Better Foot Forward Project: Third-Party Evaluation Services

Author: Nick Petten, Petten Consulting, Sole Proprietorship Company

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Contents

Summary

This report provides a summary of evaluation activities that were conducted as part of a third-party investigation into whether the project, Better Foot Forward, followed its intended logic of delivering an education intervention focused on providing the skills, knowledge and confidence to unregulated healthcare workers to effectively assess the feet of people living with diabetes and who are at risk of preventable limb amputation.

Acknowledgements

It is with great pleasure to present this report to the leadership staff associated with this project for their learning and reporting purposes. I am grateful to the entire Future Skills Centre (FSC) Grant Team for giving me the opportunity to learn about the complexities of this project and the significant societal problem they are trying to address. I would also like to thank the participants from partner organizations that I had the pleasure to speak with for giving me a better understanding of their lived experiences of addressing this problem directly with people living with diabetes.

Petten Consulting Positionality Statement

Petten Consulting is a research and evaluation company specializing in conducting full scope and customized evaluation services for clients in the social sector. Petten Consulting brings a range of skills and expertise in research and evaluation to working with organizations dealing with complex social issues. We provide professional consultations on monitoring and evaluation activities, community consultations, participatory research methodologies, and ethical guidance on working with community participants. Petten Consulting also maintains a roster of specialist evaluators and subject matter experts that contribute on a project-by-project basis based on the identified needs of the client.

The evaluation services provided to the University Health Network (UHN) and the findings generated in this report are largely the work of a single evaluator, Nick Petten, who offers a description of their positionality in relation to the content of the project. A statement of positionality is a method for authors of a narrative to demonstrate their relative social position and power so that readers can build a sense of trust and understanding with that author and the concepts they are expressing. Like how this report and similar reports demonstrate scientific competency by explaining their methodology, a positionality statement attempts to demonstrate self-aware cultural competency and humility in relation to a culture that the author does not fully identify with.

Positionality Statement of Nick Petten

I identify most of the time as a cis-hetero male, but occasionally as gender-non-conforming, with bi-racial ancestry from the Netherlands and Indonesia, and with a diasporic group in the Netherlands called, Indos. As an evaluator, I emphasize the social utility of evaluation as a method of social liberation from oppressive forces and a tool for social, economic, and environmental justice. This is sometimes in contrast with the emphasis on objectivity and neutrality that evaluators and scientists sometimes claim to have. In this report, I aim to represent the people involved in the project through the application of rigorous and efficient methods while taking responsibility for my own cognitive biases along the way through critical reflexive practice.

Program Evaluation Praxis

Nick Petten is heavily engaged in two professional associations that provide continued education, communities of practice, and emerging scientific evidence on effective and impactful ways of conducting program evaluations and engaging in evaluative thinking. One of the associations is the Canadian Evaluation Society which provides guidance on evaluation standards using the Joint Committee on Standards for Educational Evaluation (JCSEE) and ethics. His primary engagement with the Society is to develop, promote and advocate for evaluation practices to be anti-oppressive, socially just and equity-focused. He is involved in several committees, working groups, and communities of practice with these explicit aims. The other association is the American Evaluation Association, representing evaluators from across North America with an increasing global presence and participation through EvalIndigenous and EvalYouth. Nick was formally on the leadership team of the Youth-Focused Evaluation Topical Interest Group (YFE-TIG) which advocated for the ethical participation of young people in program evaluation. This evaluation adhered to the Association's Guiding Principles:

> *The Guiding Principles reflect the core values of the AEA and are intended as a guide to the professional ethical conduct of evaluators. The five Principles address systematic inquiry, competence, integrity, respect for people, and common good and equity.*

Project Description

In Canada, a need exists to increase the number and diversity of people trained to screen and assess diabetic foot problems to improve timely access to care. Recognizing this need, a team from The Michener Institute for Education and The University Health Network (UHN) developed an education intervention to provide skills in foot assessment to a broad range of people in traditional and non-traditional roles in the hospitals and the community.

This education intervention was designed to provide training for employees, learners, and staff at partner organizations and at UHN to provide foot screening to populations that are at risk of limb loss. The education intervention consisted primarily of a curriculum based on teaching a validated diabetic foot screening tool for community and healthcare workers to be able to screen and identify people with at-risk feet and connect them to the appropriate level of care. In addition, the intervention and the associated research activities were designed to highlight competency gaps and reskilling opportunities that are specific to the populations that are served by the partner organizations and at UHN. The intention of the project was to reach organizations that are serving systematically disadvantaged groups, primarily through an unregulated workforce, such as Personal Support Workers, Personal Care Attendants, Home Support Workers, shelter workers, respite care workers to name a few. The primary distinction is that the intended audience for this intervention is a workforce that lacks regulatory oversight, and the resulting lack of support services, continued education, and institutionally recognized credentials.

Over the course of the grant period, 114 people from seven organizations in three provinces and territories completed the Best Foot Forward Training. A complete summary of the number of organizations and people trained can be viewed in the Knowledge Sharing Report that is authored by the FSC Grant Team.

Evaluation Objectives

This evaluation report focuses on providing evidence of the project's fidelity to its intended outcomes. The Principal Investigators from The Institute for Education Research (TIER) and the Michener Institute of Education at University Health Network wanted to know whether the project followed a logical sequence of activities that would produce an intended outcome. In addition, this report attempts to indicate areas where the project deviated from the plan, the reasons why and whether the deviation was perceived as necessary, an improvement or a challenge to accomplishing the project's intended outcomes. While the project had several overarching objectives, this evaluation focused on the educational components of the project, including the co-design process of creating the curriculum with partner organizations. This report should be read in conjunction with the Knowledge Sharing Report that is authored by the FSC Grant Team and provides more evidence of the project's effectiveness and outputs, such as, the total number of partners, trainees, and the various knowledge products produced.

Objectives:

- Assess to what extent the project followed a logical sequence of activities that would produce the intended outcomes for community health workers and people with diabetes.
- To document any adjustments/deviations made to the project design and the implications on project effectiveness.

An intended goal of the evaluation is to consider the cognitive integration of evaluation activities and evidence to make the evaluation findings as universally accessible as possible. This aligns with the pedagogical orientation of the project (as the evaluation findings will demonstrate). While the nature of this report is technical and based on industry standards and practices, the writing style is meant to convey the most meaningful and substantive information in a simple way, while acknowledging the complexities of the project and the context it operates in.

