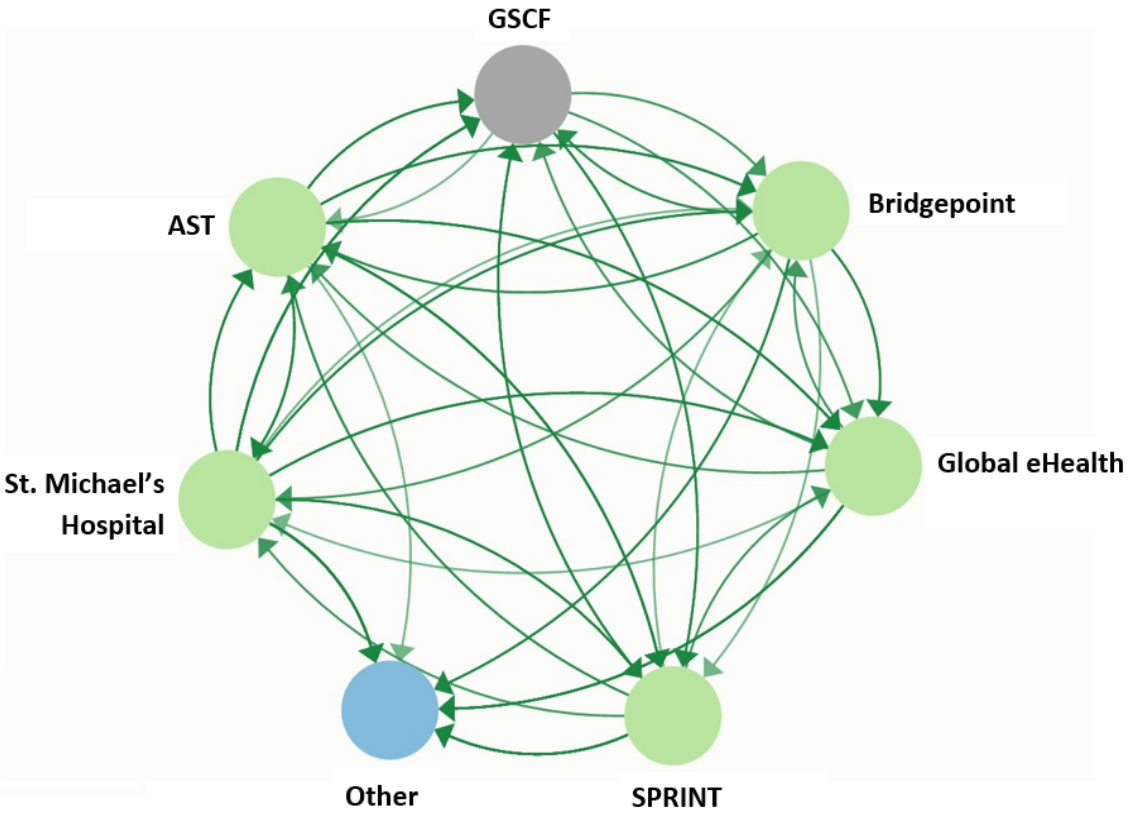
- In the absence of measurable goals that applied to all projects, **partners struggled with the best way to measure success,** both for the HIC and their own projects. Not surprisingly, measurement capacity and focus varied. In response to questions on the 2015 survey about data collection…
  - Several partners did not report collecting any outcomes data
  - Those who did report collecting data indicated this was on organizational and individual outcomes rather than community and partnership outcomes

- Partners did not always feel the tools used to measure HIC outcomes were appropriate, given the nature of their projects or the collaborative. For example:
  - Stakeholder stories – most partners indicated it was difficult to achieve individual-level outcomes or attribute these to their projects; even projects involved in service provision struggled to find appropriate clients for interviews
  - Partners resisted an early attempt to monetize HIC outcomes, because they felt this was premature
  - Evaluation activities did not always resonate with partners

"Sometimes, some of the meetings or the evaluation forms or the evaluation process, I think, has felt almost artificial, or not totally true to capturing the spirit of the experience." [Project partner interview]

A key benefit has been sharing and learning about cross-system perspectives

- Learning comprised almost two-thirds (63.5% or 186/293) of activities included in the KT Tracker
- The average number of learning activities per month increased each year from 2012 to 2014, and decreased in 2015
- Common activities included presentations of partner projects, open houses/site visits, and sharing relevant resources
- A large number of learning activities were with organizations outside of the HIC (29.6% or 55/186 reported learning activities)



Note: Lines in the Kumu diagrams do not represent all HIC interactions; multiple activities between partners are condensed into a single, darker line for clarity.

A key benefit has been sharing and learning about cross-system perspectives

- Most **partners said they really appreciated the diverse perspectives among HIC partners**, and the "richness" that added to the HIC. In the 2015 survey, for example, all partners either agreed or strongly agreed that the HIC helped their organization acquire knowledge about services, programs or people in the community.

> *"Working with the HIC has made it clear that complex issues such as caring for frail seniors with multiple chronic conditions requires broad networks of health care providers who have diverse and complementary perspectives, skill sets, and resources."* [Project partner final report]

