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COMMUNITY AND PATIENT VOICES IN HEALTH PROFESSIONAL EDUCATION

Improving care for vulnerable populations through their participation in the education of health professionals

Research Report 4: University Dialogue

April 2014

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a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

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Contents

Overall CVHEd Project summary

Our health care system has many barriers for people who are vulnerable or marginalized including access to services, communication with health professionals, and receipt of true patient-centred care.

Changes in health professional education can help to reduce these barriers.

We believe that an important change is to draw upon the lived experience of citizens and include their authentic and autonomous voices in an enhanced education for students at the University of British Columbia.

This 3-year community-based participatory action research project will inform i) development of a mechanism for communities to engage with the university and ii) development and evaluation of an educational model leading to participation by communities in health professional education.

The research should lead to diverse end-users of the health care system having the power and a mechanism to have sustained influence and participation in the education of health professionals.

Core Project Team

Angela Towle (Lead Researcher UBC), Co-Director Division of Health Care Communication, College of Health Disciplines, UBC

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Research Advisory Committee

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Executive Summary

CVHEd University Dialogues

December 10 and 12, 2013, Woodward IRC, UBC Campus

Purpose of the Dialogue

The University Dialogue was the fourth major participatory activity in the Community and Patient Voices in Health Professional Education (CVHEd) project. Previous stages were:

- Interviews with key informants representing 13 Lower Mainland community-based organizations. The interviews explored their ideas about how the involvement of community organizations, patients and citizens in the education of health professionals could be made a core part of health professional education at the University of British Columbia (UBC).
- A Community Dialogue held in June 2013 to discuss the 15 key findings from community interviews; receive input on process to identify action items and next steps; and build connections and collective commitment to take the work forward.
- Interviews with 22 key informants from the university including deans, associate deans, directors, department heads, curriculum coordinators and course directors in 10 faculties, schools and units, as well as decision makers in the Vice President and Provost's Office.

The purpose of the Dialogue was to discuss the 20 key findings from the university interviews, receive input on process to identify action items and next steps, and to build connections and collective commitment to take the work forward.

1. Key Points and Action Items from the Dialogue Discussion

1.1 Participants validated the key findings from the interviews to the degree it was possible.

1.2 Increased patient/community involvement in health professional education was desirable. The discussion was not about *whether to increase involvement*, but about *how*.

1.3 Involvement of the community in assessment raised concerns about legal issues and whether community members had the expertise to assess the learning performance of students. Initial steps might be to involve community educators in formative, rather than summative, assessment and in working with faculty to set the objectives that are assessed.

1.4 Involvement of the community in decision-making activities such as assessment or curriculum development raises fundamental questions about the extent to which the faculty and the institution is ready to consider changing its practices, or is community involvement only to be undertaken on the university's terms?

1.5 Systems of compensation for patient /community educators are necessary to facilitate involvement. They must be developed in collaboration with the community and translated into policies and procedures.

1.6 Preparation and support of faculty, students and community are very important and need to be coordinated among groups. Common themes that emerged from many practical suggestions were to: co-ordinate activities, build on current best practice, adopt flexible and collaborative approaches and to provide individualized support where possible.

1.7 Trust and reciprocity should be promoted by early involvement, demonstrating serious commitment, valuing contributions and avoiding one-off interactions. Past problems with relationships between the university and community should be acknowledged as part of moving forward and finding better ways to work in partnership.

1.8 A designated office would be a tangible symbol of commitment and provide continuity but we need an incremental approach (form follows function). Any entity should be co-created between the university and community and involve minimal bureaucracy.

1.9 An incremental approach should be taken to change management that identifies and supports faculty role models (champions and early adopters), and opportunities for community members and faculty to co-create learning experiences for curriculum pilot projects.

2. **Project Team's Conclusions**

2.1 The spectrum of involvement diagram is useful because it provides a framework to capture the various ways in which patients / community could be involved in education, moving beyond patients just talking about their experiences. It needs to be shared more widely.

2.2 Student preparation and faculty development should be approached by broader consideration of the full design of the educational experience, including curriculum design, objectives, lesson plans and assessment.

2.3 The community has a wealth of expertise in education and experiential learning, and there are many educators in the community. An ongoing university-community dialogue about the fundamentals of teaching and learning would broaden views about teaching, learning and curriculum design and build a common understanding around experiential learning.

2.4 Opportunities for faculty and community to work, learn and have fun together are needed. Although the focus of the project is on student learning if there is a reciprocal process of co-creation of education then we expect that faculty will also have an enriched experience.

2.5 Financial support and faculty rewards and recognition will have to be addressed at the university level if patient and community involvement is to be embedded in health professional education.

3. Next steps for the Project Team

3.1 Students: we will increase the involvement of students in the project.

3.2 Project reports: will be disseminated on the project website so that community members and university faculty can learn about each other's perspectives on the issues.

3.3 The University-Community Forum: is the next step in the project process. It should be planned as an opportunity to co-create partnerships by identifying priorities and working together on practical and achievable tasks.

Introduction

The University Dialogue was the fourth major participatory activity in the Community and Patient Voices in Health Professional Education (CVHEd) project. Previous stages were:

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- A Community Dialogue held in June 2013 to check and confirm the 15 key findings from community interviews; get input on process to identify action items and next steps; and build connections and collective commitment to take the work forward.
- Interviews with 22 key informants from the university including deans, associate deans, directors, department heads, curriculum coordinators and course directors in 10 faculties, schools and units, as well as decision makers in the Vice President and Provost's Office.

The purpose of the University Dialogue was three-fold

- Check and confirm the 20 key findings from the interviews,
- Get input on process to identify action items and next steps,
- Build connections and collective commitment to take the work forward.

We invited all those who participated in the key informant interviews to the Dialogue, as well as additional opinion leaders who had been identified as potential key informants and students from a newly created Student Advisory group. To maximize participation two Dialogues were held (on 10 and 12 December 2013). A copy of the summary report of the key informant interviews was pre-circulated to participants. The Dialogue was attended by 23 participants, including 2 students, from 9 different programs (audiology and speech language pathology, kinesiology, nursing, medicine, midwifery, occupational therapy, pharmacy, physical therapy, psychology), the Faculty of Medicine Dean's Office, College of Health Disciplines, Faculty of Education, Aboriginal People's Health and UBC Community Partnerships Office, plus members of the Core Project Team (Appendix A)

The Dialogue program consisted of presentations about the overall project, a summary of the findings from the key informant interviews, dialogue tables, and finally a report back of the key ideas from each table (see Appendix B for details).

