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Mentorship: A Powerful Tool for IPG Success

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Abstract

Because Canada espouses principles of diversity and multiculturalism, many international pharmacy graduates (IPGs) immigrate to Canada expecting to find employment using skills for which they trained in their home country. Upon arrival, they often face challenges in credential recognition and licensure. Barriers include systemic discrimination, socio-psychological isolation, the precipitous decline in social status, and financial challenges of navigating the steps that bridge the training received in their home countries to the scopes of practice in Canada. The problem of practice (PoP) explored in this organizational improvement plan (OIP) focuses on the lack of opportunity that IPGs have to access clinical workplace settings prior to being assessed for entry to practice competencies. Health Alliance is an organization that works in the regulatory space for IEHPs and that provides a service that facilitates the IPG path to licensure in Canada. This OIP proposes housing a mentorship program at Health Alliance, to specifically address the experiential learning and knowledge and skill gaps that have been identified as barriers to success for IPGs pursuing licensure, and ultimately, gainful employment as pharmacists in Canada. This OIP examines the PoP through the lenses of sense of community theory and critical race theory to explore how the lived experiences of diverse internationally educated skilled immigrants are impacted by the process of seeking credential recognition and licensure. Change at the leadership, cultural, and operational levels will be facilitated through Kotter's eight stage change model and will be evaluated using an empowerment evaluation approach.

Keywords: international pharmacy graduate, clinical assessment, mentorship, shared leadership, sense of community theory, critical race theory

Executive Summary

Many internationally educated professionals immigrate to Canada, encouraged by Canada's Multiculturalism Act and the promise of a better life, but upon arrival, face numerous challenges as they seek to have their credentials recognized to practice in their chosen professions. Barriers include systemic discrimination, socio-psychological isolation, the precipitous decline in social and economic status, and financial challenges of navigating the steps that bridge the training received in their home countries to the scopes of practice in Canada. The PoP centres specifically on the barriers faced by international pharmacy graduates (IPGs), and the significant lack of opportunities for them to become familiar with Canadian workplace culture and clinical settings prior to their mandatory practical training or clinical assessments. No formal network exists to allow IPGs to connect with each other or with licensed pharmacists who may share similar lived experiences. The PoP will be anchored in two theoretical frameworks: critical race theory to examine the power imbalances for marginalized professionals in acclimating to a Euro-centric hegemony, and sense of community theory to support the examination of how an established cohort of mentor leaders can support IPGs by providing tools, resources, and safe spaces for IPGs to explore professional and clinical practice prior to formal clinical assessment.

Health Alliance is a coalition of regulators that works in the regulatory space for pharmacists. It is a small, conservative organization that is mandated is to provide a common platform where regulators can collaborate and take a pan-Canadian approach to addressing challenges that affect regulators in each jurisdiction. On behalf of its members the organization provides a service that registers IPGs as a mandatory first step to licensure in Canada. It is therefore well-positioned to understand the challenges of IPGs as they

seek licensure. Health Alliance is now focusing on the problem of practice (PoP). Several frameworks are used to analyze and frame the PoP, including Armenakis et al.'s (1999) readying an organization for change model, Bolman and Deal's (2017) framework, and a PESTLE analysis. These reveal challenges to the change model, particularly the need to have senior leadership and management properly advised and prepared for change. As one of its values, Health Alliance espouses collaborative leadership; however, this type of change that involves empathy, mutual influence, and a diverse set of skills requires a transition to shared leadership.

This organizational improvement plan uses Nadler and Tushman's (1989) organizational congruence model to diagnose the organization and begin to set organizational context within which to consider possible solutions to the PoP. Three possible options are presented. The first is micro-credentialing, which are portable, stackable credentials that recognize microlearning or the acquisition of a specific skill. The second is to leverage existing organizational programs and resources to create a fully sustainable mentorship program. The third option is clinical simulation, which involves creating a clinical setting that simulates a real-world work placement. Social justice and equity considerations, such as the ethical responsibility of organizations and the professional isolation and other psychosocial barriers experienced by some IPGs, also informed the selection of an option. Ultimately, mentorship is identified as the most viable option for its ability to address the PoP in a manner that does not bring prohibitive costs to the organization, is accessible for IPGs, and can have positive immediate and downstream (i.e., post-licensure) implications for IPGs. The selected monitoring tool for the OIP implementation will be Deming's four-step process for quality improvement, the Plan, Do, Study, and Act (PDSA) Cycle. This cycle is a well-established and familiar tool in healthcare, which facilitates its implementation.