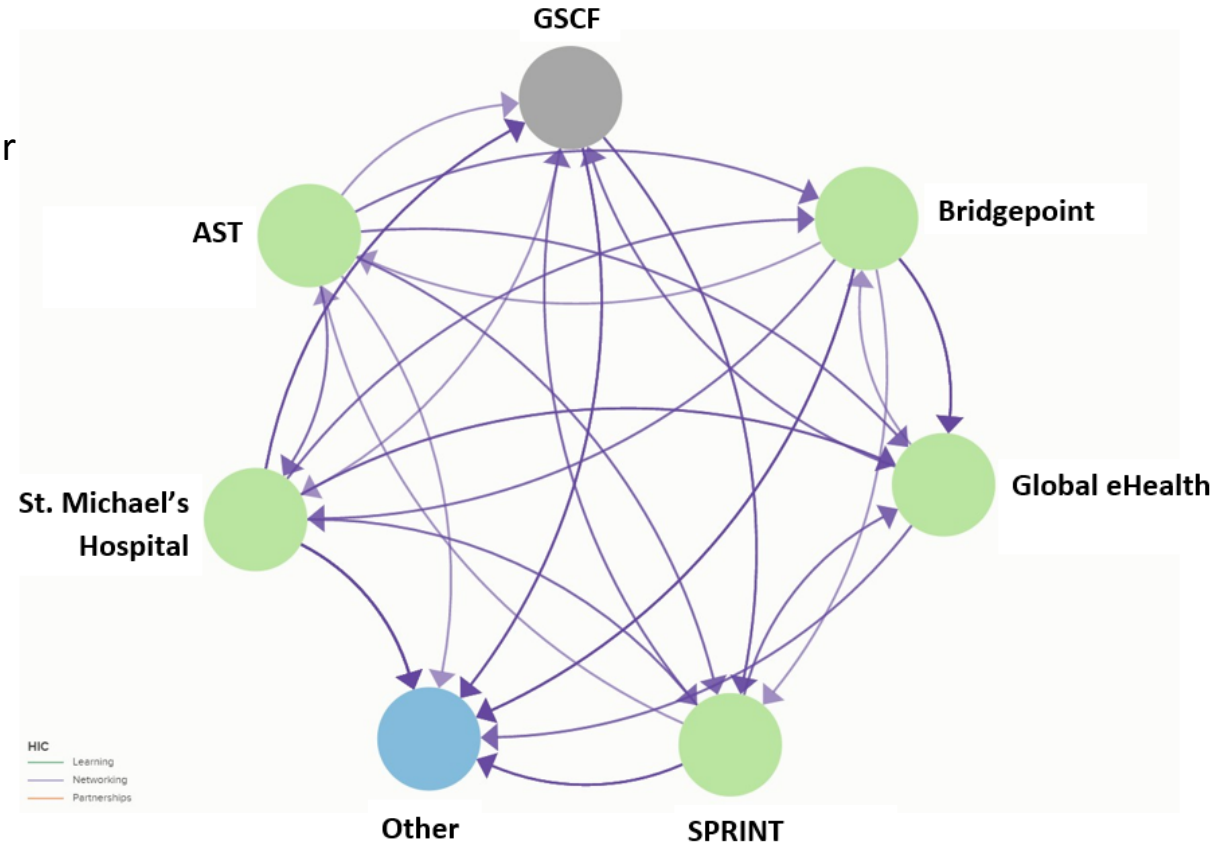
- In several cases, learning about cross-system perspectives had benefits for partners' work outside of the collaboration and the HIC projects.

> *"One of the things I appreciated about being a part of this has been seeing health care provision and service provision from a different lens than I'm used to... Clinical training is really narrow, I think, and my research has been, prior to this, focused on very medical elements of care. And this was really an opportunity to get other perspectives."* [Project partner interview]

> *"I think that corporate perspective [from GSCF], and then that… non-physician health services perspective were both very interesting. It's hard because it's very intangible [but]… just spending all this time thinking about care of elderly, frail populations has definitely changed the way I take care of individual patients."* [Project partner interview]

Partners valued opportunities for networking

- Networking comprised 20.5% (60/293) of all activities in the KT Tracker
- The average number of networking activities per month increased each year from 2012 to 2014, and decreased in 2015
- Common activities included discussions regarding current and future work



Note: Lines in the Kumu diagrams do not represent all HIC interactions; multiple activities between partners are condensed into a single, darker line for clarity.

Partners valued opportunities for networking

- In most cases, **the HIC has led to an expansion of partners' networks** – many partners said other HIC partners were people and organizations they would not have encountered otherwise.

> *"I didn't know the people who were coming to the table regularly. So, I did meet new people, that's for sure."* [Project partner interview]

> *"Creating new relationships that we wouldn't have had. I think our relationship with [partner X] wouldn't have happened. We wouldn't, I don't think, have known their work, or known how they could work with us. I think with each of the agencies there's been sort of a tightening of our relationship that might not have existed prior to that."* [Project partner interview]

- Even when partners were aware of other HIC partners prior to the collaborative, the HIC encouraged regular contact, and in several cases, introduced other individuals into their professional networks.

