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Inviting a Hospital Healthcare Team to Change : A Framework for Building Capacity to Provide Intersectional, Trauma-Informed Care

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Abstract

This Organizational Improvement Plan is designed for Open Doors (a pseudonym), a Canadian hospital invested in providing stigma-free, social, and structural determinants-based care to patients who are marginalized from healthcare vis-à-vis previous experiences of exclusion and institutional trauma at healthcare settings. In the context of deepening scrutiny on healthcare institutions for their role in perpetuating systemic oppression and for failure to mitigate inequitable health outcomes for marginalized populations, Open Doors' commitment to justice-centered care offers a compelling case study in hospital-based strategies for addressing health inequity. The specific Problem of Practice (PoP) addressed is the hospital's care team's limited capacity for providing trauma-informed care for patients from diverse communities who face complex, intersecting, and systemic barriers to hospital-based care. Broader systemic failures and contextual factors shaping this PoP are discussed and situated using organizational theory and the recent groundswell in literature on socially conscious caregiving. The need to instigate transformative, adaptive third order change to address the PoP is highlighted using transformative and adaptive leadership theories. Critical appreciative inquiry and dialogic change models are blended to propose a change framework that can mobilize such change within Open Doors' context. Guided by the change framework and an evaluation-driven design process, a specific solution is detailed, namely, a patient-centered design and learning hub. A detailed change plan is presented, whereby patients, staff, community representatives and leaders are invited into a knowledge-based, dialogic process of co-creating intersectional, trauma informed practices to address a high-priority intersectional area of need for Open Doors.

Keywords: healthcare change management; transformative leadership; health professions education; critical reflexivity; critical appreciation; evaluative thinking

Executive Summary

This Organizational Improvement Plan (OIP) was initially conceived of in the Fall of 2020. I was just beginning my tenure as organizational lead for evidence and knowledge mobilization (EKM) (wording changed to ensure anonymization), at Open Doors (a pseudonym)—a small Canadian hospital with a socially progressive outlook, and deeply transformative mission. Canada had just come out of its first wave of the COVID-19 pandemic which had laid bare egregious health inequities for systemically marginalized individuals and communities. Among other highly publicized social injustices in 2020, the degradation—and eventual death by neglect—of Indigenous mother of seven, Joyce Echaquan, inside a Canadian hospital, had prompted painful reflection for healthcare leaders about systemic failures that were creating the conditions under which healthcare discrimination, harm, and trauma were increasingly manifesting as (i) structural violence against Black and Indigenous patients (Blanchet-Garneau et al., 2021); (ii) harsher consequences for people who use substances at healthcare settings when they are Indigenous, Black and/or LGBTQ+ (Browne et al., 2021; Ismail et al., 2022); and, (iii) incapacity to care for those with co-occurring symptoms of acute mental health concerns, homelessness and/or poverty (Ayisire & Choi, 2022). Within this context, my role as a leader at a socially progressive hospital provided an invaluable opportunity to launch a theory and practice-informed leadership inquiry into how systemic trauma manifests—and must be mitigated—at institutions that are supposed to be safe-havens of care. This OIP details insights from this inquiry.

Chapter 1 begins with a description of my role as the Director of EKM at Open Doors. The transformative paradigmatic assumptions, theories and lived experiences of intersectionality, and my professional experience as a credentialed evaluator, all of which shape the strategies I employ as a healthcare leader in a knowledge-based role is described in relation to my positional power in the organization. This chapter also outlines Open Doors' unique characteristics as a hospital, including its genesis as a community-based, activist healthcare organization whose founding mission was to care for

a specific community that was historically excluded from mainstream healthcare settings. Organizational theory, namely Capper's (2019) organizational epistemologies are used to contextualize how Open Doors creatively navigates tensions between (i) structural-functionalist, interpretivist and transformative paradigmatic assumptions, and (ii) broader political, socio-economic and cultural nuances of the Canadian healthcare system. It is in the context of navigating these tensions that the leadership Problem of Practice (PoP) addressed in this OIP emerges. Even as the hospital is firm in its transformative stance, limitations in how it historically situated itself as a justice-centered hospital are discussed.

The PoP is articulated as the hospital's care team's limited capacity to provide trauma-informed care to patients from diverse communities who face complex, intersecting systemic barriers to hospital-based care. In the context of the rapidly changing patient population at Open Doors, this is a problem that requires urgent attention. Responding both to broader health system failures, and Open Doors' contextual factors that contribute to the problem, a leadership-focused vision for change is described outlining priorities for enabling the hospital to become an intersectionally inclusive and trauma-informed care setting.

Chapter 2 builds on this vision for change and proposes that the type of change needed to address the PoP is transformative, adaptive, third-order change (Bartunek & Moch, 1987) whereby stakeholders who will experience the most significant impacts of change are empowered to be co-creators of change. Given the necessity for the change to be centered on the needs of intersectionally marginalized patients, the leadership approach blends transformative leadership theory (Shields, 2022) and adaptive leadership theory (Heifetz et al., 2009). Building on this leadership approach, the framework for leading change integrates the critical appreciative inquiry model (Ridley-Duff & Duncan, 2015) and the dialogic change model (Kuenkel et al., 2021). Using an evaluative thinking design process, a patient-centered design hub (the *Hub)* is detailed as the preferred solution for operationalization. The goal is to support Open Doors' care team to critically reflect on their strengths and limitations for

providing intersectional, trauma-informed care, and make necessary changes to their practice and processes in collaboration with patient advisory groups and broader community stakeholders.

Chapter 3 details the implementation, communications, and monitoring and evaluation (M&E) processes that will operationalize the *Hub*. The scope of implementation is presented as a 1.5 year pilot with the objective of testing the *Hub* model to (i) determine the extent to which it is effective for operationalizing the type of transformative, adaptive, third order change envisioned in the OIP, and (ii) to determine the extent to which the *Hub* model builds capacity for intersectional, trauma-informed care. In outlining the scope of the pilot project, I am transparent about the fact that building total intersectional fluency for a hospital care team is a goal that is unrealistic within the auspices of this OIP; implementation scope is limited to addressing one area of high intersectional health need at the hospital. This should provide a blueprint and invaluable knowledge about future possibilities for addressing the complex, intersecting barriers that create inequitable health outcomes for individuals who are marginalized from care at multiple and/or intersecting axes of social inequality.

Given the increasingly urgent need for healthcare institutions to mitigate harm for structurally marginalized populations, this OIP proposes a timely leadership intervention that has potential for broad application across any healthcare setting. Given Open Doors' unique history as a socially progressive healthcare setting, and its commitment to care for the most marginalized individuals within its community—this hospital is the right setting to innovate and experiment with such a complex, and important frontier for broader health equity. Regardless of the extent to which implementation occurs precisely as envisioned, the approach for dialogic stakeholder engagement for reconciling patient, staff, community and leadership perspectives, as well as the evaluative orientation of the pilot positions the organization for rich insights and learning about how to begin addressing intersectional health inequities.

Acknowledgments

For the many folks who need safe and high-quality care, who feel anything but safe in healthcare spaces—I hope this work will contribute to changing that.

For the educators who've kept me alive—literally and figuratively—since I was 7, it is not a surprise I found my way into your tribe. And on this particular EdD journey:

- Thank-you Dr. Ken MacKinnon, for pulling the courage out at a moment when I'd forgotten where I'd hid it.
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For my colleagues at Open Doors—you are my living testament that organizations can create belonging even as they remain places of work. I would be remiss not to name my thought partners Myna and Lisa—your integrity, consummate professionalism, incisive intellect and the joy your bring to the work makes all the difference on days when it feels like the odds are insurmountable. This work is as much yours as it is mine.

For my sister Shahindha, who is as wise as she is fierce, who will never be kept down by systems nor nations. How lucky am I to be around people who know deep in their bones, that laughter is the best medicine, and that playfulness is the antidote to the seriousness of Trauma.

And dearest Greg, for whom all this is finally dedicated: the certainty of your goodness is home. Always, the joy of everything between us; always the love.

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List of Acronyms

AI	Appreciative Inquiry
ALT	Adaptive Leadership Theory
CAI	Critical Appreciative Inquiry
C.E.	Credentialed Evaluator
DCM	Dialogic Change Model
EKM	Evidence and Knowledge Mobilization
OIP	Organizational Improvement Plan
PESTL	Political, Economic, Social, Technological and Legal
PoP	Problem of Practice
SSDH	Social and Structural Determinants of Health
TLT	Transformative Leadership Theory

Definitions of Terms

Critical Reflexivity: Refers to ways in which individuals use processes of self-reflection and/or self-monitoring "as a way of locating oneself in the structure of society" (Flores-Sandoval & Kinsella, 2020, p. 227). Critical reflexivity (i) supports the recognition of "one's own position in the world to better understand the limitations of one's own knowing and to better appreciate the social reality of others" (Ng et al., 2019, p. 1123), (ii) brings explicit attention to the power dynamics that shape social relationships, and (iii) encourages reflexive practitioners to redress the impacts of inequitable power and social dynamics.

Holistic Healthcare: Healthcare approaches in which a person's physical, mental, cultural, and social well-being are considered as fundamental components of wellness. Holistic approaches to healthcare are often designed to be inclusive of the social and structural determinants (SSDH) of health (see below), in how healthcare programs are designed.

Iatrogenesis: The unintentional perpetuation of harm by health professionals. Iatrogenesis includes physical harm (e.g., medication errors that cause allergic reactions) and psychosocial harm whereby "care providers or healthcare institutions may cause injury to individuals and populations through social, cultural, political, and economic arrangements that exclude, harm, or exploit" (Tao & Clements, 2022, p. 717).

Open Doors Hospital: The pseudonym given to the organization the OIP is based on.

Second order change: Sometimes referred to as 'transformational change', these are change processes in which change is made not incrementally within established frameworks or ways of working but by changing the frameworks themselves (Bartunek & Moch, 1987, Capano et al., 2009). Attitudinal, behavioural and cultural change are considered second order change.

Social and Structural Determinants of Health (SSDH): The non-medical factors that influence health outcomes encompassing "the conditions in which people are born, grow, work, live and age, and the

wider set of forces and systems shaping the conditions of daily life." (World Health Organization, n.d., para 1).

Third Order Change: Change efforts that implement second order (transformational change) in a manner that invites those affected by the change to employ their own agency to participate in navigating transformational change (Bartunek & Moch, 1987).

Trauma-informed Approach: Health and social services approaches that recognize the pervasive effects of trauma and focuses attention on "recognizing signs and symptoms of trauma; and seeking to actively resist re-traumatization through the creation of both physical settings and interpersonal processes that support safety" (Shimmin et al., 2017, p.4) for both service provider and patient.

Chapter 1: Problem Posing

Open Doors Hospital (a pseudonym) is a small, Canadian public hospital with a mission to empower health and well-being through holistic, stigma-free, justice-centered care (wording changed to ensure anonymization). The hospital's explicit transformative stance resonates with my own views of leadership that are deeply rooted in transformative paradigmatic assumptions, theories and lived experience of intersectionality, and my practice as a credentialed evaluator (C.E.). In my role as the hospital's inaugural Director of Evidence and Knowledge Mobilization (EKM), (wording changed to ensure anonymization), I have a broad mandate and agency to generate and mobilize data and knowledge across clinical and non-clinical organizational portfolios. This chapter describes my leadership role and lens, as well as the organizational context within which a leadership problem of practice (PoP) emerges as related to barriers to intersectional, trauma-informed care at Open Doors. After describing how the PoP emerges in the context of Open Doors' current organizational structures and broader health-system failures, a leadership focused vision for change is outlined. Priorities for addressing this PoP, and to support Open Doors to achieve its transformative goals are also highlighted.

Positionality and Lens Statement

As the hospital's leader responsible for analytics, research, evaluation, patient-centered design and learning, my mandate is twofold: (i) set direction for data and community-informed knowledge generation and (ii) mobilize insights into patient-centered learning. Reporting to the Chief Executive Officer (CEO), I closely collaborate with the Chief Nursing Officer (CNO) who oversees patient-facing teams at the hospital. I lead a team of knowledge professionals including data scientists, community health researchers and patient engagement specialists. Our team is accountable for the cycle of knowledge mobilization at Open Doors, including (i) identification of emergent needs for our patient population and (ii) co-design of mission-forward strategic initiatives in collaboration with the patient

facing teams. Appendix A includes an Organizational Chart depicting the composition of clinical and non-clinical teams.

Theoretical and Experiential Frameworks Shaping Leadership Lens

Operationalized within the mandate of my leadership position, my leadership lens is grounded in (i) transformative paradigmatic assumptions; (ii) the guiding principles of intersectionality; (iii) my lived experience of navigating intersecting systems of power; and (iv) my professional background as a C.E. working within a transformative evaluation stance. How each of these frameworks shape my leadership lens is discussed below, attached as a heuristic in Appendix B.

Transformative Paradigmatic Assumptions

As synthesized across the work of Capper (2019), Kivunja and Kuyini (2017), Mack (2010) and Mertens (2008; 2017), the driving assumption of the transformative paradigm is the axiological assumption, that is, the fundamental ethical imperative to center and address the needs of groups pushed to the furthest margins of society. Aligned with this ethical stance, I believe that any leader, in any leadership context, has a responsibility to redress imbalances of power and mitigate systemic inequities as it is feasible to do so within their scope of influence. As a leader at a Canadian hospital, I take a transformative stance to mitigate iatrogenesis (the unintentional perpetuation of physical and psychosocial harm by health professionals). Iatrogenesis includes physical harm, but also structural violence whereby care providers or healthcare institutions may cause “injury to individuals and populations through social, cultural, political, and economic arrangements that exclude, harm, or exploit” (Tao & Clements, 2022, p. 717). I am committed to dedicate attention to patients and populations who have historically experienced, and continue to experience, structural violence and healthcare trauma based on various and often intersecting aspects of their identity and/or lived experiences. To this end, transformative leadership theory (TLT) with its “focus on emancipation,

democracy, equity and justice" (Shields, 2022, p. 29) is a leadership theory that wraps around my work—as further detailed in Chapter 2.

Intersectionality: Re-framing Inequity as Shaped by Multiple, Intersecting Social Injustices

While a transformative stance emphasizes the need to mitigate social inequities, the systemic forces that perpetuate such inequities—the continued socio-economic impacts of colonialism, systemic racism, classism, and patriarchy—are often thought of as separate phenomena even while attempting to mitigate their impacts through a transformative stance. Consequently, "their interactions remain invisible" (Collins, 2019, p. 43). Theories of intersectionality challenge "this taken-for granted assumption" and guides social action to mitigate "intersecting systems of power and their connections to intersecting social inequalities" (Collins, 2019, p.43). Intersectionality provides new angles of vision on systems of power (Collins, 2019), enabling a deeper inquiry into and a reframing of complex health inequities as shaped by multiple, intersecting systemic forces. As will become evident in the articulation of the PoP, such a re-framing invites a critically reflexive notion of caregiving. More specifically, theories of intersectionality shed distinct light into the ways structural iatrogenesis is (i) shaped for those who are excluded from care systems by virtue of multiple, intersecting identities (Garcia & Lopez, 2022; Wilson et al., 2019), and (ii) requires intersectional, trauma-informed perspectives for addressing the complex needs shaped by such exclusion. These ideas form the core of my healthcare leadership lens—and is further punctuated by my own lived experience, discussed next.

Social Reality and Lived Experience

The dynamic social locations I navigate as a person and as a leader at a hospital deeply informs my leadership lens. As a Queer, cis-gendered man who is also dark-skinned, has an Arabic name, and a specific migration history that included a period of precarious immigration status resulting in the lack of access to social safety nets—I am deeply aware of how the social locations at which individuals negotiate intersecting identities impact their access to social safety nets, including access to health care.

I have firsthand experience of how access to dignified care varies depending on how aligned the particular intersections of my identity are with the dominant culture of the spaces in which I access care. For example, as a Queer man with an Arabic name (read: Muslim), I often encounter intersecting barriers that limit my access to meaningful care. In mainstream health spaces, I often camouflage my queerness to avoid inviting judgmental narratives about my relationship to health. In queer health spaces, I often code-switch to disguise my obvious 'otherness' as related to the racial/ethnic and immigrant aspects of my identity that might invite a fraught engagement with care providers, especially if I am not overtly performing my queerness. In cultural and spiritual spaces where I have sought mental and spiritual solace, my queerness becomes problematic, often inviting stigmatized narratives of who I am. In each of these spaces, the different anxieties and disempowerment I experience shapes my ability to trust and receive the care I need. The net result is one in which my access to care becomes narrower along the multiple, overlapping axes of identity I navigate as a person. I use these examples to demonstrate the need for employing an intersectional lens into how we understand complex health inequity. At the same time, I caution the reader to reflect that this is just one individual's entry-point into intersectional ways of navigating the world. Intersectionality is as complex and expansive as the multiple axes of social inequalities it seeks to provide angles of vision into (Capper, 2019; Collins, 2019; Wilson et al., 2019). That said, my personal view into intersectionality is one that deeply informs my leadership lens and how I envision the work within this Organizational Improvement Plan (OIP).

Professional Lens

As a C.E., my professional practice is based in measurement and evaluation (M&E). Although M&E are used for a range of organizational purposes in the public sector, I align with evaluation scholars who propose that any evaluative activity should generate insights about "value, merit, worth and significance" (Fournier, 2005, p. 139). In evaluative terms, merit refers to how well a program meets program recipient's needs, whereas worth refers to the value of the program to the larger community or

society (Patton, 2008). The focus on merit and worth situates evaluation as a fundamentally normative exercise, not just a descriptive one as in most research contexts. The normative competency that is integral to evaluative thinking is useful for any leadership practice because core aspects of any leadership practice include articulating and assessing the extent to which success has occurred based on the goals of the organization and/or program/project.

Further to this, my stance as a transformative evaluator—and my beliefs in intersectionality's guiding principles— shape my leadership lens more specifically. Given the transformative evaluator's central concern with the experiences of communities that are most marginalized (Mertens, 2008; 2017), my approach to the notions of merit and worth are framed explicitly from an intersectional lens, engaging the experiential knowledge of a broad range of stakeholders as a core component of defining merit and worth, as will become evident in Chapter 3. Given the scope of my role to influence how evaluative insights are mobilized across the hospital, there is strong potential to influence health equity for people who have experienced/ continue to experience systemic exclusion. To imagine possibilities for identifying and addressing the needs of the most marginalized patients needing Open Doors' services, Open Doors' organizational context and how its transformative journey since inception shapes an emerging leadership PoP is next discussed, highlighting current barriers to intersectional, trauma-informed care.

Organizational Context

Open Doors specializes in care related to a highly stigmatized chronic illness (illness left unspecified to support anonymization) and has committed to a deeply transformative approach to "holistic, stigma-free, justice-centered care" (Open Doors, n.d.-a) grounded in the principles of equity, diversity, inclusion and decolonization. The hospital's *Approach to Care* articulates the following commitments: holistic care that recognizes the physical, mental, social and cultural nature of health, explicit recognition of historic and systemic inequities that have profound effects on patients' lives, and

an explicit trauma and harm-reduction informed approach to care (Open Doors, n.d.-a). Its model of care is based in the hospital's unequivocal position that health and well-being are inextricable from social and structural determinants of health (SSDH) including systemic racism, poverty, the housing crisis, the toxic drug supply and opioid overdose crisis, and the framing of substance use as a criminal rather than health issue. This is an unusual ideological positioning for a hospital to state so explicitly; as medical establishments rooted in scientific and rationalist ideologies, hospitals tend not to acknowledge or address SSDH as explicit components of care. Open Doors' transformative ethos is shaped both by its (i) history as an activist community health organization and (ii) how throughout its evolution into a public hospital, it has continually navigated the tensions between its own organizational ethos and the political, socio-economic and cultural nuances of the broader Canadian healthcare system. Open Doors' history, the nuances of its broader socio-political context and how these shape current organizational practices are discussed next.

How Open Doors Evolved from Community Hospice to Public Hospital: A Brief History

Although it has existed for over thirty years, Open Doors incorporated as a publicly funded hospital less than a decade ago. Originally founded as a community-based healthcare facility, Open Doors was established in response to the urgent need for providing dignified, end-of-life care to people who succumbed to a mysterious and deadly illness (Open Doors, n.d.-b). Fear of the disease ran deep among both the general public and healthcare institutions, ostracizing the people and communities affected by it. Hospitals treated victims of the disease punitively, and without dignity (Open Doors, n.d.-b) causing great psychological harm and trauma to the those affected by the disease, and significantly breaking the trust of specific affected communities towards formal healthcare systems (Open Doors, n.d.-b). However, owing to pharmaceutical innovation over the last two decades, the disease Open Doors was created to specialize in has become a manageable chronic illness for many individuals. Access

to treatment is widely available without the need for institutionalized care, and the majority of individuals living with the disease can access care through a family physician/ general practitioner.

Despite these medical advances, individuals continued to access Open Doors' care. These patients increasingly were people who had (i) experienced the effects of experimental treatments during the early years of the disease, (ii) experienced disease-related stigma, (iii) were socio-economically disenfranchised, and/or (iv) who were often criminalized for substance use. In other words, those who continued to access Open Doors care tended to be people who continued to experience complex co-occurring health conditions (co-occurring symptoms of uncontrolled illness, impacts of substance use, and/or malnutrition) and who were excluded from mainstream healthcare settings vis-à-vis healthcare stigma, discrimination and/or criminalization.

As Open Doors saw its patient population increasingly represent higher proportions of these populations, it became increasingly challenging to provide the complex healthcare needed for such patients within the mandate of a community health agency. Open Doors' Board's decision to incorporate as a speciality hospital was driven in large part to ensure it continued to meet the complex and evolving needs of a population otherwise excluded from mainstream care settings. Thus, from its genesis throughout its transformation into speciality public hospital, Open Doors maintained its identity as a progressive healthcare facility. This progressive/transformative outlook continues to be shaped in relationship to broader political, socio-economic and cultural contexts informing broader Canadian beliefs about health and healthcare.

Canadian Beliefs about Healthcare: Broader Political, Socio-Economic and Cultural Contexts

Health sociologists Power and Polzer (2016) and Whiteside (2009) trace Canadian conceptualizations about health as a persistent negotiation between two opposing ideological views. The first, a broadly neoliberalist view, is underpinned by values of individualism; privatization and decentralization (Power & Polzer, 2016). In this conceptualization of health, the extent to which

individuals' social positioning affects their ability to pursue health is not acknowledged as a determinant of health (Power & Polzer, 2016). The second view, a broadly socialist one, contends that health is shaped as much through individual, biological processes as they are in relation to social structures. This conceptualization frames care as a social entitlement, especially in the context of social and structural inequities that challenge individuals' ability to pursue health (Hankivsky, 2008; Power & Polzer, 2016). Open Doors' transformative stance rejects neoliberal conceptualizations of health, even as it is enmeshed within a healthcare system governed by neoliberalist, healthist mechanisms discussed below.

Neoliberal Healthism and its Impacts on Canadian Healthcare Governance

Neoliberal governance of Canadian healthcare occurs through two pervasive mechanisms: (i) continual structural and financial reforms driven by privatization and decentralization (Whiteside, 2009) and (ii) public discourses that shape socio-cultural beliefs about what health is, how it should be pursued, and, who deserves public healthcare. (Power & Polzer, 2016). While both mechanisms shape healthcare delivery, the latter as it manifests in the discourse of healthism directly informs Open Doors' transformative stance. Pervasive across all forms of media, healthism is underpinned by "the tendency in public and professional discourse to privilege individual behaviours and biological processes as explanations of health over social determinants" (Power & Polzer, 2016, p. 4). Healthist discourses perpetuate the notion that healthcare is a public good *earned* by fulfillment of an individuals' *moral obligation* to pursue health, specifically through (i) consumption of health promoting behaviours (e.g., routine medical check-ups) and (ii) the avoidance of behaviours framed as health risks (e.g., substance use) (Power & Polzer, 2016).

Healthism manifests in Canadian healthcare governance in two ways. First, it shapes the type of healthcare services that are publicly available, which reflect healthist values about who deserves care. The best example of this is how Canadian Drug Policy shapes the lack of harm reduction programs across Canada (Hyshka et al., 2017; Wild et al., 2017). Since 1908 Canadian law has framed substance use as a

criminal issue to be dealt with punitively (Boyd & MacPherson, 2018) versus a personal choice like any other with health implications, that becomes a health issue that requires care. This perpetuates the belief that people who use substances deserve any consequence, and receive only punishment, not care, even at healthcare settings. The consequence is continued exclusion of people who use substances from healthcare settings vis-a-vis (i) stigma, (ii) not making accommodations for their care, and (iii) in extreme cases, criminalization at the point-of-care (Carusone et al., 2019; Dong et al., 2020; Strike et al., 2020). Open Doors rejects implicit healthcare system beliefs that exclude people who use substances by not making abstinence a requirement of care access at Open Doors, and by providing supervised consumption services for patients to use substances safely while accessing care at Open Doors.

Beyond shaping the type of healthcare services that are available to the public, healthism also manifests in the proliferation of a narrowly biomedically focused model of care that is pervasive across healthcare settings (Paton et al., 2020a). This approach focuses on the biological symptoms of health conditions without considering the role of social determinants in shaping health (Metzl & Hansen, 2014). As outlined in its *Approach to Care,* Open Doors recognizes the systemic inequities that challenge individuals' ability to pursue healthy lives and situates all patients as deserving of care. In doing so, Open Doors rejects healthist notions and aligns itself with an intersectional conceptualization of health.

Intersectional Conceptualizations of Health as Antidote to Healthism

Despite pervasive neoliberal ideologies, socially conscious views of health have gained momentum over the last decade, particularly in how intersectional approaches to public health resist conceptualizations of health that privilege individual and biological aspects of health. Focusing "on the ways in which multiple axes of social inequality intersect and co-construct one another…to produce a broad range of unequal outcomes," (Hankivsky et al., 2017, p. 78) this approach offers an antidote to neoliberal conceptualizations of health. Aligned with this ideology, Open Doors has positioned itself as a hospital delivering a SSDH-based, trauma-informed care model. Although the broader socio-economic

and political contexts within which Open Doors functions does not align with intersectional views of health, such a view is enabled at Open Doors because of its commitment to serve populations excluded from healthcare throughout its thirty year history. How this continued transformative evolution manifests in current organizational practices is next described in more detail.