In Dialogue 1, participants self-selected into three dialogue tables, each of which focused on a cluster of the key findings from the key informant interviews as summarized in Research Report 3 (see Appendix C):

Table 1: Patient/community involvement in the education of students

Table 2: Supporting patient/community educators

Table 3: Engagement between university and community

Each dialogue table was given the following tasks:

1. Review your subset of key findings (provided on a separate sheet for each group)
2. Identify issues or disagreements and make a brief statement about them
3. What are the two or three priorities?
4. Suggest action items for each key finding
5. Identify two or three specific next steps to act on the key findings in your subset
6. Propose ways to build these into the overall project process

The Dialogue concluded with presentations of the key points from each group and a summary of next steps, including modifications of the project process based on ideas emerging from the dialogue tables.

In Dialogue 2, the participants individually identified the findings of most interest or importance to them. The priorities were collected on a flip chart and those of most interest to the group as a whole were discussed in turn, starting with the ones that received the most 'votes'. For each, the questions were:

- Why is this finding of interest?
- What are the action items?
- What are the immediate next steps?

Key findings that related to *Educating health professionals at UBC* provided the context for the discussion of the other findings. These were that health care programs at UBC:

- Provide a good education in the basic science of health care;
- Need to produce graduates who are better at working in partnership with patient, communities and other professions;
- Could do a better job of teaching about the broader contexts of health and illness including helping students acquire a good understanding of the social determinants of health and patients' lived experiences.

Results

General response to findings

1. To the degree it was possible, participants at the Dialogue validated the key findings from the key informant interviews, i.e. although participants probably did not go back to the details of the analysis, we did not hear anything to suggest that the findings were inconsistent with their own views or experiences.

2. Participants pointed out the absence of students and front-line clinical teachers in the study process.

3. University participants were interested in what the community had to say.

Key findings and Dialogue discussion

Findings for which there were no additional comments made at the Dialogue [4, 5, 7, 9, 20]

Patient/community involvement varies across programs [key finding 4]

The amount and range of patient involvement varies in the different health professional programs at UBC. The two main approaches are to bring patients into the classroom and send students into community settings.

Most patient involvement at UBC is small scale and episodic [key finding 5]

With the exception of the volunteer and standardized patient programs, patient involvement in health professions education at UBC could be characterized as small-scale, episodic and largely dependent upon the efforts of committed individual faculty members to make it happen.

Patient involvement in creating learning materials, standardized/volunteer patient involvement in clinical settings, and opportunities for patients to share his/her experience with students should be enhanced [key finding 7]

Informants identified different ways in which patients/community are involved in education at UBC along a spectrum of involvement (see Appendix X). They gave many examples of categories 1 to 3. There was a lot of interest in working with patients to create learning materials, inviting more feedback to students from standardized/volunteer patients, and developing patient involvement activities to address gaps in curricula.

Some types of patient/community involvement require involvement of university leadership [key finding 9]

Some informants were enthusiastic to "push the envelope" of patient involvement in the areas of assessment, evaluation, curriculum development and strategic planning, but thought that this would require widespread agreement, endorsement and leadership within their faculty and/or the university. These types of involvement were also thought to require more careful attention to the selection, preparation and support of people from the community for these roles in order to avoid tokenism or raising expectations of special interest groups that could not be met. Since current patient involvement is done largely at the discretion of individual faculty members, course directors or departments, involvement in assessment and decision making activities were seen to be complicated by the need to have more people involved and be more purposeful about recruitment, preparation and support for community members to take on more sophisticated roles.

Partnership with the university is beneficial to community [key finding 20]

The opportunity to influence health care education, research and practice were identified as main benefits to community. A partnership with a large post-secondary institution also validates the work and expertise of community.

Key Points from the Dialogue Tables on the Findings

Patients and lay community members could play important roles in training health professionals [key finding 6]

Real patients add "authenticity", make learning interesting and meaningful and help students connect their classroom learning to practice and develop patient-centred values. Patients and other people from the community have important expertise to contribute to health professional education particularly in helping students understand patients' lived experiences, advocacy, cultural differences, community needs and resources.

1. VALUE: Key points from the Dialogue Tables

- Participants expressed surprise at the extent of agreement that patient voices are valuable in education. This tells us we are moving in the right direction.

Assessment of students, curriculum development and institutional decision making require patients /community to have special expertise if they are to be involved [key finding 8]

There were few examples of involvement in these areas. Partnering with patients/community on student assessment, curriculum development and strategic planning were new ideas for most informants. Many informants had reservations about these types of community engagement and there was disagreement about the extent to which patients/community should be involved in decision making. There were concerns that people from the community would not have the necessary knowledge and expertise for educational and institutional decision making and some queried how involvement of lay people in these areas might affect the confidence, autonomy and professional identity of students. Some informants were concerned about the potential for patients to give students feedback that undermines evidence-based practice. Others thought these could be opportunities for students to consider what to do when faced with patients who make decisions that are contrary to best practice.

2. ASSESSMENT & DECISION-MAKING: Key points from the Dialogue Tables

- Concerns raised in the interviews were endorsed by participants in the Dialogue and discussion focused on assessment and expertise.
- Involvement in assessment, specifically, was contentious. Concerns raised included legal issues and whether community members had the expertise to assess.
- Assessment standards are currently determined by professional bodies. There may be tension between what patients and professionals want students to learn.
- However, it was acknowledged that as recipients of care patients can make a significant contribution to assessment in areas where they want to hold health professionals to account.
- Assessment reflects our values. Therefore, if patients/community are not involved in assessment that devalues their contributions.
- Is patient involvement in student assessment analogous to inclusion of students' evaluations of their professors in tenure and promotion decisions?
- Involvement of community educators in formative, rather than summative, assessment may be a way to get started. There are examples in the literature.
- Assessment needs to be seen in the context of the whole educational experience and the role of the community within that. Involvement of community educators in setting the objectives and teaching may open up possibilities for how they might also be involved in assessment (rather than expecting community members to assess objectives determined and/or taught by faculty).
- Faculty picked up on the potential for patients to give 'wrong information' and undermine evidence-based practice which faculty espouse. However, it was also noted that evidence comes from multiple sources, including patient and community experience.
    - This concern could be overcome by the co-creation and/or co-teaching of educational experiences by faculty and community members.
- Involvement of patients in decision-making activities such as assessment or curriculum development raises fundamental questions about the extent to which faculty/the institution is ready to consider changing its practices. Or, is community involvement only to be undertaken on the university's terms?

- Although no program has systematically embedded community participation in educational decision-making, there are examples of successful and useful community involvement in specific decision-making bodies in many programs that we need to study and learn from.
- It was pointed out that the professional colleges have consumers on their advisory councils. There are many different kinds of community advisory boards. We should investigate models in existence, how they work and who are the members.