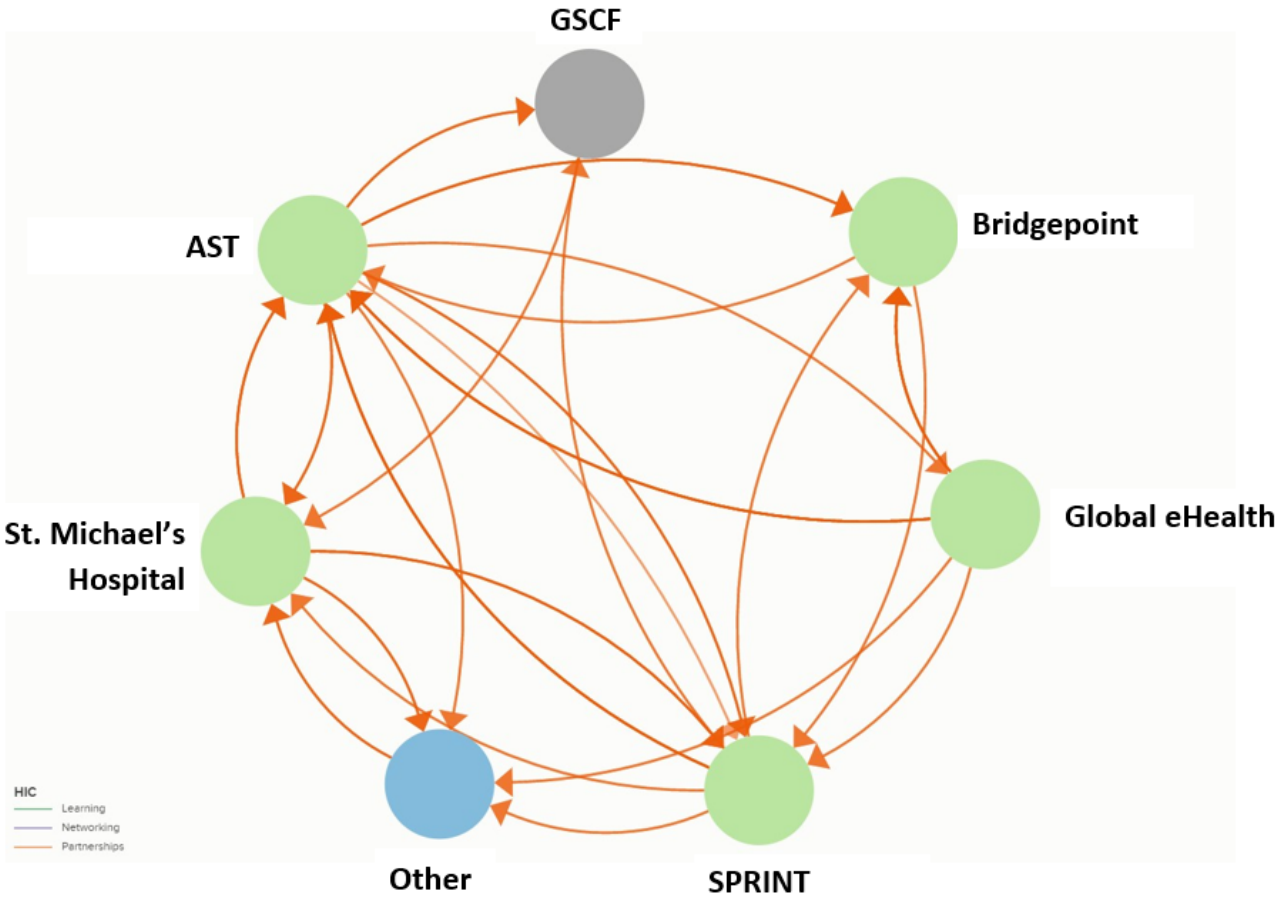
> *"Meeting with and creating bonds with the other HIC collaborators opened many doors for us and created new lines of communication between our organization and the others."* [Project partner final report]

Partners valued opportunities for networking

- In addition to the relationships developed within the HIC, partners also engaged in **substantial networking with organizations outside of the HIC**. While it is impossible to determine if these connections can be attributed to the HIC, they accounted for 30.3% of all reported activities. Examples include:
  - Health eConcierge sharing a case study with the Head of Transformation of Vulnerable People at the National Health Service (NHS) in the UK
  - Bridge2Health connecting with the Woodgreen Community Health Centre and the East Toronto Health Link Team
  - AST connecting with Brock University regarding potential research collaborations
  - St. Michael's Hospital connecting with the Cardiac Care Network and the Spanish Society of Internal Medicine
  - HouseCalls working with Toronto EMS and their community paramedicine program
  - GSCF brokering a number of connections for partners, including to the McConnell Foundation, which recently approved AST's grant application for $350,000

Partnerships and joint work developed, though this was limited

- Partnerships comprised 16% (47/293) of all reported activities
- Most partnership activities were initiated earlier on in the HIC – 25/47 partnership activities took place in 2013, an average of just over 2 per month



Note: Lines in the Kumu diagrams do not represent all HIC interactions; multiple activities between partners are condensed into a single, darker line for clarity.

Partnerships and joint work developed, though this was limited

- Partnership activities were defined as new projects and activities undertaken beyond the GSCF funded projects. Examples include:
  - AST providing training for Bridgepoint and SPRINT staff on dementia care and behavioural support
  - The Centre for eHealth Innovation working with AST on the re-development of the Toronto Dementia Network database
  - An AST social worker working on site once a week with the HouseCalls Enhanced Adult Day Program
  - The Centre for eHealth Innovation and Bridgepoint working together on shared data analysis
  - St. Michael's Hospital referring discharged Virtual Ward patients to HouseCalls and AST
  - Bridgepoint working with the Inclusive Design Institute at OCADU
  - St. Michael's Hospital working with Cancer Care Ontario to support their Integrated Care Project
- Of the three short-term goals – learning , networking, and partnership – the latter had the least activity reported. On the 2015 survey, for example, opinions varied on whether by working together, partners were able to carry out comprehensive activities that connected multiple services, programs or systems better than any of them could by working alone. This could be due to the lack of operational affinities among projects and the resources needed at the project level.

There were many project-level achievements

- In their final project reports, HIC project partners said they had achieved the goals set out in their Funding Agreements with GSCF. These achievements include:
  - Health eConcierge has developed, user-tested, and validated both a back-end (database infrastructure, account system, validated service information form, service information validation protocol and web-interface), and a front-end (web interface, search engine and API) for their web-based search and discovery platform, and connected the two to produce a functional end-to-end proof of concept
  - The GEMINI project, while ongoing, has developed a data collection platform and expanded their pilot to an estimated 100,000 patients
  - The Bridge2Health program added over 200 new resources to their website, and facilitated numerous research studies on digital inclusion and 'point of care' use for clinicians
  - The implementation of AST's Online Dementia Care Training Program (ODCTP) helped PSWs increase their dementia care knowledge and increase their confidence in caring for people with dementia, according to an external evaluation finalized in 2015. Participants were very satisfied with the training and would highly recommend the program to other health care providers
  - HouseCalls' staff growth, including an additional Occupational Therapist, a Physiotherapist, a Program Manager and additional family doctors, allowed for an increase in its active client caseload and a decrease in client attrition

There were many project-level achievements

- Project partners also reported additional achievements beyond their initial goals, including:
  - Health eConcierge's validated service information form, which captures the essential information seniors and their caregivers need to determine the suitability of a service, and is a flexible system for administrators to validate information from service providers before making the information public
  - GEMINI's development of a community of researchers and leveraging of additional funds to support project development
  - Bridge2Health's research partnership with OCADU's Inclusive Design Research Centre
  - AST's creation of the ALZeducate.ca online learning platform and expansion of the courses and webinars offered
  - Results from a study of HouseCalls patients enrolled following discharge from hospital, indicating that patients active in the program for more than 90 days had a 53% reduction in hospital readmissions, and a 65% reduction in length of stay if readmitted

CONCLUSIONS

What can be concluded about the HIC?