Open Doors Today: Organizational Structure and Established Leadership Practices

Open Doors' transition from a community healthcare agency to a speciality hospital that is government funded and governed by provincial hospital legislation has brought tremendous opportunities and challenges for its transformative mission. Despite the major organizational transformations in motion, it creatively balances tensions between its transformative goals, its interpretivist history, and the newer structural-functionalist characteristics that have emerged during its evolution into a government funded hospital. Using Capper's (2019) framework, Table 1 summarizes and compares Open Doors' historical and current organizational and leadership practices.

Table 1

Epistemologies Shaping Organizational Practices

Organizational Epistemologies (Capper, 2019)	How Related Organizational Practices Emerge at Open Doors	
	Historically	**Today**
Structural functionalist	▪ Not at all typical of a structuralist-functionalist epistemology.	▪ Emergent quantitative pressures from funders. ▪ Greater focus on specialized teams & roles. ▪ Vertical organizational hierarchy introduced, reflecting the hierarchies of healthcare system.
Interpretivist	▪ Humanistic roots: dignified end-of-life care to stigmatized individuals. ▪ 'Saviour mentality' without challenging broader structural inequities, that is., "charity not justice". ▪ Small team of <30 staff; flat organizational structure, and collaborative decision-making.	▪ Maintains strong sense of the organization's compassion-based roots. ▪ Although more hierarchical, maintains a high level of cross-portfolio collaboration amongst its >90 staff, and across layers of the hierarchy. ▪ Commemorative rituals and symbolism continue to be embedded into everyday life.
Critically Oriented/ Transformative	▪ While the hospital served a marginalized population, it did not apply a broad-based equity lens into its work. ▪ Until recently, focused on the sub-population it had always served without much thought to other marginalized populations that have needed its services.	▪ Dominant epistemology at *Open Doors.* ▪ Equity-centered innovation centers the needs of populations who are marginalized from healthcare. Examples include: o One of <5 Canadian hospitals to offer supervised consumption services to make care accessible for people who use substances. o One of <5 Canadian hospitals that advocates for decriminalizing substance use in Canada.

As detailed in Table 1, Open Doors' transition from charity-based hospice to its incorporation as a public hospital has brought newer elements of structural-functionalism, especially in terms of emergent quantitative pressures (mandated minimum patient visit numbers to meet funding formulas) to which Open Doors was previously unaccustomed. Yet, it maintains strong interpretivist characteristics including a shared sense of 'uniting behind mission' and a strong collaborative culture. While the context necessarily propels the need to reconcile elements of seemingly opposing organizational epistemologies, these mixed characteristics in-fact creates the groundwork for further motivating Open Doors' transformative mission. Because the hospital is deeply invested in its transformative mission to mitigate deeper structural inequities shaped beyond its walls (Capper, 2019; Mertens, 2008; Shields, 2022), it is creatively utilizing both its historically interpretivist characteristics (namely, Open Doors' staff's deep commitment towards holistic, SSDH-based care) and its newer structural-functionalist characteristics (emergent quantitative pressures) to use the requirement to increase visit numbers as motivation for broadening reach to specific marginalized communities it has not historically served. It is within the tensions of balancing these epistemological characteristics that the leadership PoP at the heart of this OIP is formed. The PoP and the intertwining phenomena that shape it are next discussed.

The Leadership Problem of Practice

Resulting from Open Doors' intentional outreach efforts to broaden access to many of the systemically excluded communities within its catchment, its patient base has begun to diversify substantially—and at a more rapid pace than anticipated. Consequently, its patient-facing care team consisting of clinical staff (regulated medical and allied health professionals) and non-clinical care providers (patient engagement staff who are not regulated health professionals) are beginning to engage patients from diverse backgrounds, and with a level of complex, intersectional health need for which the team has limited experience. This is creating unforeseen challenges for the team's ability to deliver compassionate, justice-centered care. Appendix C describes a fictionalized practice scenario

created from a composite of interactions I witnessed, that illustrates the types of challenges that were becoming increasingly common. Based on these challenges, the PoP is clear: the front-line care team is limited in its capacity to provide trauma-informed care for individuals from diverse communities who face complex, intersecting systemic barriers to hospital-based care. Next, drilling deeper into the practice scenario outlined in Appendix C, the PoP is further framed in relation to broader organizational and societal factors that shape it within and beyond Open Doors.

Framing the Leadership Problem of Practice

The practice scenario outlines a situation in which an experienced care provider's otherwise exemplary skills did not translate well to intersectional patient needs that challenge the care provider's current knowledge and capacity. The error in judgment was made in the context of multiple factors: an overwhelming environment and burn-out amidst a pandemic, but also what appears to be deficit narratives, (Shields, 2004; 2022) about the patient (subconscious beliefs that the patient's circumstances are the result of their personal limitations rather than also the consequences of socio-economic circumstances). The result is that the clinician has neglected to provide care to a patient in need, and unintentionally positioned the patient as undeserving of care. The scenario reveals a deeper set of political, economic, sociocultural, technological, legal (PESTL) and contextual factors framing the PoP. The PESTL factors framing the PoP build on the previous discussion of the political, socio-economic and cultural factors shaping broader Canadian beliefs about healthcare, although the PESTL factors frame the PoP more specifically. Further, the PESTL factors are interrelated, and emerge both as drivers of change and as deeper-rooted systemic factors influencing healthcare practice and culture, which in turn shapes the PoP. The interrelated political/sociopolitical and technological factors which emerge as external and internal drivers of the change (visualized in Appendix D) is discussed next.

External Drivers of Change: Political and Sociopolitical Factors

Throughout Open Doors' evolution into a publicly funded hospital, the world around it became increasingly attuned to pervasive social inequities. Sociopolitical movements starting with Occupy Wall Street in 2012, the Black Lives Matter movement in 2013, and the Canadian Truth and Reconciliation Commission in 2015 highlighted egregious systemic inequities historically embedded within political institutions, and how they continue to plague the lives of systemically marginalized populations. Further, after a decade of government hostility towards harm reduction, with substance use framed as a criminal rather than health issue in Canadian law between 2006 and 2014 (Boyd & MacPherson, 2018; Hyshka et al., 2017), the Canadian harm reduction movement had also begun to regain momentum in 2015 amidst an escalating opioid overdose crisis (Ladha et al., 2021). Responding to these pressures, in 2015 the newly elected government committed to Truth and Reconciliation as a governance priority (Philpott, 2020) and re-framed substance use as a health issue rather than criminal issue, legitimizing harm reduction as a healthcare approach. These changes in the political environment created direct pressure on public institutions to address the systemic inequities continued to be perpetuated under their watch.

The abrupt emergence of the COVID-19 pandemic and its intersections with the opioid overdose epidemic (Gomes, 2021), along with the series of horrific and highly publicized social injustices such as the murder of George Floyd and Joyce Echaquan laid bare the still continuing impacts of the systemic inequities that earlier sociopolitical movements had called attention to. Particularly, health disparities for systemically marginalized groups revealed during this period were blatant (Cahill, et al. 2020; Dryden & Nnorom, 2021; Perritt, 2020). In particular, the degradation, and death by neglect, of Joyce Echaquan by regulated healthcare providers at a Canadian hospital (Palmateer, 2021; Philpott, 2020) prompted serious reflection for publicly funded healthcare institutions about the continued impacts of structural inequity perpetuated within their walls. For Open Doors, this emerged as the imperative to provide trauma-informed care from the intersectionally inclusive perspective that the contemporary Canadian

moment demands. Responding to these events, Open Doors' organizational understanding of healthcare justice evolved to explicitly recognize that complex health inequity increasingly manifests as:

(i) violence against Black and Indigenous patients (Paton et al., 2020b; Perritt, 2020)

(ii) harsher consequences for people who use substances at healthcare settings when they are Indigenous (Browne et al., 2021), Black (Perritt, 2020), and/or LGBTQ+, (Ismail et al., 2022)

(iii) incapacity to care for those experiencing untreated mental health concerns (Ayisire & Choi, 2022), homelessness (Davenport, 2000), and/or systemic poverty (DeBonis et al., 2020).

Recognizing the need to mitigate such harm within its walls, Open Doors' board endorsed organizational frameworks for anti-oppression, anti-racism and harm reduction (Open Doors, n.d.-c), intentionally setting the stage for capacity building within a broad and intersectional anti-oppression framework. Combined with the recent technological improvements discussed below, the stage is increasingly set for addressing the need to build capacity for intersectional, trauma-informed care as highlighted in the PoP.

Technology and Innovation: Internal Drivers of Change

At the same time the board endorsed its anti-oppression framework, the hospital inaugurated three new portfolios, one of which was a new EKM portfolio under my leadership. An initial data and evaluation capacity assessment conducted at the beginning of my tenure revealed two important gaps in Open Doors structures and processes. First, that there was no reliable data-infrastructure in place to conduct population level analytics, which made it challenging to determine the diversity of Open Doors' reach or its patients' holistic health needs related to the SSDH.

Second, an initial data-collection exercise revealed that despite the diverse communities in need of services within its catchment, Open Doors' patient population remained a very specific sub-population unreflective of the needs of diverse communities within its catchment. These insights led to the organization swiftly implementing changes to support its journey towards more inclusive healthcare

practice. Specifically, one of the changes implemented included revising the hospital's formal intake process to integrate an intersectional, holistic health assessment (HHA) into its Electronic Health Record I, and enabling related analytics to track patient socio-demographics and SSDH-related holistic health needs for its patient population, in real time. In effect, these data related technologies have built organizational capacity to meaningfully evaluate the quality and outcomes of its efforts to reach diverse populations—a significant component of success when thinking of what success would look like after the PoP is addressed (discussed further in Chapter 3). Further to these external and internal drivers of the change the systemic factors framing the PoP are explored next.

Systemic Barriers: Socio-Cultural, Economic and Legal Factors Shaping Healthcare Practice

In addition to the more immediate drivers of change discussed above, the scenario detailed in Appendix C invites an exploration of broader systemic barriers associated with the problem: what systemic factors contribute to a situation in which a compassionate, experienced clinician cannot determine how to provide care to a patient who is need of compassion and care? This problem is not unique to Open Doors' care team. In fact, it is a problem that is shaped—and extends far beyond—Open Doors. The lack of health professional capacity to deliver intersectionally sensitive care emerges in the context of a broader culture of healthcare provider training and practice, including:

(i) the narrowly biomedical model of care-giving that pervades healthcare delivery,

(ii) the lack of health professionals' preparation for intersectional, trauma-informed and SSDH-based care during their pre-licensure training; and,

(iii) the lack of adequate post-licensure regulatory focus on critical reflexivity.

Sociocultural Factors: The Biomedical Perspective at the Heart of Healthcare Culture

At the heart of the problem is the narrowly biomedical model of caregiving that is pervasive across westernized healthcare settings including Canadian healthcare settings (Martimianakis et al. 2021; Paton, et al., 2020a). In this approach to caregiving, symptoms of illness are the primary focus of

health professionals' engagement with their patients (Wilson et al., 2019), and interpersonal and social power systems at play during patient-caregiver interactions are neither recognized nor addressed as a component of caregiving (Metzl & Hansen, 2014; Ramsden & Spoonley, 1994). The biomedical model came into prominence in post-enlightenment Parisian clinics (Davenport, 2000; Foucault, 1973) where socioeconomically disenfranchised patients who could not pay for treatment, (in order to receive care) had to submit to the public display and discussion of their symptoms to advance practitioners' understanding of health conditions (Foucault, 1973). In doing so, attending to patients' privacy, dignity, and understanding of how the conditions of their lives shaped their illness was erased from the model of caregiving (Davenport, 2000; Mizrahi, 1987). As it manifests today, the approach continues to reduce patients to constellations of symptoms (Davenport, 2000; Mizrahi, 1987; Rose, 2007).

In the absence of patients' own perspectives on their ability to address ill health, the model is rife for perpetuating deficit-narratives about them (Shields, 2017; 2022) similar to how the clinician in the practice scenario had used the conflicting rationales of a 'lack of clinical indication' and 'there's too much going on there' to simultaneously avoid engaging the patient in care while also presenting judgmental assumptions about the patient's life. Further to this, the narrow search for the 'clinical indication' also entirely erases "significant trauma histories" which have direct impact on the health of marginalized patients such as the patient in the scenario, but also patients' "responsiveness to health interventions" (Shimmin et al., 2017, p.3). Clinicians' primary focus on clinical indications as the de-facto rationale for care is the foundational systemic factor shaping the PoP.

More Sociocultural Factors: Lack of Health Professional Training Beyond the Biomedical Model

In the Canadian context, de Vries et al. (2020), Paton et al. (2020b), and Sukhera et al. (2020) note the dearth of training for health professionals as related to issues of intersecting social inequalities and how these shape health and well-being. The result is a serious gap in knowledge and skills related to intersectional trauma-informed care when health professionals enter practice. In turn, the lack of

capacity to provide critically reflexive care (Ng et al., 2019; Ramsden & Spoonley, 1994) alienates patients experiencing complex health inequities; people who have often also had previous disempowering and/or traumatic experiences at institutional settings. For Open Doors, it is a significant challenge that the health professionals it hires onto its interdisciplinary care team have not been consistently prepared during their individual discipline's training for the intersectional, trauma-informed caregiving necessary for engaging its emerging patient population.

Legal Factors: Lack of Effective Post-Licensure Regulation Related to Complex Health Inequity

The post-licensure mechanism through which health regulators compel their constituents to stay current in their practice is through Quality Assurance (QA) programs, which rely on self-assessment (Austin et al., 2017). Accurate self-assessment and metacognitive competence are noted in the literature as the cornerstones of safe practice (Huang et al., 2016). The process of critical self-reflexivity (Kinsella, 2010; Ng et al., 2019; Schon, 2017) is an important process recommended by regulators to support clinicians to reflect on the power dynamics that shape trust between provider and patient. These reflective processes should mitigate some of the ways in which clinical interactions perpetuate hegemonic relationships (Grzanka & Brian, 2019; Wilson et al., 2019).

In reality, regulatory QA programs have been demonstrated to be largely ineffective. A seminal review of QA programs demonstrated failures in how Canadian regulators implement QA (Austin et al., 2017). Systematic reviews (Colthart, 2009; Davis, 2006) and empirical studies across a range of health professions highlight that left unguided, clinicians are unable to accurately assess their own competence (Gadbury-Amyot, 2015; Kajander-Unkuri, 2018; Li, 2015; Takase, 2018). Importantly, Curtis et al. (2019), and Paton et al. (2020b) note that Canadian regulators have been slow to integrate a social justice lens into their standards of practice, meaning that even for practitioners of critical reflection, this practice is not necessarily being encouraged from a transformative or health-equity stance.

Combined, these systemic factors become barriers for health professionals to build their awareness of intersecting social inequalities that shape complex, systemic barriers to care access (Shimmin et al., 2017), for marginalized patients. These are all factors that perpetuate what TLT would frame as the systemic preservation of knowledge frameworks that perpetuate inequity (Shields, 2017; 2022). In addition to these systemic barriers, it is also important to consider the contextual factors that shape the problem at Open Doors.

Contextual Factors that Shape the Practices associated with the Problem

Two contextual factors shape the practices—or lack thereof—associated with this problem, specifically at Open Doors. First, its historical lack of an intersectional view on justice-centered care and second, its lack of learning mechanisms to engender meaningful, intersectional caregiving. Both are described below in further detail.

Historical Lack of Intersectional Perspective on Justice-Centered Care

Despite Open Doors' activist origins, its views of social justice have historically been framed narrowly through the perspective and needs of the specific subpopulation it originally served. Capper's (2019) work on social justice leadership and organizational identity development theory is particularly helpful for framing this contextual aspect of the PoP: even in organizational contexts where social justice is the focus, "some identities and differences are addressed more so than others" (Capper, 2019, p. 215). In Open Doors' case, this has inadvertently resulted in the organization historically not putting in structures or processes to ensure that its outreach, patient engagement and caregiving intentionally incorporates an intersectional, trauma-informed perspective on social justice. Capper (2019) asserts that social justice based organizations need to explicitly address "race, ethnicity, language, ability…social class, religion, and their intersections to eliminate inequities" (p. 216). In the healthcare context, Shimmin et al. (2017) insist that an intersectional, trauma-informed approach is necessary for developing health services that do not "reiterate existing health inequities" (p. 8). The lack of such an

intersectional perspective on patient engagement and care is one of the factors that frame the PoP, because this deficit obfuscates angles of vision on systems of power and how they intersect to create (i) varying degrees of inequity (Collins, 2019) and (ii) compounded trauma (Shimmin et al., 2017) for the diverse communities in Open Doors' catchment. Another aspect of Open Doors' structure that contributes to the PoP is the lack of routine, systematic and continual learning mechanisms which would engender intersectional, trauma-informed caregiving.

Lack of Learning Mechanisms to Engender Meaningful, Intersectional Caregiving

Even as Open Doors deepens its transformative ethos through an intersectional lens and intentionally broadens its reach to diverse communities it has historically not specialized in caring for, organizational practices for intersectional capacity building are only just being put into motion. To this end, TLT's key tenet of the need to create mechanisms for the deconstruction of knowledge frameworks that perpetuate inequity and for the re-construction of knowledge frameworks that honour resilience (Shields, 2017; 2022) is vital to explore. Capper's (2019) theory of social justice organizational identity development insists on the simultaneous development of individual leader; staff; patient; community and organizational identity orientation towards social justice. The current dearth of mechanisms to engender routine, systematic and continual learning related to intersectional, trauma-informed caregiving is another contextual factor that frames the PoP. Keeping these systemic and contextual factors in mind—and grounding our thinking in intersectional and transformative leadership theories (Capper, 2019; Shields, 2017; 2022), I now articulate three guiding questions emerging from the PoP. These questions will ground further exploration of the PoP and envision the change required to address it.

Guiding Questions Emerging from the Problem of Practice

Three guiding questions deepen the inquiry into the problem and how Open Doors can address it. First, what does it mean to provide intersectional trauma-informed care for diverse patients who

have previously experienced iatrogenesis (the unintentional perpetuation of physical and psychosocial harm by health professionals), faced systemic barriers to care, and suffered indignity and/or trauma at the hands of caregivers? The literature on transformative caregiving suggests that such care should presuppose that (i) safety of care should be judged by the people receiving care (Curtis, 2019; Ramsden & Spoonley, 1994), (ii) effective clinical practice views the downstream biological symptoms of disease as significantly shaped by the effects of upstream systems such as access to nutritious food, clean water and healthcare (Metzl & Hansen, 2014), (iii) caregivers be critically reflexive of intersecting interpersonal and structural power dynamics that perpetuate hegemonic power relations during the clinical interaction (Grzanka & Brian, 2019; Wilson et al., 2019), and (iv) caregiving be grounded in intersectional, trauma-informed approaches (de la Perrelle et al., 2022; Lanphier & Anani, 2022; Pride et al., 2021; Shimmin et al., 2017). Further to this, at the core of the transformative paradigmatic assumptions that wrap around this OIP is the need to center the voices and needs of those who are pushed to the margins of society. Transformative evaluation is guided by the ethical imperative to understand and respond to the needs of such individuals and communities (Mertens, 2008; 2017). Given the direct opportunities my role offers to engage patients through evaluative inquiry, there is rich opportunity to solicit input from a diverse range of incoming patients to share recommendations about what makes them feel welcome, included and engaged in care.

Second, what are promising approaches for building care-provider capacity to recognize and meaningfully address intersecting, systemic health-inequities during caregiving? Two principles of TLT (Shields, 2004; 2022), namely (i) the need to deconstruct/reconstruct knowledge frameworks that perpetuate inequity and injustice—and—(ii) a focus on emancipatory educational strategies (Shields, 2017, 2022) offer a theoretical framework for deepening the educational inquiry into the PoP. Within the overarching umbrella of TLT, a review of the existing health professions' education literature has surfaced promising frameworks for engendering socially conscious healthcare practice. These

frameworks—further discussed in the leadership vision for change—can be explored as a means to address the PoP.

Finally, what organizational practices will support the front-line patient-facing care team to participate in and sustain learning? First, patient-driven definitions and descriptions of meaningful care, along with front-line staff's input on the challenges they face, as well as promising educational approaches for building health professional capacity for socially conscious care need to be considered in the context of Open Doors' organizational ethos, leadership practices and the daily operations of the hospital. Further, it will be important to take care to sensitively engage the patient-facing team in the change effort, in order to ensure that the change effort is accepted as valid, credible, just and useful (Davidson, 2014). Guided by these questions, the final section of this chapter describes a leadership-focused vision for change, that is, the desired future state of the organization and how this change will unfold as the PoP is addressed.

Leadership Focused Vision for Change

Previous sections of this chapter described Open Doors' journey from community healthcare agency to public hospital, driven by the transformative desire to provide complex hospital-based care to its patients who were increasingly in need of such interventions. Open Doors' transformation brought about significant growth and culture change and prompted Open Doors to reflect critically on the limitations of its present state. There are a number of challenges it must navigate on the way to its desired state of becoming a more intersectionally sensitive, inclusive healthcare setting as visualized in Appendix E, and discussed in more detail below.

Present State

Until very recently, Open Doors' patient population has remained mostly a homogenous one, largely unreflective of the diverse communities within its catchment area who need its services. There are many explanations for this. First, it is a direct result of the hospital's history as a neighbourhood and

community-based agency that responded to emerging, often urgent needs without having the resources to think broadly about health inequities beyond the specific community it historically served. Second, the current patient population is one that became a community over Open Doors' thirty plus year history. Indeed, Open Doors is often referred to as 'home' by many longstanding patients; the result being that the agency's values and culture evolved—from the beginning—to center its original community's perspective and needs. As such, the care-team's expertise, confidence and compassionate 'way of doing things' have also inevitably been shaped—albeit somewhat myopically—around this particular community's needs.

As the hospital recognized these limitations in perspective, structure and process, it has begun to deepen its transformative ethos from an intersectional perspective. It has intentionally expanded its reach to diverse communities in its catchment area. Its patient population has begun to diversify rapidly, presenting emergent intersectional health needs that are challenging its care team. While the hospital has begun to accelerate its capacity towards inclusive care through the use of the holistic health assessment (HHA) tool and by beginning to gather routine patient input on what makes them feel safe, cared for and included, there is currently a lack of mechanisms to translate these quantitative and qualitative insights into learning for Open Doors' leadership and staff, including its care team.

Desired State

It is critical that the change effort focus on building the care team's capacity to bridge the biomedical model of care they are trained in with more critically reflexive approaches to caregiving by deepening their existing skills for stigma-free care from an intersectional, trauma-informed perspective. Ultimately, the type of change that is envisioned predominantly focuses on third order change, although there are fundamental elements of second order change that will be triggered in this process. Bartunek and Moch (1987) and Capano et al. (2019) define second-order change as change processes in which change is made not incrementally within established frameworks or ways of working but by changing

the frameworks themselves (transformational change); whereas third-order change efforts implement transformational change in a manner that invites those affected by the change to employ their own agency to participate in navigating transformational change (Bartunek & Moch, 1987). For Open Doors' care providers to begin providing meaningful intersectional trauma-informed care, it will be important to create a shared understanding of the range of systemic forces (racism, classism, patriarchy) that shape societal power relationships and shape even healthcare delivery, and build understanding about how to mitigate the inequitable impacts of these forces in care team members' own practice.

The literature on engendering socially conscious healthcare practice offers three promising frameworks and practices that can support this capacity building effort. These frameworks, namely critical reflexivity (Halman et al., 2017; Ng et al., 2019); structural competence (Brady & L'heureux, 2021; Butler et al., 2021; Metzl & Hansen, 2014; Waite & Hassouneh, 2021) and cultural safety (Browne et al. 2021; Curtis et al., 2019; Urbanoski et al., 2020; Wilson et al., 2022) are integrated in this Organizational Improvement Plan (OIP), to lay the conceptual groundwork for imagining necessary capacities for Open Doors' care team. Underlying all three frameworks is the notion that it is vital to facilitate care provider recognition of (i) inequitable power structures, (ii) consequent trauma for marginalized patients, and (iii) consequent impacts on healthcare access and outcomes. These principles lay the groundwork for deconstructing knowledge frameworks that perpetuate inequity (Shields, 2017; 2022) and for reconstructing knowledge frameworks that support emancipation (Shields, 2017; 2022).

Addressing the PoP will result in Open Doors' care team strengthening their knowledge about how societal power structures and their intersections shape individual heath and well-being, and will build skills for intersectional, trauma-informed care. This learning will translate to improved caregiving for the diverse patients coming through Open Doors at a rapid pace, especially those marginalized by the intersecting socio-economic impacts of colonialism, systemic racism, systemic poverty, the housing crisis, disease-related stigma, and the opioid-overdose crisis. While the change effort has no 'end-state',

the desired state is one in which Open Doors' patient population will—at any given time—adequately achieve positive health outcomes, including those facing complex health inequities.

In imagining the future, I harken back to Open Doors' beginnings; it was founded to provide dignified care to a marginalized community that had been cruelly excluded from mainstream healthcare settings (Open Doors, n.d.-a). In the context of current health disparities reflected within its own catchment, Open Doors has the opportunity to adapt and deepen its care approach to serve the diverse intersections of marginalized populations in need of care now. Getting to the desired state of an inclusive caregiving space involves urgent mitigation of the PoP. Addressing the PoP requires thoughtful navigation of leadership considerations for how the change will unfold.

Leadership Considerations and Priorities for Change

The vision for change encompasses a number of leadership considerations that enable and/or challenge the vision for change. The hospital's deepening outlook on intersectional care delivery, its newer capacities for population level analytics, and its collaborative culture of working are all strong enablers for the needed change—and should be leveraged as such. Within this context, two priorities for change are identified.

Continued Use of Data to Enable Practical Application of Intersectionality

In my role as the Director of EKM, it is possible to generate population level socio-demographics and SSDH-related patient data that will enable the hospital to keep a real-time pulse on who is coming through its doors; their holistic health needs; the extent to which care interventions are addressing health needs; and, how successfully they are keeping diverse patients engaged in care. Additionally, the use of external data sources, for example, cross-tabulated epidemiological and socio-demographic data for Open Doors' catchment area would identify communities requiring specific supports. Developing a nuanced, intersectional perspective necessarily requires deep knowledge of the intersecting phenomena as separate phenomenon, and the complexities of how they intersect (Collins, 2019; Hankivsky, 2008).

To this end, quantitative and qualitative data will identify specific intersections that offer practical opportunities for learning and improvement at Open Doors. Further, monitoring of the change effort; continuous improvement and course-correction will also be data-informed. Multiple data sources including patient, staff and stakeholder engagement feedback will help comprehend how well perceived, accepted and useful the change effort is as it is being implemented, per Chapter 3. To this end, an effective stakeholder engagement strategy will be a critical priority for the change effort.