The key evaluation questions are:

1. Was the co-designed education initiative implemented as intended?
2. Did the initiative produce new information that was adapted in content, context, and mode of delivery?
3. Were the educational components of the initiative culturally appropriate and provided safe practices for Indigenous populations?
4. What was the impact of COVID-19 on the intended process of the co-designed education initiative?
5. Was the model of education effective for the cognitive integration of healthcare and community workers?
6. What was the impact of engaging and partnering with "non-traditional" healthcare providers?
7. Did the initiative equip healthcare and community workers with the knowledge to identify and prevent high risk foot wounds and diabetic foot ulcers? To what degree?
8. Did the initiative result in an increase in the number of identified people with at risk feet and link them to care to prevent limb loss?

The findings section of this report is organized according to this list of questions. A discussion of where the questions intersect is offered in the conclusion section of this report.

Though a lesser focus, some outcome-related data was also gathered according to questions number 7 and 8 in the list above. At the time of writing this report, the project was still being implemented, namely the final delivery of the curriculum to partner organizations. Therefore, it would be too early to report on any substantive outcomes related to this project. However, this evaluation will attempt to demonstrate that if the process of developing and implementing the project followed a logical sequence of activities that is informed by evidence and is properly resourced, this would indicate that the project can achieve its ultimate impact, given more time and, possibly, more resources.

Privacy and Confidentiality

This evaluation received approval from the Quality Improvement (QI) Project at UHN to include human participants that prioritized their privacy and confidentiality. Interviewees were reminded that data obtained through the interview process would be anonymized and stored on a password-protected UHN server for up to 5 years and accessible only to the project manager.

Interviewees were provided an information sheet (see Appendix) prior to the interview that was approved by QI at UHN listing their rights as research participants, the set of key evaluation questions, contact information and a section to provide consent for future contact for evaluation reporting. Interviewees were reminded of their rights as research participants at the beginning of the interview and given a chance to end the interview and/or ask follow-up questions.

Approaches

The approaches to this evaluation considered various conceptual frameworks to guide the development of evaluation questions and methods.

Equity-focused

Throughout project documentation, the equitable treatment of specific populations was highlighted as an overarching objective of the project. As such, the evaluation focused on whether the education intervention was able to design and implement activities in equitable ways and to structure evaluation activities that prioritized the participation of groups of people that have been historically marginalized from participating in healthcare planning and program development.

Purposeful Program Theory

Purposeful Program Theory (PPT) recommends the use of a *theory of change* and *logic model* to demonstrate the logic of a social program with a special focus on risk mitigation efforts during the lifecycle of a program[1]. It also recommends the use of *scenario-based counterfactuals*. In addition, PPT recommends the use of a *critical review process* to investigate elements of a logic model where alternative explanations can account for any outcomes that are realized.

Cultural Responsiveness

An understanding of the cultural dimensions of designing and implementing an education intervention was a major focus of this project. Similarly, an evaluation process that considers the cultural dimensions

[1] Funnell, S. C., & Rogers, P. J. (2011). *Purposeful program theory: Effective use of theories of change and logic models*. John Wiley & Sons.

of asking questions to participants and representing their answers in a report format was considered for the chosen methodologies. For example, a slightly altered version of the interview protocol was used when interviewing a participant that came from an Indigenous-led organization, which included a statement of positionality of the evaluator (similar to what is written at the beginning of this report), emphasizing a reporting style of not attributing any deficiencies to specific populations, and contextualizing this project within a broader society that historically, and continues, to oppress non-dominant cultures, especially within the medical healthcare system. The evaluator also identified themselves as an individual that is a racialized minority. Ideally, this disclosure was done to build a sense of trust and reciprocity between the interviewer and interviewee, which is important in indigenous research methodologies. A summary of the interview notes was sent to the Indigenous interviewees to review and check for accuracy, as well as remind them that they own the data and could use it as they see fit.

Methods

Data Collection Methods

In accordance with the evaluation objectives and questions, evaluative data was collected primarily based on process-related measures of whether the project followed its intended logical sequence of activities. The development and use of a logic model was used throughout the evaluation as a practical visual aid to understand a complex and dynamic project and was developed using a software application called Miro. The logic model was shared during all the interviews to assist in the collection of data.

Primary Data

Document Review

Project documentation was given to the evaluator to use as evaluation data. Documentation was used to develop a logic model of the project and for the evaluator to become familiar with the project before engaging with project staff. The evaluator made several requests throughout the evaluation process to obtain more documentation that was referenced in other project documents and during interviews with project staff. A list of documents that were considered in this evaluation are listed in the Appendix of this report.

Qualitative Interviews

Qualitative data from interviews represents most of the evaluation data collected that informed the findings section of this report. The scope of the evaluation did not include the extensive collection of quantitative data which is contained in the Knowledge Sharing Report. Qualitative interviews with participants were not audio recorded, partly due to limited access to suitable and secure technologies, as well as to limit the amount of personally identifiable data that would be stored on UHN servers. To compensate for the lack of a rigorous qualitative analysis process, several other methodologies are articulated below to improve the quality of the data and increase the legitimacy of the evaluation findings. Interviews with participants also included questions about whether other projects or programs that currently exist at UHN or at the partner organization exist and can potentially account for the intended outcomes for this project.

Interviews with team members

Interviews with the FSC Grant Team (n=9) were conducted before interviews with partner organizations and trainees to help the evaluator understand the complexities of the project, to receive feedback on the Logic Model and to answer the set of key evaluation questions. The interviews with FSC Grant Team members were conducted through two separate interviews. The first interview consisted of asking open-ended questions about the project based on findings from the document review as well as asking the key evaluation questions. For the second interview, a summary of the first interview was presented to the interviewees to check for accuracy and to ask follow-up questions. The data given to this evaluation by the FSC Grant Team was covered by the Quality Improvement (QI) Project at UHN.

Interviews with partner organizations and trainees

Most interviews with the partner organizations and trainees (n=9) were conducted after the interviews with the FSC Grant Team using the logic model that was developed from that process. A list of potential participants (n=106) was gleamed from project documentation and a negotiated process of confirming interview participants was followed. The resulting list of potential participants represented partners and trainees that received the training and worked with equity-seeking populations. Only one trainee that was not considered a partner organization participated in the interviews. The rest were individuals that represented a partner organization.

Secondary Data

As mentioned above, quantitative data was not extensively collected for this evaluation report. Any quantitative data that is used in this report comes from secondary sources, primarily data that was collected by the FSC Grant Team throughout the project's lifecycle.

