Acting as a Change Agent: Effects of a Customized Training Program to Develop the Skills of Health and Social Services Professionals

Virginie Savaria[1,2], Anne Hudon [3,4], Denis Bédard[5], Marie-Josée Drolet[6], Michaël Beaudoin[1,2], Emmanuelle Jasmin[1,7], Étienne Lavoie-Trudeau[1,2], Annie Carrier[1,2*]

[1]School of Rehabilitation, Faculty of Medicine and Health Sciences, Université de Sherbrooke, Sherbrooke, Québec, Canada
[2]Research Centre on Aging, University Integrated Health and Social Services Centre of the Eastern Townships – Sherbrooke University Hospital (CIUSSS de l'Estrie–CHUS), Sherbrooke, Québec, Canada
[3]School of Rehabilitation, Faculty of Medicine, Université de Montréal, Montréal, Québec, Canada
[4]Centre for Interdisciplinary Research in Rehabilitation of Greater Montreal (CRIR) – University Integrated Health and Social Services of the South-Center-of-Montreal-Island (CIUSSS du Centre-Sud-de-l'Île-de-Montréal), Montréal, Québec, Canada
[5]Department of Pedagogy, Faculty of Education, Université de Sherbrooke, Sherbrooke, Québec, Canada
[6]Department of Occupational Therapy, Université du Québec à Trois-Rivières, Trois-Rivières, Québec, Canada
[7]University Institute of Primary Health and Social Services (IUPLSSS), CIUSSS de l'Estrie–CHUS, Sherbrooke, Québec, Canada

ABSTRACT

Background: Acting as a change agent (CA) is a key role for Health and Social Services (HSS) professionals. It involves working collaboratively with actors across and outside the HSS system and influencing decision-makers. However, this role requires specific skills that HSS professionals generally feel that they have not mastered. The overarching goal of this research partnership is to explore the development of CA skills by HSS professionals using a customized training program.

Methods/Design: Through a research partnership, 128 HSS professionals will receive 7 hours of training using a professional co-development approach and a checklist. The immediate and medium-term effects of the training on their skills development will be evaluated with a self-administered questionnaire before and immediately following the training and again nine months later. The data will be analyzed using descriptive and inferential statistics.

Discussion: This study will shed light on the effects of a customized training program on CA skills development. It will also have three main benefits: (1) development of an easy-to-reuse CA training program and checklist; (2) partner's ownership of these products through close involvement; and (3) development of a sustainable partnership between a team of researchers and a recognized organization with an extensive HSS network.

Keywords: change agency, change agent, professional practice, co-development

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* Correspondence regarding this article should be directed to Annie Carrier, [1]School of Rehabilitation, Faculty of Medicine and Health Sciences, Université de Sherbrooke, Sherbrooke, Québec, Canada. Email : Annie.Carrier@USherbrooke.ca

1. Background

1.1 Literature review

A series of institutional reforms aimed at ensuring the performance of the Health and Social Services (HSS) network in Québec (Canada) has been introduced since 2003: management agreements, performance indicators (Ministère de la Santé et des Services Sociaux [MSSS], 2004; *Act respecting health services and social services* [LSSSS], 1991; MSSS, 2012; MSSS, 2017), LEAN methods (Carrier, Levasseur, Freeman, & Desrosiers, 2016; MSSS, 2017), and institutional mergers (*Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies*, 2015). Not only have these types of initiatives not produced the expected results, they also seem to have had a negative impact on HSS performance in Québec (Benoit & Perron, 2019; Bourque, 2009; Richard, Maltais, Bourque, Savard, & Tremblay, 2007) and elsewhere in Canada (Gray, Berta, Deber, & Lum, 2014) and Europe (Rostgaard, 2012; Vabø, 2012).

These reforms were based on the premise of having a simple system, which explains these disappointing results. In a simple system, change emanates from a formal hierarchy (e.g., performance targets) and generates a predictable, proportional and linear effect (e.g., improved access). However, the HSS system is complex (Anderson & McDaniel, 2000; Lamarche, 2014; Maillet, Lamarche, Roy, & Lemire, 2015). For a complex system to perform well, it must evolve non-linearly from its base and thus from the people who work in it and their actions (Anderson & McDaniel, 2000; Lamarche, 2014). An efficient and innovative HSS system requires professionals who are involved in the desired change (Champagne, 2002), such as improving access to HSS, and can adapt their local actions (Greenhalgh & Papoutsi, 2019). Thus, with a clear goal in mind, HSS professionals and their local managers can organize and coordinate their actions in order to quickly adapt their services to their external environment, such as the community and the organization's partners (Lamarche, 2014; Maillet et al., 2015; Müllern & Nordin, 2012).