Select people who are committed to student learning and ensure that different perspectives are represented [key finding 10]

Selecting the "right people" was top of mind for most university informants. They were committed to providing good educational experiences that expose students to different perspectives/world views and help them be more empathic to patient experiences. Although they were enthusiastic about involving individual patients, some were wary about working with community organizations based on previous experiences with special interest/lobby groups and/or concerns about the agenda these groups might bring that may conflict with the university's educational agenda. There were also concerns about "essentializing" experiences that could reify stereotypes and desires to safeguard students from people with an "axe to grind". The key, they thought, is to select people who share their educational agenda and want to "reach out to students as learners".

3. PERSPECTIVES: Key points from the Dialogue Tables

- There was strong support for a wider range of exposure to patients and community members, going beyond stereotypes and 'classic' cases, to be more representative of the population. Participants cautioned against the extreme cases which may be of great interest to students but risk voyeurism and reinforce stereotypes.
- There was support for moving from one-off exposures to a focus on developing relationships, i.e. increased involvement of patients should not just mean more people coming into the classroom to talk about their experiences, which can promote a tick-box mentality.
- Personal stories can help students to relate to patients but there are also other media that may speak to students – fiction and poetry, music, theatre, visual arts, film etc. [and may provide more appropriate ways for some community members to express themselves]

Develop systems to compensate patients/community members for their service to the university [key finding 12]

Informants were clear that patients/community educators need to be compensated for their service to the university. Compensation was viewed as an important way to recognize the value of their contributions and also pay for their time and inconvenience. However, some informants spoke about the difficulties they have in properly compensating community participants for their contributions as a result of various rules and regulations, fears of affecting disability allowances, etc. When it comes to rewards, recognition and compensation for patients/community members some thought there is a need to find ways to "do business differently". A range of rewards and recognition were recommended such as monetary payments, tuition credits, honorary appointments, recognition at graduation ceremonies, access to university resources, bus tickets, thank-you cards, certificates of appreciation, etc.

4. COMPENSATION: Key points from the Dialogue Tables

- Dialogue participants confirmed that systems of compensation are key – they are the nuts and bolts that facilitate involvement.
- Forms of recognition and reward need to be developed in consultation with the community.
- Ideas then need to be translated into policies and procedures.

Provide preparation and support for patient/community educators [key finding 13]

Most informants thought it is important to prepare and support patient/community educators. This should include an orientation about the university learning environment and culture, curricular learning objectives and assessment criteria. Depending on the individual's role and prior experience, specific training on how to speak to large groups, facilitation skills, and opportunities to debrief, and/or similar training (e.g., instructional skills workshops) and support (e.g., problem-based learning tutor support meetings) currently offered to faculty should be offered to patient and community educators.

Accommodate special needs and vulnerabilities [key finding 14]
University informants acknowledged that vulnerable/marginalized people and people living with chronic conditions/disabilities have burdens and life circumstances that might interfere with their ability to reliably participate in education and they recognized the need to create safe spaces to facilitate participation and plan for times when they are unable to take part.

5. COMMUNITY SUPPORT: Key points from the Dialogue Tables

- These two findings were linked: accommodating special needs is an inherent part of supporting community educators.
- Preparation and support for community educators should be coordinated between the different professional programs.
- The first step is to define the educational role(s) and ask community educators what they need.

- There is a need for both generic and program-specific orientation and materials.
- We should find out what is currently happening in different programs and build on and share current best practice and what is currently available at the university.
- What is the role of community organizations versus individual community members in this process? Who has credibility?

Prepare students for a different way of learning [key finding 18]

Informants recognized that opportunities to learn from patients/community can be powerful and transformative experiences that have the potential to influence students' professional values and identities – especially when students are put into unfamiliar contexts. Given that these learning environments can be "messy" and unpredictable, many thought that students need to be in some way prepared for a different learning experience. The facts that many health professional students come from relatively privileged backgrounds, and that the university learning environment privileges scientific knowledge over experiential knowledge, were also reasons to prepare students. By preparing students, informants hoped it would help students "be receptive" to patients/community as teachers and avoid it being treated like "another experience for them to check-off their list."

6. STUDENT SUPPORT: Key points from the Dialogue Tables

- Student preparation was considered very important because learning from community educators provides a great contrast to other learning experiences in the rest of the curriculum. Community-based education is messy, unpredictable and cannot be standardized (it doesn't fit neatly into a prescriptive curriculum framework).
- Student preparation cannot be done without faculty development/preparation.
- Not all students are ready for learning from and in the community. Taking students out of their culture is non-trivial. Some encounters may challenge beliefs or cause discomfort and there were concerns that if it doesn't work out faculty would bear the brunt of student discontent through complaints and poor evaluations.
- Students have bright ideas but often come with the attitude of "we know and we tell the community". However, a metamorphosis may occur when they go out and discover what the community really needs. Those considered experts may be different for different students.
- Some solutions are:
    - voluntary participation by students,
    - a menu of graduated experiences (individualized or non-voluntary but a smorgasbord with lots of choices, i.e. forced choices) that recognizes the fact that students are at different stages in their readiness for these experiences,

  - creation of an environment in which students are always being nudged but in which their variability to change is considered,
  - involvement of students in designing the educational experiences.
- We need a way to manage huge student numbers. Can we provide an individual approach and support?

Offer faculty development [key finding 19]

If patient/community involvement were to become mainstream, some suggested that faculty would need some training. Training was needed on how to include patients, manage vulnerability, prepare students for learning from patients, and what to do when things go wrong. A suggestion was to identify interested faculty and support them by reducing their work load in order to develop the necessary partnerships in the community and create curricula.

7. FACULTY SUPPORT: Key points from the Dialogue Tables

- Faculty development was seen as a key component and a pre-requisite to student and community preparation and support, and development of flexible approaches to education to overcome potential barriers to patient and community involvement.
- There is a need for practical support, e.g., a unit where faculty can go for help, tools, resources and liaison with the community.
- Faculty development should be collaborative, not top-down, and provide opportunities for faculty to collaborate, share experiences, explore different models.
- This is another example for which cultural change is required – for it to be OK for our curricula to be messy. Faculty who are prepared to take risks need to be supported and offered 1:1 mentorship.

Establish true partnerships with community based on trust, mutual respect and reciprocity [key finding 11]

A lack of mutually beneficial relationships was identified as a major barrier to involvement and many thought there is a need to develop community-university partnerships that are based on trust, mutual respect for the expertise each side brings to the table, and reciprocity. Informants recognized the potential for relationships with the university to be seen as one-sided and exploitive, especially when the community is engaged “too late in the process”, when university faculty see themselves as the primary experts or problem solvers in the relationship, and when student engagement in the community is short term and structured around the needs of the academic calendar. Some thought that these problems could be overcome if the university were to invite community partners as “equals at the table”, invest in building “win-win” relationships, and develop systems of reciprocity and ways of “giving back” to community.