Quality of Data

The quality of the data collected for this evaluation report was supported by a critically reflexive process that the evaluator followed throughout their engagement on the project. A set of critically-informed, equity-focused questions were used to reflect on the positionality and cultural competence of the evaluator. Most of the risks identified relate to cognitive biases that the evaluator has in relation to their positionality, including their educational background, identification with a dominant culture, and ethics of care towards participants in this evaluation. This methodology is informed partly by the pedagogical orientation of some of the FSC Grant Team members and their respective organizations (TIER, Michener, UHN) as well as through the communities of practice in research on evaluation that this evaluator is an active participant of. The results of this process influenced the interview protocol, the style of reporting to focus on generalities, and to limit the extent to which this report represents cultures and groups of people that the evaluator does not personally identify with.

Data Analysis

Data that was collected as part of this evaluation was organized along a matrix to conduct a cross-tabulation analysis between the various data sources (interviews, project documentation and secondary measurement data) and the key evaluation questions. For each data source, the strength of the data (how often a concept appeared between participants), the methodological strength, and data availability was considered for the Findings section. The Findings section is organized by key evaluation questions using data obtained from all sources.

The Conclusions section of this evaluation report considered areas of the project where there was high program fidelity and/or a logical reason for programmatic changes to offer some conclusive statements about the overall effectiveness of the project, but primarily the co-design process of developing an education intervention.

Limitations

Evaluation Fidelity

The evaluation activities as originally conceived during the inception of the project were not comprehensively followed. Various evaluation activities were either missing a dedicated person or separated between various people potentially leading to data integrity issues.

Evaluation activities were identified as a core component of the project since its inception, however, evaluation activities were disjointed and not always adhered to. For example, there is indication that a program evaluator was to be hired near the beginning of the project, however, it was not until June 2023 (two years after the project had been running) that this evaluator was hired to conduct a third-party evaluation of the project. Several evaluation functions were delegated to various project staff members throughout the project, for example, collecting measurement data after training sessions, developing a data visualization dashboard to demonstrate the spread of the project, and to develop a model of the project that can be shared with local hospital networks, shelters and community organizations. It remains unclear whether these evaluation functions will continue. There are indications that the granting agency (Future Skills Centre) will no longer exist after the final reporting is complete for this project, risking any ongoing and future evaluation activities. Regardless, this evaluation considered and utilized guidance from FSC on evaluation activities, namely the use of a logic model to investigate the logical explanations for project outcomes.

A limitation of this evaluation is that most of the evaluation activities that were under the control of this evaluator, were conducted near the end of the project and, as such, quantitative baseline and outcome data are not being considered in the findings of this report.

Findings

This section of the report focused on data obtained from various sources including interviews, project documentation and secondary sources. Most of the findings come from interviews because this represented a major evaluative activity that generated evaluation data that is not as accessible to members of the FSC Grant Team. It is recommended that readers also read the Knowledge Sharing Report which reports on data obtained throughout the project's lifecycle. An interpretation of the findings is explored in the subsequent Conclusion and Recommendations section.

Co-Design Process

Key Evaluation question: Was the co-designed education initiative implemented as intended?

The *co-designed process* of this project is a significant component to achieving its intended educational outcomes. The *process* was articulated in several project documents since the inception of the project, however, not all documents were dated, and some documents appeared as unfinished products. This

created some uncertainty about what exactly the intended process was. With that in mind, the reader is encouraged to review the Knowledge Sharing Report for a comparison. A visual depiction of the *intended* logical sequence of activities is presented below.

Figure 1: Intended logical sequence of activities.

A version of a logic model did exist near the beginning of the project, however, most FSC Grant Team members were unaware of its existence. Additionally, the logic model did not demonstrate the logical connections between different parts of the project, as the name implies it should. As such, the version of the logic model that was developed through evaluation activities was used in all interviews to help participants quickly remember the project, be able to locate where in the project they participated in and contribute to, and then be able to reflect on whether this was the actual process they followed or were lead through. The findings of this process are presented throughout this report. A version of this model is also reproduced in the Appendix of this report.

Partner organizations that participated in evaluation interviews validated that the **general process was followed for their unique partnership**, with some caveats, mainly that the process was delayed, sometimes producing significant unintended impacts. Some of the impacts include a loss of relationship trust and the utilization of operational and administrative resources at the partner organization which was not planned for. In addition, the method of obtaining feedback on the curriculum for each partner did not follow the same process. The processes ranged from a few meetings with trainers on the curriculum to conducting focus groups with initial trainees from a partner organization. The process of conducting focus groups with trainees is articulated in the Community Education Pilot Report and in the Knowledge Sharing Report.

Many of the findings of this evaluation relate to the fact that this project began near the same time that the **COVID-19 pandemic** began. The pandemic caused many unintended impacts on the project's ability to achieve its intended outcomes, as well as preventing a thorough investigation into the causes of potential delays through evaluation activities. In other words, because the pandemic had such an overwhelming impact on the healthcare system, and society in general, it is challenging to differentiate between delays caused by the pandemic versus delays caused by other factors. Considering this, the evaluation attempted to be explicit about this and ask specifically what the impact of COVID-19 was on the project with follow-up questions on whether other factors contributed to delays. Those factors are discussed in the following sections.

Alignment of Curriculum Adaptation Processes

It was intended that the Realist Review, an academic exercise in searching for evidence of program effectiveness in unique contexts, was going to influence the creation of the curriculum. The logic of using the Realist Review to influence the development of the curriculum is indeed aligned with the overall pedagogical intent of the project, however, there were challenges with timing the two activities in sequential order (see Figure 2).

The risk is that the Realist Review may not have been comprehensively utilized in the curriculum design. An example of this may be observed in the way the project was named, as well as the different ways that

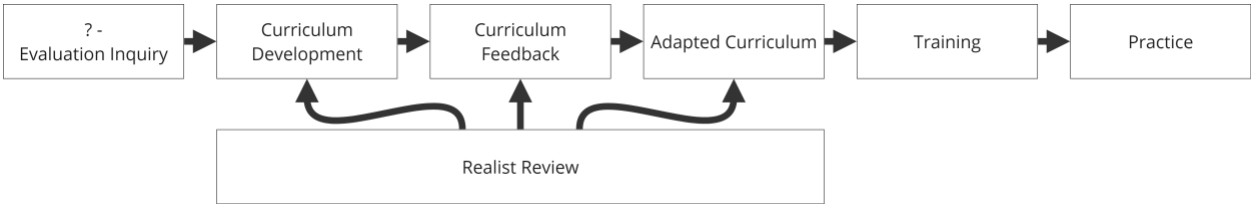
the intended audience of the education intervention was conceptualized. The name of the project changed throughout the project's lifecycle and some interview participants expressed that the name did not reflect a critical, equity-informed lens. As one participant put it, "not everyone has a foot that they can put forward [due to limb amputation]", as the title of the project would encourage. The other example is that throughout the project documentation and during interviews, the **population that this project should have an ultimate impact on** were referred to and conceptualized in different ways. They include the following:

a. most marginalized within society
b. people at risk of foot complications
c. under-served Canadians living with diabetes
d. underserved populations that included the needs of individuals living with diabetes in these communities
e. those who are the most structurally disadvantaged, such as racialized people, Indigenous people, people with insecure housing or who are unhoused
f. systematically marginalized groups