Meaningful Stakeholder Engagement

At the heart of any transformative change is meaningful stakeholder engagement. It is important to consider who needs to be involved, at what stages of the change, and how, for the change effort to be considered valid, credible, just and useful (Davidson, 2014). Stemming from the transformative paradigmatic assumptions that shape this OIP, engaging Open Doors' patient population and input from the heterogenous communities within its catchment will need to be centered within the change effort. Second, Open Doors' staff, especially the care team will need to be meaningfully engaged in the change effort. Framing the change effort as a third order change process will be key since the change centers on building staff capacity for intersectional caregiving. Attending to staff's psychological safety during this process, demonstrating the need for change, inviting them into the change in ways that support them to engage dialectically with change, and is meaningful for their practice—will be critical. Finally, leadership buy-in will be key to ensure resources are dedicated to the change effort. Chapter 3 details the engagement strategy as part of the implementation plan.

Combined, these priorities will ensure that the change effort centers the voices of intersectionally marginalized patients, while supporting the care team to engage learning towards improved intersectional trauma-informed caregiving. In Chapter 2, I will describe the leadership and change approaches that will support bringing this vision to life, followed by a description of organizational readiness and proposed solutions to address the PoP.

Chapter Summary

Open Doors Hospital is a recently incorporated public hospital. Rooted in its history as a community-based health agency, the hospital has taken a transformative and justice-centered stance operationalized through its holistic SSDH-based model of care. The hospital's transformative stance challenges predominant Canadian neoliberal conceptualizations of health that center individuals and emphasize biological views of health over SSDH of health. At the same time, Open Doors has come to recognize limitations in its transformative outlook: its structures are inadvertently set-up to serve a homogenous population that does not adequately reflect the diverse communities within its catchment area who are marginalized from healthcare access vis-à-vis multiple, intersecting systemic barriers. The hospital must address its care team's limited capacity to provide intersectionally sensitive, trauma-informed care, to serve the communities in need of its services.

As the hospital's inaugural EKM Director, I am afforded strong influence to address this PoP. My leadership lens is underlined by transformative paradigmatic assumptions that align well with the hospital's mission. Further, my affinity with the guiding principles of intersectionality as critical social theory (Collins, 2019), grounded in my own lived experience of navigating intersectional barriers to healthcare access positions me well to lead a meaningful transformative and intersectional inquiry into the PoP. My professional practice and leadership role as an evaluator further situates me to facilitate organizational success as described by a range of stakeholders, including patients from diverse backgrounds, the hospital's care team and its leadership team. With promising practices for health professions' education, an equitable stakeholder engagement strategy and relevant sources of data to guide the change effort, I hope to implement this OIP to contribute towards moving Open Doors towards its desired state of becoming an intersectionally sensitive and inclusive healthcare setting.

Chapter 2: Planning and Development

Chapter 1 outlined the need to support Open Doors' care team to adapt their skills in providing stigma-free care to provide the intersectional, trauma-informed care needed to address the complex health needs of its increasingly diverse patient populations. To enable the envisioned third order change process in a valid, credible, useful, and just manner, there is need to: (i) use data to routinely identify specific sociodemographic and social and structural determinants of health (SSDH)informed intersections of high need, (ii) integrate promising practices for building health professionals' capacity for intersectional, trauma-informed care, and (iii) facilitate capacity building processes using stakeholder engagement strategies designed to increase the likelihood of generating transformative learning for the care team.

To these ends, this chapter will first discuss a blend of transformative leadership theory (TLT; Shields, 2004; 2017; 2022) and adaptive leadership theory (ALT; Heifetz, 1994; Heifetz et al., 2009; Heifetz & Laurie, 1997) that guides my leadership approach to change. Building on this leadership approach to change, the blend of critical appreciative inquiry (CAI; Boje, 2010; Grant & Humphries, 2006; Ridley-Duff & Duncan, 2015) and the dialogic change model (DCM; Kuenkel et al., 2021), that shape my framework for leading the change process is also discussed. Further, Open Doors' organizational readiness for change is assessed followed by a detailed discussion of three evidence-informed solutions to the address the Problem of Practice (PoP). A preferred solution is identified at the end of the chapter.

Leadership Approach to Change

The defining characteristic of the PoP is that it is deeply transformative. As such, my leadership approach to change is necessarily grounded in a leadership approach that honours transformative change: I ground my leadership approach primarily in TLT (Shields 2004; 2017; 2022) including recent applications of the theory in change contexts that share similarities with Open Doors (Gélinas-Proulx &

Shields, 2022; Kirk & Osiname, 2022; Shields & Hesbol, 2020). At a practical level the PoP also presents fundamentally adaptive challenges. Addressing the PoP will require me to support clinical staff—who do not directly report to me—to build capacity beyond technical, clinical skills. ALT (Heifetz, 1994; Heifetz et al., 2009) and its recent applications in healthcare contexts (Anderson et al., 2015; Corrazzini et al., 2015; Kuluski et al., 2020; Valeras & Cordes, 2020) resonates with the practical challenges underlying the PoP and aligns with Open Doors' interpretivist organizational characteristics, discussed in Chapter 1. My leadership approach to change is a blend of TLT and ALT, which are each briefly summarized next.

Transformative Leadership Theory

A review of the literature on social-justice oriented leadership elucidates that leadership theory has historically been dominated by structural functionalist and interpretivist assumptions, for example, Bolman and Deal's Four Frames, which are often inadequate for influencing socially just change (Capper, 2019; Shields & Hesbol, 2020). While numerous scholars address the need for social-justice oriented leadership (Bogotch, 2002; Capper, 2019; Dantley & Green, 2015; Furman, 2012; Khalifa et al., 2016; Shields, 2004; 2012; 2017; 2022; Theoharis, 2007; Zembylas, 2010), a recent systematic review of social-justice oriented leadership literature (Gümüş et al., 2021) contends that "notions of SJ [social justice] in general, and models of SJ leadership in particular, are politically loaded and remain elusive" (pg. 82). TLT is the most mature, and actionable social justice oriented leadership theory within the educational leadership discourse.

Developed over two decades, TLT is based in Burns' (1978) concept of leadership as a practice focused on questions of democracy and justice (Shields, 2004; 2012) and Freire's concept of conscientization, as "learning to perceive social, political, and economic contradictions, and to take action against the oppressive elements of reality" (Furman, 2012, p. 202). Informed by the body of social justice leadership literature that emerged prior to and in tandem to it, TLT guides leadership practice towards (i) the need to center and continually re-define justice as a leadership objective; (Dantley &

Green, 2015; Shields, 2004; 2022); (ii) the need to critically examine and dismantle structures that contribute to disparity (Furman, 2012; Khalifa et al., 2016); (iii) a relational and communal orientation to the work (Bogotch, 2002; Capper, 2019; Shields 2004; 2012), and (iv) acknowledging the affective nature of social justice leadership (Shields, 2022; Zembylas, 2010).

Further, TLT has recently been applied successfully in several contexts where there have been substantial socio-demographic changes similar to Open Doors (Gélinas-Proulx & Shields, 2022; Kirk & Osiname, 2022; Shields & Hesbol, 2020) offering practical guidance on the application of theory to practice. Eight "holistic and interactive" tenets (Shields, 2022, p.29) guide the practice of TLT. While all eight tenets require simultaneous attention, the application of the theory to practice is contextually driven (Gélinas-Proulx & Shields, 2022) and it is likely that some tenets are more applicable than others in a given context. In this sense, the three tenets of TLT that are most relevant to this Organizational Improvement Plan (OIP) are: (i) the mandate for deep equitable change, (ii) the need to dismantle knowledge frameworks that preserve injustice and reconstruct frameworks that support emancipation, and (iii) the need to balance critique and promise (Shields, 2022). Together with the principles of ALT, these tenets of TLT form my leadership approach to change. I will briefly describe ALT next, followed by a discussion of how both theories shape my leadership approach.

Adaptive Leadership Theory

While TLT necessarily orients my leadership approach towards social justice centered change, ALT (Heifetz, 1994; Heifetz et al., 2009; Heifetz & Laurie, 1997) and its recent applications in healthcare contexts (Anderson et al., 2015; Corrazzini et al., 2015; Kuluski et al., 2020; Valeras & Cordes, 2020) inform my approach. The fundamental premise of ALT is that people need to be mobilized to tackle challenging situations and thrive (Heifetz, et al., 2009). Central to ALT is the necessity to distinguish between adaptive challenges and technical challenges; adaptive challenges are complex problems without clear cut solutions (Corrazzini et al., 2015; Heifetz & Laurie, 1997) that can "only be addressed

through changes in people's priorities, beliefs, habits, and loyalties" (Heifetz et al., 2009, p. 4). Reflecting on Open Doors' care team's pride in and commitment to their work, and the type of third order change relevant for the PoP, it is clear that the envisioned change is one that would benefit from building on the past rather than "jettison it" (Heifetz, 2009, p.21).

To this end, Heifetz et al.'s (2009) articulation of four 'archetypes' that signal the need for an adaptive leadership approach is a helpful taxonomy for further defining the particular type of adaptive challenge presented in the PoP. More specifically, Archetype 2 (Gap Between Espoused Values and Behaviour) and Archetype 4 (Speaking the Unspeakable) (Heifetz et al., 2009) offer useful guidance for the leadership approach to change, as facilitating the envisioned change will require (i) bringing to attention the ways in which inequitable practices are currently perpetuated because of staff's limited capacity to provide intersectional, trauma-informed care and (ii) making space for transparent discussion about risky topics—for example, the potential for specific thresholds of intersectional complexity that may never be effectively addressed within the limitations of the hospital's expertise.

Considering the complexities that such adaptive archetypes present, ALT's clear process for leading is one of the most useful aspects of the theory. Unlike many leadership theories, ALT is prescriptive in nature, with Heifetz and Laurie (1997) offering six clear leadership principles—"get on the balcony," (p. 125), "identify the adaptive challenge" (p.126), "regulate distress" (p.127), "maintain disciplined attention" (p. 128), "give the work back to people" (p. 129) and "protect voices of leadership below" (p. 129)—to mobilize teams into collaborative problem definition and solving. In fact, ALT is a widely implemented leadership approach in healthcare (Corrazzini et al., 2015; Kuluski et al., 2020; Valeras & Cordes, 2020) due to its inclination for supporting the navigation of complex, adaptive challenges typical for healthcare settings.

In particular, Anderson et al.'s (2015) recent use of ALT to facilitate collaboration between patients suffering from chronic illness and their healthcare providers with the purpose of shifting care

provision out of “reliance on curative, provider-centered care” (p. 93) offers direct insights on how ALT can be utilized to inform the approach for this PoP. ALT’s relational focus on mobilizing others to engage in adaptive work without formal authority as demonstrated by both Anderson et al. (2020) in the context of researcher-clinician-patient collaboration, and by Corrazzini et al. (2015), in the context of “bringing together staff and residents, empowering them to collaboratively identify barriers to care and to generate novel solutions” (p. 625) provides guidance for me to support collaborative learning for a team that does not report to me. Further, Kuluski et al.’s (2020) translation of “adaptive leadership concepts to person-centered care”(p. 179) is a useful framework to invite the care team into a conversation about trauma-informed care. Returning to the scenario discussed in Chapter 1 (Appendix C), I will now demonstrate how the blend of these theories shape my leadership approach in context of the PoP.

Leadership Approach to Change and Implications for the PoP/OIP

In the practice scenario, we witnessed an exemplary clinician who made a considerable error in judgment. A patient with a history of disempowering experiences with healthcare providers was potentially re-traumatized by a care provider. Unfortunately, the result is what TLT (Shields, 2017; 2022) points to as knowledge frameworks that perpetuate inequity. Interestingly, none of the other care team members, nor the clinical leads, nor myself were able to address the situation in the moment—there was a combination of lack of knowledge, skill and moral courage that prevented anyone from engaging directly with the issue right away.

The scenario is rife with opportunities to be addressed using a blend of these two leadership approaches. First, TLT’s mandate for deep, equitable change and its call to moral courage (Shields, 2017; 2022) would compel the situation to be addressed from a trauma-informed and health-equity perspective. Second, the situation would require supporting the team to deconstruct the deficit narratives that are underneath the clinician’s overwhelmed reaction, and to support the team to

reconstruct new knowledge frameworks that are more equitable and emancipatory (Shields, 2017; 2022). To do this, ALT guides us to define the adaptive challenge at hand by creating space to address difficult topics, (Heifetz et al., 2009) and to reflect on the distance between what is said and what is acted upon (Heifetz et al., 2009). Further, the six principles of ALT (Heifetz & Laurie, 1997) listed previously outlines a clear process to support giving the care team agency for navigating towards a solution while holding themselves accountable for high-quality care, and while also ensuring that the team has a safe learning space to experiment, fail, learn and improve.

Stepping back from the scenario to look at the bigger picture, TLT's mandate for deep equitable change also requires keeping an objective pulse on changing socio-demographics and inequities within and beyond the walls of the organization. The team needs support to routinely 'get on the balcony' (Heifetz and Laurie, 1997) and re-start the adaptive process on two levels. First, to use data to understand the demographic changes within the patient population that will inform the type of learning needed to care for an increasingly diverse patient base. Second, to conduct routine environmental scanning, track emerging population health needs within the hospital's catchment area, identify communities in need, and proactively prepare to serve them.

Additionally, both theories emphasize the relational and communal aspects of learning—the change approach should integrate learning from (i) data and evidence, (ii) patients, (iii) community and (iv) each other. The learning also requires moral courage (Shields, 2012; 2022; Zembylas, 2010) and potentially having team members transform difficult truths about themselves and/or their colleagues. To mitigate inequity within the change process, the leadership approach will integrate measures for creating a psychologically safe learning environment, including giving agency to the care team to engage in third order change ideal for the PoP. To this end, next is a discussion about the change framework that will enable a third order change process.

Framework for Leading the Change Process

Various frameworks for leading change were considered throughout the articulation of the PoP and the leadership vision for change, reflecting on what needs to change and how the change should unfold (Deszca et al., 2020). Frameworks that emphasized top-down change management such as Lewin's three stage model (1951), rigidly linear models such as Kotter's eight steps (1996), and predominantly process-oriented models such as the change path model (Deszca et al., 2020) were excluded for three reasons. First, such models inherently emphasize problem solving from a deficit-perspective that can be demoralizing (Cooperrider, 2013) and potentially damaging for the Open Doors' care team, given their passion, belief and pride of providing compassionate care. Second, the relational and adaptive learning required from the change effort does not lend itself well to linear change. Finally, the top-down nature of these models fundamentally misaligns with the OIP's transformative stance given that such approaches have the potential to tokenize the most marginalized patients for whom this PoP is centered around, as well as exclude the perspectives of the care team whose capacity this OIP seeks to build. The CAI approach (Boje, 2010; Ridley-Duff & Duncan, 2015) and the DCM (Kuenkel et al., 2020) form the basis of my framework for leading change. Next, both frameworks and their alignment with the OIP are described.

Appreciative Inquiry

In order to discuss CAI, it is important to describe the origins of the approach in Appreciative Inquiry (AI), originally developed by Cooperrider and Srivastva (1987). AI's distinctiveness is in its strength-based orientation to change management (Carlsen & Dutton, 2011; Quinn, 2000). AI is operationalized through the 4-D-learning cycle: discover, dream, design and destiny (Cooperrider & Srivastva, 1987; Whitney & Trosten-Bloom, 2010). The 4-D cycle invites stakeholders into a collaborative process based on two fundamental principles. The principle of appreciating what is 'life-giving' to any work, which results in the discovery of a positive core (Grieten et al., 2018; Whitney & Trosten-Bloom,

2010) around which the appreciative change effort is generated. Grounded in this positive core, the principle of inquiry propels the change effort by envisioning what's next or possible (Cooperrider, 2013; Grieten et al., 2018).

AI's successful application in complex healthcare settings provides key insights for the OIP. Roberts and Machon (2015) demonstrate that the use of AI can support care-providers to conduct "predominantly positive, more person-centered, less judgmental and more appreciative" (p. 36) patient assessments. Sandars and Murdoch-Eaton (2017) have formulated principles for the practical application for AI in medical education. A recent study of AI at a Canadian hospital also demonstrated successful bridging of research evidence and practitioner insights to improve person-centered care for patients living with dementia (Hung et al., 2018). This study has critical insights for how a non-clinical research team used AI to influence clinical practice, similar to the change I will need to influence within this OIP. De la Perrelle et al.'s (2022) recent integration of AI approaches within a trauma-informed approach to improve the quality of aged and dementia care is particularly insightful for the OIP. The study used AI to empower aged patients to be partners in their own care-planning and demonstrates an approach for how AI can be operationalized within a trauma-informed lens. However, it is also important to note the critiques of AI for its over-emphasis on the positive; its potential to repress undesirable organizational experiences and cancelling their potential to be generative (Bushe, 2010) and its neglect of social systems that perpetuate hegemonic systems of power (Grant & Humphries, 2006; Grieten et al., 2018). These critiques have led to the emergence of critical AI (CAI), which is particularly resonant for a social justice centered leadership change process.

Critical Appreciative Inquiry

While the AI approach has significant strengths that ground change efforts in generative, adaptive and collaborative principles, AI does not take a critical methodological stance in stakeholder identification. AI does not necessitate the centering, or even inclusion of marginalized stakeholders in

the process. Building on Boje's (2010) focus on modes of inquiry that highlight structural inequities, and Grant's and Humphries' (2006) integration of critical theory into AI processes Ridley-Duff and Duncan (2015) extend their definition of appreciating by "creating spaces to share harrowing accounts" (p. 593) as a potential first step when inviting structurally marginalized populations to participate in AI processes. By enabling the open sharing of unpleasant or even difficult aspects of experience, Ridley-Duff and Duncan (2015), like Boje (2010), Bushe (2010), and Grant and Humphries (2006), shift the focus of the AI process to focus on the generative rather than the positive. A fundamental premise of CAI as defined by these authors is that experiences that are not positive still have the power to be generative (Ridley-Duff & Duncan, 2015). As demonstrated by Hung et al. (2018), "when aligned with critical social theory, appreciative inquiry supports an egalitarian form of open dialogue" (p. 2). Grieten et al. (2018) also suggest that AI processes should deliberately broaden the inquiry scope to "related multistakeholder approaches…where multiple stakeholders are thrown back on each other to define and cocreate new solutions for complex societal" (p. 12) problems. To this end, the DCM (Kuenkel et al., 2021) offers a process for multi-stakeholder collaboration that complements CAI to ensure the OIP stays on a transformative course.

The Dialogic Change Model

The DCM (Kuenkel et al., 2011; 2021) provides a process framework for transformative stakeholder engagement and collaborative change mobilization within the OIP. Although the DCM was designed for large scale, cross-sectoral, multi-stakeholder collaboration (Kuenkel et al., 2021), three characteristics make it especially relevant for the OIP. First, it will ensure that the process for multistakeholder engagement will be equitable, further shifting the CAI approach towards a critical orientation. Second, the DCM's ability to be applied at small and large scales, along with its focus on institutionalizing sustainable change makes it relevant for Open Doors' context: the scale of the initial change process will likely be small, in order to test broader acceptability and feasibility. However, it will

be important to ensure the solution is scalable and that learnings are sustained and expanded upon as relevant, which the DCM is poised to support. Finally, the DCM is also aligned with CAI both in terms of its focus on "overall system aliveness" (Kuenkel et al., 2021, p. 72) and how the DCM's four phase process can easily wrap-around the phases of a critically adapted 4-D learning cycle. Table 2 summarizes my framework for leading change, demonstrating alignment between the AI and DCM models discussed.

Table 2

Framework for Leading Change

<table>
<tr><th>Stages of the Framework for Leading the Change Process</th><th>Alignment with Dialogic Change Model Phases (Kuenkel et al., 2021)</th><th>Alignment with Critical Appreciative Inquiry Phases (Ridley-Duff & Duncan, 2015)</th></tr>
<tr><td>Stage 1:
Enhancing readiness for capacity building</td><td>1. Exploring and engaging
Raising the energy for collaborative change and preparing stakeholders for collaboration.</td><td rowspan="2">Generative Topic Choice
Appreciation as valuing the meanings that participants discover in their experiences. Appreciation as acts of resistance to disempowering experiences.

1.Discovery/ Critical Inquiry
Appreciation as respecting the value of constructive forms of inquiry that expand possibilities in each individual's experience.

2.Dream/ Appreciative Inquiry
Appreciation as valuing the 'critical acts' that create new narrative possibilities (the way aspirations are given expression as alternatives to the status quo)

3.Design/Imagination
Appreciation as valuing the power to act in a way that creates and embeds new narratives (by demonstrating that new system imperatives can supersede old ones)</td></tr>
<tr><td>Stage 2:
Co-creating the plan with stakeholders who will experience impacts of change</td><td>2. Building and formalizing
Consolidating the system of stakeholders into a collaboration ecosystem that can deliver.</td></tr>
<tr><td>Stage 3:
Getting it done and evaluating it</td><td>3. Implementing and Evaluating
Implementing planned activities, ensuring mutual learning and focusing on delivery of tangible results.</td><td rowspan="2">4. Destiny/Innovation
Appreciation as respecting the value of deconstructive forms of inquiry to understand how system imperatives colonize each individual's life world.</td></tr>
<tr><td>Stage 4:
Planning to scale & sustain impact</td><td>4. Sustaining and expanding impact
Bringing the collaboration ecosystem to the next level of impact and creating long-term structures for transformative change</td></tr>
</table>

As shown in Table 2, I adapt the DCM's four-step framework as the process component of my change framework whereas CAI's adapted 4-D process adds the inquiry-based elements and methodology of the envisioned change. In blending these approaches, a significant strength of this change framework is its deep alignment with the leadership approach for change, discussed below.

Alignment with the Leadership Approach to Change

The beginning of this Chapter outlined my leadership approach to change as based in TLT (Shields 2004; 2022) and ALT (Heifetz 1994; Heifetz et al., 2009). Given that the envisioned change seeks to support Open Doors' care team to deepen their expertise in providing compassionate care from an intersectional trauma-informed perspective, the leadership approach to change highlighted the need for the envisioned change to be adaptive, generative and justice-centered. The envisioned change is one that should center the needs of the most systemically marginalized patients as per TLT (Shields, 2004; 2022) and one that enables third order change (Bartunek & Moch, 1987) by inviting the team to reflect on their current practices, identify the adaptive challenges (Heifetz et al., 2009) in centering intersectionally marginalized patients' needs, and supports the team to thrive during such adaptive change (Heifetz et al., 2009) by inviting them to be co-creators of change.

To these ends, the change framework founded upon CAI processes (Ridley-Duff & Duncan, 2015) and the DCM (Kuenekel et al., 2021) is a strong fit, as the overall gestalt of this blend invites all parties on whom the change will have an impact to enter into critical dialogue with each other, through structured, generative and collaborative processes towards a co-designed future state. The CAI framework lends itself well to the critical, adaptive and generative spirit of the intended change process, whereas DCM provides a process that will ensure that the appreciative change effort is also grounded in equitable stakeholder engagement, transformative collaboration and a view towards sustainable, scalable change. Further, both CAI and DCM are change models that lend themselves strongly to

formalized inquiry, experimentation, and learning, which make these models intuitive to operationalize from the Evidence and Knowledge Mobilization (EKM) portfolio. Next, Open Doors' readiness to embark on such change is examined.

Organizational Change Readiness

The evaluation of the organization's readiness for building its care team's capacity for intersectional, trauma-informed care, triangulates between three change readiness assessment tools. The primary tool used is Deszca et al.'s (2020) "readiness for change" instrument (pp. 113—115), however the insights generated from this instrument are complemented using Deszca et al.'s (2020) "stakeholder's readiness to take action" tool (p. 218) and an adapted version of Kuenkel et al.'s (2021) DCM's "readiness checks" (pp. 102—110). These tools complement each other's strengths and weaknesses in assessing readiness for the change envisioned as related to the PoP. Each assessment and its results are discussed next in more detail.

Readiness for Change Tool (Deszca et al., 2020)

The greatest strength of Deszca et al.'s (2020) organizational readiness instrument is its straightforward assessment of internal readiness for change along six comprehensive organizational dimensions. Such a broad-based, holistic scan is particularly relevant for the envisioned change related to the PoP based on the literature on capacity building strategies for engendering socially conscious healthcare practice. Health professions scholars highlight the onus on healthcare settings such as Open Doors to promote on-the-job learning related to socially-just care practices in their role as employers of health professionals, and as institutions that are ultimately accountable to their patients (de Vries et al., 2020; Paton et al., 2020; Sukhera et al., 2020).

These scholars note that shifting towards a socially-just healthcare setting and promoting structurally competent and culturally safe practices within clinical care is enabled through broader institutional commitment to equity and social justice (Baima & Sude, 2020; Doubeni et al., 2020; Taira &

Hsieh, 2019). Additionally, Curtis et al. (2019) note that commitment to critique 'taken for granted' power structures is needed at the organizational leadership level, while Taira and Hsieh (2019) outline the role of integrating accountability measures and metrics that track and incentivize structural competence as measures of quality and success for individuals and institutions. In light of these insights from the literature, Deszca et al.'s (2020) readiness for change tool provides the opportunity for a holistic organizational assessment resulting in two types of insights for the change agent.

First, a quantitative assessment in the form of an overall score indicates the extent to which the organization is ready to embark upon the change as a whole; the authors suggest that an overall score of 10+ out of the range between -25 and +50 is necessary for change efforts to be successful. Second, and perhaps most useful for the actionable insights they provide, the assessment also enables the change agent to identify and qualitatively reflect on areas where the organization is less or more ready for change. Table 3 summarizes the overall scores for each dimension, ordered from strongest to weakest as applied to Open Doors.

Table 3

Results – Readiness for Change Assessment Tool (Deszca et al., 2020)

	Readiness Dimension ***(In order of strength for Open Doors)***	**Actual Score**	**Highest Possible Score**	**% Out of Highest Possible Score**
1.	Measures for Change and Accountability	**4**	**4**	**100%**
2.	Executive Support	**6**	**7**	**86%**
3.	Credible Leadership & Change Champions	**6**	**11**	**55%**
4.	Openness to Change	**12**	**22**	**55%**
5.	Previous Change Experiences	**0**	**4**	**0%**
6.	Rewards for Change	**0**	**2**	**0%**
	Total score	**28**	**50**	**56%**

As seen in Table 3 (and presented in much more detail in Appendix F), Open Doors' overall readiness score of 28/50 indicates it is ready to embark on the intended change. Organizational readiness is highest as related to (i) measures for change and accountability and (ii) executive support; whereas (iii) credible leadership and change champions as well as (iv) openness to change is of medium readiness. Finally, (v) experience with previous change experiences and (vi) rewards for change are

weakest, although neither are in a deficit score. Actionable insights as related to strengths and weaknesses from this assessment are briefly explored next.