All HSS professionals in Canada are expected to lead institutional change, which means they must take on the role of change agent (CA) (Canadian Alliance of Audiology and Speech-Language Pathology Regulators [CAASPR], (2018); Canadian Association of Occupational Therapists [CAOT], 2012; Canadian Nurses Association [CNA], 2017; National Physiotherapy Advisory Group [NPAG], 2017; Ordre des travailleurs sociaux et des thérapeutes conjugaux et familiaux du Québec [OTSTCF], 2012; Royal College of Physicians and Surgeons of Canada [RCPSC], 2015). As CAs, these professionals use their expertise and influence to promote individual and community health and well-being. They seek to improve services by working collaboratively with actors across and outside the system. Since it is possible to achieve sustainable change when 25% of a group adopts the change (Centola, Becker, Brackbill, & Baronchelli, 2018), acting as a CA could have significant potential to generate institutional change and transform the management and organization of the HSS system and thus improve services.

As CAs, HSS professionals have a responsibility to advocate for and with their clients (individuals and communities) and try to influence organizational and policy decision-makers (CAASPR, 2018; CAOT, 2012; CNA, 2017; NPAG, 2017; OTSTCF, 2012; RCPSC, 2015). For example, to improve services, professionals who wish to act as CAs should be able to analyze the organizational and sociopolitical context (Carrier & Prodinger, 2014; Hole, Brenna, Graverholt, Ciliska, & Nortvedt, 2016), use communication strategies (Carrier & Contandriopoulos, 2015; Hole et al., 2016), and systematically plan their actions (Carrier & Contandriopoulos, 2016; Drolet, Carrier, Hudon, & Hurst, 2020). The knowledge and skills required in CA practice are distinct from professional competencies usually taught in university (Drolet et al., 2020). This role requires multidisciplinary knowledge and skills such as political

literacy, argumentation, strategic approach, good communication, knowing how to unite people around a project, and assuming a certain amount of leadership (Drolet et al., 2020; Finlayson, 2013; Picotin, Beaudoin, Hélie, Martin, & Carrier, 2021). The knowledge and skills practitioners need to employ usually relate to human beings and their neurological, physical, and psychological states, as well as how to assess these states and intervene (Bessette, Généreux, Thomas & Camden, 2020; Townsend & Polatajko, 2007).

Given this observation, as a course of action for improving HSS professionals' training, it has been proposed to incorporate the CA role more explicitly in university programs and continuing education (Bhate & Loh, 2015; Kirsch, 2015). Competency frameworks for HSS professionals include the role of CA (CAOT, 2012; NPAG, 2017; RCPSC, 2015). Therefore, training programs leading to these professions are explicitly expected to provide instruction in the CA role. However, according to recent studies, this teaching is uneven and incomplete (Bessette et al., 2020; McDonald, Lavelle, Wen, Sherbino, & Hulme, 2019). For example, although they address some aspects of the CA role, educators involved in university physiotherapy programs feel that the training needs of future professionals are not being met (Bessette et al., 2020). In occupational therapy, only one of the Québec programs appears to formally include the multidisciplinary knowledge and skills listed above in elective courses offered in other programs (Rahimaly, Beaudoin, Bédard, Hudon, Jasmin, Verville, & Carrier, 2019). These incomplete programs could be attributable to the complexity of teaching this role (Hubinette, Ajjwa, & Dharamsi, 2014) and an already heavy course load (Bessette et al., 2020), as is the case with other professions (Bhate & Loh, 2015).