8. PARTNERSHIPS: Key points from the Dialogue Tables

- We need to establish mutual ground rules about how we engage with each other to promote reciprocity and trust.
- Trust can be built by early involvement, demonstrating serious commitment, valuing contributions and avoiding one-offs.
- An office (see below) may make commitment tangible but there needs to be a personal interface.
- Problems in the past with relationships between university and community should be acknowledged as part of moving forward to build trust and find better ways to work in partnership.
- The co-creation of partnerships is an important next step and should be a theme for the University-Community Forum.

Address the power differential and share power [key finding 15]

UBC is a place of privilege. The difference in power between the university and community was seen as perhaps the most significant barrier to authentic participation of patients and community members in health professional education. To begin to address power differences and achieve authentic community engagement will require a cultural shift within the university to sharing power and valuing the unique knowledge and expertise of patients and community. Informants suggested that a shift toward sharing power would be complicated by issues associated with risk management, liability, what knowledge is considered valid and fears of losing jurisdiction over what students learn.

9. POWER: Key points from the Dialogue Tables

- There was an awareness and sensitivity to power differences within the university and within the community (hierarchies of organizations), as well as between the university and community.
- There was concern about who we are dealing with in the community – are we connecting with people with a specific agenda or leaders who have lost touch with their community? How do power differentials in the community play out? People who are skilled and able to communicate may not be typical of the group that they represent. How do we engage a balanced and broad representation?
- We need to find a way of engaging with members of organizations not just organizations themselves. Organizations vary in the extent to which they engage with their own members and the ways they involve them in decisions/activities. However, building relationships with a large number of individual community members takes longer than with organizations.

Systemic involvement requires institutional commitment and leadership [key finding 16]

Many thought that large-scale, institutional level involvement of patients/community requires leadership and support from executive levels within the university. Introducing faculty rewards and incentives and building it into performance reviews and program evaluations were seen as important university structures that would embed patient/community involvement into the fabric of the university.

10. REWARDS: Key points from the Dialogue Tables

- There was uncertainty about rewards for faculty that would contribute to Promotion and Tenure: will these activities count or be a barrier?
- Investigation of how patient and community involvement links to the recognition of new forms of scholarship would be important.
- This is an area where leadership is needed to change the culture at the university.

Establish an office or unit to facilitate involvement [key finding 17]

The majority of university informants talked about the need for an office or unit to facilitate a more integrated approach to patient involvement. An office, they thought, would be a "clearing house" for a wide range of community-university partnerships and a place where faculty could go to find people with the right expertise. Likewise, it would serve as a single entry point for people in the community who wanted to become involved. Most envisioned a university-based office. Some envisioned an office in the community like the UBC Learning Exchange. Regardless of location, there was consensus that embedding patient involvement across health professions education at UBC requires, at minimum, "a facilitator" or "leadership group" to be responsible for its management and coordination – especially activities related to building and maintaining relationships, recruitment, preparation, support, program development and evaluation.

11. OFFICE: Key points from the Dialogue Tables

- The idea of an office was controversial.
    - Pros: an office would be a tangible symbol of commitment; it would provide continuity; it would provide opportunities for collaborative work across the university.
    - Cons: personal relationships are still important; bureaucracy may interfere and add complexity.
    - Therefore: there should be an incremental approach by which we first determine needs and form follows function.
- We should discover the levels at which coordination needs to occur (within the university and between university and community) and identify what is currently missing.

- Any new entity should be co-created between the university and community and involve minimal bureaucracy.

- Investigation of the advantages and limitations of different models to facilitate systemic involvement should be made.

12. CHANGE: Key points from the Dialogue Tables

Throughout the Dialogue ideas emerged not only in relation to what should be done but *how* the findings might be taken forward.

- We hope for collaboration and a paradigm shift but not everyone will feel comfortable about involving patients/community members in education.

- We need to identify champions with passion and early adopters to be role models.

- A bottom-up approach is preferred in which ideas come from faculty members with support, but is then embedded into the curriculum. New initiatives should be brought in slowly so faculty can see how it works and how it fits into the curriculum.

- We should look for curriculum-change opportunities to create pilot projects or test cases that may lead to embedding some patient involvement in new curricula. Curriculum change is a time when the faculty are likely to be open to novel components, especially if they are given assistance with it. Such components that were seen to be or shown to be ‘best practice’ may lead to new accreditation standards.

- We should continue and maintain the ‘dialogue’ at all levels – especially in individual units or departments i.e., engineer a way that a discussion of the issues and ideas presented in the findings could be continued with various new or existing groups at the university.

- The ongoing education of faculty and administrators about the different levels of involvement is important as an ongoing next step. The use of the spectrum of involvement would permit raising awareness of the many layers of involvement and what is missing, and stimulate discussion of relationships (which may not all be partnerships).

- Involvement of individual patients and of organizations may raise different issues. Exploration of partnership and reciprocity needs to be worked out at grassroots level.

- We should take an incremental approach so people enjoy what they’re doing.

Conclusions

Project Team commentary on the Dialogue

1. The spectrum of involvement diagram is useful because it provides a framework to capture the various ways in which patients/community could be involved in education, moving beyond patients simply talking about their experiences. It needs to be shared more widely.

2. Faculty expressed concerns about patient expertise. However, there are many versions of the 'truth' and expertise takes many forms. We have not found patients giving 'wrong' information to be a problem in other educational programs that involve patients as teachers (e.g., Patient and Community Voices workshops or the Interprofessional Health Mentors program). Students are generally able to put into context or question some of the things that their teachers say or do, including patient teachers.

3. Some of the issues raised by a need for student preparation and faculty development can, and should be, approached by broader consideration of the full design of the educational experience, including curriculum design, objectives, lesson plans and assessment. Preparation of students by an orientation before the experience is necessary but not sufficient; preparation needs to be considered in the context of the overall design of the experience.

4. There are many educators in the community and the community has a wealth of expertise in education and experiential learning. We perceive that an ongoing university-community dialogue about the fundamentals of teaching and learning would broaden views about teaching, learning and curriculum design and help to build a common understanding between university and community around experiential learning.

5. A scholarly approach to patient and community involvement will generate new opportunities to advance the scholarship of engagement.

6. Community engagement is a resounding theme at the university but we heard little from our informants and dialogue participants about the potential benefit to faculty of ways and means to develop relationships with community which they could use in their teaching and research. A question for the future is to explore ideas that faculty might have for benefits to the university beyond the direct education of students.

7. Much discussion touched on a need to change the attitudes and behavior of colleagues (speakers regarded themselves as enlightened about patient involvement but suspect less acceptance among their colleagues). This was usually framed in terms of faculty development and change management strategies. Some additional ideas to those mentioned include:

    - Need to have opinion leaders doing pilots
    - Document, disseminate and learn from what has happened here and what has been done elsewhere
    - Host an International conference
    - Start a Journal club

8. We need to create opportunities for faculty and community to work, learn and have fun together – there may not be much other reward. The incremental approach advocated as a change management strategy is a great opportunity for faculty to learn from the community not just for student learning. How do we evaluate this process? We have focused on student learning but the changes may actually be more significant for faculty if there is a reciprocal process of co-creation.