Readiness Strengths: Actionable Insights

Open Doors' significant investment in integrating an EKM team over the last three years has produced a robust data-infrastructure at the hospital, along with vastly improved ability to generate meaningful insights from multiple, mixed methods data sources related to patient and staff socio-demographics; holistic health needs and outcomes; patient satisfaction; staff engagement; and safety/quality of care interventions. As discussed in Chapter 1, the improved capacity for data and knowledge-based decision-making is one of the drivers of the PoP. Moving forward, this strength related to data and knowledge-based change will be leveraged as a key component of the change process.

It is also evident that the intended change is one that has strong executive support. Given the need for broad organizational and leadership buy in for building healthcare capacity for socially conscious care (Baima & Sude, 2020; Doubeni et al., 2020; Taira & Hsieh, 2019) this is another strength to be leveraged in the change process. Further, given that the need for the change related to the PoP is recognized across front-line staff, management and senior leadership, there is potential to leverage senior leadership support for the change while using the change effort as a means for deepening the organization's collaborative, creative problem-solving culture to establish meaningful links between the layers of the hierarchy. This will have additional benefits for overall organizational culture and belonging. Further, leveraging the energy of the influx of diverse and energetic change leaders that the organization is attracting through its commitment to inclusion and justice-centered compassionate care, there is opportunity to transform the remnants of pandemic fatigue and cynicism.

Readiness Weaknesses: Actionable Insights

One area where there is opportunity for improvement is internal communications related to change management. Reflecting on previous experiences of major change in the organization, one of the

key areas for improvement is related to proactive, timely and meaningful communication of change: the why, the what and the how. Related to the need for communication, there is also the sense that wherever possible, staff and patients should be more meaningfully involved in creating the change, per third order change processes that improve staff investment in change (Bartunek & Moch, 1987). In-fact, the organization's recently introduced cross-portfolio collaboration model supports deepening collaborative, de-centralized change to the extent possible within a structural-functionalist hierarchy. Building on the intent of these broader organizational changes, there will need to be strong staff and community engagement throughout the change process. Given the need for stakeholder involvement in the change, Deszca et al.'s (2020) stakeholder readiness to take action tool and Kuenkel et al.'s (2021) readiness checks provide complementary readiness assessment tools specifically related to the necessary stakeholder engagement and dialogic processes of the envisioned change.

Stakeholder Readiness to Take Action (Deszca et al., 2020) and Readiness Checks (Kuenkel et al., 2021)

Whereas Deszca et al.'s (2020) readiness for change tool offers a comprehensive assessment across holistic organizational dimensions, it does not delve into the nuances of individual stakeholder groups' readiness. The envisioned change is necessarily grounded in transformative ethics (Mertens, 2008; 2017, Shields, 2004; 2022), centering the voices of current patients from multiple marginalized communities. These voices will need to be a key part of the change process. Further, building on the principles of ALT (Heifetz, 1994; Heifetz et al., 2009) and CAI (Ridley-Duff & Duncan, 2015; Grant & Humphries, 2006) engaging front-line staff in envisioning meaningful change will be paramount—this is ultimately the stakeholder group for whom the practical aspects of the change stands to be highest, and most meaningful. To this end, a preliminary stakeholder readiness assessment was conducted using the stakeholder readiness to take action tool (Deszca et al., 2020), as detailed in Appendix G. Based on this analysis, it is evident that the majority of stakeholders, internal and external are supportive of the change and ready to engage more deeply. Two further insights emerge from this analysis. First, one of

the key collaborators for this change—the clinical educator role—is vacant and about to be filled. Therefore, there is opportunity to contribute to the hiring process to ensure that the right values, mindset and skills required to support the envisioned change are assessed in potential candidates. Second, the care-team has been assessed as "aware" on the continuum of readiness to take action: the majority of this group is aware and supportive of the need to build capacity; but will need to be engaged for input, feedback and re-imagining more deeply once a proposed solution is clear.

Finally, while both the organizational readiness tool and stakeholder readiness tool outlined by Deszca et al. (2020) provide a strong foundation for assessing change readiness at the outset, neither tool seriously considers the iterative nature of the type of multi-stakeholder, collaborative change envisioned. To this end, Kuenkel et al.'s (2020) readiness checks (pp. 102—110), broken down for each phase of the intended change is a meaningful tool to plan and assess ongoing readiness for change throughout the phases of a change initiative. The Phase 1 readiness check was completed (Appendix H), given that the writing of this OIP is in the pre-change phase. Results from phase 1 assessment give clear insight about the actions needed to create a strong core group for the intended change. At the same time, the readiness checks for phases 2 through 4 will be highly useful as process monitoring and evaluation tools as the change is being implemented.

Summary of Key Insights Related to Readiness for Change

The triangulation of the three readiness assessments provided both a holistic and nuanced understanding of Open Doors' readiness to embark on strategies to build its care team's capacity to provide meaningful care to patients from diverse communities they are serving more frequently. Results from Deszca et al.'s (2020) readiness for change instrument suggests that Open Doors is ready to embark on this change while highlighting opportunities to lean into the strengths related to measurement and accountability for change and executive support, while paying close attention to proactive and clear communication about the change to ensure meaningful engagement. Deszca et al.'s

(2020) stakeholder readiness analysis also supports a more nuanced identification of an initial set of stakeholders and assessment of their readiness. Results from this assessment highlighted key stakeholders to engage while preparing for the change. Kuenkel et al.'s (2021) Phase 1 Readiness Check provides additional nuance about the specific actions that should be taken to prepare stakeholders for change in the early stages of the change, while their readiness checks for phase 2-4 will be integrated into the implementation and evaluation plan to ensure continuous monitoring and iterative evaluation of the readiness for each phase of the change, as it is implemented. Three potential solutions are now presented and compared to identify the preferred solution that will be implemented.

Solutions to Address the Problem of Practice

Open Doors' care team needs to be supported to bridge their expertise in compassionate, judgement-free care delivery with improved knowledge, skills, confidence and judgment related to complex, intersectional, trauma-informed caregiving for diverse and marginalized communities. To this end, the recent groundswell in socially conscious healthcare practice, education and scholarship provides nuanced insights into how these changes in caregiving should look. Appendix I tabulates the broad range of contexts that were included in the literature review informing these findings.

According to Halman et al. (2017), socially conscious care manifests as explicit articulation of health equity as an integral component of effective clinical practice. For Levine et al. (2021), Metzl and Hansen (2014), and Waite and Hassouneh (2021) such care also emerges as the need for health professionals to balance the immediate needs of their patients (symptom management) in the context of the broader SSDH influencing patients' ability to engage in care. Across the literature, promising practices emerge, as discussed in the next section. These practices are based in critical reflexivity (Ng et al., 2019; Paton et al., 2020); structural competence (Metzl & Hansen, 2014) and cultural safety (Curtis et al., 2019; Urbanoski et al., 2020).

Promising Practices for Intersectional, Trauma-Informed Caregiving

For Open Doors' care providers to deepen their approach for intersectional trauma-informed care, it is important to first create learning and shared understanding of the holistic range of systemic forces (racism, classism, patriarchy) that shape societal power relationships and shape healthcare systems, including within their own organization. Although an intersectional transformative stance requires investigation of how systemic forces intersect to shape complex health inequities, a necessary starting point for developing such a perspective is to develop knowledge and familiarity with how systemic forces perpetuate inequity as separate phenomena (Collins, 2019; Hankivsky, 2008). The structural competence framework, with its focus on preparing health professionals to engage with multiple stakeholders to promote patient health (Metzl & Hansen, 2014; Waite and Hassouneh, 2021) is one framework that can build such capacity. Second, there is need to support care providers to recognize and mitigate their own privileges and biases as shaped by these systems (Grzanka & Brian, 2019; Halman et al., 2017). The cultural safety framework, underlined by a shift in focus towards critically interrogating the culture of the clinical environment rather than the culture of the patient, the 'exotic other' (Urbanoski et al., 2020; Wilson et al., 2022) is another evidence-informed framework that can help build capacity.

In addition to these practices and frameworks, the literature also outlines clear strategies on how to build capacity for caregiving as described above, including a range of strategies for building institutional capacity to enable socially conscious caregiving. Combined with the insights discussed above as related to what needs to change in caregiving, the literature provides a wealth of evidence-informed strategies that could be utilized in solution design and implementation. In order to systematically explore a range of potential solutions, the comparative likelihood of their success, and the feasibility of their implementation, an evaluation-driven solution design approach is used to explore and assess three potential solutions related to the PoP.

Potential Solutions to Address the PoP

My professional practice as an evaluator is one of the practical frameworks shaping my overall leadership lens—my evaluative toolkit translates directly into my leadership toolkit. As such, five dimensions of an evaluation-driven design tool (Gargani & Donaldson, 2014) become the broader framework within which twenty eight evaluative criteria are organized (see Appendix J) to inform solution design. The criteria themselves are derived from the synthesis of the multiple literature reviews that form the scholarly foundations of the OIP, including the extant literature on (i) building health professions' capacity for socially conscious care; (ii) leadership approaches to change; (iii) frameworks for leading change and (iv) assessing organizational change readiness. The twenty eight criteria outlined in Appendix J were used as the parameters for solution design. Using this approach, three potential solutions to the PoP have been explored, namely:

(i) an externally designed online social justice professional development curriculum;

(ii) reflective interprofessional learning during clinical rounds; and

(iii) a transformative patient-centered design and learning hub.

While all three solutions are evidence-informed as per the approach described above, each solution highlights/emphasizes different insights gleaned from synthesis of literature. The potential solutions are described and assessed next.

Potential Solution One: Externally Designed Online Social Justice Curriculum

The first solution is to engage external expertise to develop an online, social justice and health-equity centered professional development program tailor-made for Open Doors. To these ends, the solution may involve engaging one or more external consultants who would bring expertise of (i) curriculum design, (ii) intersectional health complexity and/or (iii) digital learning design.

The curriculum would be informed and shaped by Open Doors' anti-racist/anti-oppression framework; its SSDH-based approach to care; and insights about patient socio-demographic and health needs as

generated through Open Doors' Holistic Health Assessment (HHA) tool. The consultative, generative and dialogic elements of the approach to change would be integrated into the front-end of curriculum design: the EKM team would facilitate appreciative interviewing with patients, staff and community members to inform the curriculum designers of contextual needs, strengths and areas for focused learning. The curriculum can be delivered using the online platform that already exists for delivering professional development education at Open Doors.

Strengths of Solution One. Across scholars that focused on social justice healthcare curriculum in the literature, there is strong agreement that transformative learning goals need to be grounded within a critical theoretical framework that orients learning activities to be constructed such that issues of power, privilege and systemic oppression are explicitly addressed throughout the learning process. Browne et al. (2020), Halman et al. (2017), Paton et al. (2020b), and Van Bewer et al. (2020) name Paulo Freire's critical pedagogical framework as an overarching framework to support curriculum development. For Halman et al. (2017), this manifests as a curricular goal of engendering critical consciousness, one that builds learner capacity to recognize "the ways in which learners…as members of a healthcare culture can contend with unexamined assumptions that foster oppression" (p. 13). Further, Doobay-Persaud et al. (2019), Sukhera et al. (2020), and Wilson et al. (2022) discuss transformative learning theory—implemented within a critical pedagogical framework—as a particularly promising approach for triggering the disruption of unconsciously held biases. This solution is an attractive one as it would be possible to engage transformative pedagogical expertise that does not currently exist within the hospital, which could expand our perspective of how to integrate transformative pedagogical nuance across the hospital's professional development activities.

Further to this, the literature also highlights the need to build a curriculum that covers a broad range of topics relevant to the health equity and SSDH (DeBonis et al., 2020; Hagle et al., 2017; Taira & Hsieh, 2020)—which could be feasibly addressed in multiple learning modules. Another advantage is

that the hospital's current professional development program is delivered primarily through digital learning modules, making it an easier solution to implement. A large proportion of front-line staff are shift workers, and this solution would also make it operationally feasible to implement the curriculum through asynchronous learning.

Opportunities to Address Within Solution One. While externally developed online modules have strong potential to build foundational knowledge related to a range of justice-centered healthcare topics, it may be difficult to build capacity for intersectional application through the use of individual learning modules. The knowledge of specific systems of power (colonial hierarchies in healthcare, patriarchal social codes in institutions) is a necessary precursor to intersectional competence (Collins, 2019; Metzl & Hansen, 2014); however, this solution does not intuitively enable practical application of knowledge to actual patient cases, hampering the ability to link learning to practice. Interprofessional learning—highlighted in the literature as an important strategy for engendering socially conscious care (Levine et al., 2021; Waite & Hassouneh, 2021)—is also hindered in this solution given that such learning is optimized through collaborative learning (Levine et al., 2021). This solution could also be costly as it may be necessary to engage multiple experts in order to cover the full range of topics required for a comprehensive intersectional health curriculum. Further, the integration of the learning into the existing digital professional development library runs the risk of it feeling like a 'checkbox' learning activity when it needs to feel like a higher stakes activity linked to patient safety (Urbanoski et al., 2020).

Potential Solution Two: Integrate Interprofessional Learning into Clinical Rounds

The second potential solution is to integrate routine reflective, interprofessional case and/or topic based learning into clinical rounds. Similar to solution one, reflective learning sessions would be informed by insights from the HHA tool, thereby integrating the review of local data into capacity building, as suggested by Doobay-Persaud et al. (2019), Dunleavy et al., (2022) and Levine et al. (2021). In-fact, because the HHA tool is currently used at weekly rounds to discuss patient cases from a holistic

lens, the care team will be familiar with the SSDH-based challenges that mitigate patients' ability to pursue their health goals.

Strengths of Solution Two. By building critical reflexivity as suggested by Ng et al. (2019) and Paton et al. (2020b) into the care team's existing discussion of patient cases, there is strong potential to encourage interprofessional and collaborative learning related to emergent patient cases. Further, by integrating routine reflective learning into an existing team process, there is opportunity to foster longitudinal learning for the care team, a factor highlighted in the literature as a means to (i) build a trusting learning environment (Sukhera et al., 2017); and (ii) to incrementally build knowledge and skill throughout health professionals' tenure (Butler et al., 2021; Doobay-Persaud et al., 2019; Doubeni et al., 2020; Halman et al., 2017; Urbanoski et al., 2020; Taira & Hsieh, 2019).

Further to this, this solution does not require additional resources nor incur additional costs. Interprofessional learning rounds would also be an avenue to emphasize institutional commitment to structural competence, another factor identified in the literature as a broader organizational strategy for engendering socially conscious care (Waite & Hassouneh, 2021; Wilson et al., 2022). Open Doors is one of the rare healthcare institutions where there is a leadership role dedicated to public policy and advocacy (PPA). Indeed, Open Doors' PPA lead has been experimenting with "Issues Rounds" once a month, where the impact of key public policy issues on Open Doors' patient population (the opioid overdose crisis; the housing crisis and income insecurity) are discussed to foster interprofessional knowledge sharing on the structural mechanisms that mitigate patient ability to pursue health. Dunleavy et al. (2022) and Ziegler et al. (2021) identify engagement in public advocacy as an effective mechanism through which health professionals can build their own capacity for integrating tacit knowledge of systems of oppression into providing effective and socially conscious care. Solution two could likely build on and adapt on the work of the PPA lead in bringing problem-based and reflective learning based on relevant intersectional health topics.

Opportunities to Address Within Solution Two. Integrating reflective learning into an existing practice mechanism would require careful thought and attention on how to delineate learning from practice: the literature is very clear that a component of fostering safe learning environments include creating clear boundaries between learning spaces and clinical practice (Blanchet-Garneau et al., 2021; Butler, et al., 2021). Additionally, the change agent's agency is limited in influencing how clinical rounds are organized. Finally—and perhaps most importantly—while the HHA tool ensures that patient health needs are viewed in the context of the SSDH impacting their ability to pursue health, the nature of clinical rounds is such that it is a dedicated space for health professionals to come together as colleagues to discuss clinical practice, making it difficult to integrate direct patient perspectives into these discussions. Furthermore, for this solution to be effective, there has to be a clinician who is deeply familiar with socially conscious caregiving and intersectional bioethics, who is willing and able to lead reflective case-based learning at rounds. Currently, Open Doors' care team does not include this skill set, although the incoming clinical educator role includes these competencies. The third solution mitigates for the limitations of this solution by proposing a dedicated learning space that is within the change agent's scope to implement.

Potential Solution Three: Transformative Patient-Centered Design and Learning Hub

The third proposed solution is to create a transformative patient-centered design and learning hub (the *Hub*) dedicated to building capacity for socially conscious caregiving. The *Hub* would be led by a member of the EKM team who would facilitate small working groups of patient representatives, care team members and community representatives to implement capacity building activities for prioritized intersectional health topics. The defining characteristic of this solution is that it would bring together dedicated individuals from the EKM team, care-team, patient advisory groups, representatives from community agencies, and subject matter experts, to explore specific intersections of health disparity. Similar to previous solutions, insights from the HHA tool, along with population level analytics for Open

Doors' catchment, and feedback from community partners would guide us towards specific intersections of socio-demographic and health needs to be explored. For example, recent insights from the HHA suggest that a high proportion of incoming patients experience mental health concerns exacerbated by income insecurity, precarious housing and systemic barriers to healthcare access (Open Doors, n.d.-a). At the same time, Open Doors has begun working with neighbouring Indigenous healthcare agencies to provide access to care for their community members who are not connected to primary or mental health care. An example of the type of intersectional topic that could be explored within the *Hub* could be based on questions of what it means to provide inclusive, trauma-informed, mental health services to Indigenous patients, including those experiencing income insecurity and homelessness, in a care-setting that has historically not served Indigenous populations.

Strengths of Solution Three. Bringing together members of the patient advisory group, community representatives, Indigenous health scholars, elders and members of the care team who are dedicated to exploring caregiving in the context of these intersections, and to collaboratively (re)imagine strategies for meaningful care would embody the essence of transformative care ethics. In creating the space for honouring multiple ontologies (Mertens, 2008), centering patient voice (Doobay-Persaud et al., 2019; Van Bewer et al., 2021), integrating knowledge of local communities (de Vries et al., 2020; Doubeni et al., 2020) and enabling interprofessional learning (Levine et al., 2021; Waite & Hassouneh, 2021) this solution would encapsulate all of the key practices highlighted in the literature for institutional capacity-building for socially conscious care.

The *Hub* solution would also mitigate the limitations of the other two solutions by creating a dedicated space for dialogue, collaborative and interprofessional learning and experimentation removed from daily clinical practice, a necessity for creating a safe environment for learning (Blanchet-Garneau et al., 2021; Butler, et al., 2021). The *Hub* space would also allow for care-team members and patient advisories to co-facilitate engagement sessions, fostering the type of collaborative learning that is

paramount to creating a culture of care (Sukhera et al., 2020) and, improvement and learning (Brady & L'heureux, 2021). Further, the format of the *Hub* builds on existing organizational practices for collaboration. The solution can also be scaled according to need; working groups can be as small or as large as the topic at hand requires and the specific topic under investigation can be explored by a group of willing individuals with the intention of broader knowledge sharing strategies to be communicated and implemented by members of the core group as the work unfolds. Finally, this solution is within the change-agent's scope of influence to implement and sustain over the long term.

Opportunities to Address Within Solution Three. At the same time, this solution would incur additional staff time and resources. Some costs would also be incurred in the form of honoraria for patient representatives and external subject matter experts. Given the strong buy-in from executive leadership and the enthusiasm from the care team to have dedicated learning space and time to address the complexities they are facing in caregiving, these are not insurmountable challenges.

Comparing Solutions to Identify Preferred Solution

Table 4 compares the summary of scores for each solution based on the evaluative criteria that was defined at the outset of solution finding (Appendix K provides detailed comparative scores).

Table 4

Comparative Scores for Proposed Solutions Using Evaluative Criteria

Program Design Dimension	Score		
	Solution 1	**Solution 2**	**Solution 3**
Impact Design: likelihood of intended impacts achieved. *(12 total points: 6 evidence-informed criteria @ 2 points each)*	5	8	10
Values Design: likelihood of stakeholder values being respected/ promoted. *(8 points: 4 evidence-informed criteria @ 2 points each)*	2	3	8
Process Design: likelihood of processes linking to outcomes by design. *(14 points: 7 evidence-informed criteria @ 2 points each)*	6	8	13
Sustainability Design: likelihood that the solution is feasible to sustain. *(10 points: 5 evidence-informed criteria @ 2 points each)*	8	5	5
Evaluation Design: likelihood that the solution can prove/improve impact. *(12 points: 6 evidence-informed criteria @ 2 points each)*	2	6	10
Total Scores (Out of 56 Points)	**23**	**30**	**50**

As evident in Table 4, scores for all three solutions are summarized across the five dimensions of Gargani and Donaldson's (2014) evaluation-driven program design tool that guided solution design. While solution 1 consistently scored lower across most dimensions, it scores slightly stronger in the sustainability dimension. As seen in the detailed criteria for this dimension in Appendix K, this is because solution 1 scores well in terms of feasibility for time required to engage stakeholders in the solution and ease of implementation. Solution 2 scores stronger across all other dimensions, however, solution 3 scores considerably stronger than the alternatives, across all five dimensions. Notably, this is the only solution that truly creates space for the type of third-order change that is envisioned in the overall vision for change discussed in previous sections, and therefore scores much higher in the values and process dimensions of the tool. As seen in Appendix K, it is the solution that is strongest on the criteria related to integrating and centering the voices of the most marginalized patients. Further, in the dimension of process design, solution 3 is designed to give key stakeholders collaborative agency in the types of change strategies they wish to implement in relation to the PoP, which deeply aligns with the process elements of ALT discussed earlier in the chapter. It is also within the change agent's agency to design, implement and sustain over the long term. As such, solution 3, the *Hub*, is the preferred solution, and the one that will be explored for implementation in this OIP.

Chapter Summary

To facilitate Open Doors' journey towards justice-centered care, it needs to address its care team's limited capacity to provide intersectional, trauma-informed care for its emergent, diverse patient population with complex, intersectional health needs. This capacity building effort will be led using a blend of TLT (Shields, 2017; 2022) and ALT (Heifetz, 1994; Heifetz et al., 2009). This will ensure that the OIP is based in transformative ethics and centered on the values of equity, diversity, inclusion and decolonization while also using a leadership process that supports adaptation and thriving. CAI (Boje,

2010; Ridley-Duff & Duncan, 2015) along with the dialogic change model (Kuenkel et al., 2021) will support this transformative adaptive approach to unfold in a generative and dialogic manner that centers social justice. Open Doors' readiness for such a change effort was assessed using three readiness assessments; the results of which conclude that the organization is ready to delve into this change, while highlighting specific areas to exercise extra care (stakeholder engagement and communications related to change management) while planning and implementing the change process.

Building on the vast range of scholarly work that has informed this OIP, an evaluation-driven approach was used to define evaluative criteria that can assess the success of the change effort. Using these criteria as parameters for solution design, three potential solutions were explored. These options were assessed and compared to identify solution three—the transformative patient-centered design and learning hub (the *Hub*)—as the preferred solution. This solution will be further unpacked into an integrated implementation, communication and evaluation plan in the Chapter 3.

Chapter 3: Implementation, Communication and Evaluation

Chapter 1 described Open Doors' desire to become an inclusive hospital that can more effectively serve diverse patients who (i) are systemically excluded from Canadian social and health care systems; (ii) have likely been subjected to iatrogenesis, discrimination and/or trauma at healthcare settings based on various, and often intersecting aspects of their identity and/or lived experiences; and (iii) stand to benefit from Open Doors' judgment-free, social and structural determinants of health (SSDH) based model of care. To achieve this desired state the hospital needs to increase its care team's limited capacity to provide intersectional, trauma-informed care to patients with a diverse range of identities and lived experiences. Accordingly, Chapter 2 proposes setting up a transformative, patient-centered design and learning hub (the *Hub*) as the preferred solution to address this Problem of Practice (PoP). This final chapter of the Organizational Improvement Plan (OIP) describes the implementation, communications, and monitoring and evaluation (M&E) processes needed to operationalize the *Hub.* While these three processes are presented as three distinct plans within this OIP, they are highly inter-related. While highly inter-related, the starting point for all three components is the implementation plan, which effectively guides the communications plan and the M&E plan. The implementation plan is next discussed in detail, articulating the role of all stakeholders in the activities needed to realize the vision for the *Hub.*

Change Implementation Plan

The implementation plan is predicated on the four stages of the change framework articulated in Chapter 2. The change framework encompasses the underlying principles of transformative leadership theory (TLT; Shields, 2022), adaptive leadership theory (ALT; Heifetz et al., 2009), critical appreciative inquiry (CAI; Ridley-Duff & Duncan, 2015) and the dialogic change model (DCM; Kuenkel et al., 2021), the combination of which strongly guides the centering of meaningful stakeholder engagement throughout all change processes. Meaningful stakeholder engagement is (i) the foundation

upon which the implementation plan is designed, and (ii) the shared element across the implementation, communication, and M&E plans in this OIP. As such, prior to detailing the other elements of the implementation plan, the stakeholder engagement strategy will be first discussed.

Stakeholder Engagement Strategy

A meaningful stakeholder engagement strategy ensures that the right people are involved at the right times, and in the right ways, to ensure that change efforts are accepted as valid, just, credible, and useful (Davidson, 2014). Initially identified under leadership considerations and priorities for change in Chapter 1, the key stakeholders central to the change efforts are listed and further described in Table 5.