The Realist Review used the concept of 'systematically marginalized populations', however it also found that there was a lack of literature for this group on the impact of education interventions like the ones in this project. It is possible that if the Realist Review was conducted well before the development of the curriculum and project planning documents, and that there was broader agreement in the literature about what concepts to use, the alignment of language and program activities could have been tightened and expressed more coherently.

Instead of the intended process of having the Realist Review inform the development of the curriculum, the primary author of the Realist Review conducted their work at the same time (see Figure 2, below).

Figure 2: Actual sequence of activities in relation to the Realist Review.



The team used their weekly team meetings to discuss the literature and evidence being generated through the Realist Review to iteratively inform the curriculum. However, there are conflicting views on whether this method was appropriate to the overall process of developing the curriculum. There is the belief by some that the curriculum might have influenced the Realist Review, which is the opposite of the intended process.

Part of the approach of using Purposeful Program Theories (PPT), includes **investigating counterfactual explanations for perceived outcomes**. As such, interviewees that were part of the FSC Grant Team were asked whether there were other initiatives at UHN that were influencing the curriculum development process, and subsequently all other parts of the education intervention. Various projects, initiatives, and departments were mentioned and includes the Chiropody Clinic at Michener, Caring Safely, the UHN Footcare Pathway, and a housing initiative at UHN. It is possible that this project benefitted significantly

from the available resources and existing educational content from these other sources, which this evaluation could not fully account for and measure to what degree. However, no other projects or programs were identified that are like this one and could account for the same outcomes. In fact, many appreciated the novelty and uniqueness of this project and that it addressed a long-standing gap in the healthcare sector.

In addition to the intention that the Realist Review was to be used to design a curriculum that was culturally appropriate to the intended audiences, there were several other **curriculum adaptation processes** that took place, some of which were conducted reactively rather than proactively. For example, partly due to the delay in initiating project activities due to COVID-19, the intended process of delivering an early version of the curriculum and then conducting focus groups and interviews to assess the appropriateness of the curriculum were not always comprehensively followed.

Only with two partner organizations was the intended method followed, Dixon Hall and Streethaven, which produced a report called Community Education Pilot. It is unclear why this was called a pilot project, considering that the function of the pilot should have been applied to all partner organizations since it seems like an important part of the intended co-design process. In addition, only one of the two partner organizations completed the pilot process at the writing of this report.

According to project documentation and planning, it appears that the co-design process was going to follow a specific set of activities moving from initial meetings with partner organizations to the final delivery of an adapted curriculum that is **unique to each partner site and audience**. However, the specific steps of the co-design process were different for each partner and, for many of the partners, there was not a unique adapted curriculum for each. Instead, each partner had a slightly different process, possibly reflecting the flexibility and responsiveness of the team to carry out project activities, as well as that each team member was assigned a different partner. Overall, this was seen as a benefit to the project, from the perspective of staff team members, as well as partner organizations that provided evaluation data for inclusion in this report. Except for one partner organization, it is expected that the final curriculum will be the same for each partner organization, possibly indicating that the curriculum has elements of a **universal design** that is appropriate and useful for the use of unique partners in unique contexts. While a curriculum that is universally designed is an objective of many educational initiatives, there lacks evidence that this was an intended outcome of this project. In most of the project documentation, it is intended that each partner organization would receive their own adapted and customized curriculum for their specific use.

Pedagogical Orientation of the Co-Design Process

Many pedagogical considerations went into the design and implementation of the co-design process, with an overall emphasis on a **social constructivist pedagogy** and the use of **evidence-informed** (or -based) education practices and content on footcare. The initial development of the curriculum was designed to accommodate both theory and then practice and include quick feedback response mechanisms within the curriculum, for example through knowledge-based questions and reflections, which is aligned with the literature on effective educational practices. Many of the FSC Grant Team members that facilitated the training workshops and the train-the-trainer workshops, demonstrated a social constructivist pedagogy, where a large intention was to better understand the learners in the room and accommodate as much dialogue as possible throughout the educational experience.

It was understood by a few FSC Grant Team interviewees that the **cultural competency** aspects of the curriculum would be the responsibility of the partner organizations, however, this was not always clear to the partner organizations. A partner organization expressed that cultural competency should be the responsibility of UHN, or at least to train their staff on the minimum requirements to be culturally competent. In addition, it was well understood by many that the cultures across the project's geographic scope and between partner organizations would be very different from each other. Additional findings that relate to cultural considerations in the education intervention are explored in a proceeding section of this report.

There were several efforts to make the curriculum align with **principles of trauma-informed care** to be more inclusive, partly to acknowledge an approach to working with Indigenous populations. Over the course of the curriculum development process, it became more apparent that the resources available for curriculum development were not inclusive enough for the audiences it was intended for. For example, imagery that is owned by UHN that can be used in curriculum development did not have a large enough selection to account for things like different skin tones and culturally relevant footwear.

Staffing of FSC Grant Team

Many team members that were involved in the initial proposal did not remain with the project during its entire lifecycle (potentially unrelated to pandemic staffing changes). Since early in the project, there were **staffing changes** with the FSC Grant Team that potentially interrupted the intended process of implementing the grant. There was a risk throughout the project that a high-quality curriculum would be compromised with high staff turnover and insecure employment contracts with team members. However, the risk was partly mitigated by the availability of resources and other staff that are a part of the UHN system. For example, it was mentioned that UHN-affiliated organizations like The Institute for Education Research (TIER) and the Centre for Advancing Collaborative Healthcare & Education provided important contributions to this project that were not necessarily planned for. Interviewees also referenced various other UHN research and educational initiatives, for example an environmental scan of community health worker programs in Ontario, which FSC Grant Team members participated in.