9. An issue not dealt with yet, but which must be, are the costs and models for financial support if we are to move forward as a partnership between university and community. We should investigate whether there are any models already in existence for a joint organization between the university and the community for the purpose of educating students.

10. Language, for example the use of the word "patient", which was so contentious in the Community Dialogue, was not raised as an issue for discussion at the University Dialogue.

Action items and next steps

1. Meaningful ways to increase the involvement of students and front-line clinical faculty in the project will be easier as we move into the implementation phase and set up pilot projects and working groups for specific tasks.

2. We are at a stage in the project where we can disseminate the four project report s (Community Interviews, Community Dialogue, University Interviews and University Dialogue) on the project website so that community members and university faculty can learn about each other's perspectives on the issues.

3. The University-Community Forum is the next step in the project process. It should be planned as an opportunity to explore and understand areas of divergence, to seek commonality and to co-create partnerships through identification of priorities and working together on practical and achievable tasks.

Appendix A: Dialogue Agenda and Participants

University Dialogue

10 December 2013: 5.30 – 8.30 pm

Room 414, Woodward IRC Building, UBC Campus

Agenda

5.30: Registration

5.35: Welcome and introductions

5.45: Overview of the project and process

- Project rationale and purpose
- Origins of the project
- Description of the proposed process and timeline of the project
- Goal for today and overview of the agenda

6.00: Key informant interviews and summary of the main findings

- Brief description of key informants
- Summary and explanation of key findings

6.15: Question and Answer period

6.30: Introduction to the dialogue process

Participants will self select into three tables. Each table will take a cluster of findings

Cluster 1: Patient/community involvement in the education of students (Key findings 4, 5, 6, 7, 8, 10)

Cluster 2: Supporting patient/community educators (Key findings 12, 13, 14, 18, 19)

Cluster 3: Engagement between university and community (Key findings: 9, 11, 15, 16, 17, 20)

Note: Key findings 1-3 (*Educating health professionals at UBC*) provide the context for the discussion of the other findings

[Break for dinner]

6.45: Dialogue tables:

Each dialogue table will have a dialogue host and note taker and will respond to the following tasks:

1. Review your subset of key findings (these will be provided on a separate sheet for each group)
2. Identify issues or disagreements and make a brief statement about them
3. What are the two or three priorities?
4. Suggest action items for each key finding
5. Identify two or three specific next steps to act on the key findings in your subset
6. Propose ways to build these into the overall project process

7.50: Report back from dialogue tables

Five minute presentations of key ideas from the three groups

8.10: Next steps

- Next steps and the project process and timeline
- Who else should be involved in the project?
- Communications strategy

8.30: Close

[Note: modifications were made to the agenda for the Dialogue held on 12 December as described in Appendix B]

University Dialogue Participants

Tuesday 10 December 2013

Catherine Backman, Head, Dept Occupational Science & Occupational Therapy

Leslie Bainbridge, Associate Principal, College of Health Disciplines

Suzanne Campbell, Director, School of Nursing

Valter Ciocca, Director, School of Audiology & Speech Sciences

Shafik Dharamsi, Co-Lead Social Accountability & Engagement, Faculty of Medicine

Trevor Evangelista, Psychology Student

Blye Frank, Dean, Faculty of Education

Jayne Garland, Head, Department of Physical Therapy

Isabella Losinger, Interim Administrator, Division of Midwifery

Shermaine Ngo, Pharmacy student

Gurdeep Parhar, Associate Dean, Equity & Professionalism, Faculty of Medicine

Barbara Purves, School of Audiology & Speech Sciences

Wayne Riggs, Associate Dean Academic, Faculty of Pharmaceutical Sciences

Ian Scott, Department of Family Practice, Faculty of Medicine

Melinda Suto, Dept Occupational Science & Occupational Therapy

Jennifer Vadeboncoeur, Faculty of Education & Research Advisory Committee

Deb Zehr, Director Community Partnership, UBC

CVHEd Core Team

Angela Towle (Lead Researcher UBC), Co-Director Division of Health Care Communication, College of Health Disciplines, UBC
Cheryl Hewitt (Lead Researcher Partnering Organization), past Executive Director, PeerNetBC
Wafa Asadian (Graduate student), UBC Faculty of Education
William Godolphin (Team Member), Co-Director UBC Division of Health Care Communication
Scott Graham (Team Member), Social Planning and Research Council of BC (SPARC BC)
Cathy Kline (Research Coordinator), UBC Division of Health Care Communication

Thursday 12 December 2013

Jane Buxton, Doctor, Patient & Society (DPAS 420) course director

Carrie de Palma, Curriculum Coordinator, College of Health Disciplines

Michael Lee, Curriculum Coordinator, Dept Occupational Science & Occupational Therapy

Bill Miller, Associate Dean Health Professions, Faculty of Medicine

Robert Sparks, Director, School of Kinesiology

Leah Walker, Associate Director, Aboriginal People's Health, School of Population & Public Health

CVHEd Core Team

Angela Towle (Lead Researcher UBC), Co-Director Division of Health Care Communication, College of Health Disciplines, UBC
Wafa Asadian (graduate student), UBC Faculty of Education
William Godolphin (Team Member), Co-Director UBC Division of Health Care Communication
Cathy Kline (Research Coordinator), UBC Division of Health Care Communication

Appendix B: Description of the Dialogue Process

Dialogue preparation

The format of the Dialogue was based on that of the Community Dialogue which had been developed by the Core Project Team and Research Advisory Committee based on previous experience with designing community-based participatory events. An important preparatory step was to reorganize the key findings from the key informant interviews which, in Research Report 3, had been summarized in the same sequence as the interview questions. For the purpose of the Dialogue the findings were clustered into three themes to facilitate more coordinated discussion. Dialogue participants were provided with the agenda and report of the key findings from the university interviews in advance.

Dialogue program and format

The program consisted of presentations about the overall project and findings from the key informant interviews, followed by dialogue tables and report back of the key ideas (see Appendix A).

Overview of the project and process (presented by the co-project leads) included the following:

- Project rationale and purpose (including reference to problems with terminology such as patient community and the Core Team definitions).
- Brief description of the origins of the project including existing DHCC initiatives to involve patients and community organizations in health professional education at UBC which some of the Dialogue participants have been involved in, and how this project will take the work forward. These were mapped out on a wall poster.
- Description of the proposed process and timeline of the project (depicted on a large wall poster)
- Purpose of today's dialogue in relation to the process (emphasis on the project as a research study to identify best ways to build a partnership between community organizations and the university to enhance the education of students).
- Overview of the agenda

Key informant interviews and summary of main findings included:

- Brief description of key informants and their selection;
- Summary and explanation of findings
- Question and answer period.