Table 5

Description of Stakeholders Central to the Organizational Improvement Plan (OIP)

Stakeholder Type	Description
1. Open Doors' Emergent Patient Populations	Two broad patient categories that are important to the *Hub's* transformative goals: ▪ **Emerging patient demographics** that are beginning to access Open Doors' care *(patients whose health is increasingly compromised by income insecurity and/or unsafe/unstable housing, acute metal health concerns, and/or systemic exclusion from healthcare)* ▪ **Patient demographics not adequately represented** considering the populations living and working in the hospital's catchment area who could benefit from Open Doors' care (*trans-men and women, Indigenous patients)* As aligned with the theories of intersectionality that weave through the OIP, the population focus will be on the intersections of highest need as evident in the HHA intake data, patient experience interviews and staff input.
2. Open Doors' staff	All staff at Open Doors are important to the change effort, however the most important sub-group within this stakeholder group are the members of the patient-facing care team. This is the group whose capacity the Problem of Practice (PoP) is centered on addressing. Their input on specific areas of challenge, and strategies for addressing them will be key inputs for focusing the *Hub's* work.
3. Open Doors' Leadership	As the decision makers in charge of resourcing the change effort, Leadership members are a key stakeholder group that will guide the *Hub* to be aligned with the organization's mission and approach to care. They will guide the overall implementation process and enable success on multiple fronts.
4. Community Partners	Considering the patient categories described above, it is important to recognize there are community healthcare agencies within Open Doors' catchment that are highly experienced at serving many of the populations Open Doors seeks to serve. Leveraging their experience and expertise will be an important source of knowledge for the *Hub's* work.

As evident in Table 5, these are stakeholder perspectives that are necessary for the transformative, adaptive, third-order change process that has been envisioned. The success of the envisioned change process depends on bringing these key stakeholder perspectives into dialogue, to create a shared understanding of the adaptive challenges at hand, and to mobilize all stakeholders to

tackle these challenges and thrive (Heifetz et al., 2009.). The implementation plan is formulated to align with the principles of TLT (Shields, 2004; 2022) by first centering the voices of patients who have been systemically excluded from healthcare (Capper, 2019; Mertens, 2017). The *Hub's* work will engage patient representatives who can speak to the intersections among those with experiences of the highest needs.

Second, the care team will be engaged. This will need to be done sensitively because the change effort will require care team members to potentially critique their current practices, which will likely trigger some transformational/second order change elements (Bartunek & Moch, 1987; Capano et al., 2019) including the need to de-construct deficit narratives about marginalized patients, and re-construct narratives to engender more equitable practices (Shields, 2022). Because such significant culture change requires "changes in people's priorities, beliefs, habits, and loyalties" (Heifetz et al., 2009, p. 4), it may trigger deeply held resistance. Therefore, the change team must guide the change effort as an adaptive, third order change process (Bartunek & Moch, 1987). This will be achieved by engaging care team members as co-creators of change who deeply understand the need for, and have agency to build sustainable, intersectional, trauma-informed care practices to serve the most intersectionally marginalized patients.

Third, as the key decision-makers endorsing the *Hub's* work, Open Door's leadership is a key enabler in resourcing the overall change effort. Their buy-in is key throughout all stages of the implementation plan. Finally, engaging community partners who have experience serving the populations of interest, and who are willing to share their knowledge and practices will support the *Hub* to validate and expedite its transformative strategies. As such, community partners are an important group of stakeholders who will be integrated throughout the change process as needed and as feasible. Prior to discussing the key implementation activities and the role of each of these stakeholders in these

activities, determining the scope of the implementation plan is essential to think through the OIP's feasibility.

Scoping the Implementation Plan as Feasible for the OIP

It is important to recognize that building a hospital care team's capacity for intersectionally inclusive, trauma-informed care is an ambitious and long-term project that cannot be achieved overnight, in a comprehensive manner. Thus, feasibility in scope is a key consideration for the implementation activities outlined within the OIP. The nature of intersectionality is such that it requires knowledge and competence about systems of oppression as individual forces, as well as the multiplied effects created at their intersections (Collins, 2019). Moreover, the nuances of oppression vary greatly depending on precisely which systemic barriers to care are intersecting in any given patient's life.

Consider how a health professional might navigate such nuances: for example, for a physician who is a South Asian settler, gay, and a cis-gendered male, to sensitively engage with a trans-woman who is Indigenous, experiencing complex co-occurring impacts of tuberculosis and HIV, visibly exhibiting signs of anxiety, irritability and anger, and who is resistant towards the recommended course of medical treatment, will require fluency on the physician's part to mitigate a range of power dynamics that may or may not have direct bearing in this scenario. The primary power dynamic herein is the physician's positional power as a healthcare professional, considering the distinct ways in which iatrogenesis and institutionalized healthcare trauma manifests each for trans women (Sampath, 2022) and Indigenous peoples (Palmateer, 2020; Philpott, 2020). Another power dynamic to mitigate is the physicians' social privilege as a cis man interacting in a power relationship with a trans-woman. Yet another complex dynamic is the physician's own unique history of navigating the legacies of colonialism and systemic racism as they manifest for a South Asian settler, as distinct from the colonial impacts on Indigenous people, which may add a gnarly complexity to the scenario. How any of these intersecting power dynamics may or may not manifest for the individual patient in-front of him is a factor to navigate most

sensitively. In any case, the complex, intersecting power dynamics at play must be considered if the physician is to establish trust and provide effective care. For this, the physician needs intersectional competence to assess, recognize and mitigate potential symptoms/triggers of previous healthcare trauma, all the while attempting to address the root causes and effects of the patient's health conditions.

To make things even more complex, in another instance, this same care provider may have to exercise similar intersectional, trauma-informed competency and draw on an entirely different content-knowledge and critical-reflexivity when engaging with a heterosexual, cis-male, Latino patient with precarious immigration status, who speaks little English, is presenting both acute mental health and physical health concerns, and is beginning to use racist and homophobic slurs as he becomes increasingly dysregulated due to stress and anxiety. I compare these situations to demonstrate the complexity of navigating intersectional bioethics (Grzanka & Brian, 2019; Wilson et al., 2019) discussed in Chapter 1, and to acknowledge that building capacity for total intersectional fluency for a care team is an unrealistic goal for this OIP. Intersectional fluency must be built over time, as (i) intersectional competence along with critical reflexivity improves, and (ii) relationships between the care team and diverse communities are established, tended to, and deepened.

Having said this, the scope and value of this OIP is to pilot the *Hub* model as a capacity building approach for supporting practicing healthcare professionals to develop both intersectional competence and skills for critical reflexivity, while also creating the opportunity to develop relational approaches to caregiving. For the purposes of the OIP, this can be achieved by limiting the focus of the OIP's implementation on piloting one transformative learning project specific to an area of intersectional health need as per Open Doors' changing population. Thus, the implementation plan is designed for one cycle of implementation over a 1.5-year pilot project. Implementation activities are outlined next, as fits within the scope of this pilot project.

Overview of the Implementation Plan as aligned with the Framework for Leading Change

This section describes key aspects of the implementation plan, including priorities for each stage of the change framework, and the roles and responsibilities of key stakeholders at each stage. Intended outcomes for all key activities are also detailed, along with timelines for implementation. The stages of the CAI model (Ridley-Duff & Duncan, 2015) as well as the DCM (Kuenkel et al., 2021), are integrated into the four-stage change framework upon which implementation activities are built. Table 6 provides an overview of the implementation plan as aligned with the overall framework for leading the change presented in Chapter 2.

Table 6

Implementation Stages Aligned with Change Framework

Stage of the Framework for Leading Change outlined in Chapter 2		**Intended Outcomes for each Implementation Stage**
Stage 1: Enhancing Readiness for Intersectional Capacity Building	*Stage 1 integrates:* ***Dialogic Change Model (DCM) Phase 1***: Explore & Engage ***Critical Appreciative Inquiry (CAI) Step 1:*** Generative Topic Choice	**(4 months)** ***Months 1 to 4:*** The *Hub* is endorsed by *Open Doors'* decision-makers; the need for it is understood across the organization. Key stakeholders are engaged to review emerging intersectional health needs at Open Doors that could benefit from a transformative learning project. One emerging area of intersectional health need is prioritized for the *Hub's* pilot project. A small core innovation group consisting of patient and staff representatives has convened and are trained for broader engagement and implementation.
Stage 2: Co-create the Plan with Key Stakeholders	*Stage 2 integrates:* ***DCM Phase 2:*** Build and Formalize ***CAI Step 2-*** Discovery/Critical Inquiry ***CAI Step 3-***Dream ***CAI Step 4-*** Design	***(4 months)*** **Months 5 -8:** The core group has engaged broader stakeholders in CAI processes to create a deep understanding of "what is" currently in relation to the selected intersectional health topic, and activated the dream phase to understand unique stakeholder perspectives about what the new reality would look like when the challenges are successfully addressed. The core group has synthesized insights across stakeholder perspectives and designed a transformative learning and organizational capacity building plan for achieving this future. The core group has generated stakeholder buy in and finalized resource commitments to implement this plan, as needed.
Stage 3: Getting it done and Evaluating it	*Stage 3 integrates:* ***DCM Phase 3:*** Implement and Evaluate ***CAI Step 5-***Destiny/ Innovation	***(6 months)*** **Months 9-14:** The learning and organizational capacity building plan designed by the core group is fully implemented, engaging the care team in learning, and resulting in broader organizational practices that create an inclusive culture. At the end of this stage, early outcomes emerge, as related to the specific intersectional health topic being addressed. Insights from rapid feedback processes, monitoring and evaluation activities are routinely and transparently shared with all key stakeholders, and used to course-correct implementation efforts, as needed.
Stage 4: Planning to Scale and Sustain Impact	*Stage 4 integrates:* ***DCM Phase 4:*** Sustaining and expanding impact	***(4 months)*** **Months 15 -18:** A comprehensive external evaluation of the first cycle of implementation is completed to generate understanding of the extent to which the *Hub* was an effective solution to address the Problem, of Practice (PoP). Using evaluation findings, what worked well and what did not work is highlighted, providing recommendations for if and how the *Hub* should be continued, scaled and further developed to address a different intersectional health topic, under the leadership of a different core innovation group.

Appendix L provides a detailed implementation plan, which further specify key priorities in each stage of the above implementation process, identifies detailed tasks, stakeholders responsible for implementing tasks, intended outcomes for each task and timelines associated with each stage of implementation. The most salient aspects of the implementation plan are described below, highlighting its alignment with broader organizational strategy and the leadership approach to change discussed in Chapter 2.

Stage 1: Enhancing Readiness

During the first four months, stage 1 of the change process includes enhancing readiness for launching the *Hub* and raising the energy for collaboration with internal stakeholders as described in the DCM (Kuenkel et al., 2021). A review of multiple patient data-sources, and patient and staff feedback will help determine the specific intersectional health topic to be addressed as the *Hub*'s pilot project. As aligned with TLT (Shields, 2004; 2022), patient representatives who are willing to share their lived experiences of these intersections will be invited to become paid members of the core innovation group, which will center patient voice and experience in the change effort. Similarly, guided by the principles of ALT (Heifetz et al., 2009), members of the care team who wish to co-create meaningful solutions to the emergent intersectional challenges will also be invited to become part of the core innovation group.

By the end of this stage, the core innovation group will be meeting regularly and will have a shared understanding of the historical, contextual and experiential factors shaping the health challenges related to the topic. The core group will be familiarized with the range of evidence-informed frameworks and strategies for building care provider capacity for critically reflexive, structurally sensitive and culturally safe care, as discussed in Chapter 2. The group will also be trained in the CAI change model that forms a core component of the change framework, and be prepared to engage their peer

groups, using the CAI processes (Ridley-Duff & Duncan, 2015), to gather additional experiential perspectives on the emergent challenges and hopes related to the selected topic.

Stage 2: Co-create the Plan

Over the subsequent four months, stage 2 will extend the core group's work to the broader care team, patient population and community partners, as relevant. Using CAI processes typically used during the discovery step of the CAI model, the core group will engage these stakeholders to make critical inquiries about the current state of patient health and experience at the intersection being explored. Staff feedback on their experience, and the challenges they face in this context will be explored. The activities implemented as part of the 'discover' step will be key for articulating a baseline rubric to describe the current state of both patient and provider experience as related to the intersectional health topic being addressed. To build trust and safety for participants, enable frank discussions, and mitigate potential power imbalances as much as possible, the process of engagement will be designed so that members of the core innovation group will engage their peers one-on-one or in small groups (members of the core group who are care team members will engage members of the care team, whereas members of the core team who are patients will engage other patients). Once the discovery step is complete, the 'dream' step of the CAI process will be utilized to solicit each stakeholder's perspective about what the desired state looks like for staff capacity, and patient health and experience once emergent challenges are addressed. The insights gathered about what success looks like have potential to be framed as evaluative criteria against which success can be evaluated in stages 3 and 4.

The principles of TLT (Shields, 2004; 2022) and ALT (Heifetz et al., 2009) that inform the leadership approach to change become particularly relevant during the design step: synthesizing the insights gathered from the preceding CAI processes, the core group will center patient experience and needs, as they imagine and co-create the mechanisms required to engender adaptive, third-order change, that is, change co-created by those whose practices will most likely need to change as a result of

the change effort (Bartunek & Moch, 1987). During this stage, there will be opportunity to engage community partners who can validate and provide feedback on the group's plans based on their expertise in serving similar communities of patients. At the end of this stage, a clear learning and organizational capacity building plan will be shared with decision-makers, highlighting further resource commitments, including funding dedicated time for front-line staff to participate in longitudinal learning, reflection on and practice of intersectional, trauma-informed caregiving.

Stage 3: Getting It Done and Evaluating It

The next six months will see the implementation of activities planned by the core innovation group. Because the third order change envisioned in this plan necessitates the details of the change process to be co-created with key stakeholders, it is not possible to predict what the precise implementation activities for stage 3 will be at the time of writing the OIP. At this time, stages 1 and 2 of the change process have not yet been initiated. However, it is likely that capacity building activities for the care team will include a combination of didactic, experiential and problem-based learning activities, and which incorporate the evidence-informed capacity building frameworks and strategies for building care provider capacity for intersectional, trauma-informed care, as detailed in Chapter 2.

The front-line care team at Open Doors is a small team of fewer than 50 full time clinical and non-clinical staff and the purpose of approaching the implementation as a pilot is to keep the change effort tightly scoped to a specific intersectional health topic. Although it is anticipated that implementation of an initial cycle of capacity building activities will be completed over three to four months, six months have been allotted for this stage to allow for course corrections and emergent learning, as needed. This breathing room is helpful, also given that it will be important to pace learning activities and engender longitudinal reflection and learning. Enabling longitudinal learning is a promising practice identified by scholars who discuss curricular strategies for engendering socially conscious healthcare practice (Butler et al., 2021; Dunleavy et al., 2022; Halman et al., 2017). During this stage, the

role of continuous quality improvement (CQI) processes will be critical in ensuring implementation efforts are monitored and adjusted as needed.

Stage 4: Planning to Scale and Sustain Impact

Over the final four months of the pilot, the focus of the implementation plan shifts towards understanding and demonstrating the extent to which the *Hub* is an effective model for (i) enabling transformative, adaptive, third-order change and (ii) building care provider capacity for intersectional, trauma-informed care. An external evaluator aligned with the transformative values of the organization and fluent in transformative evaluation will be engaged to conduct a process and early outcomes evaluation of the pilot project. Results from this evaluation will be used to determine the processes for the *Hub's* continuation and scale-up as appropriate. The implementation plan's alignment with Open Doors' organizational structure and mission is discussed next.

Alignment with Organizational Structure and Mission

Using Capper's (2019) organizational epistemologies framework, Chapter 1 demonstrated Open Doors' deeply transformative journey in taking an explicit SSDH-centered stance in both its mission and strategic initiatives. The hospital embarked on this transformative journey while maintaining the historical aspects of a humanist/ interpretivist epistemology, and while simultaneously incorporating elements of a structural functionalist epistemology, including establishing vertical hierarchies that reflect the public healthcare system it is embedded in, increased standardization of procedures, and a greater focus on quantitative knowledge. These aspects of structural functionalist epistemology are important for Open Doors to maintain credibility within the broader healthcare system. The need to reconcile the opposing tensions between Open Doors' historically interpretivist outlook, the structural-functionalist elements of its systems' context, the transformative nature of its desired state—and the specific ontological and epistemological challenges these tensions create—is not lost on me. However, the seeming paradoxes of this context is precisely what invites the creative problem solving that is

presented within this OIP. Indeed, the change process responds to the ontological and epistemological challenges of Open Doors' organizational journey.

First, the implementation process heavily draws on evaluative, evidence and data-informed approaches. The use of both quantitative and qualitative data is a key driver of all aspects of the change plan, resonant with the evidence-informed needs of a structural-functionalist healthcare system. Second, the ultimate objective of the change effort is to build the hospital care team's capacity to provide more meaningful and equitable care to marginalized communities, which is strongly aligned with the hospital's transformative mission. Third, as discussed at the beginning of the chapter, the change process is fundamentally centered around stakeholder engagement. This draws on the blend of both TLT (Shields, 2017; 2022) and ALT (Heifetz, 1994; Heifetz et al., 2009) and resonates strongly with Open Doors' transformative intent and strong history of humanism. Despite such strong alignment, there are anticipated challenges and resistances.

A Key Challenge and Mitigation Strategies

While the establishment of the *Hub*, the envisioned collaborative process and even the capacity-building needs being addressed will likely be welcomed by the care team, the effects of the change will likely not be experienced until we begin to delve into the details of the chosen intersectional health topic. Because the care team is currently overwhelmed by the speed and volume of socio-demographic change in its patient population and its emergent intersectional health complexities, a dedicated learning and design hub established to support them to navigate this change is a desirable idea. However, as the hard work of reflecting on biases, prejudices and privileges leads the way to the work of needing to dismantle everyone's own part in holding up oppressive structures, there may be deeply held, deeply human resistances that surface in the form of what Kotter and Schlesinger (1989) identify as low tolerance for change, that is, individual's fear that they may not be able to adapt or develop the new skills required of the change.

Although this type of resistance is anticipated, the blend of TLT (Shields, 2017; 2022) and ALT (Heifetz, 1994; Heifetz et al., 2009offers important principles and strategies that can transform such resistance. First, TLT's core principle of the need to balance critique with promise, and its call for moral courage (Shields, 2004; 2022) are important affective strategies that may inspire shifting fear and despair towards experimentation, learning and hope. Similarly, ALT explicitly names (i) the regulation of distress; (ii) maintaining disciplined attention, and (iii) protecting leadership voices from below as necessary leader behaviours (Heifetz et al., 2009)—all of which would support compassionate management of uncertainty and fear of change. Additionally, the hope is that the third order change (Bartunek & Moch, 1987) envisioned within this OIP will mitigate low tolerance for change and empower staff and patients to co-create the change they want to see, together. Along with CQI processes, the communications plan will support navigating these challenges and the change implementation process more broadly, as discussed below.

Communications Plan

While organizational development scholars and change management leaders approach communications processes in vastly different ways, embodying different beliefs and espousing various processes from the linear (Kotter, 1996) to the poetic (brown, 2017), the importance of communications processes in preparing and mobilizing stakeholders for change cannot be understated (Saruhan, 2014; Simoes & Esposito, 2014). Many of the popular and more traditional communications approaches favour top-down, one-way communication strategies with the purpose of informing rather than engaging (Dawson, 2003), and almost always assumes that one way communication channels will effectively mitigate the human anxieties provoked during change (Dawson, 2003; DuFrene & Lehman, 2014). While these approaches all offer useful tools (stakeholder analysis tools, multi-mode communication channels), such approaches are fundamentally misaligned with the transformative, adaptive, critically appreciative and dialogic implementation processes described in this OIP.

Because the implementation plan is centered around enabling patient-centered, third-order change, the communications approach will need to critically consider the power dynamics at play between key stakeholders involved in the change process. It is important to recognize that the change agent, the Director of Evidence and Knowledge Mobilization (EKM), is a member of the hospital's senior leadership team, who is attempting to introduce a patient-centered learning and design *Hub* that has potential to trigger significant knowledge and practice shifts for members of the care team. As such, the communication plan will need to create awareness of the need for change in a manner that invites both patients and the care team into the change process as co-creators of change.

Second, given that the plan relies on bringing key stakeholders into dialogue with each other through CAI processes (Ridley-Duff & Duncan, 2015), communication strategies should make space for "conversations that allow for the reconstitution of alternative organizational realities within existing discursive frameworks" (McClellan, 2011, p. 477). In other words, the communications strategy must embody the spirit of true dialogue, which does not repress resistance to change but rather engages with resistance as a constructive element of navigating change (Simoes & Esposito, 2014). To this end, Kent's and Taylor's (2002) principles of dialogic communications, namely: avoiding superiority, proactive engagement of participants, empathetic orientation, embracing ambiguity and genuine commitment to engage in alternate interpretations are woven throughout the communications approach and plan. Within this broader dialogic approach, the communications plan has two overarching objectives, integrated across the stages of the change framework and implementation plan, as discussed below.

Communicating Change Throughout the Change Framework

The two overarching objectives of this communication plan are (i) meaningful stakeholder engagement to ensure that the change effort is accepted as valid, just, credible and useful (Davidson, 2014), and (ii) knowledge mobilization to engender organizational learning throughout the stages of the change framework. As detailed below, a variety of communications channels will be used in each stage,

based on (i) the nuances of how each key stakeholder will be engaged in the change process and (ii) the types of knowledge being generated, by whom, and for whom, at each stage of the implementation process. As pertains to the latter, Appendix M depicts a one page visual of the knowledge mobilization (KM) component of this communications plan, highlighting the role of KM during and after implementation.

Communication During Stage 1, Enhancing Readiness

The overarching implementation goals for stage 1 are to ensure that all key stakeholders have a shared understanding of the need for the *Hub,* and that a core innovation group is prepared for broader stakeholder engagement using CAI processes; the corresponding communication plan objectives and strategies are discussed below.

Communications Related to Stakeholder Engagement. Since the HHA tool began generating cross-sectional and longitudinal insights about Open Doors' changing patient population, the hospital's leadership team has been acutely aware of the growing complexity of intersectional health needs that its care team must respond to on an increasingly routine basis. The leadership team has already endorsed a patient-centered design hub to be implemented as part of the EKM portfolio. Given this context, the communications objective at this stage is centered on the care team, to communicate the need for change, and to invite them to participate in the work of the *Hub's* pilot project. Communicating to the care team needs to be navigated with sensitivity.

Although the PoP is based on both (i) evidence informed insights from the extant literature on factors that contribute to health professionals' limited intersectional competence, and (ii) my direct observations of the challenges care team members are experiencing in serving diverse patients with complex intersectional health needs—I am not a care provider. To impose my definition of this problem on the individuals who experience these challenges daily, will not engender good faith and may inspire defensive reactions. Instead, one communication strategy that Schein (2003) identifies as effective for

mitigating defensive routines is to make space for, and to engage the care team in a series of reflective conversations about the changing patient population and the impact for them as care providers. Weekly team meetings provide an avenue for such conversations.

Sharing insights from the HHA that shows the changing population at Open Doors' patients would be an expected activity at such meetings and can be used as the basis for inviting the care team to share the challenges they face, strategies they use, and supports they need for responding to complex patient needs. Such conversations would also likely add a level of nuance to the PoP that is currently missing, given that conducting primary research is out of scope for PoP definition in the EdD program. This is also likely to prepare the way for members of the care team to be invited to participate in the *Hub's* pilot project to co-create a transformative learning and capacity building plan related to emergent, complex intersectional health needs. The emphasis is on inviting team members into a pilot process of co-design, not imposing top-down changes in practice or process for the whole team.

Once all team members have had opportunities to engage in ideas related to the *Hub*, communications efforts can shift to becoming push-mechanisms and could become more formal. Town-hall announcements, leveraging the hospital's weekly newsletter to explain the pilot project to all staff, and inviting asynchronous discussions and commentary on the hospital's learning management system (LMS) can be leveraged to foster input from any staff members who wants to engage in the work of the *Hub.* At this stage, a formal patient recruitment effort will also be carried out. The patient-engagement lead will work with existing patient advisory groups to identify the best ways of recruiting patients to participate in the *Hub's* work.

Knowledge Mobilization Activities. During this stage of implementation, the focus of knowledge mobilization activities will be on translating insights from the HHA data so key stakeholders including care team members, non-clinical teams, leadership and existing patient advisory groups all have a shared understanding of emergent complex, intersectional health needs at Open Doors. It will be

important to communicate the data in such a way that the quantitative insights are translated into human narratives; insights from patient interviews and care team members' experiences can be leveraged to provide examples of the ways in which changing patient demographics affect the daily experiences of all who pass through Open Doors. Perhaps most importantly, it will be important to link the trends we see in the data and the patient/care team narratives with broader organizational strategic initiatives related to harm-reduction and dismantling systemic racism. Leveraging opportunities to reinforce these broader organizational initiatives to highlight trends from the data and vice versa, will support integrating the *Hub's* work into the organization's strategic and daily operations.

Communication During Stage 2, Co-Creating the Plan

Implementation objectives during stage 2 include core innovation group members using CAI approaches to engage willing patient and care team members to (i) deepen understanding of the current state as related to the intersectional health topic being addressed, and (ii) to encourage stakeholders to share their visions of what the new reality will look like if the challenges are successfully addressed. Synthesizing the insights generated across stakeholder perspectives, the core innovation group will design the plan for learning and broader organizational capacity building. Communication plan objectives and strategies corresponding to this stage are discussed below.

Communications Related to Stakeholder Engagement: The communications processes for engaging key stakeholders during this stage will be straightforward and direct. Core innovation group members will invite their peer groups to participate in 1-1 or small group activities and facilitate typical activities associated with CAI processes. It will be important that communications include a description of the types of processes that stakeholders are being invited to participate in, in order to generate curiosity and excitement about the process. All available communications channels: email, telephone, message boards, social media and direct conversations will be used, as appropriate, to invite participation.

Knowledge Mobilization Activities. The focus of knowledge mobilization activities during this phase will be to synthesize the rich, qualitative information gathered during CAI processes and share them with key stakeholders. The knowledge that is generated through these processes may well be priceless for any organization. If the process is done well, it will generate a wealth of rich narratives about the experiences of staff and the experiences of patients as it relates to complex intersectional health needs. Moreover, the process will generate insights on how challenges inherent in these experiences may be mitigated, from the perspectives of those experiencing the challenges. Knowledge products at this stage of the process will include research reports, executive summary reports and 'highlight reels' that can be shared with community partners, Open Doors' leadership team and all staff, as appropriate. Finally, the plan for learning and organizational capacity building developed by the core innovation group will be shared with leadership, community partners and all participants who contributed their insights to the process—this will be an opportunity to validate the plan across stakeholders prior to implementation.

Communications During Stage 3, Getting It Done and Evaluating It

The goal of this stage is to roll-out the learning and capacity building activities as co-designed by members of the core innovation group. Rapid feedback and continuous quality improvement (CQI) activities will be integrated throughout implementation activities. Communication plan objectives and strategies corresponding to this stage are discussed below.