The **inter-disciplinary diversity** of the FSC Grant Team was viewed as a significant benefit to the co-design process because it allowed for different perspectives to be taken when developing the curriculum and the Train-the-Trainer Guide, and when engaging with diverse partner organizations. Each member of the team represented different aspects of the project, ranging from having direct experience working with the unregulated healthcare workforce, providing clinical care as a chiropodist, and having extensive experience in designing and delivering education interventions.

Selecting Sites for Training and Forming Partnerships

During the inception of this project, FSC Grant Team members intended to **leverage the available connections** they previously had from other projects and aspects of their work. This was viewed as a beneficial approach to the project because they had already built trust with individual people from potential partner organizations. Subsequently, during the project's lifecycle, the team members took responsibility for each partner and met often to discuss their approaches. The risk of this approach was partly realized when individuals at the partner organization engaged with UHN in official capacities (for example signing agreements) without the full knowledge and consent of their leadership and not being aligned with their governance structures. Most of these issues were resolved through dialogue in

meetings that were quickly scheduled to find solutions to moving forward with the partnership. An example of this is articulated in the Knowledge Sharing Report in a section written by staff at the Indigenous Diabetes Health Circle (IDHC).

The initial outreach and developing partnership agreements were challenged by the **timing of the project** where much of it occurred during the summer months when staff were away on vacation following the easing of public restrictions due to COVID-19. There is the expectation that September would have been a better month to conduct outreach and sign partnership agreements, however, the timing of the project did not always allow for this. Many interviewees expressed disappointment that the **partnership agreement process was slow and complicated**, and utilized more time and resources than was expected. The content of the partnership agreements was also difficult to understand, especially for smaller partner organizations without legal representation or capacity. As a result, there was some mistrust and apprehension about signing the agreements despite the perceived benefit of the partnership. Overall, many interview participants expressed that the process and time it takes to implement a project like this one, especially with communities, was not aligned with UHN policies around partnership agreements, contracting and implementing a timely response for the community's needs.

When delivering some of the training, the facilitators were surprised that the **number of expected participants** was lower, whereas in some cases, staff were pulled from the training just before. This might be explained by the decision to compensate trainees for the time taken to train was left to the partner organizations, which lead to inconsistent approaches to compensation throughout the project. It is possible that trainees, upon realizing that they were not being compensated for their time in the training, decided to not participate on the actual day of training. The difference between paid staff and non-paid staff varied between partner organizations, possibly resulting in different outcomes between organizations. Another significant reason includes the inherent nature of working in communities when issues requiring an **urgent staff response** is required and training is de-prioritized.

A target audience of the training are people that are not necessarily healthcare workers, but **people that urge others to get healthcare**, for example, workers in shelters, who have access to people daily. These types of workers typically have gained more trust in the community than healthcare workers that are not from the community. This trust between community members and workers (who are sometimes the same person) potentially increased the attendance at trainings because people were more willing to show up if they knew others that are going with whom they can speak with more casually and ask questions with.

Overall, the process of selecting sites, making contact, and signing partnership agreements within the societal context of a once-in-a-lifetime global pandemic, took much longer than planned for. A significant impact of this protracted process resulted in the training only being delivered in the final 6 months of the project. This compressed parts of the project into **very short timeframes**, especially the co-design process, where the iterative process of having the FSC Grant Team and partner organizations engage with the curriculum and allow a feedback loop to influence the final curriculum felt rushed according to many.

The IDHC Partnership

The Indigenous Diabetes Health Circle (IDHC) was considered a significant partner in the project. Part of what made it significant was the **focus on cultural sensitivity** when developing and delivering the curriculum. There is evidence in the project documentation that IDHC was considered at the inception of this project, however, their involvement throughout the project was not always clear. FSC Grant Team members expressed excitement about working with IDHC and that it represented an institutional interest in working more with Indigenous-led organizations. This is partly due to public health data that indicates that diabetes and the risk of foot amputations is higher in Indigenous populations. It was understood by many that historical and ongoing oppressions faced by Indigenous Peoples has had the effect of breeding mistrust with the medical healthcare system. A popular saying at IDHC is that "99% of foot care is having people take their shoes and socks off", possibly indicating that a healthcare worker needs sufficient cultural competency and trust to ask someone if they can check their feet.

Adapted Information

Key Evaluation question: Did the initiative produce new information that was adapted in content, context and mode of delivery?

The intention of the co-design process was to produce curriculum content and a facilitator guide (trainer-the-trainer guide) that was adapted to produce new information that did not already exist at UHN or at the partner organization. Additionally, the new information should be adapted in content (for example, the material in the curriculum modules), context (for example, information that considered the cultural context of the partner organization), and mode of delivery (for example, whether the training was delivered online or in-person).

Many interviewees expressed **agreement that the content in the curriculum modules did contain information that was new**, both from the perspective of FSC Grant Team members and partner organizations. Additionally, many partners interviewed expressed agreement that the curriculum remained relevant and useful for different kinds of staff at their organization, ranging from nurses to Personal Care Attendants and administrative staff, to name a few. There was broad agreement that you did not have to be an expert to learn the material and conduct subsequent foot assessments. Some expressed appreciation that the curriculum was delivered in-person which allowed for the facilitators to adopt a social constructivist pedagogy and adjust the training session to accommodate the learners in the room. For one partner organization, based on the new information they received in the curriculum, including the use of a specific assessment methodology, a policy at their organization was rewritten to accommodate for this new information, which was much appreciated.

The adaptation of information according to the cultural context of partner organizations was also observed, however, there was less certainty with this adaptation intention, as explained in the previous section on the co-design process with partner organizations.

One of the most significant changes during the early stages of the project was to shift from an online mode of delivery to an **in-person mode of delivery for the curriculum**. The online delivery method was influenced by the COVID-19 pandemic protocols around distancing. When the restrictions were easing, the decision was made to move to an in-person delivery method which was more appropriate for the

intended audience of the curriculum. According to the pedagogical orientation of the facilitators in this project, the knowledge and skills required to do foot assessments benefited significantly from being able to teach this in-person using real feet from training participants. This move to in-person training was also based on feedback from partners who preferred this method. The move from online to in-person required significant shifting of resources including more time to develop an adapted curriculum for in-person teaching. The budget that was transferred from the project to partner organizations did not always adequately consider **the resources needed to host an in-person gathering**, especially in remote communities. For example, a culturally significant part of hosting a community gathering in Indigenous communities is ensuring food is available, which demonstrates that the host cares about the community, and which needs to be properly resourced. Another example is that some communities are so remote that travelling to them is very challenging, which requires leaving behind resources and making things accessible online so people can continue to provide healthcare services without the physical presence of trained staff.