Insufficient training on the CA's role may be the cause of the low self-rated competence reported in the literature. HSS professionals report feeling uncomfortable (Bessette et al., 2020; Puddester, MacDonald, Clements, Gaffney, & Wiesenfeld, 2015; Verma, Flynn, & Seguin, 2005) and ill-equipped to perform this role effectively (Finlayson, 2013; Restall & Ripat, 2008). For example, in an electronic survey of 1,196 recent Québec graduates with a master's degree in occupational therapy (average 3.6 years ± 1.9), only 27.4% of the respondents felt competent to act as a CA (Xuan Shi, Rochette, & Thomas, 2017). This percentage is probably lower among Québec occupational therapists as a whole since experienced occupational therapists have had no specific training for this role since it was introduced gradually in the 2000s (Rahimaly et al., 2019). In addition, only one relevant French language continuing education program has been identified. This is important because French is Québec's official language. As part of a qualitative design-based study conducted by our team, the usefulness of this training program was evaluated from the perspective of 103 occupational therapists (Beaudoin, Bédard, Hudon, Verville, Jasmin, Éthier, Caron, Rahimaly, & Carrier, 2019). The results indicate that this program is useful, raises awareness of the importance of the CA role, and motivates people to take action. However, the specific effects of this program on the development of CA skills and feeling of competence, as well as their maintenance over time, are not known. In order to apply the relevant knowledge and skills, it is essential to feel competent to act as a CA; therefore, there is a need to provide HSS professionals with training in this role and to document its effects over time (Hole et al., 2016).

1.2 Partner's needs

The *Alliance du personnel professionnel et technique de la santé et des services sociaux* (APTS) is a union in Québec, Canada, representing HSS professionals identified as Category 4 by the government. These include occupational therapists, physiotherapists, social workers, educational psychologists, special educators and speech pathologists, but not nurses or medical doctors. With 88% of public HSS Category 4 personnel as members (60,000), the APTS is their main representative . One of the APTS' priorities is to support HSS professionals in carrying

out CA activities. Although it is a trade union, the Alliance has a larger mission than defending the interests of its members and is committed to promoting and defending universal, high quality HSS accessible to all (APTS, 2011). The APTS also supports the development of its members' professional practices.

Within this framework, the APTS has a specific objective to contribute to the change agency training of its members in a sustainable manner. Specifically, HSS professionals would like to know how to execute a planned CA action process (e.g., describe precise change objectives, analyze the organizational and sociopolitical context, set realistic and measurable goals, choose effective strategies, plan and implement their strategies according to the target population, and measure their effects, as well as master the analytical, communication and argumentation skills needed to execute the process). However, since the APTS does not have the knowledge its members require, it decided it needed the input of researchers with expertise in pedagogy and the CA role, which is why it approached the research team. With the support of these researchers, the APTS would like all participating members to understand the CA action planning process, develop specific change agency knowledge and skills that are sustainable over time, and be ready to take concrete action.

2. Methods/Design

2.1 Objectives

Based on recognized pedagogical principles and currently available evidence, the goal of this research partnership is to provide contextualized, active pedagogy-based training to equip APTS members to act sustainably as CAs. The overarching research objective is to explore the development of CA skills by HSS professionals. More specifically, the aim is to answer the following exploratory questions: Does the training have an immediate and medium-term impact on the participants' sense of competence? Does the training lead to the acquisition of the knowledge required for the CA role and is this acquisition sustained over time? Does the training enable CA skills to be deployed in real-life contexts? The specific objectives are to describe the immediate and medium-term effects of the training on (1) feeling competent to act as a CA, (2) acquisition of the knowledge required for the role, and (3) anticipated and proven deployment of CA skills in a real-life context.

2.2 Conceptual frameworks

Two theoretical frameworks support the conceptualization and operationalization of this approach. First, the CA Action Planning Model (CAAP Model; Carrier & Contandriopoulos, 2016) describes a systematic process for analyzing and planning CA actions. This model was developed to help HSS professionals play their CA role; it is based on the skills required for this role and on the results of a targeted review of the literature on CAs: (1) evaluation-intervention models, (2) intervention contexts, and (3) communication strategies. The model involves eight iterative and dynamic steps (see Figure 1). Its application is not prescriptive: it allows for flexibility and responsiveness, which are essential in any CA action.