Communications Related to Stakeholder Engagement. As learning activities and organizational capacity building strategies are implemented, Open Doors' leadership team, patients who contributed to the CAI processes during stage 2, and community partners who shared their insights during planning will all be kept abreast of progress. During this phase, fortnightly communications in the form of updates at team meetings, newsletters and/or email communications and face-to-face/real time virtual updates will help keep the momentum and energy throughout the change effort. During this stage, there may be

elements of significant second-order change occurring for members of the care team—as such, it will be important for communications to embody TLT's principles of balancing critique with promise (Shields, 2022), ALT's principles of regulating distress (if needed) and maintaining disciplined attention (Heifetz et al., 2009) and CAI principle of maintaining generative energy throughout change processes.

Knowledge Mobilization Activities. During this stage, the focus of knowledge mobilization activities will be to analyze, synthesize and generate insights across rapid feedback and CQI mechanisms. The core innovation group will be the key stakeholder for these insights, as they will be monitoring the process to identify emerging barriers and/or the need to course-correct. The leadership team will also be a key recipient of these insights reports as their support will be needed for potential course-corrections. Finally, learners' insights will be shared across teams, which will be a key component of sharing insights and learnings across the organization's teams.

Communications During Stage 4, Planning to Scale and Sustain Impact

The goal of stage 4 is to conduct evaluation of the *Hub's* pilot project to determine the value of this model as a transformative learning and capacity building model. Using evaluation findings, stakeholders will decide if and how the model should be continued and scaled up. Communication plan objectives and strategies corresponding to this stage are as follows.

Communications Related to Stakeholder Engagement. Communications will focus on sharing insights gained through the evaluation. The core innovation group and the leadership team will be primary recipients of this information; however, evaluation insights will need to be transparently shared across all who contributed to the *Hub's* work, using push communications channels. It will also be important to create space for reflection and dialogue on the process, to reflect on learning across stakeholders and to celebrate the joint effort by all stakeholders.

Knowledge Mobilization Activities. At this stage, the knowledge mobilization activities will necessarily focus on the recommendations from the evaluation, as it will guide potential future

implementation activities. The core group, along with the leadership team may formalize the model for implementation for the next project and invite a new core group to engage in the process of scaling up and preparing for additional learning topics. Having detailed the communications plan as it corresponds to the stages of the change framework and implementation plan, the next section focuses on the M&E plan, which will also be integrated throughout the implementation process.

Monitoring and Evaluation (M&E) Plan

Chapter 1 highlighted my professional experience as a credentialed evaluator as one of the factors shaping my leadership lens. It is one of my deeply held beliefs that evaluative thinking is a core leadership competency in any context. In thinking more specifically about the M&E plan for the *Hub,* it is important to recognize that evaluation is a transdiscipline, which like statistics or ethics, has "unique ways of approaching issues but is also used in other areas of inquiry (e.g., education, health and social work)" (Mertens & Wilson, 2018, p. 12). The purposes for which M&E is used varies from performance measurement to organizational learning. An almost innumerable menu exists of evaluation types (formative, summative, developmental), M&E models (results-based management, utilization focused, PDSA), and the applied research methodologies (experimental, quasi-experimental, qualitative, mixed-methods) used within M&E models. With this in mind, the use of M&E for the specific purposes of monitoring and evaluating the *Hub* is contextualized by first differentiating between and monitoring and evaluation.

Monitoring

Mertens and Wilson (2018) define monitoring as "observing and reviewing the progress of a program over a period of time to see if it is achieving its objectives" (p. 5). Monitoring supports programs to 'keep track' of progress, often based on established metrics and reported on at pre-determined points in time. A well-conceptualized monitoring plan should also support the use of data and insights to transparently engage stakeholders about the extent to which programs are working

(McDavid et al., 2018). In the context of the stakeholder centered approach to implementation as related to the *Hub*, this is an important component of the M&E plan.

Evaluation

Trochim (1998) defines evaluation as using "formal methodologies to provide useful empirical evidence about public entities (such as programs, products, performance) in decision-making contexts that are inherently political and involve multiple, often-conflicting stakeholders…" (p. 248). Additionally, evaluation scholars (Davidson, 2005; 2014, Scriven, 1967), emphasize the unique role of evaluation as a process of inquiry that attends to the concepts of merit and worth, meaning evaluation is a process that "culminates in conclusions about the state of affairs, value, merit, worth and significance" (Fournier, 2005, p. 139). Given that each stage of the implementation plan for the *Hub* iteratively builds on the success of the previous stage, a summative evaluation component—in addition to routine monitoring—is built into each stage of the implementation plan, as elucidated later in the detailed M&E Plan. Further to the distinctions between monitoring and evaluation, given the widely varied purposes and methodologies used for M&E, M&E plans need to be intentionally aligned with the values of the context. Although there is much overlap in M&E tools, not all approaches will be appropriate for all implementation efforts.

Alignment of the M&E Plan with Broader OIP context

As discussed previously, the organizational context in which the *Hub* will be implemented is one that is navigating aspects of multiple organizational epistemologies, but where the intent of the organization's broader journey is deeply transformative. As such, it is important to critically consider the alignment of the M&E plan with the transformative, adaptive goals of the change effort. Table 7 summarizes four evaluation paradigms as articulated by evaluation scholars Mertens and Wilsons (2018) and aligns them with Capper's (2019) articulation of organizational epistemologies.

Table 7

Aligning Evaluation Paradigms with Organizational Paradigms

Mertens' & Wilson's (2018) Summary of Major Evaluation Paradigms			Alignment with Capper's (2019) Epistemologies
Paradigm	**Primary Focus**	**Description**	
Post-positivist	Methods	Focuses primarily on quantitative designs and data; quantitative methods dominate	Structural Functionalist Epistemology
Constructivist	Values	Focuses primarily on identifying multiple values and perspectives primarily through qualitative methods;	Interpretivist Epistemology
Pragmatic	Use	Focuses primarily on data that are found to be useful for stakeholders; mixed methods	Either of the above, depending on how M&E is conceptualized
Transformative	Social Justice	Focuses primarily on viewpoints of marginalized groups and interrogating systemic power structures through mixed methods to further social justice and human rights.	Critically Oriented Epistemologies

This comparison helps us to reflect on paradigmatic assumptions as they influence M&E. Table 7 guides us to recognize the *Hub's* transformative, adaptive orientation should be evaluated using an M&E approach grounded in the transformative paradigm. The assumptions of this paradigm align with Open Doors' transformative desired state, and the M&E plan for the *Hub*, as outlined in Table 8.

Table 8

Alignment of Transformative Evaluation Paradigmatic Assumptions with M&E Plan

Transformative Paradigmatic Assumption (Mertens, 2008)	Alignment with the *Hub's* implementation processes including M&E
Axiology: primarily centers the voices of marginalized communities.	Similar to the implementation plan, the M&E plan will also center engagement with patient representatives and patient feedback throughout the plan.
Ontology: recognizes multiple versions of reality, as based in power relationships.	The adaptive components of the *Hub* require the inclusion of the care team's perspectives and input, as the stakeholder group for whose every day practice the effort will have great impact.
Epistemology: is based in relationship between evaluator and stakeholders.	The M&E plan will produce insights in relationship with key stakeholders to ensure the *Hub* is not perpetuating existing inequities or creating new ones.
Methodology: utilizes qualitative, quantitative and mixed methods, as needed.	This enables the centering of marginalized voices, while drawing on mixed evaluation methods to meet the needs of the structural functionalist, interpretivist and transformative components of the organizational context.

Framed within the assumptions detailed in Table 8 above, Table 9 further elucidates the M&E plan as aligned with the implementation plan. Note that the EKM team will be responsible for all data collection noted in Table 9.

Table 9

M&E Plan Aligned with Implementation Plan

Implementation Objectives by Stage	Key M&E Questions	Monitoring Indicators	Data Collection Methods
Stage 1: Enhancing Readiness ▪ The need for *Hub* is understood across the organization. ▪ One emerging area of intersectional health prioritized for pilot project. ▪ Core innovation group convened and trained for broader engagement and implementation.	1. To what extent do internal stakeholders understand and accept the need for the *Hub?* 2. What is the baseline measure of the target patient population's health outcomes and care experience? 3. How prepared are core group members for engagement?	▪ % of care team members volunteering to participate in core group ▪ # of patient and community reps willing to participate in core group ▪ % of leadership team members championing the Hub ▪ % of core group members expressing confidence with CAI tools/ readiness for broader engagement	▪ All staff survey. ▪ Focus groups with care team. ▪ HHA data and patient interviews. ▪ Leadership meeting minutes ▪ Minutes from reflective discussion with core-group after each meeting.
Stage 2: Co-create the Plan ▪ Stakeholders participate in CAI processes. ▪ Deep understanding of "what is." ▪ Stakeholders imagine what new reality looks like ▪ Learning and organizational capacity building plan developed. ▪ Finalized resource commitments	4. What is the extent of engagement in CAI processes of (i) the broader care team and (ii) broader patient base? 5. What is the quality of feedback received from these stakeholders? 6. To what extent is there a collaborative understanding of the current state and a clear vision for the future?	▪ % of care team members actively participating in and contributing to CAI processes ▪ % of target patient population participating in and contributing to CAI processes ▪ Clear, evaluative rubric for success developed—current and future state. ▪ Clear plan with resources committed	▪ Attendance records from CAI processes (care team and patients) ▪ Notes from CAI activities (appreciative interviewing; group brainstorming) ▪ Validation focus groups with care team and community partners
Stage 3: Getting It Done and Evaluating It ▪ Capacity building plan implemented. ▪ Care team engaged in learning activities related to topic. ▪ Ongoing reflection on learning and practice change ▪ Rapid feedback and CQI activities integrated throughout implementation *(see data-sources/methods)*	7. To what extent are learning activities creating a safe space? 8. To what extent are learning activities helping dismantle deficit narratives/ re-construct more equitable knowledge frameworks? 9. To what extent is patient experience beginning to reflect care team's newer capacities?	▪ # of learning activities deemed meaningful by care team ▪ % of care team reporting positive reflections on the learning process ▪ % of care team reporting negative reflections on the learning process ▪ % of patients reporting experiences aligned with the principles of intersectional, trauma-informed care.	▪ Pre-post learning surveys ▪ Monthly focus groups with care team members ▪ Ongoing patient experience interviews
Stage 4: Planning to Scale Impact ▪ External evaluation of pilot project ▪ Discern strengths and areas for improvement ▪ Recommendations for future	10. To what extent did the *Hub* build intersectional trauma-informed care capacity? 11. To what extent is the *Hub* an effective model for transformative learning?	*TBD (as per external evaluator's guidance)*	*TBD (as per external evaluator's guidance)*

Description of the M&E Approach and Tools

As detailed in Table 9 above, the M&E approach and tools are integrated into the stages of the implementation plan. Given the iterative nature of both the CAI and DCM models that inform the basis of the implementation plan, it is critical that M&E processes be integrated into each phase of the implementation, and tailored to understand the extent to which the objectives of each stage are met, prior to moving onto the next stage. As with any iterative process, M&E feedback loops are necessary to refine implementation processes as they unfold. To this end, key evaluation questions (KEQs) form the foundation for M&E at each stage and are linked to the implementation objectives of each stage, as discussed below.

Key Evaluation Questions (KEQs)

To summarize, the KEQs for stage 1 address baseline measures of the target population's care experience as well as stakeholders' perceptions of/ buy-in to the *Hub,* and the readiness of the core group for broader engagement. KEQs for stage 2 focus on capturing the extent to which broader stakeholder groups are engaging with the core group, and critical insights from their contributions to the CAI processes to inform the nuances of the current state as it relates to the intersectional health topic, as well as their envisioned future state. KEQS for stage 3 shift gears and become focused on continuous quality improvement, focusing on assessing (i) the extent to which the learning and capacity building plan is creating a safe and effective space for learning, (ii) the extent to which learning activities are having the desired outcomes, and (iii) the extent to which the target population's care experience is beginning to improve as per the principles of intersectional, trauma-informed care. Finally, stage 4 KEQs will focus on evaluating the *Hub* model's effectiveness overall as a transformative learning and capacity building model. Along with KEQs, high level indicators included in Table 9 give a sense of the types of data that will help answer these questions, and help identify the data collection methods needed, as described below.

M&E Data Collection Methods

Data collection tools in the M&E plan correspond to the KEQs and enable the mixed methods evaluation approach needed to generate insights as per the mixed epistemological needs of the organizational context. Table 10 categorizes and describes in more detail the data collection methods that were identified in Table 9, and which will be used to implement the M&E plan. Members of the EKM team will be responsible for all data collection and analysis, in collaboration with the core innovation group.

Table 10

Breakdown of M&E Data Collection Methods

	Quantitative Methods
Stakeholder	**Method/Implementation Stage/Description**
Patients	▪ **HHA Data:** HHA data will be a key source of data to a) determine emerging intersections of patient socio-demographic and health needs and b) to establish the baseline of health needs for the target population once an intersectional health topic is chosen. This data will be used in stage 1 to understand aforementioned baseline and in stage 3/4 to measure patient health outcomes against the baseline.
Staff	▪ **All Staff Survey:** During stage 1, an all staff survey will be used to understand staff acceptance of the *Hub* as an organizational pilot project. This survey will also be used to gather input on emergent intersections of high health needs, and the areas in which staff are most challenged in terms of these intersections. ▪ **Pre-post Surveys:** Throughout stage 3, as learning activities are implemented, pre-post surveys will be used as the main source of data for CQI activities. These surveys will help understand highest areas of need, areas where capacity is improving, and areas that need further attention.
	Qualitative Methods
Stakeholder	**Method/Implementation Stage/Description**
Patients	▪ **Care Experience Interviews:** These interviews are a routine part of Open Doors' patient engagement evaluation function. Insights from these interviews will be used in Stage 1, to describe current state of patient experience as related to the intersection of interest. As the project progresses, in stages 3/4, interviews with the target patient population will help us complement HHA data with rich qualitative insights using patients' descriptions of the extent to which they are receiving meaningful care. ▪ **Notes from Critical Appreciative Inquiry (CAI) processes:** During stage 2, notes from CAI exercises will be a source of qualitative information to develop an evaluative rubric/vision of success from the patient perspective.
Staff	▪ **Notes from CAI processes:** Same use as described for patients, above, except from care team's perspectives. ▪ **Validation focus groups:** At the end of stage 2, care team members will provide feedback on the core group's plan for implementation, highlighting potential areas for course-correction. ▪ **Monthly reflective focus groups:** During stage 3, along with pre-post surveys, this will be a key mechanism for feedback, course-correction, building on strengths, and co-creating change.
Community Partners Leadership	▪ **Validation focus groups:** At the end of stage 2, community partners may also be engaged to provide feedback on the validity of the learning plan, based on their expertise/ experience. ▪ **Minutes** from routine meetings, where progress updates on the *Hub* will be discussed.

As described in Table 10, quantitative and qualitative methods are further organized by stakeholder type, to build on the foundational premises of the transformative evaluation paradigm by (i) centering the voices of marginalized communities in evaluation work, while also (ii) attending to multiple ontologies (the perspectives of various stakeholders) within a relational epistemological approach (quantitative and qualitative insights generated with input from all stakeholders). As evident throughout the implementation, communications and M&E plans, aligning the activities of each of these plans to the unique role and needs of key stakeholders is critical given that the leadership approach to change is designed to ensure that a) the process of change would challenge existing systemic inequities for Open Doors' most diverse and marginalized patients, while b) ensuring that the change process is implemented as an adaptive, third order change process. Structuring the M&E plan as it has been described enables M&E processes to be interwoven throughout the stages of implementation to keep a live pulse on the progress of the *Hub* as it is being implemented for the first time, to ensure that implementation and communication efforts are yielding intended outcomes for all key stakeholders, and to enable course-correction and refinement of the implementation plan throughout the pilot period. Now that the stakeholder centered implementation, communications and M&E plans that will be used to operationalize the *Hub* have been described*,* what follows are the next steps and future considerations for the OIP.

Next Steps and Future Considerations

The articulation of the PoP on which this OIP is centered began soon after I had just started my tenure with a social justice centered hospital, and as the COVID-19 pandemic swung full-force into its second wave, revealing the stark health inequities faced by Black, Indigenous, racialized, socio-economically and/or otherwise marginalized individuals in our communities. While I was grateful for finding myself at a healthcare institution that prided itself on a transformative and socially progressive care model, I was also struck by the limitations in meaningfully caring for patients who faced multiple

and complex, intersectional barriers to care, including previous histories of iatrogenesis and intersectional healthcare trauma. The OIP is my attempt to shift evidence and knowledge mobilization as strategies for supporting front-line care providers to build capacity to serve the complex, intersectional health needs of the patients who are perhaps in most need of compassionate, SSDH-based care that Open Doors was positioned to provide.

Having said that, and as addressed earlier in the chapter, the notion of attempting to build total intersectional fluency at a hospital is not an achievable goal, certainly not within the auspices of this OIP. However, reflecting on the multiple literature reviews informing the OIP, one of the main challenges of providing intersectional, trauma-informed care is that care-providers are not trained to provide socially conscious care, let alone address the complexities of socially conscious care utilizing intersectional bioethics (Grzanka & Brian, 2019; Wilson et al. 2019). Thus, the OIP has been developed to test out the possibilities for developing capacity for intersectional competence, critical reflexivity and relational ways of caregiving, even as I acknowledge the impossibility of building every individual's capacity for content knowledge of all existing systems of oppression that impact our patients.

Hence, the iterative implementation plan has been designed to be evaluated step-by-step to learn as we progress. In the spirit of true stakeholder centered, dialogic and iterative change, it is important to acknowledge that what is proposed in this OIP as an academic exercise may need further refinement as the plan is socialized with stakeholders. This would not necessarily be a failure. In-fact, framing the implementation plan as a pilot is intentional, so that any learning that emerges as we move into implementation can be captured as insights about operationalizing an innovative process to address health care providers' ability to build intersectional competence. Regardless of what is learned in the process, the learnings/knowledge will become important contributions to the organization—and beyond—for how to approach this daunting, but necessary topic if healthcare aims to center the needs of the most marginalized individuals who have so many doors closed to them.

Chapter Summary

This final chapter of the OIP articulates the integrated implementation, communication, and M&E processes to operationalize the *Hub.* The implementation plan is the starting point for all three highly inter-related processes. All three plans focus on bringing all key stakeholders into dialogue and collaborative change, using quantitative and qualitative sources of information to guide co-created transformative, adaptive, second and third-order change. The implementation plan is organized based on the change framework articulated in Chapter 2, and creates a pathway for change, from generating stakeholder buy-in to the need for change to data-informed identification of an emergent, intersectional health topic of interest, to co-designing and implementing a pilot project for capacity building and organizational learning as related to this topic.

The communication plan is sensitive to the need for acknowledging and redressing power imbalances in the process of change—and is designed to create reflective and invitational opportunities for key stakeholders to enter into the change process as co-creators of change. A detailed knowledge mobilization plan outlines the various types of knowledge that will be generated throughout the implementation process, highlighting who will be responsible for generating knowledge, using what methods, for whom and for what purposes. Finally, the M&E plan is predicated on the paradigmatic assumptions of transformative evaluation, and is designed to generate insights both about process: the extent to which the *Hub* model is an effective one for engendering collaborative third order change, and about outcomes: the extent to which the pilot project built the care team's capacity for intersectional, trauma-informed care as related to the specific intersection at hand. The chapter concludes with reflection on the importance of framing any emergent learnings from the pilot as valuable. Given the dire need for building intersectional competence, there is great need to continue opening doors within healthcare institutions for those who most need but are often the most systemically excluded from healthcare institutions.

Epilogue

I end on a profoundly personal note. I began the EdD following a summer of battling a debilitating numbness and a terrifying, cold rage spurred by George Floyd's and Joyce Echaquan's murders. These events ignited a pain in me, intentionally buried far out of sight since leaving my childhood homeland; I felt as wild and dysregulated as a powerline that had snapped in half. A month after I started the EdD program, I also started working at Open Doors. The combination of these experiences has spurred nothing short of personal and professional transformations, that I am barely beginning to articulate. Here are two reflections on my continuing journey as person, a scholar, and as healthcare leader.

First, the need for intersectional healthcare competence is real. As I grapple with theory, literature and observations of justice-centered care, it is clear to me that social justice approaches that do not take an intersectional lens into problem definition runs the risk of perpetuating further harm for the most marginalized individuals in society, who find themselves at multiple, and often invisible, intersections of injustice. While this OIP presents one framework for engaging with this mercurial idea, I suspect a great deal of my future will be spent trying to address the need for intersectional competence. I hope to find more people doing this work—and that together, we will create a system where Joyce Echaquan's seven children can come to a hospital and receive the care they need, knowing they will be taken care of with compassion, respect, and the competence that any patient deserves.

Second, I am deeply humbled by the human impulses I have witnessed get triggered during transformative change. I cannot believe that radical change can occur in a manner that is healing, in the absence of compassion and meaningful relationships. For these reasons, I believe sustainable, healing change can occur only when what needs to change is invited into the human relationships surrounding change, in all its chaos and messiness. Carl Jung's words resonate deeply: "learn your theories as well as you can but put them aside when you touch the miracle of the living soul" (Jung, 1928, p. 361).

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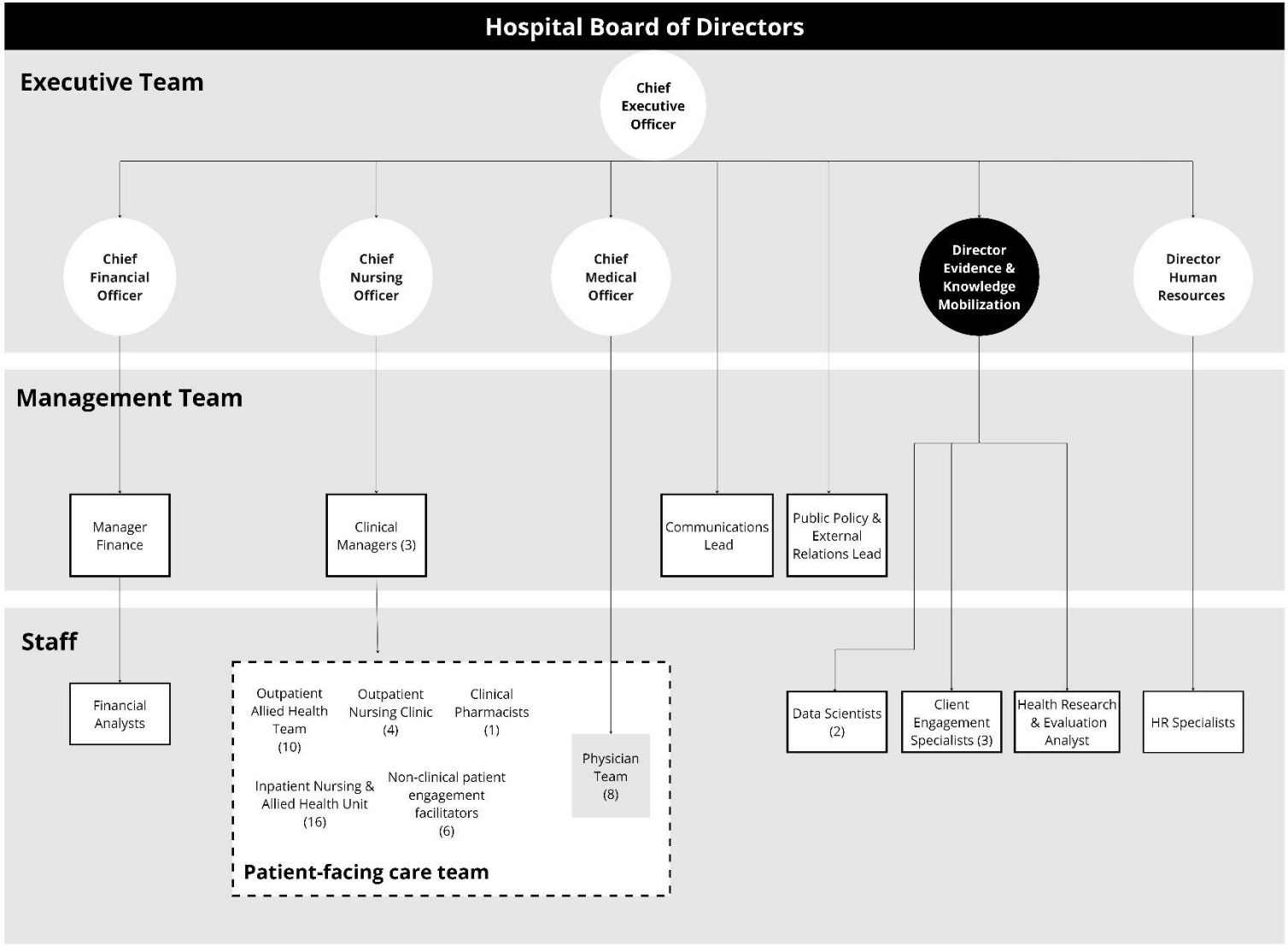
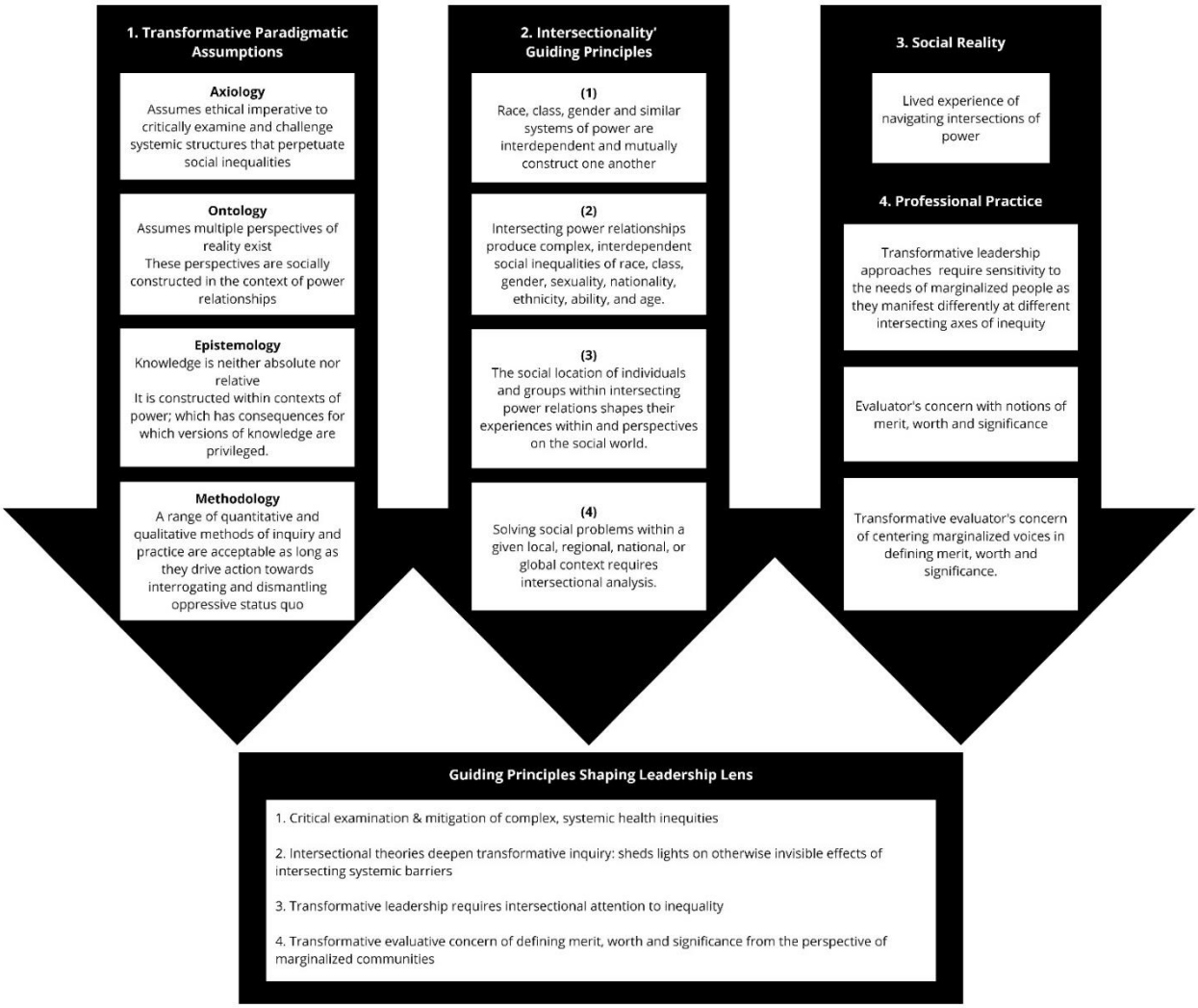
Appendix A – Abbreviated Organizational Chart

The black circle indicates my position. Roles that are not directly relevant to the Organizational Improvement Plan (OIP) have not been included.