Dialogue process

Dialogue 1 (10 December 2013)

Participants self selected into three dialogue tables. Each table took a cluster of the key findings from the key informant interviews as summarized in Research Report 3 (see Appendix C):

Table 1: Patient and community involvement in the education of students (Key findings 4, 5, 6, 7, 8 10: patient/ community involvement varies across programs; most patient involvement at UBC is small scale and episodic; patients and lay community members could play an important role in training health professionals; patient involvement in creating learning materials, standardized/ volunteer patient involvement in clinical settings and opportunities for patients to share his/her experiences with students should be enhanced; assessment of students, curriculum development and institutional decision making require patients/community to have special expertise if they are to be involved; select people who are committed to student learning and ensure that different perspectives are represented)

Table 2: Supporting patient/community educators (Key findings 12, 13, 14, 18, 19: develop systems to compensate patients/community members for their service to the university; provide preparation and support for patient/community educators; accommodate special needs and vulnerabilities; prepare students for a different way of learning; offer faculty development)

Table 3: Engagement between university and community (Key findings: 9, 11, 15, 16, 17, 20: some types of patient/community involvement require involvement of university leadership; establish true partnerships with community based on trust, mutual respect and reciprocity; address the power differential and share power; systemic involvement requires institutional commitment and leadership; establish an office or unit to facilitate involvement; partnership with the university is beneficial to the community)

[Note: key findings 1, 2 and 3 provide the context for the discussion of the other findings.]

Each dialogue table had a dialogue host and note taker from the core project team and were given the following tasks:

1. Review your subset of key findings (provided on a separate sheet for each group)
2. Identify issues or disagreements and make a brief statement about them
3. What are the two or three priorities?
4. Suggest action items for each key finding
5. Identify two or three specific next steps to act on the key findings in your subset
6. Propose ways to build these into the overall project process

Report back and wrap up

Each Dialogue facilitator made a five minute presentation of the key points from the group, with invitation to all other group members to contribute. The final discussion summarized next steps with reference to the wall diagram of the project process and identified modifications to the process based on ideas emerging from the dialogue tables.

Dialogue 2 (12 December 2013)

The Dialogue process was modified; there were fewer participants and we had only a single dialogue table. Participants individually identified the findings of most interest or importance to them. The priorities were collected on a flip chart and those of most interest to the group as a whole were discussed in turn, starting with the ones that received the most 'votes'.

For each, the questions were:

- Why is this finding of interest?
- What are the action items?
- What are the immediate next steps?

There was no report back session, but concluding remarks about next steps.

Appendix C: Key findings from the key informant interviews

University key informant selection and recruitment

University key informants were initially identified by the core project team using the following criteria: 1) Faculty who already **involve** community members; 2) People who are **interested** in the idea of community engagement broadly; and 3) People who are **influential** at UBC but not necessarily involved in health professional education or community engagement. Snowball sampling identified additional informants.

Invitations were sent to 25 potential informants at the university. Twenty-two were interviewed (Appendix A). Participants included deans, associate deans, directors, department heads, curriculum coordinators, course directors and professors from the following faculties, schools and units: Audiology and Speech Sciences, College of Health Disciplines, Dentistry, Education, Nursing, Medicine, Occupational Therapy, Pharmaceutical Sciences, Population and Public Health, and Physical Therapy. Interviewees also included decision makers in the Vice President and Provost's office who are responsible for the academic mission of the university, implementation of the Aboriginal strategic plan, and oversight of key academic centres such as the Centre for Teaching Learning and Technology and the First Nations House of Learning.

Interview design

The interview schedule (Appendix B) was adapted from the interview questions used with community key informants in the preceding consultation. Questions were re-phrased where appropriate. For example, "How should health professionals behave differently?" became "How should health professional students be educated differently to make them more responsive to societal needs?" As in the community interviews, an information sheet with examples of patient /community roles in health professional education along a spectrum of involvement was e-mailed in advance of, and referred to during, the interview to help participants identify aspects of patient involvement in education that were of most interest/relevance to them (Appendix C). All interviews were conducted by the lead UBC researcher. Interviews ranged from 42 to 68 minutes (average 55 minutes).

Analysis

Interviews were audio-recorded and transcribed verbatim. An interpretive thematic analysis identified recurring ideas within each topic area covered in the interviews. Selections of narrative were organized by themes in each of the following topic areas: How should health professionals be educated differently to better meet the needs of society? (Interview Question 2); What ways are patients/community involved in the education of students at UBC? (interview Question 3); What roles could patients/community play in educating health and human service students at UBC? (interview question 4); What levels of involvement are of most interest and relevance? (interview question 5); What needs to happen to enable and support community members to participate in health professional education at UBC? (interview question 6); What are the barriers to authentic participation of patients and community members in health professional education? (interview question 7); What structures would facilitate involvement? (interview question 8); What are the benefits? (interview question 9).

Summary of key findings

The following summary is drawn from interviews with 22 key informants (e.g., deans, academic leaders) at the university. Interviews were designed to explore their ideas about how the involvement of community organizations, patients and citizens in the education of health professionals could be made a core part of health professional education at UBC.

1. **Health professional programs at UBC provide a good education in the basic science of health care.**
   Scientific knowledge is paramount in most programs. Anatomy, physiology, pathology, risk factors and population health norms were thought to be well covered. Informants were satisfied with the training students receive on practical health care skills.

2. **Health professional programs at UBC need to produce graduates who are better at working in partnership with patients, communities and other professionals.**
   Discussions about how healthcare professionals should be educated differently were focused on the need for them to be able to work in partnership and be more "patient-centred." For many informants, this meant providing students with more opportunities to develop better "patient-based skills", particularly communication skills (especially listening) and cultural competence. For some it also meant learning to work with communities on community-defined problems and addressing a lack of interprofessional education so that students are better equipped to work collaboratively with other professionals.

3. **Health professional programs at UBC could do a better job of teaching about the broader contexts of health and illness, including helping students acquire a good understanding of the social determinants of health and patients' lived experiences.**
   Most teaching about the social determinants of health and patients' lived experiences was described as patchy and occurring predominantly "in the early years" of training. Informants thought that these and related topics such as advocacy and social justice need to be embedded throughout training so that they are not seen by students as "add-ons" and easily forgotten by the time they are in practice, but rather become "an integral part of their everyday thinking".