This section presents SRDC's conclusions about the HIC, based on the findings presented in the previous section. It starts with conclusions about how the HIC fared in relation to each element of the Collective Impact Framework, then provides answers to the main evaluation questions about the HIC's effectiveness and potential impact. The Conclusions section ends by summarizing what collaboration looked like within the HIC.

The subsequent section then briefly presents implications of the HIC project for others who may be interested in undertaking collaborative work, in the form of lessons learned.

A high-level common agenda

The overall, long-term vision of the HIC was to improve the quality and accessibility of care for seniors with complex chronic health conditions. GSCF selected projects on the basis of their commitment to finding new ways to address pressing issues in seniors' health, from organizations they felt had strong track records in improving seniors' care. As such, the HIC aligns closely with GSC's mission to create innovative solutions that improve access to better health, and its strategic direction of supporting care coordination to help people age at home. It also aligns with provincial priorities for reforming Ontario's healthcare system.

Moreover, HIC partners have a shared understanding of the problems facing medically complex seniors and remain committed to the overall vision of improving their care. At the highest level, HIC partners had this common agenda, one of the pre-conditions for achieving collective impact.

A key challenge for HIC partners has been making the common agenda *actionable* – translating the vision into *collective* goals, rather than those that relate to individual projects. According to the authors of the Collective Impact framework, these types of initiatives need to have common goals that supersede those of any one member or group; such goals do not mask the complexity of the problems being tackled, or the need for action on multiple fronts by diverse stakeholders, but they form the basis for joint effort.

A high-level common agenda (cont'd)

The early portrait of the HIC noted problems with how its goals were defined: in operational terms that were not relevant to all projects; as long-term and systems-level goals (such as reducing Emergency Department visits) that were likely beyond the scope of the HIC's influence in terms of timeframe, resources, scope and scale of activity; and without obvious links to current HIC-level activities such as meetings and committee work.

A common agenda requires a link between present action and the future vision; in other words, a plan that connects current activities with short-term goals, and shows how these in turn connect with intermediate and long-term goals. The Evaluation Committee had already identified learning, networking and joint work/partnership as key objectives for the HIC. What remained was to identify intermediate goals that would link these to long-term goals and vision, and to focus on the short-term time horizon.

The logic model SRDC developed for the HIC identifies *capacity building* as the intermediate goal or purpose of these three objectives, and the means by which long-term goals might be achieved. Capacity building was defined as delivering on project goals, improving the quality of support and care, and developing each partner organization. This definition provided a way to begin assessing the HIC's success – albeit mostly in qualitative terms – that applies to all projects and partners. When asked, all project partners noted ways in which their projects, organizations, and/or work had benefitted from involvement in the HIC.

A high-level common agenda (cont'd)

Another iteration of the HIC would see the group jointly develop success indicators or metrics for each of these short-term and intermediate goals (recognizing that some might be more challenging than others to measure), and make explicit links to feasible, long-term goals. Goals related to a specific geographic area would help focus activity and make measurement easier. However, for a relatively short-term initiative, we feel the HIC has been quite successful developing a high-level common agenda that has served as both a vision and the basis for an evaluation framework.

Mutually reinforcing activities slowly developed

Mutually reinforcing activities are those that are differentiated from each other while also being coordinated in a shared plan of action that stems directly from a common agenda. The HIC's focus on interaction nicely linked networking, learning, and partnership, but it took time for partners to understand how these furthered the common agenda.

As noted in the first report, this lack of understanding appeared to stem from the absence of a practical common purpose or "raison-d'être" for the HIC. It has been further complicated by the sheer diversity of the projects and partner organizations, which partners told us made it challenging at first to see commonalities among the projects, except in terms of overall vision. Collaboration – whether learning, networking or partnership – among projects in the first year was highest among those with clear operational synergies (e.g., SPRINT and AST), though this was no guarantee of joint work (e.g., there were few cross-service referrals between Virtual Ward and SPRINT). Moreover, early collaboration usually occurred in pairs rather than among all HIC members.

With the benefit of hindsight, the story of Bob both helped and hindered the HIC's progress on joint work – it helped keep the HIC focused on the needs of patients, their families, and caregivers, but did not link the ongoing work of each project operationally. Finding a common, tangible purpose would have helped articulate ways in which each project or partner could further the work of the others.

Mutually reinforcing activities slowly developed (cont'd)

On the other hand, we heard that collaboration improved once HIC activities re-focused on joint problem-solving, and broadened to include not just *project* needs and challenges, but those of the partner organizations. As emphasis shifted away from projects *collectively* having to meet long-term HIC goals, and partners shared their visions of collaboration, most said they felt able to explore other possible areas and types of collaboration. In this respect, we heard about the benefits of having diverse partners involved in the HIC, especially in terms of opportunities for cross-system learning and networking.

As part of the early portrait of the HIC, SRDC had recommended creating more opportunities for collaboration among all projects, and developing a joint work plan as a way of creating more synergy among projects. With support from GSCF, HIC partners selected three tasks they wanted to focus on for the remaining 18 months of the initiative – developing individual project videos, interviews with project beneficiaries, and an event to share lessons learned. While the work of coordinating and implementing these tasks has fallen to GSCF as the backbone organization, we have heard that this common focus helped make meetings more productive.