Appendix B – Theoretical and Experiential Frameworks Shaping Leadership Lens



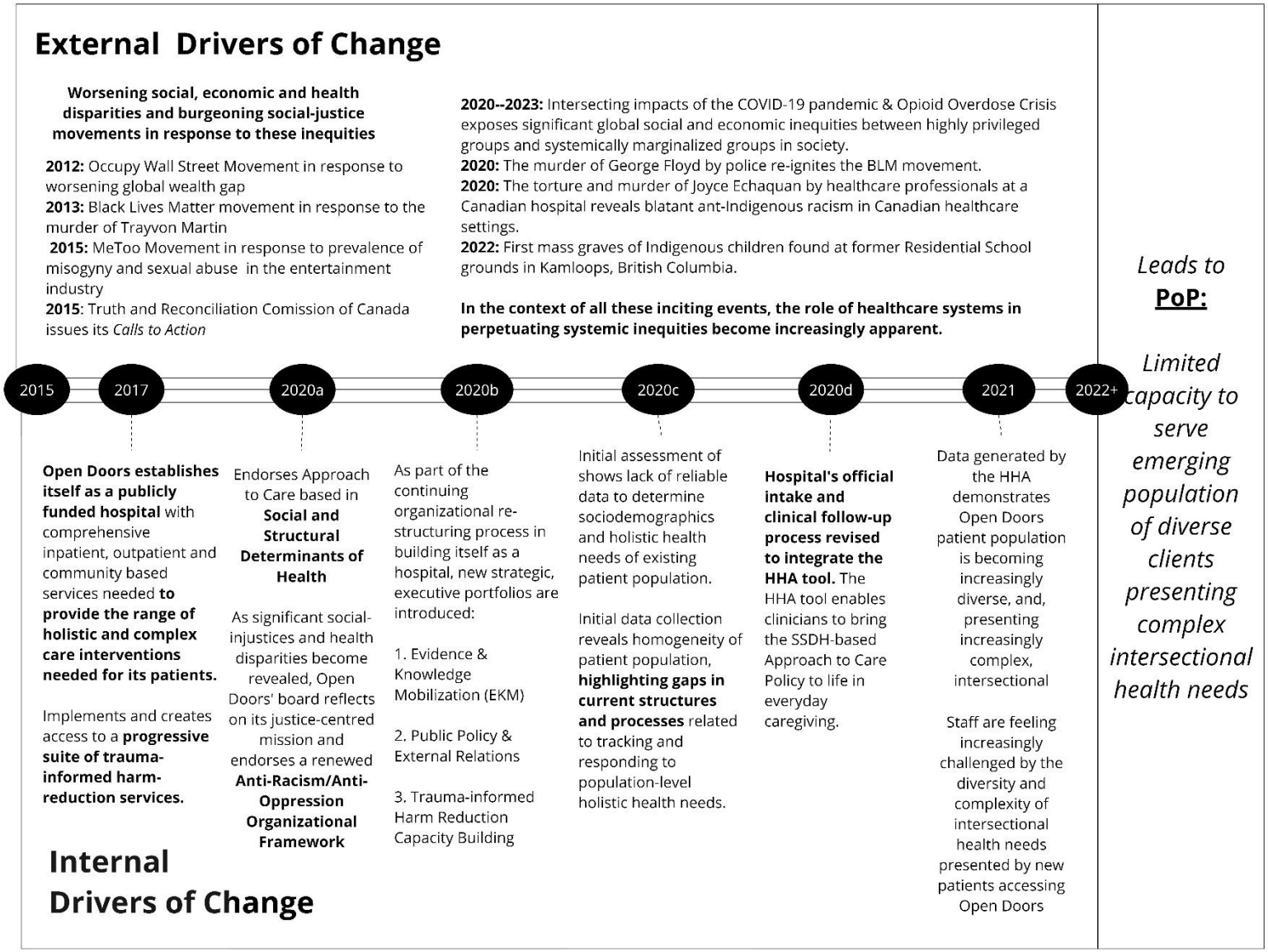
Note: The summary of transformative assumptions are synthesized across the work of Capper (2019), Kivunja and Kuyini (2017), Mack (2010) and Mertens (2008; 2017). The guiding principles of intersectionality are summarized from Collins (2019).

Appendix C – Practice Scenario

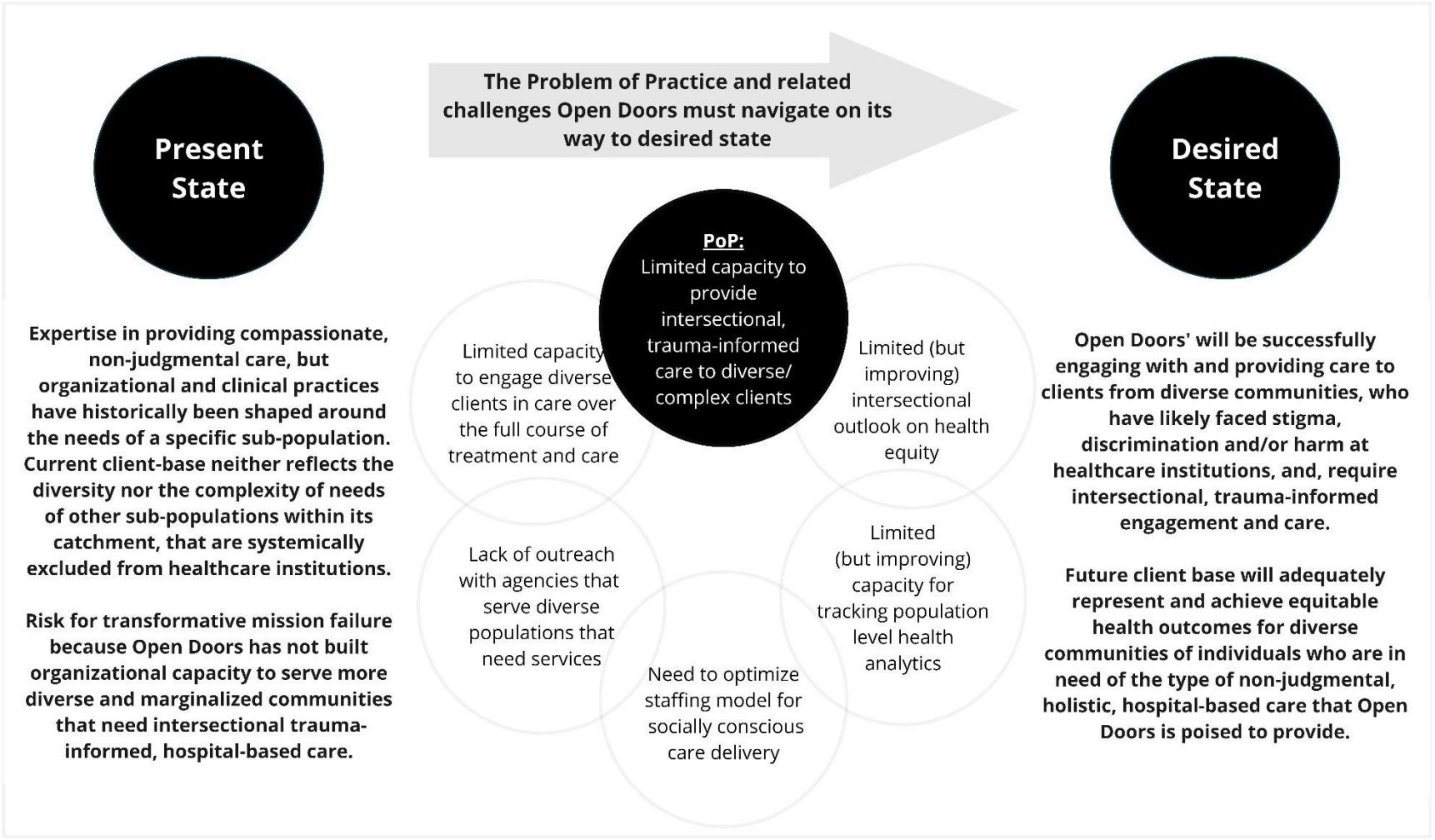
I regularly attended clinical rounds where care team members support each other in care planning, using the team's collective insights on patient needs. On this day, at the height of the COVID-19 pandemic, members of the care team were visibly exhausted. The Manager brought up the case of Kye (name changed), a newly registered patient who was living with debilitating anxiety—exacerbated by substance use—after losing their apartment nine months prior. Unable to find safety in the shelter system, they had begun to engage in sex-work in exchange for a place to stay indoors at night. Not feeling safe to fall asleep, they used substances to keep alert through the night. Kye usually kept their sex-work and substance use hidden from health professionals for fear of being criminalized, but Open Doors' intake workers had established a trusting relationship with them and had referred them to therapeutic services (fictionalized), knowing that mental health services had a long wait time.

After completing the therapeutic services intake assessment, an experienced clinician who was known for their exemplary compassion and patient advocacy skills, had discharged Kye from their care. When probed, they first stated there was no clinical indication to engage the patient. This was an uncharacteristic response from the clinician, who often went out of their way to ensure patients received compassionate care. Surprised, the intake worker reiterated their rationale that it was important to engage Kye in therapeutic services to build trust and keep them engaged until mental health services would become available. Agitated, the clinician blurted "there's a lot going on there, Kye was rude and impossible to deal with, and who knows where they've been before coming in for treatment? I informed them that I just don't know how to help them." Many of us in the room empathized with the clinician's reactive response, but we also knew that an egregious error in judgment had been made, putting a high-risk patient at potential for further harm. There were many other options for engaging Kye in care without rejecting them in the way the clinician had, further damaging Kye's trust in their care providers.

Appendix D – Political and Technological Factors as Drivers of Change



Appendix E – Navigating Towards Desired State



Appendix F – Organizational Readiness Assessment

The following organizational readiness assessment was conducted using Deszca et al.'s (2020) "Rate The Organization's Readiness for Change" Tool (p. 113—115).

Readiness dimension indicator	1. Previous Change Experiences Actual Score *(Possible Score)*	Qualitative notes/ rationale for score
1. Positive experiences with previous change	**+1** ***(0 to +2)***	Open Doors underwent major change in size, governance, structure and policy orientation over 6-7 years. Much of this change resulted in the organization moving forward in a socially progressive direction, the spirit of which is appreciated by the majority of staff and stakeholders.
2. Recent failure experiences with change	**-1** ***(0 to -2)***	While the direction is generally appreciated, the communication around much of the why the change was being implemented was not proactively explored.
3. Mood of the organization – upbeat and positive	**+1** ***(0 to +2)***	The most recent staff engagement assessment (2022) shows vastly improved engagement compared to the previous assessment (2020).The organization's commitment to its values and unique strategic direction has also attracted new talent which has energized the hospital.
4. Mood of the organization – cynical and negative	**-1** ***(0 to -3)***	The COVID-19 pandemic and the impacts of the opioid overdose crisis have been exhausting for staff. As the organization implemented major changes, there has also been significant staff turnover.
5. Is the organization resting on its laurels	**0** ***(0 to -3)***	The organization is in the process of major transformative change and innovation.
		Previous Change Experiences Subtotal **0/4 (0)**
Readiness dimension indicator	**2. Executive Support** **Score**	**Qualitative notes/ rationale for score**
6. Senior managers directly involved in sponsoring the change	+2 (0 to +2)	The board is enthusiastic about the envisioned change; the change is directly sponsored by the CEO. The senior and management teams are deeply invested.
7. Clear picture of the future	+2 (0 to +3)	The view towards data and evaluation-informed learning across the organization is very clear. The application of such decision-making and learning specifically towards building the care-team's capacity is also becoming increasingly clear. This Organizational Improvement Plan (OIP) will be a key input into driving even better clarity of the vision.
8. Executive success dependent on the change occurring	+2 (0 to +2)	The envisioned change is a key intervention to support building the organization's capacity for socially-just, inclusive engagement and care. Implementing and demonstrating the value of the strategic direction is critical for the executive team.
9. Are some senior managers likely to demonstrate a lack of support	0 (0 to -3)	The executive team is strongly supportive and actively removes barriers to the change effort.
		Executive Support Subtotal **+6/7 (86%)**

Table continued on next page…

Readiness dimension indicator	Actual Score *(Possible Score)*	Qualitative notes/ rationale for score
3. Credible Leadership and Change Champions		
10. Are senior leaders in the organization trusted?	+1 (0 to +3)	Trust is improving after a period of mistrust related to lack of access to and understanding of why significant changes were being made, as discussed above.
11. Are senior leaders able to credibly show others how to achieve their collective goals?	0 (0 to +1)	Senior leaders have historically been strong at setting visionary direction, but less strong on showing others how to achieve goals.
12. Is organization able to attract and retain capable and respected change champions?	+1 (0 to +2)	Over the last two years, there was an influx of diverse, equity-focused change leaders into the organization.
13. Are middle managers able to effectively link senior managers with the rest of the org?	0 (0 to +1)	One area for improvement is to build middle managers capacity to better link senior leaders with front-line staff.
14. Are senior leaders likely to view the proposed change as generally appropriate for the organization?	+2 (0 to +2)	Senior leaders have strong buy-in for the change.
15. Will the proposed change be viewed as needed by the senior leaders?	+ 2(0 to +2)	As above.
		Credible Leadership and Change Champions Subtotal **+6/11 (55%)**

Table continued on next page…

Readiness dimension indicator	4. Openness to change Actual Score *(Possible Score)*	Qualitative notes/ rationale for score
16. Does the organization have scanning mechanisms to monitor the internal and external environment?	+2 (0 to +2)	Inaugurating the Evidence and Knowledge Mobilization (EKM) function has resulted in strong capacity for this over the last two years.
17. Is there a culture of scanning and paying attention to those scans?	+1 (0 to +2)	As above—there is a dedicated team to ensure this.
18. Does the organization have the ability to focus on root causes and recognize interdependencies both inside and outside the organization's boundaries?	+1 (0 to +2)	As reliable internal data has identified gaps between espoused values and results, the organization has increasingly focused its efforts on understanding root causes within & beyond the organization's walls.
19. Does "turf" protection exist in the organization that could affect the change?	0 (0 to -3)	There is a strong culture of collaboration between the leadership team. Given the org.'s small size, goals are easy to see as shared.
20. Are middle and/or senior managers hidebound or locked into the use of past strategies, approaches or solutions?	0 (0 to -4)	The culture is collaborative, creative and innovative.
21. Are employees able to constructively voice their concerns or support?	+1 (0 to +2)	Despite the major changes feeling turbulent, employees are active and empowered in offering their insights on 'how we do things'.
22. Is conflict dealt with openly, with a focus on resolution?	0 (0 to +2)	This is one of the areas that require improvement. The organization is not well-versed in managing conflict openly.
23. Is conflict suppressed and smoothed over?	-1 (0 to -2)	There has been the tendency to do this; although conflict gets addressed behind closed doors.
24. Does the organization have a culture that is innovative and encourages innovative activities?	+2 (0 to +2)	This is one of the strongest characteristics of the organization from front-line staff to middle and senior leadership.
25. Does the organization have communications channels that work effectively in all directions?	0 (0 to +2)	This is one of the clearest areas for improvement. There is need for strong and multi-faceted internal communications and engagement.
26. Will the proposed change be viewed as generally appropriate by those not in senior leadership roles?	+2 (0 to +2)	The proposed change is directly informed by front-line challenges and needs—it is seen as appropriate and needed.
27. Will the proposed change be viewed as needed by those not in senior leadership roles?	+2 (0 to +2)	Same as above.
28. Do those who will be affected believe they have the energy needed to undertake the change?	+1 (0 to +2)	Front-line staff are tired after the pandemic, but optimistic about opportunities to deepen approach to care.
29. Do those who will be affected believe there will be access to sufficient resources to support the change?	+1 (0 to +2)	Yes, this will need to be continually demonstrated and communicated.
		Openness to Change Subtotal **+12/22 (55%)**

Table continued on next page…

Readiness dimension indicator	5. Rewards for Change Actual Score *(Possible Score)*	Qualitative notes/ rationale for score	
30. Does the reward system value innovation and change?	0 (0 to +2)	There are no formal rewards processes in place—generally, innovation and change have been directly linked to the value of compassionate, patient-centered care. Given than the staff at the hospital tend to be strongly aligned with these values, there has been little need for a reward system. However, there are routine and multiple celebrations that involve staff and patients throughout the year.	
31. Does the reward system exclusively focus on short-term results?	0 (0 to -2)		
32. Are people censured for attempting change and failing?	0 (0 to -3)		
		Rewards for Change Subtotal	**0/2 (0%)**

Readiness dimension indicator	6. Measures for Change and Accountability Actual Score *(Possible Score)*	Qualitative notes/ rationale for score	
33. Are there good measures available for assessing the need for change and tracking progress?	+1 (0 to +1)	The inauguration of a team dedicated EKM has build strong capacity for these indicators. In-fact, the organization's newer capacities for data and evaluation informed problem definition has been one of the strongest internal drivers of change. As change is implemented, there is strong capacity to track progress and evaluate quality of implementation and effectiveness of outcomes.	
34. Does the organization attend to the data that it collects?	+1 (0 to +1)		
35. Does the organization measure and evaluate customer satisfaction?	+1 (0 to +1)		
36. Is the organization able to carefully steward resources and successfully meet predetermined deadlines?	+1 (0 to +1)		
		Measures for Change & Accountability Subtotal	**+4/4 (100%)**

Total Readiness Score **28/50 (56%)**

Appendix G – Stakeholder Readiness to Take Action Analysis (Deszca et al., 2020)

Stakeholder Name	Predisposition to Change	Current Commitment Profile	Aware	Interested	Desiring Change	Taking Action
Board of Directors						
Board Chair	Early Adopter	Committed			**X**	
Quality Committee Chair	Innovator	Committed			**X**	
Executive Team						
Chief Executive Officer	Innovator	Committed				**X**
Chief Nursing Officer	Early Adopter	Committed				**X**
Chief Medical Officer	Early Adopter	Supportive			**X**	
Chief Financial Officer	Early Majority	Neutral	**X**			
Director of Human Resources	Late Majority	Supportive			**X**	
Leadership Team						
Clinical Lead #1	Innovator	Committed			**X**	
Clinical Lead #2	Early Adopter	Ambivalent			**X**	
Clinical Lead #3	Early Adopter	Supportive			**X**	
Quality Lead	Early Adopter	Committed				**X**
Clinical Educator	TBD	TBD		Hiring in progress		
External Affairs Lead	Innovator	Committed				**X**
Communications Manager	Early Adopter	Supportive		**X**		
Interdisciplinary Care Team						
Health Service #1 (4 clinicians)	Early Adopter	Supportive	**X**			
Health Service #1 (15 clinicians)	Early Majority	Supportive	**X**			
Health Service #2 (2 clinicians)	Early Majority	Supportive	**X**			
Health Service #3 (2 clinicians)	Late Majority	Ambivalent	**X**			
Health Service #4 (2 clinicians)	Laggard	Supportive	**X**			
Health Service #5 (2 clinicians)	Early Majority	Ambivalent	**X**			
Health Service #6 (2 clinicians)	Early Adopter	Supportive	**X**			
Patient Advisory Groups						
Patient Advisory #1	Innovator	Committed		**X**		
Patient Advisory #2	Innovator	Committed		**X**		
External Partners						
Community Partner #1	Early Adopter	Committed				**X**
Community Partner #2	Early Adopter	Supportive			**X**	
Community Partner #3	Late Majority	Resistant	**X**			

Appendix H—Readiness Check (Kuenkel et al., 2021) Phase 1

Phase 1: Exploring & Engaging	Yes/No/Partially
1. Creating Resonance	
1.1a Have we identified relevant key stakeholders?	**Partially**
1.1b) Do we know their perspectives and have we created bonds between them?	**Partially**
1.2 Have we been able to get the vision for a transformed future across to potentially relevant actors through formal and informal conversations?	**No**
1.3 Have we been able to convince high- level or influential actors of the urgency of the initiative and gained their support?	**Yes**
2. Understand the context	
2.1 Have we explored the context of our collaboration and know other activities well enough?	**Yes**
2.2 Are we aware of positive or negative factors/structures/trends that influence the transformative change endeavour, or why change has not occurred earlier	**Yes**
2.3 Have we researched best practices or results from similar initiative that we can adopt or learn from?	**Yes**
2.4 Have we conducted a Stakeholder Analysis and assessed what needs to be done to engage both influential and interested stakeholders?	**Partially**
2.5 Have we assessed the resources required to organize the transformative change architecture?	**Partially**
2.6 Have we explored potential conflict situations that might arise?	**No**
3. Build a container for change	
3.1 Have we built a strong core group (container) composed of key stakeholders, and does it have a sufficient mandate?	**No**
3.2 Does the core group (container) meet regularly and jointly plans the roadmap and next steps?	**No**
3.3 Have we successfully completed a first meeting of key stakeholders with jointly agreed results?	**No**
3.4 Does the core group have a good overview of the stakeholder system and the ability to engage key stakeholders into a broader container?	**No**
3.5 Have we ensured that the core group and important actors are knowledgeable about content issues as well as transformative change	**No**

Appendix I—Literature on Strategies for Engendering Socially Conscious Care

			Article methodology *Conceptual/theoretical or argumentative review grounded in extant literature*			**Article methodology** *Empirical Study*		
			Health profession career continuum of focus for the article			**Health profession career continuum of focus for the article**		
Source	**Health profession (HP) of focus**	**Social/ Structural Determinant of focus**	*Pre-licensure (HP in training)*	*Post-Licensure (Regulated HP)*	*Applicable across pre- and post-licensure*	*Pre-licensure (HP in training)*	*Post-Licensure (Regulated HP)*	*Applicable across pre- and post-licensure*
Wilson et al., 2022	Nursing	Race		**X**				
Dunleavy et al., 2022	Physiotherapy	Multiple	**X**					
Ziegler et al., 2021	Physicians	Citizenship				**X**		
Waite & Hassouneh, 2021	Mental Health	Multiple			**X**			
Van Bewer et al., 2021	Nursing	Multiple				**X**		
Levine et al., 2021	Primary Care	Multiple					**X**	
Hagle et al., 2021	Across HP	Race & Substance Use			**X**			
Butler et al., 2021	Pharmacy	Race	**X**					
Browne et al., 2021	Across HP	Race						**X**
Brady & L'heureux, 2021	Dieticians	Multiple			**X**			
Blanchet-Garneau et al, 2021	Across HP	Race	**X**					
Urbanoski et al., 2020	Across HP	Race & Substance Use						**X**
Sukhera et al., 2020	Across HP	Multiple	**X**					
Paton et al., 2020	Across HP	Multiple			**X**			
Ezer & Overall, 2020	Across HP	Multiple		**X**				
Doubeni et al., 2020	Primary Care	Multiple			**X**			
DeBonis et al., 2020	Primary Care	Poverty				**X**		
de Vries et al., 2020	Across HP	Gender Identity	**X**					
Taira & Hsieh, 2020	Across HP	Multiple			**X**			
Baima & Sude, 2020	Mental Health	Race					**X**	
Doobay-Persaud et al, 2019	Physicians	Multiple	**X**					
Curtis et al., 2019	Across HP	Race			**X**			
Halman et al., 2017	Across HP	Multiple	**X**					
Metzl & Hansen, 2014	Physicians	Multiple			**X**			

Appendix J—Evaluative Criteria for Designing Potential Solutions

	Evaluative Criteria to Assess Potential Solution	Literature that supports this criterion in relation to Problem of Practice (PoP)
1.	**Impact Design: What impact should the solution have on whom?**	
1.1	Improve care team's knowledge of a holistic range of systemic disparities that shape individual health and well-being, contributing to deconstruction/reconstruction of knowledge frameworks that perpetuate inequity.	(Halman et al., 2017; Shields, 2004; 2022)
1.2	Improve the care team's skills in providing meaningful care to diverse patients including those presenting intersectional health complexities	(Curtis et al., 2019 ; Metzl & Hansen, 2014)
1.3	Improve the care team's confidence in engaging and caring for diverse patients including those presenting intersectional health complexities	(Grzanka & Brian, 2017; Hankivsky, 2008)
1.4	Build trust with and safety for patients from diverse backgrounds including those presenting intersectional health complexities	(Curtis et al., 2019 ; Urbanoski et al., 2020)
1.5	Support care team to sustain engagement with patients throughout the duration of patients' care journey at Open Doors	(Doobay-Persaud et al., 2019)
1.6	Result in high quality care and equitable health outcomes across Open Doors' patient populations	(Blanchet-Garneau et al., 2021)
2.	**Values Design: How will the solution respect and promote stakeholder values?**	
2.1	Honour transformative ethics by integrating and centering the voices, experiences and needs of patients who are most marginalized	(Mertens, 2008; 2017; Shields, 2002; 2022)
2.2	Honour transformative ethics by engaging and addressing the needs of the diverse communities in Open Doors' catchment area that are in most need of Open Doors' services	(de Vries et al., 2020 ; Doubeni et al., 2020 ; Shields, 2002 ; 2017)
2.3	Employ critical appreciative inquiry processes to create a psychologically safe learning environment for all involved	(Arnold, 2022; Grant & Humphries, 2006)
2.4	Employ critical appreciative inquiry processes to balance critique with promise	(Arnold et al., 2022)
3.	**Process Design: How will processes enable outcomes and values?**	
3.1	Utilize quantitative insights generated by Open Doors' Holistic Health Assessment Tool to ensure that emerging sociodemographic and Social and Structural Determinants of Health (SSDH) trends are meaningfully addressed	(Dunleavy et al., 2022 ; Levine et al., 2021)
3.2	Utilize qualitative insights to deepen, cross-check and make practice use of intersectional data	(Blanchet-Garneau et al., 2021)
3.3	Employ Adaptive Leadership principles to guide the overall change process	(Heifetz et al., 2009)
3.4	Integrate the principles of critical theoretical frameworks and pedagogies	(Browne et al., 2020)
3.5	Integrate key principles of the Critical Reflexivity; Structural Competence and Cultural Safety Frameworks for engendering socially conscious healthcare practice	(Halman et al., 2017 ; Metzl & Hansen, 2014)
3.6	Integrate opportunities or interprofessional learning	
3.7	Integrate opportunities for longitudinal learning and incremental building of knowledge, skills and confidence	(Sukhera et al., 2017 ; Taira & Hsieh, 2019)
4.	**Sustainability Design: How will the solution sustain its outcomes?**	
4.1	Within the change agent's agency to implement	(Deszca et al., 2020)
4.2	Within the change agent's agency to sustain over the long term	(Kuenkel et al., 2021)
4.3	Within the change agent's financial resources	(Deszca et al., 2020)
4.4	Feasible in terms of staff time required	(Deszca et al., 2020)
4.5	Feasible in terms of time required to engage patients and community members	(Kuenkel et al., 2021)
5.	**Evaluation Design: How will the solution prove and improve its impact?**	
5.1	Monitor readiness for change at each phase of the change effort	(Kuenkel et al., 2021)
5.2	Assess quality of the learning experience for the care team	(Brady & L'heureux, 2021)
5.3	Assess quality of the change effort for community stakeholders	(Kuenkel et al., 2021)
5.4	Integrate direct patient feedback mechanisms to measure success	(Curtis et al., 2021)
5.5	Evaluate short, medium and long-term outcomes	(Mertens, 2008;2017)
5.6	Translate insights and continually communicate results with all stakeholders	(Kuenkel et al., 2021)

Appendix K – Detailed Comparative Scores for Each Solution

Legend:

S1 – Proposed Solution 1: Externally Developed Online Social Justice Curriculum/Modules

S2 – Proposed Solution 2: Reflective Interprofessional Learning at Clinical Rounds

S3 – Proposed Solution 3: Transformative Learning Laboratory and Knowledge Hub

For the evidence base informing these criteria, refer to Appendix J.