4. **Patient/community involvement varies across programs.**
   The amount and range of patient involvement varies by program, but the two main approaches are to bring patients into the classroom and send students into community settings. Guest speakers, standardized patients and community service-learning occur in most programs. Many of the patients brought into classrooms to tell their story are from marginalized/vulnerable groups. Community involvement was broadly defined and

included people from a range of non-profit, corporate and government sectors such school boards, patient organizations, professional bodies, health authorities and other government agencies (e.g., Work Safe BC, ICBC). Nursing, Medicine and Occupational Therapy reported a wide range of community involvement, including in advisory roles and student selection. Audiology reported several mentorship type initiatives. Dentistry reported a lot of community service-learning. Pharmacy and Physical Therapy wanted to expand patient/community involvement in their programs.

5. **Most patient involvement at UBC is small scale and episodic.**
   With the exception of the volunteer and standardized patient programs, patient involvement in health professions education at UBC could be characterized as small-scale, episodic and largely dependent upon the efforts of committed individual faculty members to make it happen.

6. **Patients and lay community members could play important roles in training health professionals.**
   Real patients add "authenticity" and make learning interesting and meaningful. Informants saw patients and other people from the community as having important expertise to contribute to health professional education particularly in helping students understand patients' lived experiences, advocacy, cultural differences, community needs and resources. Patient/community involvement was also seen to be an important way to help students connect their classroom learning to practice and develop patient-centred values.

7. **Patient involvement in creating learning materials, standardized/volunteer patient involvement in clinical settings, and opportunities for patients to share his/her experience with students should be enhanced.**
   Informants identified different ways in which patients/community are involved in education at UBC along a spectrum of involvement (see Appendix C). They gave many examples of categories 1 to 3. Informants were unanimous that patient involvement is an important part of student learning and there was a lot of interest in working with patients to create learning materials (especially to increase authentic case development since most cases are developed only from clinicians' experiences), inviting more feedback to students from standardized/volunteer patients, and developing patient involvement activities to address gaps in curricula (e.g., interprofessional education, social determinants of health and patients' lived experiences).

8. **Assessment of students, curriculum development and institutional decision making require patients/community to have special expertise if they are to be involved.**
   There were few examples of involvement in these areas, e.g., an example of a community-based course in which community members determine the students' final grades and some programs that have invited community input into curriculum reviews. However, partnering with patients /community on student assessment, curriculum development and strategic planning were new ideas for most informants. Many informants had reservations about these types of community engagement and there was disagreement about the extent to which patients/community should be involved

in decision making. There were concerns that people from the community would not have the necessary knowledge and expertise for educational and institutional decision making and some queried how involvement of lay people in these areas might affect the confidence, autonomy and professional identity of students. Some informants were concerned about the potential for patients to give students feedback that undermines evidence-based practice. Others thought these could be opportunities for students to consider what to do when faced with patients who make decisions that are contrary to best practice.

9. **Some types of patient/community involvement require involvement of university leadership.**
   Some informants were enthusiastic to "push the envelope" of patient involvement in the areas of assessment, evaluation, curriculum development and strategic planning, but thought this would require widespread agreement, endorsement and leadership within their faculty and/or the university. These types of involvement were also thought to require careful attention to the selection, preparation and support of people from the community for these roles in order to avoid tokenism or raising expectations of special interest groups that could not be met. Since current patient involvement is done largely at the discretion of individual faculty members, course directors or departments, involvement in assessment and decision making activities was seen to be complicated by the need to have more people involved and be more purposeful about recruitment, preparation and support for community members to take on more sophisticated roles.

10. **Select people who are committed to student learning and ensure that different perspectives are represented.**
    Selecting the "right people" was top of mind for most university informants. They were committed to providing good educational experiences that expose students to different perspectives or world views and help them be more empathic to patient experiences. Although they were enthusiastic about involving individual patients, some were wary about working with community organizations based on previous experiences with special interest and lobby groups and/or concerns about the agenda these groups might bring that may conflict with the university's educational agenda. There were also concerns about "essentializing" experiences that could reify stereotypes and desires to safeguard students from people with an "axe to grind". The key, they thought, is to select people who share their educational agenda and want to "reach out to students as learners".

11. **Establish true partnerships with community based on trust, mutual respect and reciprocity.**
    A lack of mutually beneficial relationships was identified as a major barrier to involvement and many thought there is a need to develop community-university partnerships that are based on trust, mutual respect for the expertise each side brings to the table, and reciprocity. Informants recognized the potential for relationships with the university to be seen as one-sided and exploitive, especially when the community is engaged "too late in the process", when university faculty see themselves as the primary experts or problem solvers in the relationship, and when student engagement in the community is short term and structured around the needs of the academic calendar.

Some thought that these problems could be overcome if the university were to invite community partners as “equals at the table”, invest in building “win-win” relationships, and develop systems of reciprocity and ways of “giving back” to community.

12. **Develop systems to compensate patients/community members for their service to the university.**
    Informants were clear that patients/community educators need to be compensated for their service to the university. Compensation was viewed as an important way to recognize the value of their contributions and also pay for their time and inconvenience. However, some informants spoke about the difficulties they have in properly compensating community participants for their contributions as a result of various rules and regulations, fears of affecting disability allowances, etc. When it comes to rewards, recognition and compensation for patients/community members some thought there is a need to find ways to “do business differently”. A range of rewards and recognition were recommended such as monetary payments, tuition credits, honorary appointments, recognition at graduation ceremonies, access to university resources, bus tickets, thank-you cards, certificates of appreciation, etc.

13. **Provide preparation and support for patient/community educators.**
    Most informants thought it is important to prepare and support patient/community educators. This should include an orientation about the university learning environment and culture, curricular learning objectives and assessment criteria. Depending on the individual’s role and prior experience, specific training on how to speak to large groups, facilitation skills, and opportunities to debrief, and/or similar training (e.g., instructional skills workshops) and support (e.g., problem-based learning tutor support meetings) currently offered to faculty should be offered to patient and community educators.

14. **Accommodate special needs and vulnerabilities.**
    University informants acknowledged that vulnerable/marginalized people and people living with chronic conditions and disabilities have burdens and life circumstances that might interfere with their ability to reliably participate in education and they recognized the need to create safe spaces to facilitate participation and plan for times when they are unable to take part.

15. **Address the power differential and share power.**
    UBC is a place of privilege. The difference in power between the university and community was seen as perhaps the most significant barrier to authentic participation of patients and community members in health professional education. To begin to address power differences and achieve authentic community engagement will require a cultural shift within the university to sharing power and valuing the unique knowledge and expertise of patients and community. Informants suggested that a shift toward sharing power would be complicated by issues associated with risk management, liability, what knowledge is considered valid and fears of losing jurisdiction over what students learn.

16. **Systemic involvement requires institutional commitment and leadership.**
    Many thought that large-scale, institutional level involvement of patients/community requires leadership and support from executive levels within the university. Introducing faculty rewards and incentives and building it into performance reviews and program evaluations were seen as important university structures that would embed patient/community involvement into the fabric of the university.