Figure 1. CAAP Model. Illustration from Rahimaly et al. (2019).
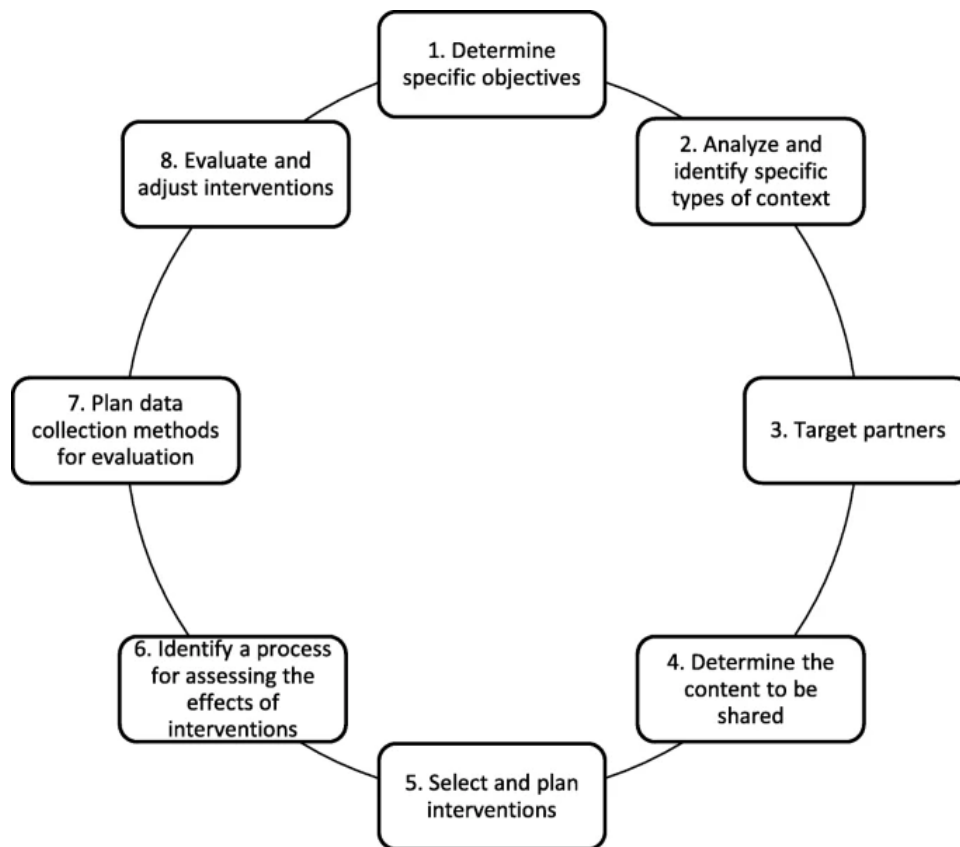
Second, the Miller Competency Framework (Miller, 1990) structures the acquisition of the knowledge and skills required for a specific role in four progressive levels of complexity. According to this model, the development and assessment of competence, that is, a person's ability to adequately apply knowledge and skills to an actual task in order to perform it effectively, involves four levels, i.e., the person (1) knows, (2) knows how, (3) shows how, and (4) does. In this study, levels 1 and 2 will be specifically targeted. Both frameworks will be useful when developing the training program and collecting data for the checklist.

2.3 Conduct of the study and data collection

Phase 1: Conceptualization

Guided by Miller's theoretical framework (Miller, 1990), this phase was structured around the training needs already identified by the APTS. The research team's pedagogical and change agency expertise and their previous experience in training and research (Rahimaly et al., 2019; Beaudoin et al., 2019) were used, as well as the CAAP Model. Closely supervised by the researchers, a research assistant and a research trainee designed the training program (content, pedagogical and technological methods), the CA checklist (content, format of the synthesis document), and the self-administered questionnaire (see Evaluation phase). The checklist synthesizes important theoretical content related to carrying out CA actions and a reminder of the training topics. These topics are systematic CA action planning (CAAP Model), contextual analysis (internal and external contexts), and communication strategies, including argumentation and partnership development (e.g., stakeholders). Feedback will be actively sought from all team members, including APTS representatives. The APTS secretary and research officer will provide technical support (e.g., layout, photocopying, scheduling of team

meetings, booking of rooms, etc.). Prior to implementation and to prepare for the training, two trainers (research assistant and principal investigator) will meet with six facilitators (APTS representatives).

Phase 2: Implementation

The APTS will send an email inviting its members to participate in the training and research; the message will be relayed on the APTS' social networks and newsletters. Because they face significant challenges with respect to access to their services, APTS members from the following services will be targeted: home care (CLSC), long-term care center (CHSLD), addiction rehabilitation center (CRD), and rehabilitation center for intellectual disabilities and autism spectrum disorder (CRDI-TSA). Interested individuals will be invited to contact the APTS to indicate this and get more information; for specific questions about the study, they will be redirected to a research assistant. If still interested, applicants will be able to register on the APTS' GEMS platform. This platform is used by the APTS to register participants and generate union release requests to give to the employer. Once the list of participants is complete, a web link to the virtual declaration of consent will be emailed to each of them. This declaration contains contact information for the research assistant, who can answer questions as needed.