Kotter's change management model (1996) is used to implement change. The development of a fully sustainable mentorship program will unfold in three phases. The first phase, creating a climate for change, will take place in the first six months of the plan, with a guiding coalition formed and a sense of urgency established. The second phase, engaging and enabling the profession will occur in Months 7–15, and will allow the guiding coalition to promote mentorship vertically within the organization and outward to mentors, mentees, and other stakeholders. The final phase, sustaining the change, will occur in Months 11–18. Here stakeholders will work together to look for improvements, institutionalize lessons learned, and undertake a formal evaluation. The selected evaluation approach is empowerment evaluation, which allows for knowledge transfer and skill development among all evaluation participants.

Mentorship is a comparatively inexpensive, accessible, person-centred approach. This organizational plan is meant to support the development of a program that will help IPGs successfully become licensed and, therefore, transition more quickly to the Canadian workforce.

Acknowledgements

I have so many to thank for the privilege of participating in this doctoral journey. God has blessed me with an incredible family. I owe an enormous debt of gratitude to my husband Marq who often held down the home front as a solo parent over the past three years to allow me the space to stretch my horizons and grow through this program. I have/had fabulous parents, who were always there to offer guidance and support and an amazing older brother Greg who, from my earliest memories, could make me laugh like no one else could. My father Dodd is no longer with us, but I have often felt his spirit urging me forward along the way, and my mother Orial has been a constant and steadying force in our lives, acting as a cheerleader and supportive "grandmother extraordinaire." I'm also grateful for my boys, two wonderful young people who are the reason I continue to challenge myself and to strive for better – so that they never lose sight of their dreams and know success is accessible to them as well. Of all the titles I've ever held, the one that I will always cherish the most is "Mom" (though I've got to tell you, boys, "Doctor" is pretty sweet too).

If it takes a village to raise a child, the same is true of an EdD candidate. I would never have been able to accomplish my studies without the support of a tribe of friends and family who have been unfailingly encouraging and supportive, and for whom I have tremendous love and respect: Michael, Maureen, Trish, and Wayne who have been extra parents for my children when life became overwhelming; Debbie who lit the spark in me and introduced me to the possibility of doctoral studies when I thought this dream was out of reach; my Godmother Daphney who prayed me through; Amanda, Angela, Ann, Heather, Pati, Tasia, and Vani, for cheering me on; my colleagues who gave me guidance and support to complete this work; and a cohort of the best

classmates who inspired me along the way. So many others to thank, and I hope you know who you are.

I also often say that the best gifts my parents ever gave me were my extended family members. I have the most endearing nephews, nieces and Godchildren who bring so much joy and light to my life. My aunts and uncles were a loving, boisterous and colourful cast of characters who taught me what it meant to persevere, face adversity with grace, and to embrace every opportunity to celebrate accomplishments. And it is not by chance that I have been drawn to mentorship: my cousins exemplify the term, intentionally nurturing a community of coaching, guiding and uplifting one another. They have not only inspired me to be a better scholar, employee, and learner, but they have taught me how to live authentically, act with integrity, and just how to be a better human being. Their tenacity, strength, and compassion have shaped me, and I am eternally grateful for every one of them.

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Acronyms

CNAR (Canadian Network of Agencies for Regulation)

CRT (Critical Race Theory)

EE (Empowerment Evaluation)

IEC (Immigrant Employment Council)

IEHP (Internationally Educated Healthcare Professional)

IEN (Internationally Educated Nurse)

IEP (Internationally Educated Professional)

IPG (International Pharmacy Graduate)

IRCC (Immigration, Refugees and Citizenship Canada)

MOU (Memorandum of Understanding)

OSAP (Ontario Student Assistance Programs)

OSCE (Objective Structured Clinical Examination)

PEBC (Pharmacy Examination Board of Canada)

PRA (Pharmacy Regulatory Authority)

PDSA (Plan, Do, Study, and Act)

PESTLE (Political, Economic, Social, Technological, Legal and Environmental)

UWI (University of the West Indies)

WES (World Education Services)