The mode of delivering educational content through curriculum modules and in-person facilitation should also consider the specific audience and whether they **already come together for continued professional development and training**. Some interviewees articulated that this had an impact on the overall effectiveness of education intervention.

Across Cultures

Key Evaluation question: Were the educational components of the initiative culturally appropriate and provided safe practices for Indigenous populations?

While this evaluation question was posed to everyone that participated in interviews, the answers to this question were very limited, partly because the evaluation did not intentionally seek out a broad and representative sample of Indigenous Peoples that could accurately answer this question. Many interview participants identified as non-Indigenous and avoided answering this question, possibly demonstrating cultural competency to avoid making substantive comments on a culture that they do not identify with. For those that did provide some insights into this question, there were conflicting views on the degree to which the curriculum reflected cultural competency and/or encouraged cultural reflection during the training sessions, however, many did see aspects of cultural competency in the curriculum and the pedagogical orientation of the facilitators during training sessions.

It is recommended by this author to read the IDHC section of the Knowledge Sharing Report for a first-voice perspective of the partnership.

Impact of COVID-19

Key Evaluation question: What was the impact of COVID-19 on the intended process of the co-designed education initiative?

The beginnings of the project occurred while COVID-19 was having a large impact on the healthcare sector in Ontario, Canada around July of 2021. As a result, many aspects of the project were changed to accommodate for this new reality, especially since **many of the FSC Grant Team members were involved**

in emergency pandemic responses as part of their roles at UHN. Overall, COVID-19 had an impact on the project primarily because there was less time to spend on developing the curriculum, engaging fully with the co-design process and then subsequently delivering the training. During the project's lifecycle, the impact of COVID-19 and the public health restrictions were easing for UHN and for the partner organizations. While the original intention included delivering the curriculum online to account for pandemic-related restrictions as well as 'pandemic-proofing' the curriculum, with the easing of restrictions, it was decided to move the delivery of the curriculum to in-person, which represented an ideal pedagogical orientation of the FSC Grant Team.

FSC Grant Team members were acutely aware that colleagues and workers in the healthcare sector were **significantly overwhelmed and exhausted by the pandemic response**, which had a large impact on the project's ability to find people that would take the training. However, some partnerships were developed regardless of the strain on the healthcare sector. For the partners that were fully engaged in the project towards the end, and participated in interviews, they expressed that there was **minimal impact of the pandemic on their participation in the project**. This possibly demonstrates the team's ability to respond to the needs of the project quickly and effectively to keep it on track, despite the large disruption at the beginning. Partners also expressed an understanding that the project would have been delayed due to the pandemic.

Additionally, it was mentioned during interviews that the pandemic had an impact on the project in the sense that it placed a **spotlight on the work of unregulated healthcare workers**, such as Personal Support Workers (PSWs). Many wanted to take advantage of this spotlight and advocate for increased training for unregulated healthcare workers who were heavily impacted by and involved in the pandemic response. There was also the realization for some that the pandemic significantly impacted the way that UHN engages with the community. For example, because of the expanded role of hospitals to provide vaccines to the public, UHN had to consider how to more effectively work *in* communities, rather than having communities come to them for healthcare services.

Effective Cognitive Integration

Key Evaluation question: Was the model of education effective for the cognitive integration of healthcare and community workers?

The ability to measure the cognitive integration of the curriculum was partly accomplished through the assessment data that was collected after each training session and can be read in the Knowledge Sharing Report. The post-training assessment process is often referred to as an evaluation, which should not be confused with the evaluation process included in this report. This report is mostly focused on the qualitative answers that interview participants provided for this question, rather than reporting on the quantitative outputs from the training sessions.

Through a review of the project documentation, there was **very little reference to a specific model of education**. Instead, there were references to adult education, using an equity-informed, critical lens to deliver training to specific populations, and the balancing of theoretical and practical information in the curriculum.

It was well understood by FSC Grant Team members that they were **delivering training to adult populations** that require a specific approach to teaching that is different from children and young people, who are typically seen as the primary learners in society. Indeed, there is some advice given in the Facilitator's Guide on how to approach this population in education interventions. One particular approach that was perceived as valuable by partner organizations was the intention of the trainers and FSC Grant Team to better understand the types of learners at each organization. Partners expressed their appreciation that the FSC Grant Team were responsive to the learners' needs and adapted their facilitation technique to the people in the room.

The extent to which the curriculum reflected and incorporated **critical reflection**, which was an explicit intention of the education intervention, was not immediately clear to interview participants, including FSC Grant Team members. During the interviews, a description of Critical Reflection, as a pedagogical methodology, taken from the Collaborative Advocacy and Partnered Education (CAPE) website was used to ask interviewees to reflect on whether their experience of the education intervention included this component. Upon reflection, many were not able to demonstrate an understanding of the activities involved in critical reflection.

The **balancing of theoretical and practical information** which many participants spoke about was highlighted as something that needs to be considered in education interventions such as this one. There were conflicting views on whether the curriculum contained too much or too little theoretical information. Part of the theoretical information that was identified as important to cognitive integration is the extent to which the curriculum addressed the reasons 'why' unregulated healthcare workers need to have competencies to assess feet and make referrals, in addition to the 'how' to assess feet and make referrals. In addition, some participants perceived a difference between clinical information and practical information to deliver clinical information to unique cultural and community contexts.

Partnering with Unregulated Healthcare Providers

Key Evaluation question: What was the impact of engaging and partnering with "non-traditional" healthcare providers?

The idea that unregulated healthcare providers and workers are undervalued in society and therefore have a **lack of continual education** was a significant understanding of the FSC Grant Team and is often reflected in the project documentation and through the interviews. Interview participants articulated that not many training opportunities such as this one is available for unregulated healthcare workers and were greatly appreciative of the opportunity. Indeed, one of the project's intentions was to demonstrate to unregulated healthcare providers that they are appreciated by offering training and showing recognition that they are a part of the entire community of healthcare providers. The additional activities of conducting program evaluations, focus groups, and inviting partners to celebrate the success of the project were seen very positively by partner organizations.

There is a **lack of regulated healthcare providers in remote northern communities**, especially providers that are culturally competent enough to build trust with community members. The cultural competence of healthcare providers and the healthcare sector, in general, has been lacking for a long time in these remote northern communities. Therefore, a training program that does not rely on regulated healthcare providers is expected to have a large impact for the communities that lack regulated healthcare workers.