A total of 128 APTS members from a variety of disciplines will be recruited using a convenience sampling strategy. No exclusion criteria will be applied. These 128 members will be given leave to participate in the training. Sixteen groups of eight participants will receive two half days of virtual training (total of 7 hours). Virtual training was chosen because of pandemic-related uncertainties. The ZOOM Pro platform was selected because it meets the partner's needs and ensures computer security and confidentiality. During the training, each group of participants will actively acquire specific CA knowledge and skills with the guidance of a facilitator (research assistant, principal investigator or APTS representatives). The pedagogical method used will be professional co-development (Hoffner-Lesure & Delaunay, 2011; Payette, 2000; Payette & Champagne, 1997). This approach allows participants to learn from one another through a structured consultation exercise (Payette, 2000). In this case, participants will play the role of client or consultant (Hoffner-Lesure & Delaunay, 2011; Payette & Champagne, 1997). The client will be a participant who needs help in a particular situation. The consultants will be all the other members of the group who provide input based on their experience. The facilitator will guide the process and the theoretical content of the session.

This sequence will be repeated to allow two different situations to be explored. During these consultations, facilitators will note elements addressed by the consultants and pertaining to the theoretical content that will follow in the training program ("golden nuggets"). These nuggets will be shared with the two trainers (research assistant and principal investigator), who will use them as examples in their theoretical presentation. Then the theoretical content (CAAP Model, contextual analysis, and communication strategies, including argumentation and partnership development) will be presented in a plenary session. At the end of the day, participants will return to their respective groups and choose one of the two situations already explored in order to apply the theoretical content. Facilitators will provide them with the checklist to support this application.

Table 1. Six steps in the professional co-development approach according to Payette and Champagne (1997) and Hoffner-Lesure and Delaunay (2011).

Steps	Process
1. Statement of the situation requiring change	The client presents the problem and consultants listen. The problem is a situation that needs to be changed and where CA actions are necessary.
2. Clarification	Consultants ask questions, the client answers and clarifies.
3. Contract	The client submits a request to the group and specifies the type of consultation desired. Both (client and consultants) make sure that the contract will allow the consultation.
4. Consultation/exploration	Consultants share their impressions, reflexive questions, reactions, comments, ideas, suggestions, etc. The client listens without debate, clarifies if necessary, and notes the consultants' suggestions.
5. Synthesis of learning and action plan by the client	The client assimilates the information and designs an action plan. During this time, consultants synthesize their day's learning.
6. Learning and regulation	The client and consultants describe their learning. They regulate themselves and evaluate the session.

Phase 3: Evaluation

To achieve the research objectives, a summative evaluation design will be used (Brousselle, Champagne, Contandriopoulos & Hartz, 2009) to judge the effects of an intervention. In this case, the intervention is the training program designed to meet the needs of APTS members. Based on a previous medical study (Roth, Barreto, Sherritt, Palfrey, Risko, & Knight, 2004), a self-administered electronic questionnaire was developed by the team (see below). To describe the immediate effects of the training on participants' feeling of competence to act as a CA (objective 1), knowledge acquisition (objective 2), and the anticipated deployment of skills (objective 3), participants will complete this questionnaire prior to and immediately after the training. Nine months later, they will complete the questionnaire again without the sociodemographic and pre-training sections. For the distribution of the questionnaire, the research team will benefit from the close collaboration of APTS representatives, following the recommendations of Dillman, Smyth, & Christian (2014).