Chapter 1: Introduction and Problem

Many internationally educated healthcare professionals (IEHPs) immigrate to Canada, encouraged by Canada's Multiculturalism Act, which promises each citizen equal treatment and opportunity under the law (Canada, 1990). Upon arrival, however, they often face numerous challenges as they seek to have their credentials recognized to practice in their chosen professions. The path to licensure in regulated health occupations can be exceptionally daunting for skilled immigrants, many of whom enjoyed prominent careers in their home countries but face discriminatory barriers in their search for gainful employment in Canada. For many, this has led to "a potent mix of emotions including sadness, disappointment, and hurt as well as frustration, resentment, and anger" (Grant, 2019, p. 136). Barriers include systemic discrimination, socio-psychological isolation, the precipitous decline in social and economic status, and financial challenges of navigating the steps that bridge the training received in their home countries to the scopes of practice in Canada (Cheng et al., 2013).

Addressing the problem of practice (PoP) begins by examining the organizational context and the effects of leadership and organizational appetite for change. Chapter 1 of this organizational improvement plan (OIP) frames a PoP within a specific organizational context. I will present my leadership position and agency and will further describe the organizational frameworks and change processes that will be used to lead change within the organization. I will also present the influence of equity, ethics, and social justice on my PoP. Finally, I will discuss the drivers for change and the assessment of the organization's readiness as mechanisms in change planning, before concluding with a chapter summary. The context of the organization where the OIP will be implemented is foundational to understanding the best approach to

addressing the PoP. The power dynamic, decision-making, and values of the organization are outlined in the Organizational Context section.

Organizational Context

The organization at the centre of this PoP is a small non-profit organization, given the pseudonym "Health Alliance" to protect the organization's anonymity. Health Alliance is an association of pharmacy regulators whose mission is the pursuit of regulatory excellence, and its vision is to uphold the highest patient care by optimizing its regulatory structure. As an organization, it espouses the values of leadership, innovation, and collaboration. Its members are the regulators of a particular profession, with their own mandates to serve public interests. While Health Alliance also concerns itself with public protection, its stated mandate is to provide a platform for regulators to share, debate, and collaborate on common issues and challenges that affect pharmacies and pharmacy professionals across Canada.