Shared measurement – a shared challenge

Given the difficulties partners encountered trying to find commonalities among their projects and to define appropriate and feasible goals for the HIC, it is not surprising that shared measurement is one area that has been particularly challenging for the HIC, especially for individual-level goals. Mid-way through the initiative, partners agreed to do this qualitatively, by having Judy Steed interview 'typical' clients (or family members or staff) to get a sense of their experience with a given project, at two time points, several months apart. This work will be wrapped up shortly.

A few partners – especially those whose projects were not involved in direct service – noted they had problems finding an appropriate person for these interviews, since many were not directly affected by the project or service, had more pressing concerns, or could not be contacted.

The only shared measurement tool for the HIC has been the Knowledge Transfer (KT) Tracker, which captured information from project reports and status meetings on different types of interactions among partners for learning, networking and partnership/joint work. Since partners' emphasis on documenting these activities has varied over the duration of the project, the data are not particularly robust and likely under-represent partners' actual activities.

Shared measurement – a shared challenge (cont'd)

At the request of project partners, SRDC began experimenting in the last year of the project with ways to visually depict the information in the KT Tracker. Despite the limitations noted on page 26, these diagrams provide some insight into the types of interactions and extent of collaboration among project partners.

Were the HIC to continue, we would recommend more time be spent with partners to define shared goals, indicators, and appropriate tools for their measurement, and that these cover both implementation and desired outcomes. SRDC would also recommend that partners explore how to improve the KT Tracker so that it could directly inform and measure progress toward achieving the collaborative's short-term goals.

While measurement is never as straightforward as it seems, finding ways to achieve this pre-condition would make it easier to document progress toward goals and, in a longer-term initiative, realization of collective impacts.

Continuous communication established

Collective impact initiatives rely on consistent and open communication across all partners, which nourishes trusting, collaborative relationships. Our early portrait of the HIC noted that initial site visits, brainstorming sessions, and a regular cycle of meetings and reports had helped establish continuous communication, which in turn, helped develop relationships among partners and their engagement in the HIC.

However, we also noted that, while initial meetings were characterized as dynamic brainstorming sessions, by the time of our early report, reports and meetings tended to focus more on providing project updates rather than discussion, and to emphasize project and HIC-level achievements, rather than challenges or partners' concerns (which for many, centred on accountability for goals). We recommended then that steps be taken to foster more open discussion and problem-solving, and to differentiate these from communications and marketing of the initiative.

To GSCF's credit, they responded immediately to this issue. Staff clarified expectations and supported a focus on shorter-term, process outcomes (learning, networking, and partnership) as opposed to long-term collective goals, which were considered aspirational. The experimental nature of the HIC was also reinforced. Reports were adapted to include more focus on interactions among partners, and meeting agendas focused explicitly on developing an action plan for the remaining time period. We observed this to have an immediate effect: partners began identifying challenges they were encountering with their projects, and worked to develop joint solutions (e.g., the reciprocity exercise, ongoing 'Give and Gets').

Continuous communication established (cont'd)

There are still those who feel a certain reluctance to voice concerns, however. It may be inevitable that not everyone will feel entirely forthcoming in the presence of a funder. However, we expect this may be also related to the ongoing issue of staff turnover – which undoubtedly affected the group's comfort with frank communication – as well as uncertainty about the role and purpose of communications and marketing efforts.

On the whole, we think this is one area which, though already strong, has seen considerable improvement over time. Credit is due not only to GSCF for addressing communication issues, but to HIC partners as a group for their commitment to working through challenging issues – about the HIC's purpose, functioning, and definitions of success – to the point where the value of the partnership is generally acknowledged and supported.

GSCF – an engaged backbone organization

SRDC congratulates GSCF for taking a novel approach to support innovative healthcare solutions for medically complex seniors.

GSCF has demonstrated considerable leadership by the way in which it tackled one of the 'wicked' problems of the day – healthcare reform – through consultation, innovation, and collaboration. By informing itself about the issues, connecting with organizations with new ideas – some already developed, and others still on the drawing board – and introducing them to each other under the auspices of the HIC, GSCF took the traditional model of collaboration and turned it on its head. While some aspects of that approach have entailed considerable challenge for the group, GSCF has been fully engaged with other HIC partners to work through these challenges, and has allocated additional resources (e.g., for training, evaluation, conference attendance) where these were seen as a potential help.

We feel one of GSCF's key contributions to the HIC has been to infuse it with a spirit of experimentation, risk-taking, and learning. When a focus on collective impacts was starting to generate unease among HIC partners and stifle communication early on, GSCF staff reiterated the commitment to innovation and learning, and supported a move to measure process outcomes instead. Moreover, GSCF has fully embraced the idea of learning from failure for itself as well as the HIC - lessons learned from the HIC have already been incorporated into GSCF's new Frontline Care strategy for other granting programs. This openness and flexibility is key to learning and innovation.

GSCF – an engaged backbone organization (cont'd)

GSCF's work supporting innovative healthcare solutions will not end with the HIC. As a backbone organization in future collaborations, we are sure GSCF will maintain the commitment to learning it has demonstrated in the HIC. Being an actively engaged partner does not change the fact that the funder yields tremendous influence, including over group dynamics. In other collaborations, it will undoubtedly be important for GSCF to continue to encourage critical thinking and frank discussion among partners, facilitate joint problem-solving, and find opportunities for joint work on concrete, collective goals.

With the HIC, GSCF committed itself to an experiment in social entrepreneurship, trying a new model of collaboration as a means of stimulating both organizational and systems-level change. Despite the HIC's challenges – or perhaps because of them – this experiment has yielded tremendous learning, as seen in the next section on Lessons learned. With its experience as the backbone organization to the HIC, GSCF has signaled the important role foundations and grant making can play in supporting the development of innovative solutions to issues of healthcare access and quality, and acting as a catalyst for change.