It is seen as a positive direction if large institutions like UHN and Michener recognize unregulated healthcare providers. However, when developing training programs for unregulated healthcare providers, large institutions that typically train regulated healthcare providers might have biases that benefit regulated workers more often.

Conclusions and Recommendations

Objectives:

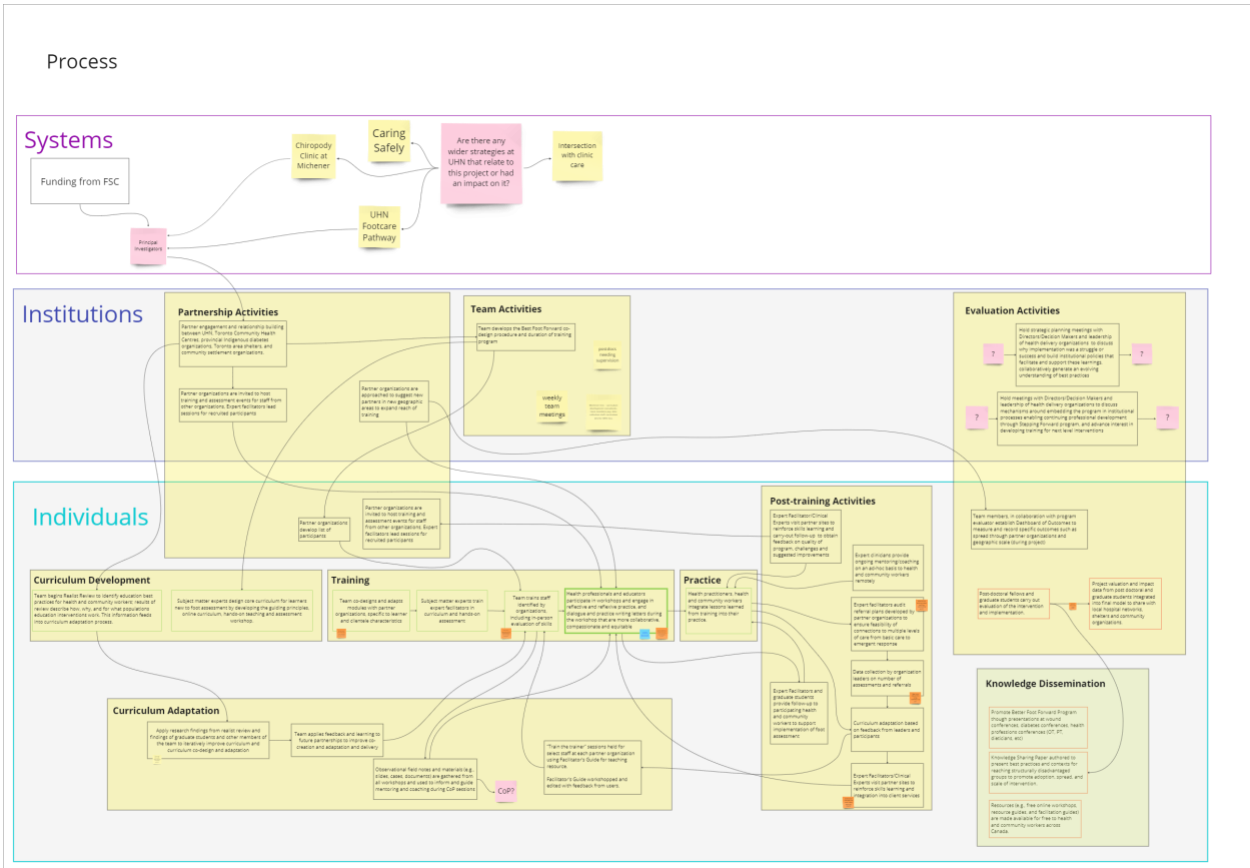
- Assess to what extent the project followed a logical sequence of activities that would produce the intended outcomes for community health workers and people with diabetes.
- To document any adjustments/deviations made to the project design and the implications on project effectiveness.

In conclusion, through an investigation into the *intended* and *actual* logical sequence of project activities, this report hopes to demonstrate the ways in which the project stayed on course to achieve its intended outcomes, while also responding to significant societal challenges, like COVID-19 and complex bureaucratic and governance structures that are not aligned with the ebb and flow of communities. The most significant impression left on me as a third-party evaluator engaged in this project is that people and the relationships between them have a significant impact on whether an organization like UHN can achieve its intended goals with projects like this one. This includes ensuring that staff and partners are fairly compensated and resourced to do their work, as well as taking advantage of the institutional and community resources that are available and ready to be used. In addition, large organizations like UHN inherently reflect existing power structures in society which have been historically designed to disadvantage specific populations with the goal of maintaining cultural dominance. Careful attention needs to be given to this dynamic when working with communities that lack political and institutional powers. For example, whenever a member of a dominant culture speaks about Indigenous Peoples, it is recommended to either use a strength-based approach to mitigate the bias that societal challenges are due to inherent deficiencies in Indigenous populations, and/or contextualize challenges within historical and ongoing oppressions from imperial and colonial powers that intentionally subjugate specific populations to establish cultural dominance. Additionally, as recommended by Indigenous participants in this evaluation, staff at UHN should be at least aware of the Truth and Reconciliation Commission's 94 Calls to Action.

It is also strongly recommended that the project maintain better records and project planning documents over the course of the project to ensure the fidelity of the intended logical sequence of activities. This will also aid in any evaluative and learning activities as part of the project.

Lastly, since a major focus of this evaluation was the co-designed process, it is recommended to be more explicit about the pedagogical orientation of the education intervention. There was lots of evidence of a social constructivist and equity-informed pedagogy, which partners seemed to value, however, many participants were not able to specifically identify this pedagogy from other forms of pedagogy. Having a clearer understanding of one's pedagogy can significantly influence the overall design of an education intervention and the effectiveness on participants' learning outcomes. Future projects like this one should consider training their staff on effective pedagogical approaches when working specific populations that is grounded in evidence.