17. **Establish an office or unit to facilitate involvement.**
    The majority of university informants talked about the need for an office or unit to facilitate a more integrated approach to patient involvement. An office, they thought, would be a “clearing house” for a wide range of community-university partnerships and a place where faculty could go to find people with the right expertise. Likewise, it would serve as a single entry point for people in the community who wanted to become involved. Most envisioned a university-based office. Some envisioned an office in the community like the UBC Learning Exchange. Regardless of location, there was consensus that embedding patient involvement across health professions education at UBC requires, at minimum, “a facilitator” or “leadership group” to be responsible for its management and coordination – especially activities related to building and maintaining relationships, recruitment, preparation, support, program development and evaluation.

18. **Prepare students for a different way of learning.**
    Informants recognized that opportunities to learn from patients/community can be powerful and transformative experiences that have the potential to influence students' professional values and identities – especially when students are put into unfamiliar contexts. Given that these learning environments can be “messy” and unpredictable, many thought that students need to be in some way prepared for a different learning experience. The fact that many health professional students come from relatively privileged backgrounds, and that the university learning environment privileges scientific knowledge over experiential knowledge, were also reasons to prepare students. By preparing students, informants hoped it would help students “be receptive” to patients/community as teachers and avoid it being treated like “another experience for them to check-off their list.”

19. **Offer faculty development.**
    If patient/community involvement were to become mainstream, some suggested that faculty would need some training. Training, they thought, was needed on how to include patients, manage vulnerability, prepare students for learning from patients, and what to do when things go wrong. A suggestion was to identify interested faculty and support them by reducing their work load in order to develop the necessary partnerships in the community and create curricula.

20. **Partnership with the university is beneficial to community.**
    Campus-community partnerships are beneficial to the community. The opportunity to influence health care education, research and practice were identified as main benefits to community. A partnership with a large post-secondary institution also validates the work and expertise of community.

Appendix D: Project Activities and Timeline

Previous educational initiatives of the UBC Division of Health Care Communication with community partners		
2005	"Where's the Patient's Voice in Health Professional Education?"	International conference in Vancouver
2006 - present	Aboriginal Community as Teacher	Partnership with Fraser Valley Aboriginal Children & Family Services Society (Xyolhemeylh). JW McConnell Family Foundation national award for community-service learning 2012
2008 – present	Patient & Community Voices workshops	Patients and clients teach UBC students about living with HIV, arthritis, mental health, epilepsy, aphasia and other chronic health problems.
2009 – present	Community & Patient Fair for Health Professional Education	Yearly 'in-reach' from 40+ community organizations and patient support groups to UBC students and faculty.
2011 – present	Interprofessional Health Mentors program	The first 'patient' they meet is their 'teacher'. UBC students in groups of 4 over 1 ½ years learn from a mentor with a chronic condition.
Community Voices in Health Professional Education (CVHEd) – a Participatory Action Research Project		
2012 Jan	Request to Vancouver Foundation: Community Based Health Research	"Improving care for vulnerable populations through their participation in the education of health professionals"
2012 Jun	Funding awarded	45% of total budget over 3 years for research component of project
2012 Aug	Core project team	Towle (UBC lead), Hewitt (PeerNetBC lead), Graham (Sparc BC), Godolphin (UBC), Kline (UBC coordination), Asadian (graduate student)
2012 Sep–Dec	Foundational work	Ethics approval, Literature review, Guiding principles, Definitions, Stakeholder identification
2013 Jan	Research Advisory Committee	Clague, Dyson, Naizghi, Vadeboncoeur and Core Project Team
2013 Jan–Jun	Community Key Informant interviews	Identified and invited key informants, developed interview questions, trained community interviewers, 15 interviews, analysis and draft report
2013 Jun	Community Dialogue	12+ organizations, Engage in participatory action research, Validate findings, Provide input to project process
2013 Jul–Aug	University Key Informant interviews	Identify and invite key informants, 15 interviews, develop interview questions from community ideas, analyze and draft report
2013 Oct–Nov	Apply for funding to pilot implementation	UBC Teaching and Learning Enhancement Fund for pilot project(s) – project team, students
2013 Dec	University Dialogue	23 university faculty; 2 sessions; 4 tables; Validate findings, Provide input to project process
2014 Mar-Apr	Draft research synthesis	Curriculum and pedagogical models for community involvement in health professional education, operational plan, sustainability plan
2014 May	University-Community Forum	Key informants from Community and University plus other stakeholders to discuss draft recommendations, model and implementation plan
2014 May–2015 Apr	Implementation	Committee, planning, recruitment, pilot(s), evaluation
2014 Jun–Sep	Test and refine model	Working groups with key informants and stakeholders
2014 Oct	University-Community Forum	Finalize recommendations for implementation
2014 Dec	Final report	Recommendations
2014-2015	Dissemination	Disseminate report and recommendations; Prepare and submit abstracts for meetings, conferences, other forms of communications
2015 Mar-Jull	Operational & sustainability plans	For example: Memorandum of Understanding UBC & Community entity

Appendix E: Spectrum of involvement

Examples of patient / community* roles in health professional education along a spectrum of involvement

1. Patients create learning materials

Patients involved in creating learning materials used by faculty (e.g. paper-based or electronic case or scenario; course materials; videos). Examples: real patient problems as basis for case-based learning; virtual patient cases (may involve video of patient); use of patient narratives.

2. Standardized or Volunteer Patients

Standardized or volunteer patient in a clinical setting. Examples: standardized patients widely used to teach and assess communication and clinical skills; clinical teachers may encourage volunteer patients to teach and give feedback; students write up patients' stories.

3. Patient shares his/her experience

Patient shares his/her experience with students within a faculty-directed curriculum. Examples: patients invited into the classroom to share experiences of chronic illness, disability etc.; community-based patient / family attachment programs; Senior mentor programs.

4. Patients teach & assess students

Patient-teacher(s) are involved in teaching or evaluating students. Examples: Teaching associates trained to teach and assess specific clinical skills (e.g. pelvic or breast exam); parents give feedback to students on communication skills.

5. Patients as equal partners

Patient teacher(s) as equal partners in student education, evaluation and curriculum development. Examples: patient educators involved in multiple programme areas. Patient educators collaborate in educational decision making (e.g. curriculum objectives, assessment criteria).

6. Institutional decision making

Patients involved at institutional level in addition to sustained involvement as patient-teacher(s) in education, evaluation and curriculum development. Examples: Patients given a formal position in the institution (e.g. Consumer Academic). Patients involved in institutional decision making (e.g. student selection, reviewing funding applications).

*Notes:
We use the term patient for the sake of brevity, to include people with health problems (clients, consumers, people living with [condition], community members, their care givers (including parents and family), and healthy people (community members, lay people, well women etc). Patients may be individual educators or work in organized groups set up to deliver education and provide peer support. Some education may be delivered by organizations in the community.

people. planning. positive change.