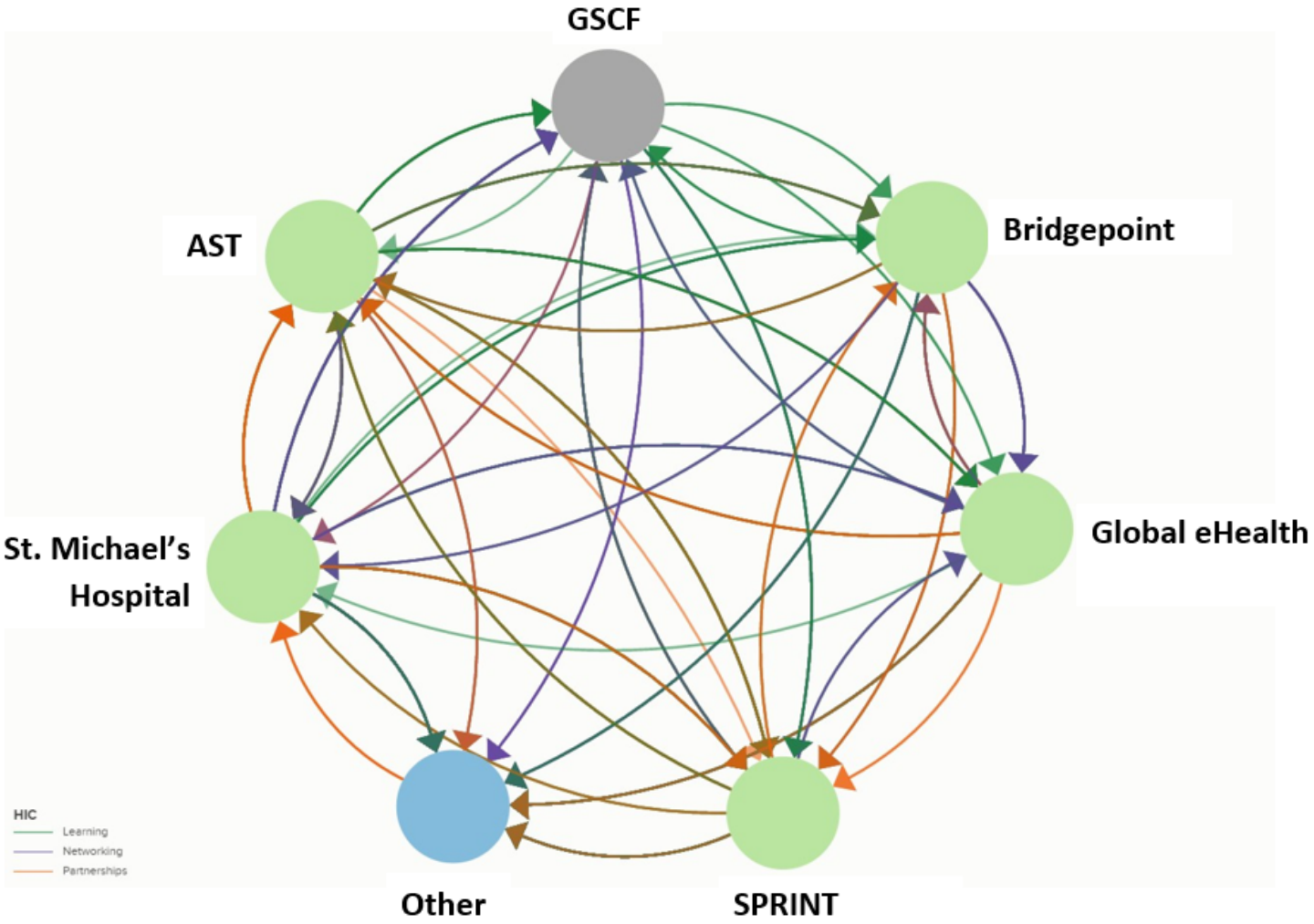
How well has the HIC worked as a collaborative partnership?

By identifying both design and operational elements of the HIC, the Collective Impact framework helps us understand its effectiveness as a collaborative partnership.

- Most aspects of the HIC worked very well over the course of its three year operation, especially the trust and communication built among HIC partners, and the effective support and leadership from GSCF as the backbone organization. GSCF's support and flexibility were particularly appreciated by HIC partners, for both their own projects and the HIC collaborative. Likewise, HIC partners devoted considerable time, energy, and skills to this initiative.
- In terms of design and structure, the HIC had many innovative features, notably, the diversity of projects and partners (e.g., a cross-sectoral approach), establishing the collaborative *after* project selection, and having a fully engaged funder who provided extra resources to projects and encouraged a focus on experimentation and learning.
- Some of these structural features posed challenges to HIC partners in developing a common sense of purpose and joint action plan to guide the collaborative-level work, as well as shared measurement of progress toward goals. In this sense, the diversity of the projects and partners was a 'double-edged sword', bringing challenges as well as benefits. Finding common ground amid diversity is a challenge with which other local health collaboratives have also struggled.
- On the whole, however, HIC partners were able to overcome many of these challenges to successful collaborative functioning, and make substantial progress toward meeting many of the pre-conditions for collective impact.

What did collaboration in the HIC look like?

Collaboration “broke down silos” across organizations and sectors



Note: Lines in the Kumu diagrams do not represent all HIC interactions; multiple activities between partners are condensed into a single, darker line for clarity.

What are the early impacts of the HIC?

There were few operational synergies among HIC projects, and none across all projects. This meant the HIC's activities – and measures of success – had to focus on partners finding ways to support each others' work; on *collaboration* outcomes, and how these affected project quality and in turn, partners' organizational capacity.

Based on several different data sources, we found evidence of considerable achievement on all three HIC goals: learning, networking, and partnership. The greatest outcomes were reported for shared learning; networking and partnerships were reported to a much lesser extent. Even with – or perhaps because of – some of the structural challenges, HIC members engaged in considerable collaboration. While a couple of partners were collaborating prior to the HIC, most have have found new ways to interact. Those that were more engaged or had some degree of alignment tended to benefit most.