Appendix: Logic Model of the Better Foot Forward Project



Appendix: List of Documents Reviewed

- Activity Reports to FSC (n=8)
- FSC- Partnership Co-Design Process--Template(3)
- Partnership Onboarding and Co-Design -- OVERVIEW (8)
- CHW Scan Update March 13 (002)
- Michener-Social Med CHW Proposal slides_May23
- RecommendationsCHW_11April
- FSC Evidence Generation User Guide(4)
- Facilitation Manual_general
- Facilitation Manual_IDHC
- 6 Modules of the Curriculum
- FSC Project Workplan + Evidence Generation for Sector-Based Projects - UHN-Final
- FSC_UHN Proposal_FINAL-2020-12-clean1(2)
- FSC-Project-Milestones-original(1)
- FSC-Project-Plan-2021-September
- FSC-Project-Plan-Education-Project-2021-10
- FSC-Upskilling-Foot-and_wound-2pg-project
- 2 images of a whiteboard that represented early project ideation
- CommunityEducation_SHDH (Community Education Pilot)
- Knowledge Sharing Report
- Preventative Diabetic Foot Care Pathway Project V2 Feb15
- UHN Collaborative Research Agreement_FSC Grant_Final
- FSC-PMT-December 2022 (1)
- FSC-Workplan-Objectives-End-Dates(1)
- Logic Model - 28.11.22-final
- Work Plan EG Plan Additional Information--UHN-draft(2)
- Upskilling Program Realist review manuscript August 27
- FSC-Reporting Data
- QIRC Submission Form FSC_FINAL1
- QIRC Submission Form FSC_FINAL
- QIRC Submission Form UHN (26July2022)

Appendix: Information Sheet

Appendix 1 - QIRC #23-0520 (October 5, 2023)
Information sheet

Hello and welcome,

You are being invited to take part in an individual interview or a focus group for a UHN Quality Improvement (QI) project entitled: **Best foot forward: Reskilling Human Resources for High-risk Foot care.** Individual interviews lasting about an hour will be conducted via phone, or virtually sometime in October 2023 at a day, time, and place/format that is convenient for you. Focus groups will involve a guided group discussion lasting about 1.5 hours with other employees/staff at your place of employment sometime in October 2023. The interview and focus group are being conducted as part of a third-party evaluation to answer the following list of questions. Depending on your involvement in the project, the interviewer will emphasize certain questions over others, which will be provided to you prior to your scheduled interview or focus group.

1. Was the **co-designed education initiative** implemented as intended?
2. Did the initiative produce **new information that was adapted** in content, context and mode of delivery?
3. Were the educational components of the initiative **culturally appropriate and provided safe practices** for Indigenous populations?
4. What was **the impact of COVID-19** on the intended process of the co-designed education initiative?
5. Did the initiative equip healthcare and community workers with the **knowledge to identify and prevent** high risk foot wounds and diabetic foot ulcers? To what degree?
6. Did the initiative result in **an increase in the number of identified people** with at risk feet and link them to care to prevent limb loss?
7. Were staff **trained to develop a local referral network** to refer people with at-risk feet to the appropriate level of care?
8. Was the **model of education** effective for the cognitive integration of healthcare and community workers?
9. What was the impact of engaging and partnering with **"non-traditional" healthcare providers?**

The information you provide will be used to support adapted management of diabetic foot and wound care. By partnering with organizations that work with populations with high rates of limb amputation, we expect that upskilling community workers who have not historically assessed patients with diabetic foot complications, will lead to organizational workflow, policy and management changes to support continued foot assessment at these organizations. It will also be used to enact education change. The co-designed foot health education interventions will provide new information that is specifically adapted in content, context and mode of delivery to equip community workers with the skills necessary to support prevention, early detection, and referral for diabetic related foot conditions.

Taking part in the individual interview and focus group is optional. If you decide not to participate, your employment will not be affected in any way. Information you provide will only be seen by the third-party evaluator that was hired by the project team members at UHN. Others within UHN and outside of UHN,

will only see a summary of the overall information collected. Your responses will not be linked to your name or personal information in any way, and will be stored separately from your personal information. It will be kept in a password protected shared folder (OneDrive) that is only accessible to the third-party evaluator and the Project Lead for a period of five years. If results of the interview and focus group interview are published or presented at meetings, your name and other personal identifying information will not be used, and your responses will not be linked to your name or personal information in any way.

If you have questions about this QI project, please contact the Project Lead, Lily Winnebota using the email address, lily.winnebota@uhn.ca. If you have any questions about the third-party evaluation, please contact Nick Petten, Petten Consulting using the email address, nick@pettenconsulting.com. If you have questions about your rights as a participant in a UHN Quality Improvement Project, please contact the UHN Quality Improvement Review Committee (QIRC) at QI@uhn.ca. QIRC is a group of people who oversee the ethical conduct of QI projects; they are not part of the project team.

Thank you for your participation!

Consent for Future Contact

We are asking for your name and [email address/phone #] to contact you in the future regarding participation in the focus group and to provide you with the summary of the study findings. If you give us permission to contact you, please fill in your contact information in the space provided. This information will be kept separately from all other information you provide. It will only be accessible by the project team and kept in a secure locked cabinet at the Wilson Centre at the Toronto General Hospital for a period of five years.

Name: _____

Email/Phone #: _____

Appendix: Interview Protocol for Best Foot Forward Evaluation with Petten Consulting

Author: Nick Petten, Petten Consulting

Steps during the interview

1. Welcome participants and remind them that they are participating in an interview, for which the data will be used in the evaluation of the educational components of the project.
2. Ask if they received and reviewed the information sheet.
    a. If 'yes', ask if they have any questions and whether they want to stay in contact about the results?
        i. If 'yes', ask that they sign the form, include their email address, and send it back to me using my email address in the invitation email.
    b. If 'no', share your screen with them and review together with them.
3. Explain to participants that I'll be taking notes throughout the interview and won't be recording. Ask for their patience while you type.
4. Ask for their verbal consent to proceed with the questions.
5. Share your screen of the Logic Model and ask them to locate themselves within the project and describe their role.
6. Ask the questions from the Information Sheet:
    a. Was the **co-designed education initiative** implemented as intended?
    b. Did the initiative produce **new information that was adapted** in content, context and mode of delivery?
    c. Were the educational components of the initiative **culturally appropriate and provided safe practices** for Indigenous populations?
    d. What was **the impact of COVID-19** on the intended process of the co-designed education initiative?
    e. Did the initiative equip healthcare and community workers with the **knowledge to identify and prevent** high risk foot wounds and diabetic foot ulcers? To what degree?
    f. Did the initiative result in **an increase in the number of identified people** with at risk feet and link them to care to prevent limb loss?
    g. Were staff **trained to develop a local referral network** to refer people with at-risk feet to the appropriate level of care?
    h. Was the **model of education** effective for the cognitive integration of healthcare and community workers?
    i. What was the impact of engaging and partnering with **"non-traditional" healthcare providers?**
7. Inform them that there are no more questions. Thank them for their time.
8. Ask them if they would like to receive compensation in the form of a gift card from UHN?
9. Close the interview.