	Evaluative Criteria to Assess Potential Solution The solution will likely…	Scores for Each Solution (Scores range from -2 to +2)		
1.	**Impact Design: What impact should the solution have on whom?**	**S1**	**S2**	**S3**
1.1	Improve the care team's knowledge of a holistic range of systemic disparities that shape individual health and well-being, contributing to deconstruction/reconstruction of knowledge frameworks that perpetuate inequity.	+2	0	+1
1.2	Improve the care team's skills in providing meaningful care to diverse patients including those presenting intersectional health complexities	+1	+2	+2
1.3	Improve the care team's confidence in engaging and caring for diverse patients including those presenting intersectional health complexities	0	+2	+2
1.4	Build trust with and safety for patients from diverse backgrounds including those presenting intersectional health complexities	0	+1	+2
1.5	Support care team to sustain engagement with patients throughout the duration of patients' care journey at Open Doors	0	+1	+2
1.6	Result in high quality care and equitable health outcomes across Open Doors' patient populations	+1	+2	+1
	Overall Impact Design Score out of 12 points	+5	+8	+10
2.	**Values Design: How will the solution promote stakeholder values?**	S1	S2	S3
2.1	Honour transformative ethics by integrating and centering the voices, experiences and needs of patients who are most marginalized	0	0	+2
2.2	Honour transformative ethics by engaging and addressing the needs of the diverse communities in Open Doors' catchment area that are in most need of Open Doors' services	+1	+1	+2
2.3	Create a psychologically safe learning environment for all involved	+1	0	+2
2.4	Employ critical appreciative inquiry processes to balance critique with promise	0	+2	+2
	Overall Values Design Score out of 8 points	+2	+3	+8

Table continued on next page...

3.	Process Design: How will processes enable outcomes and values?	S1	S2	S3
3.1	Utilize quantitative insights generated by Open Doors' Holistic Health Assessment Tool to ensure that emerging sociodemographic and Social and Structural Determinants of Health (SSDH)trends are meaningfully addressed	+1	+2	+2
3.2	Utilize qualitative insights to deepen, cross-check and make practice use of intersectional data	+2	0	+2
3.3	Employ Adaptive Leadership principles to guide the overall change process	0	0	+2
3.4	Integrate the principles of critical theoretical frameworks and pedagogies	+2	+1	+1
3.5	Integrate key principles of the Critical Reflexivity; Structural Competence and Cultural Safety Frameworks for engendering socially conscious healthcare practice	+1	+1	+2
3.6	Integrate opportunities or interprofessional learning	0	+2	+2
3.7	Integrate opportunities for longitudinal learning and incremental building of knowledge, skills and confidence	0	+2	+2
	Overall Process Design Score out of 14 points	**+6**	**+8**	**+13**
4.	**Sustainability Design: How will the solution sustain its outcomes?**	**S1**	**S2**	**S3**
4.1	Within the change agent's agency to implement	+2	+1	+2
4.2	Within the change agent's agency to sustain over the long term	+2	0	+2
4.3	Within the change agent's financial resources	0	0	+2
4.4	Feasible in terms of staff time required	+2	+2	+1
4.5	Feasible in terms of time required to engage patients and community members	+2	+2	+1
	Overall Sustainability Design Score out of 10 points	**+8**	**+5**	**+8**
5.	**Evaluation Design: How will the solution prove and improve its impact?**	S1	S2	S3
5.1	Monitor readiness for change at each phase of the change effort	0	0	+2
5.2	Assess quality of the learning experience for the care team	+1	+2	+2
5.3	Assess quality of the change effort for community stakeholders	0	0	+2
5.4	Integrate direct patient feedback mechanisms to measure success	0	0	+2
5.5	Evaluate short, medium and long-term outcomes	+1	+2	+1
5.6	Translate insights and continually communicate results with all stakeholders	0	+2	+1
	Overall Evaluation Design Score out of 12 points	+2	+6	+10
	Overall Score Across Five Dimensions out of 56 points	**23**	**30**	**50**

Appendix L – Detailed Change Implementation Plan

Stage 1: Enhancing Readiness

Stage 1 of the proposed framework for leading the change draws on:

- Phase 1 the Dialogic Change Model (DCM) with the goal of "preparing stakeholders for collaboration" (Kuenkel et al., 2021, p.) and
- Step 1 of the Critical Appreciative Inquiry (CAI) Model (Ridley-Duff and Duncan, 2015) with the goal of identifying a generative CAI topic.

Objectives: By the end of stage 1, the *Transformative Learning & Innovation Hub* (*the Hub*) will be endorsed by decision-makers; the need for it will be understood across the organization; key stakeholders (patients, staff & community members) will have been engaged to review emerging intersectional health needs at *Open Doors* that could benefit from a transformative learning project; one or two emerging intersectional health topics will have been prioritized for the *Hub's* pilot project; and a small core innovation group will have been convened and trained for broader engagement and implementation.

Priority/ Duration	Task	Who is Responsible, Accountable, Consulted & Informed?	Intended Outcomes
1. Convene the *Transformative Learning & Knowledge Hub (the Hub)* and communicate its establishment to all staff and patients.	1a. Present the Problem of Practice (PoP), the proposed solution (the Hub) and engage Hub champions for feedback on the proposed solution and implementation plan.	**Responsible:** Change agent **Accountable:** Change agent **Consulted:** Leadership team **Informed:** Measurement, Evaluation and Learning (MEL) Team	*Open Doors'* decision-makers will have a shared understanding of: ▪ the need for building the care team's capacity for intersectional, trauma-informed care. ▪ how the proposed *Hub* will address this need in the short and the long term.
	1b. Collaborate with Senior Leadership & Management Team to identify the right leadership representation to support and oversee the *Hub*	**Responsible:** Change agent **Accountable:** Change agent **Consulted:** Leadership team **Informed:** Measurement, Evaluation and Learning (MEL) Team	*Open Doors'* decision-makers will provide feedback on refining the implementation plan as needed, and guidance on resourcing and staff engagement in the *Hub.*
	1c. Announce organization-wide that the *Hub* is being established and create avenues for staff and patients to inquire about and engage with the concept of the *Hub.*	**Responsible:** Communications Team **Accountable:** Change agent **Consulted: N/A** **Informed:** All staff, Patient Advisory Committees , Patients	Staff and patient community become aware of the need for the *Hub* and begin engaging with the work of the *Hub.*

Anticipated Duration: 1 month

Much of the work required for this step has been completed by the change agent, throughout the planning & writing of this Organizational Improvement Plan (OIP). These actions are not anticipated to take longer than a month.

Stage 1 continued…

Priority/ Duration	Task	Who is Responsible, Accountable, Consulted & Informed?	Intended Outcomes
2. Use quantitative and qualitative data to communicate the intersections of highest sociodemographic and holistic health needs	2. Collect and/or Review data collected through ▪ the Holistic Health Assessment (HHA) Tool ▪ qualitative patient feedback ▪ front-line staff feedback on community needs that they are feeling least equipped to address.	**Responsible:** MEL Team **Accountable:** Change agent **Consulted:** Front-line care team **Informed:** All staff, Patient Advisory Committees , Patients	Holistic health assessment data, patient experience data and staff feedback on areas that they are challenged by will create a data-informed identification of the highest areas of intersectional sociodemographic and health need. Some examples of intersectional health areas include: ▪ *patients who are rapidly ageing, presenting multiple co-occurring health complexities and experiencing mental health needs as related to the isolation of the Covid-19 pandemic and significant challenges of increased costs of living that are hard to manage on old age pensions or government financial assistance.* ▪ *the increase in Indigenous and Black patients experiencing complex mental health needs. These patient groups experience stigma that is driven both by systemic anti-Indigenous and anti-Black racism* and *the stigmatization of complex mental health conditions.*

Anticipated Duration: 1-2 months (Month 1 and 2)
The MEL) Team routinely analyzes HHA data and patient feedback—so these insights are already widely available. Implementing a staff survey to cross check insights from the HHA and patient feedback will require 2-3 weeks to implement and analyze.

3. Select & communicate pilot intersection/topic for the *Hub's* first transformative learning and knowledge project	3a. Communicate data-informed insights on emerging intersections of need with leadership, staff & existing patient advisory groups. 3b. Hold prioritization activities that include input from leadership, all staff including the care team and the affected patient communities.	**Responsible:** MEL Team **Accountable:** Change agent **Consulted:** Patient Advisory Committees, Front-line Care Team, Leadership, Community Partners **Informed:** All staff, all patients	An area of significant intersectional health need is identified as the *Hub's* pilot learning laboratory and knowledge project

Anticipated Duration: 1-2 months (Month 2-3)
It will be important to create the time necessary to share insights from the data with all stakeholders, create avenues for engagement with the data, clarify insights and obtain input on which topic(s) to prioritize for the Hub's pilot project.

Stage 1 continued…

Priority/ Duration	Task	Who is Responsible, Accountable, Consulted & Informed?	Intended Outcomes
4. Create and train "core innovation group" based on intersectional health topic identified	4a. Convene a small "core group" as relevant to the selected pilot intersectional health topic. The core group should represent key stakeholders, but should not be larger than 6-8 individuals, to enable intimate and in-depth engagement and learning at a fast pace. 4b. Hold 4-6 capacity building, and practice sessions to build the core group's knowledge and competence of: ▪ the PoP, the findings from the evidence and literature that shaped the PoP; ▪ how systems of oppression function as individual *and* intersecting forces to create health inequities; ▪ knowledge of (academic, community and experiential knowledge) of the particular systems of oppression related to the selected pilot topic (e.g., how people living in poverty are discriminated in healthcare settings) ▪ the methods and tools of CAI	**Responsible:** Change agent **Accountable:** Change agent **Consulted:** Leadership team, Community partners, External Subject Matter Experts (SMEs) as needed **Informed:** All staff, all patients **Responsible:** Change agent with support from MEL team **Accountable:** Change agent **Consulted:** Leadership team, Community partners, External Subject Matter Experts (SMEs) as needed **Informed:** All staff, all patients The Core Group will be selected by the MEL team, as guided by Leadership & Management, based on input from front-line staff and patient advisories. The change agent, supported by the MEL team will be responsible for organizing and coordinating the necessary trainings for the core group. The MEL team will engage external subject matter experts including CAI specialists *and* relevant health and community experts to conduct these trainings.	The core innovation group adequately represents the right stakeholders for this change effort to be accepted as valid, credible, useful and just. The core innovation group and other important actors (Senior Leadership) are knowledgeable about content issues and change methodologies. The core innovation group is meeting regularly, there is sufficient trust and excitement for collaboration, and, confidence in their ability to plan & implement the learning project for the care team and the organization at large

Anticipated Duration: 1 month (Month 4)

The final month of Stage 1 will be dedicated to building the core group's competency for engaging their respective peers in CAI Processes.

Stage 2: Co-Creating the Plan

Stage 2 of the proposed framework for leading the change draws on:

- Phase 2 the Dialogic Change Model (DCM) with the goal of "consolidating the system of stakeholders into a collaboration ecosystem that can deliver" (Kuenkel et al., 2021, p.) and
- CAI Steps 2 (Discovery/Critical Inquiry), Step 3 (Dream/ Appreciative Inquiry) and Step 4 (Design/Imagination) with the respective goals of (i) discovering what is, what might have been, what gives life, and what depletes life; (ii) dreaming of what might be; and (iii) designing "how it can be".

Overall objectives: By the end of stage 2, the core group will have engaged respective stakeholders in critical inquiry processes to create a deep understanding of "what is" currently in relation to the intersectional health topic being explored, as well as appreciative inquiry processes to dream of what the future could look like and design/imagine the process for achieving this future. At this stage, the core group will synthesize information from their respective stakeholder groups and co-create have co-created a plan for capacity building, generated stakeholder buy in and finalized resource commitments, as needed.

Priority/ Duration	Task	Who is Responsible, Accountable, Consulted & Informed?	Intended Outcomes
1. Core group engages front-line staff, patients and community members using selected CAI methods and tools	Core group members engage stakeholders in the **CAI Discovery Phase,** to articulate a deep understanding of "what was, what could have been, what gives life and what depletes life" as related to the chosen intersectional health topic; Core group activates the **CAI Dream phase** by continuing to engage stakeholder groups to articulate a vision of "what might be" if the intersectional health topic is successfully addressed.	**Responsible:** Core Innovation Group **Accountable:** Change agent **Consulted:** Willing participants of each key stakeholder group **Informed:** All staff, all patients. For these tasks, members of the core innovation group will be responsible for connecting with their peer groups in small groups, members of the core group who are care team members will run sessions with the broader care team, whereas patient representatives will conduct sessions with other patients. This will enable each stakeholder type to engage in critical appreciative processes to discover the nuances of the adaptive challenges and dream of what success looks like.	All stakeholders contribute to defining the challenges of the chosen intersectional health topic from their perspective. There is a nuanced understanding of what causes the specific challenges related to this topic. All stakeholders contribute to the vision of what success would look like for them, if the intersectional health topic is addressed appropriately. Patients will describe what their ideal experience would look like; care team will describe how their practices might look different *and* the supports and process changes needed to make those shifts.

Anticipated Timeline: 2 months (Months 5 and 6)

The work during this period will be critical in ensuring that the type of second/third order change envisioned can be implemented successfully.

Stage 2 continued…

	Priority/ Duration	Task	Who is Responsible, Accountable, Consulted & Informed?	Intended Outcomes
2.	Core group formulates draft plan including learning mechanisms for the care team and broader organizational practices, based on the insights the previous tasks	Core group engages in the CAI Design phase by reflecting on the insights from various stakeholders and co-creating a plan for "how it can be".	Responsible: Core Innovation Group Accountable: Change agent Consulted: Community Partners, as needed Informed: All staff, all patients	An organizational capacity building plan that responds to the selected intersectional health topic, is co-created by members of the core innovation group. This plan will include, but will not be limited to: ▪ Training and professional development exercises for the care team ▪ Organizational policies, practices and processes needed to enable the required shifts in caregiving.
3.	Core group will share and generate buy-in and resources for their draft plan, across the organization.	Core group will share their learnings and insights from broader stakeholder engagement. Core group shares draft plan for learning and organizational capacity building.	Responsible: Core Innovation Group Accountable: Change agent Consulted: Care Team, Leadership Team Informed: All staff, all patients, community partners	Core shares insights and knowledge broadly across the organization and (i) creates a deeper understanding of the need for intersectional, trauma-informed care; and, (ii) shares an integrated stakeholder vision of what such care looks like in relation to the specific intersectional health topic. Core group generates buy-in for the learning and organizational capacity-building plan they design based on the above. Key stakeholders commit resources, as needed, to implement the learning and capacity-building plan.

Anticipated Timelines: 2 months (Months 7 and 8)
Provided that the firsts steps of this phase are done thoughtfully and respectfully with stakeholders, formalizing buy in to the plan will likely be swift.

Stage 3: Getting it done and Evaluating It

Stage 3 of the proposed framework for leading the change draws on:

- Phase 3 of the Dialogic Change Model (DCM) with the goal of "implementing planned activities, ensuring mutual learning and focusing on the delivery of tangible results" (Kuenkel et al., 2021, p.) and
- Step 5 of the CAI process: Destiny/Innovation with the goal of creating 'what will be'.

Overall objectives: By the end of stage 3, the learning and organizational capacity building plan designed by the core group will be fully implemented. At the end of this stage, we should be beginning to see early outcomes related to the specific intersectional health topic being addressed. Insights from rapid feedback processes, monitoring and evaluation activities will be routinely and transparently shared with all key stakeholders.

Priority/ Duration	Task	Who is Responsible, Accountable, Consulted & Informed?	Intended Outcomes
1. Implement learning activities and identify broader organizational capacity building activities needed to address intersectional health topic being explored.	The specific actions related to this priority is unknown at the time of writing the OIP. The core group in consultation with stakeholders will determine what these activities will be. For example, these may include: ▪ a combination of didactic, experiential and problem-based learning activities for the care team, based on the topic at hand and the evidence reviewed. ▪ organizational practices related to patient & community engagement, intake & discharge processes, patient safety policies, staff professional development resources.	**Responsible:** Core Innovation Group, Care Team **Accountable:** Change agent **Consulted:** Leadership Team **Informed:** All staff, all patients, community partners	Improve the care team's knowledge of the systemic disparities shaping the health of individuals, as related to the intersectional topic addressed. Improve the care team's knowledge of how to navigate patient engagement for individuals who are facing complex health inequities because of multiple, intersecting systemic barriers to care. Improve care team's confidence in engaging and caring for diverse patients. Improved safety and care for diverse patients, as judged by the patients themselves. Early outcomes related to the identification and planning for broader organizational practices needed to improve intersectional health equity.

Stage 3 continued…

Priority/ Duration	Task	Who is Responsible, Accountable, Consulted & Informed?	Intended Outcomes
2. Integrate continuous improvement and evaluation into the implementation of all learning and capacity building activities	Rapid feedback, monitoring and evaluation and continuous improvement activities will be integrated throughout implementation. These may include: ▪ Pre- and post-surveys for learners ▪ Interviews & focus groups with learners. ▪ Longitudinal health outcomes data for patients to track outcomes improvement. ▪ Patient experience interviews. ▪ Focus groups with community agencies serving shared patients.	**Responsible:** MEL Team, Core Innovation Group **Accountable:** Change agent **Consulted:** Leadership Team **Informed:** All staff, all patients, community partners	Real time course correction, learning and improvement is enabled by integrating feedback loops, success monitoring and evaluation of outcomes (as much as outcomes evaluation is feasible in the short term).
3. Share initial outcomes and learnings with all key stakeholders	Establish a wide range of mechanisms for continual insight and knowledge sharing about the initiative with all stakeholders. Establish synchronous and asynchronous mechanisms (townhall discussions *and* online message boards) to encourage conversation among all key stakeholders related to the *Hub's* insights, successes and challenges.	**Responsible:** MEL Team, Core Innovation Group **Accountable:** Change agent **Consulted:** Leadership Team **Informed:** All staff, all patients, community partners	Insights about the intersectional health topic will be broadly shared and discussed, along with collective reflection about what is working and what could be improved in the *Hub's* work

Anticipated Timelines: 4-6 months (Month 9 to 14)
It is likely that the first round of care team capacity building activities will be completed in 4 months, given the small size of the care team and the strong organizational buy in for this work.
Broader organizational practices will necessarily be implemented and evaluated over a much longer term.

Stage 4: Planning to scale and sustain impact

Stage 4 of the proposed framework for leading the change draws on:

- Phase 4 of the Dialogic Change Model (DCM) with the goal of "bringing the collaboration ecosystem to the next level of impact and creating long-term structures for transformative change" (Kuenkel et al., 2021, p.)

Overall objectives: A comprehensive process and outcomes evaluation of the first cycle of implementation will be completed to generate understanding of the extent to which the *Hub* was an effective solution to address the PoP. Using evaluation findings, what worked well and what did not work well will be highlighted, providing recommendations for if and how the *Hub* should be continued, scaled and further developed to address a different intersectional health topic, under the leadership of a different core innovation group.

Priority/ Duration	Task	Who is Responsible, Accountable, Consulted & Informed?	Intended Outcomes
1. Evaluate outcomes	External evaluator conducts process and outcomes evaluation of the *Hub's* pilot project	**Responsible:** External evaluator **Accountable:** Change agent **Consulted:** Leadership Team **Informed:** All staff, all patients, community partners	Arms-length assessment of the extent to which the Hub ▪ delivered a process that centered marginalized patients' voices and created a safe and collaborative learning environment for all organizational actors; ▪ effectively built *Open Doors* care team's capacity for providing intersectional, trauma-informed care; ▪ improved trust and sustained care with diverse patients. Demonstrate the value of the model including what works, and what needs to be improved about the model.
2. Conclude pilot	Decide on how best to continue the work of the *Hub*-processes, governance resourcing. Begin the task of identifying the next intersectional health topic for learning.	**Responsible:** External Evaluator supported by MEL Team and Core Innovation Group **Accountable:** Change agent **Consulted:** Leadership Team **Informed:** All staff, all patients, community partners	Successful conclusion of the first cycle of implementation, with a forward look at how to continue this model of transformative learning.

Anticipated Timeline: 3-4 months (Months 14 to 18)

Appendix M – Knowledge Mobilization Plan

	What is the knowledge is being generated?	Who is generating knowledge?	Using what methods?	For whom?	Communicated how/ using what methods?	Why?
Stage 1: Enhancing Readiness	Data and evidence informed knowledge about Open Door's patient population, and what populations have the highest, most complex needs	The 'Evidence' Team	**Quantitative:** Holistic Health Assessment (HHA) Data **Qualitative** Patient experience interviews	Care team	Reflective conversations at routine team meetings	- Generate buy-in for the change - Deepen knowledge of the PoP with direct insight from care team. - Prepare and involve the care team (primary recipients of change) before formalizing the project.
				Leadership	Presentations	- Deepen understanding of the PoP and change plan. - Use quantitative and qualitative information to make case for resourcing.
				All other stakeholders	Multiple methods: townhall, newsletter, email,	- Generate clear understanding of the project - Raise awareness and energy for collaboration.
Stage 2: Co-creating the Plan	Rich insights about the experiences of both patients and care team members as it relates to health/service needs as related to the chosen intersectional health topic.	*Hub's* Core Innovation Group.	**Qualitative:** Critical Appreciative Inquiry Processes	All stakeholders	Multiple methods: Reflective conversations at all team meetings; Townhall presentations and discussions, Email and newsletter communications; summares of CAI	- Generate understanding about the nature of the health needs being articulated - Co-create the vision of how these health needs can be meaningful addressed, - Link potential learning activities to the type of health needs and care provider challenges being identified.
Stage 3: Getting it done and evaluating it	Data and evidence informed knowledge about Open Door's patient population, and what populations have the highest, most complex needs	The Core Innovation Group	**Quantitative:** CQI/ Rapid Feedback Surveys **Qualitative:** CQI reflective processes	Care team	Reflective conversations at routine team meetings	- Identify and engage with resistance productively. - Inspire moral courage, regulate distress, - Keep the hope and momentum flowing.
				All other stakeholders	Push communications: email, newsletters, reports	- Keep all stakeholders engaged in progress, - Solicit support for care team, - Keep the momentum and energy alive.
Stage 4: Planning to scale and sustain impact	Insights from the evaluation of the *Hub's* pilot project	External Evaluator	Mixed methods evaluation--methods TBD.	Core Innovation Group & Leadership Team	Evaluation reports and reflective discussions	- Inform decisions on refining and/or continuing the model and/or scaling up.
				All other stakeholders	Multiple methods: didactive and dialogic.	- Share results of the learnings - Solicit input towards continuation of the model with a different intersectional area of focus.