More importantly, most HIC partners reported secondary or intermediate achievements as well – collaborating with other partners in the HIC generally improved the quality of their projects and the capacity of their organizations to meet objectives. Partners cited side benefits such as broadened perspectives, enhanced professional networks, and better-informed clinical practice. As a result, it seems clear that that the HIC also achieved its intermediate objective of building capacity among projects and partner organizations.

What is the potential for longer term impact?

As outlined in their final reports, each HIC partner expects to see impact on one or more of the longer-term HIC goals as a result of their project, either directly or indirectly. All goals were addressed by at least one partner:

- *Improve the quality and accessibility of care for seniors in the GTA region, aged 65+ with multiple chronic complex health issues*
  - By ensuring caregivers are educated about Alzheimer's and the services available, AST expects that they will better advocate and improve quality of care in the future
  - GEMINI will contribute to an improved understanding of the care of frail and complex senior patients in hospital and will enable interventions designed to increase the quality and accessibility of care for seniors and caregivers
- *Expand opportunities for care at home, improving the quality of life of seniors and their caregivers*
  - The HouseCalls program has expanded opportunities for care at home for elderly clients in need of medical support
  - AST's online modules and webinars increase accessibility to education sessions for PSWs, caregivers and family members of seniors receiving care at home
- *Increase the skills of personal support workers who work directly with seniors in their homes*
  - The goal of AST's certificate programs is to increase the skills and confidence of PSWs and other health care providers, leading to improved quality of care for persons with dementia

What is the potential for longer term impact? (cont'd)

- *Reduce emergency department visits, hospital admissions/re-admissions, and admissions to long-term care facilities by improving community or at-home services and support*
  - The HouseCalls program strives to ensure that clients receive the care they need within their own homes, avoiding the need for emergency department/hospital visits and relocation to long-term care
  - AST training, by increasing the skills and confidence of PSWs, provides them with the tools they need to provide a higher quality of care, which can provide family members with the confidence needed to keep their family member at home longer
- *Increase the availability of online and mobile resources that offer practical tools to connect seniors and their informal caregivers to local healthcare providers*
  - Bridge2Health is an online health resource centre trying to enhance the ability of seniors and their caregivers to navigate online health resources and locate appropriate health services
  - Health eConcierge offers an easy-to-use administrator interface that organizations can use to share information about their services, and a user-approved front-end interface that organizations can offer to the public, specifically determined with the technology needs, preferences and capabilities of older adults and their caregivers in mind
  - AST's ALZeducate.ca website is growing the number of online education options available to family and professional caregivers

LESSONS LEARNED

Lessons learned

The full story of the HIC is a complex and nuanced one. Distilling that complexity into a few key lessons learned for others' benefit has been a challenging but important exercise.

SRDC's work in the HIC – and this document – prioritizes the evaluation of the *collaboration* rather than of individual projects. While HIC partners have learned a great deal over the course of the initiative about their own project work and how to support seniors, their families, and caregivers more generally, this report provides little sense of those achievements. Instead, we focus here on what has been learned about collaboration, and specifically, how to structure, support, and evaluate collaboration in healthcare.

This section outlines lessons learned that have emerged from the previous findings and conclusions, and in discussion with HIC partners. We hope this information will prove useful as collaboration continues to be a foundation for better integrated and coordinated healthcare.

You get out of collaboration what you put into it

- You have to be willing to work hard to make collaborative relationships work.
- HIC partners who were involved longer, who attended meetings regularly and in-person, and who were actively engaged in supporting the work of the HIC tended to benefit disproportionately.
- It's important to remember that collaboration can be asymmetrical - both sides don't have to benefit equally. This happened when HIC partners referred each other on to other sources of information, advice, support, funding, etc. Asymmetry isn't necessarily negative – some collaborative interactions in the HIC were more of the 'pay-it-forward' variety, where partners would provide input, advice, or referral to other contacts without expecting benefits in return.

> *"As a system, we need to realize that there will be times that your own organization may need more support from its partners than you are able to give in return. This reciprocal nature will work itself out in the end and serves only to make us stronger as a system."* [Project partner final report]

Collaboration is an art

- Collaboration is a complex, developmental process that involves more than just getting disparate people together in the same room.
- It takes time, effort, resources and incentive, shared purpose, skilled leadership, commitment and support. The HIC was fortunate to have many of these elements in place.
- Collaboration involves finding the right partners at the right time, when there is alignment of purpose and reciprocal need. Sometimes there is a natural fit and collaboration "just happens"; in this case, there's no need to "over-think" it (though like any relationship, you can't take it for granted).
- Collaboration can be more complicated and challenging with diverse partners – it takes longer to find commonalities and build relationships – but this can also lead to broader, cross-system learning. Most HIC partners found this process of learning and discovery to be very beneficial, both to their projects, their larger organizations, and to their ongoing work.

The health sector poses specific challenges to collaboration

- The health sector has many players and settings with diverse roles, training, and organizational cultures. Finding the right partners for collaboration can be challenging in this crowded space. Conversely, there are likely many opportunities for collaboration, if connections with the right partners can be made.
- People and organizations in the health sector usually operate in siloes with very little cross-system contact. Moreover, they often have to compete for recognition and scarce resources.
- In addition, many health-related organizations experience high turnover. Staff positions may be project-funded and therefore not permanent, and/or not well paid.
- Understandably, clinical work or direct service usually takes precedence over committee work. For the HIC, this meant partners with clinical responsibilities were not always able to attend meetings, either in person or at all. A clinical or practitioner perspective is vital to have at the table, however, so this constraint needs to be anticipated and mitigated (such as with joint leads, as was the case for a few HIC projects).