2.4 Self-administered questionnaire

The content of the questionnaire was inspired by Lax, Braganza and Patel (2019). Its content and face validity were pretested using the Delphi method (Hasson, Keeney, & McKenna, 2000; Powell, 2003). Six content experts from various fields (HSS, pedagogy, CA role) were consulted during (content) and after (face) construction of the questionnaire. This systematic consultation method is particularly useful when empirical knowledge is poor or limited (Hasson et al., 2000). There were successive rounds of consultation until a consensus of 80% of the experts was reached for each question. Next, the questionnaire was pretested with ten occupational therapy graduates from the Université de Sherbrooke who received training in the CA role during the final year of their program. The questionnaire consists mainly of closed

multiple choice questions answered on a Likert scale ranging from 0 to 5 (e.g., 6 levels; from 0 = not at all to 5 = completely). Other closed questions involve from 8 to 20 multiple choice items. The questionnaire focuses on the feeling of competence to act as a CA (e.g., I feel capable of acting as a CA), as well as on the knowledge (e.g., What are the effective communication strategies to use as a CA?) and skills (e.g., I communicate effectively in my environment when I act as a CA) required for the CA role. To characterize the participants' profile, the questionnaire also includes a sociodemographic section (e.g., age, clinical setting, population served, number of years of experience). Thus, the questionnaire contains three sections: pre-training, post-training and sociodemographic data. Data obtained from each participant (pre-, post- and nine months after training) will be linked using an encrypted code to preserve confidentiality. All participants will have access to an electronic device and the questionnaire will only be available in electronic form. The electronic questionnaire was developed on Université de Sherbrooke's Microsoft Form platform because of its high security and easy data extraction.

3. Data Analysis

To analyze the data, descriptive statistics (means, standard deviations, frequencies, percentages) and inferential statistics (non-parametric Wilcoxon test, binomial distribution test) will be used. The data will be extracted on an Excel platform and analyzed in SPSS by the research assistant. The analysis will be verified by all team members, including APTS representatives.

4. Discussion

4.1 Strengths and limitations

This research partnership provides HSS professionals with an opportunity for sustainable evidence-based professional development. More specifically, it will give them highly contextualized training in the role of CA, a role that is socially important yet currently underinvested. Also, by utilizing knowledge from different areas of expertise and a partnership approach, this unique training opportunity leverages a particular strength of this research, namely the team's professional experience in pedagogy and rehabilitation. Finally, although social desirability is a potential bias (Fisher, 1993), the methodological choices made will ensure that the data are rigorously analyzed.

4.2 Contribution and anticipated impact

This innovative study is part of a co-constructive intersectoral approach to knowledge development and mobilization. Through the partnership process selected, the design of the training program and CA checklist will draw on the expertise of the researchers (theoretical knowledge) and partner (empirical and experiential knowledge). By considering the needs expressed by APTS members to their union (Conceptualization phase) and the results obtained (Evaluation phase), this strategy will ensure that the products developed are relevant. Finally, since the APTS will be involved at every step in the process (and more specifically in the Implementation phase), the APTS and its key professionals will take full ownership of the products of this study. This will enable the APTS to pursue implementation on a larger scale (e.g., in other clinical settings). Because of this close involvement, the APTS will be in a position to ensure the continuity of the implementation and sustainability of the products developed (training program and checklist). In addition to traditional methods (publication of two articles and presentations at international conferences), the APTS will disseminate the results of the study to its 60,000 members via a bimonthly newsletter to its internal committees

(Executive Committee, National Council, etc.) and delegations (e.g., General Council) as well as to various partners at union forums. The APTS will also use its information technology resources (Website, Facebook and Twitter pages) to generate publicity. Although initially developed in collaboration with and for members of the target communities, the training program and checklist could also be adapted to and implemented in other communities (e.g., professionals working with vulnerable seniors in long-term care centers). Finally, the research team will make every effort to maximize the impact of the research.

5. Ethical Considerations

The research protocol has been approved by the Research Ethics Committee of the CIUSSS de l'Estrie–CHUS. As previously mentioned, a virtual declaration of consent will be presented before the first questionnaire can be accessed. All participants will be required to provide free and informed written consent (Three Councils, 2014). Participants will be able to withdraw from the study at any time without any consequences. They will also be informed of the confidential nature of the data collected and the procedures followed to ensure confidentiality and anonymity. The data collected, both electronically and on paper, will be secured (on a password-protected computer or in a locked fireproof filing cabinet at the Research Centre on Aging) and only the research assistant, research trainee and principal investigator will have access to them.

6. Timeline

The study began in May 2020 with the literature review and synthesis, and finalization of the protocol. Ethics approval was obtained in November 2020. The Conceptualization phase was completed in July 2021. The Implementation and Evaluation phases have been postponed because of the pandemic. Data collection will take place from March to December 2022. Final analysis and dissemination of the results are scheduled for 2023.

Declarations

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