Commonality is the "glue" for collaboration

- Diversity is not the enemy of collaboration – far from it. In fact, diversity can enrich and enhance a collaborative partnership. HIC partners, for example, found that cross-system learning was one of the greatest benefits to their participation. But there has to be sufficient commonality (or complementarity) to be able to identify opportunities for collaboration. When partners are very diverse, it is even more important to spend time identifying and exploring potential commonalities and alignment.
- Commonality of *purpose* is paramount, in terms of both vision and joint action. Partners have to see the practical purpose and potential benefit of collaboration to decide it is worth the effort. If partners cannot see the value they can add to other projects, or that other projects can contribute to them, they are less likely to fully engage in collaborative activities, or be able to derive benefit to the same degree as others. Focusing on reciprocal exchanges (e.g., of information, resources, knowledge, skills, support) as HIC partners did can help reap the benefits of diversity while strengthening collaboration at the same time.

> *"If you're going to fund a group of organizations, you should look at a certain fit between organizations. So that the total is greater than the sum of parts."* [Project partner interview]

> *"If you want a partnership or a collaboration to be a success, you need to be clear at the outset about what the goals of the partnership are, and what the roles of each partner are."* [Project partner interview]

There are different ways to structure and support collaboration

- Collaboration can still be valuable and useful if it focuses on *processes* that improve project quality and capacity. This is particularly true when the goal is to support innovation, which invariably takes considerable time, effort, and experimentation, and has a high risk of failure.
- A focus on impacts – especially at the systems level – too early in an initiative can be counter-productive. Whether the focus is on outcomes/impacts or processes, partners need to have a clear, common understanding of the purpose of their work together, a joint action plan, and a way to measure progress.
- The Collective Impact framework is useful because it helps collaborative partnerships focus on the structures and processes that need to be in place to maximize potential for collective impact. The time and effort to achieve that impact can't be underestimated.
- Likewise, evaluation methods need to be tailored to the initiative's stage of development; estimating economic benefit or social return on investment requires clearly articulated, measured outcomes, neither of which were feasible in the HIC's relatively short timeframe, and with its process-based outcomes.

Collaboration needs to be sustained over time

- Staff turnover is likely to always be an issue, especially in healthcare collaboratives. Since collaboration is based on trusting relationships, frequent or substantial turnover can affect partners' engagement, potentially jeopardize collaboration, and stall momentum. Contingency plans could include joint project leads, 'buddy' partners who can help orient new members, and engaging new partners quickly in joint work. Building short-term tasks and "quick wins" into the joint work plan along with longer-term tasks can help sustain momentum.
- Collaboration can be sustained more easily when you have partners who understand the 'big picture' or have a systems viewpoint, who have vision and are open to new ways of doing things, and who are actively engaged in the collaborative process for the duration. Even when visionary leaders move out of the partnership, others can take their place and help keep momentum. AST staff were seen by several partners as the "HIC Heroes" who had collaboration "in their DNA," and with their experience, could provide leadership to the group on effective collaboration.

There is a role for private foundations in healthcare reform

- Foundations have the potential to fill a gap in the current health system. Current funding streams tend to focus on research (e.g., CIHR), operations (e.g., Ministry of Health), or infrastructure (e.g., Canadian Foundation for Innovation). Foundations can provide funding to projects that don't necessarily align with the eligibility requirements or priorities of other established funding streams.
- It can be particularly effective if foundations adopt funding strategies that are informed, consultative, actively engaged, collaborative, stable, and flexible to changing circumstances.
- A particular benefit of foundations is their ability to broker connections with other individuals or organizations who can help address sustainability issues, since they tend to have a broad knowledge of their sector or sphere of activity.
- Foundations also have the potential to have broader impact (e.g., on policy or systems-level change), to the extent they are able to use their grantmaking as a tool for experimentation and learning. Evaluation of innovative, multi-pronged initiatives that address important, 'wicked' problems – particularly over time – can be a useful tool in this regard.

Collaboration Capacity Checklist

Personal Traits

- ❑ Open to new things and experiences
- ❑ Willingness to help others connect
- ❑ Honesty & frankness
- ❑ Willingness to be challenged
- ❑ Energy
- ❑ Leadership
- ❑ Good listening and communication skills
- ❑ Patience

Organizational Traits

- ❑ Stability
- ❑ Commitment to collaboration
- ❑ Clearly defined mandate/ mission/vision
- ❑ Measurement capability
- ❑ Extensive network
- ❑ Accountability/ Transparency
- ❑ Minimal bureaucracy
- ❑ Strategic decision-making
- ❑ Willingness to take risks
- ❑ A track record of success and learning from failure

Collaboration-level Traits

- ❑ Shared goal or vision
- ❑ Diversity of expertise, perspective, skills
- ❑ Trust
- ❑ Mechanisms for effective communication
- ❑ Shared attribution of success/failure
- ❑ Sufficient, stable, shared resources
- ❑ Accountability/ Transparency
- ❑ Shared measurement
- ❑ Common/Streamlined reporting

* Based on brainstorming at a 2014 Philanthropic Foundations of Canada conference workshop

APPENDICES

Why Collective Impact?

Collaboration is not a new concept in many areas of social services, education, and health – it can be found in a variety of citizens' and community coalitions, institutional partnerships and increasingly, public/private partnerships. What is different about Collective Impact (CI)?

- Its application to so-called 'wicked' societal problems that are severe, persistent, and complex because they have multiple root causes. Examples include homelessness, poverty, educational and health care reform
- Given the nature of wicked problems, Collective Impact focuses on systems-level change
- By necessity and definition, CI involves many different people/organizations from diverse sectors, brought together out of common interest and commitment
- CI usually has a long-term time horizon that spans many years, often ten or more
- CI has a systematic focus on five characteristics of collaborative initiatives that maximize the probability of success in achieving the desired change

For these reasons, CI initiatives is as much focused on process as outcomes, particularly in early phases. As is often noted, "*Collective impact is a marathon, not a sprint.*"* The metaphor of a journey is also apt, since it implies considerable preparation and resources, planning, challenges and detours, and consultation with others (maps, guides, drivers, etc.) to arrive at one's destination. The destination can even change and be redefined en route, as goals are achieved, problems are redefined and new goals are set.

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