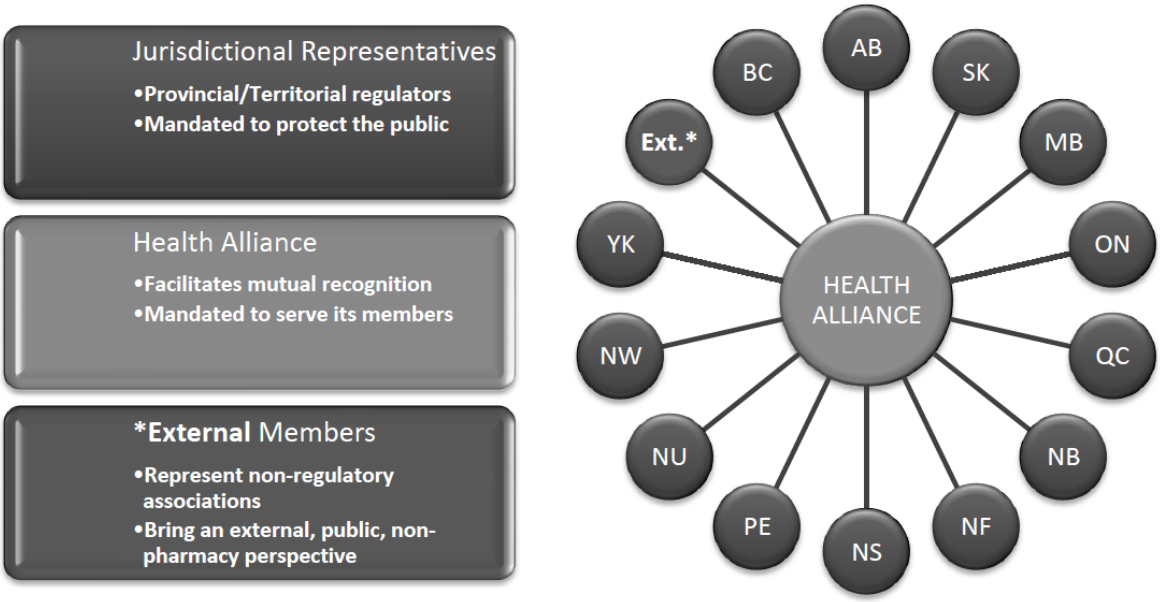
Broad Contexts of the Organization

Health Alliance consists of 17 organizational members—one representing each of the provinces and territories and three external members with non-health expertise. Figure 1 positions Health Alliance as a unifying voice in the pharmacy regulatory sector, bringing together jurisdictional regulators' and external members' perspectives. It is a governance board, and more than a third of its revenue comes from membership. Therefore, the organization shares a participatory management hierarchy with its members, described by Burke (2011) as occurring in policy decision-making that affects large groups of people made by consensus. Decisions made by the organization follow a formal approval process. Strategic directions and activities are discussed by each organizational member's board of directors for support, are brought back to Health Alliance's board table for deliberation. Formal motions are then decided by Health

Alliance's board of directors. Health Alliance has no authority to mandate or impose any changes or initiatives upon its members. All members must unanimously support motions proposed to the board in order for approval.

Figure 1

Health Alliance's Organizational Members and Their Mandates



At the senior management level, priorities established by the board are discussed and divided between three departments and their administrative staff. The vision for change is discussed at the senior management table to determine the strengths and contributions that each department can brings to the proposed solution, which is then communicated to the organization via the change management team.

An emerging challenge for professional regulators is the tension between their mandate to protect the public and the onerous nature of the licensure processes they enforce. IGPs seeking licensure in Canada must undergo a rigorous process to receive a professional designation to practice. Part of the licensure process for many health professions enforced by regulators involves a standardized practical assessment that normally takes place in the clinical pharmacy

setting. Although regulators are responsible for licensure, they are not responsible for facilitating training. At the same time, regulators are well aware that licensure candidates who were educated in Canada have had the benefit of training that includes an internship, orientation, or other form of workplace integrated learning that provides access to Canadian clinical settings.

As one of its services to its organizational members, Health Alliance houses a portal for which enrolment is a mandatory first step in licensure to practice in Canada. This gives the organization some firsthand insight into some of the barriers faced by IEHPs. Additionally, a substantial portion of the organization's revenue comes from the registration of IPGs for their licensure, which comes with a moral imperative for the organization to closely examine any barriers to success in their mandatory clinical assessments (Austin & Marie, 2004). This contributes to the tensions between the organizational members' mandates of public protection and the social obligation to provide value for registration fees from the IPGs.

Frameworks that Drive the Organization

The leadership approach at Health Alliance, along with its theoretical approach, will frame its capacity and willingness to address the PoP.

Leadership Approach

Health Alliance espouses collaborative leadership. Early theorists noted that collaborative leadership is a strategic advantage that seeks to engage diverse perspectives, reach consensus in decision-making, and allow all parties to feel involved in the process of change (Kanter, 1994; Chrislip & Larson, 1994). Shu and Wang (2021) note that collaborative leadership is "taking a leadership role in a coalition, organization, or other enterprise where everyone is on an equal footing and works together to solve a problem, create something new, or run an organization or initiative" (p. 598). Aligned with these tenets, Health Alliance embraces consensus

decision-making as their governance process. As Deszca et al. (2020) noted, the change agent's main function is to engage in activities that will influence the probability that various formal bodies will vote to support the proposed change. This collaborative approach ensures that all perspectives are considered in the vote for change.

Theoretical Framework

Health Alliance is driven by functionalist theory. Early theorists of functionalism Merton and Merton (1968) posited that each organization or system, culture, and task has a discrete role in and corresponding impact on the ecosystem of stakeholders in which it operates. As a theoretical approach, functionalism suggests that organizational design is formed in response to environmental pressures and demands and that the organization is motivated by specific incentives to resolve issues (Panke & Starkmann, 2020). Health Alliance's traditional, conservative, and complex bureaucratic structure aligns with functionalism as it seeks to undertake activities that most closely follow the prescribed mandates of its members. Plazek (2012) explained how the conservative heuristic "consists of six characteristics: maintaining the status quo, support of traditions, a pessimistic appraisal of human nature and possibilities, emphasis on nationalistic perspectives, greater focus on law and order, and a greater belief in punishment as motivation (i.e., the stick)" (p. 171). This is in keeping with a regulatory authority's role to create and enforce regulations around certification and to discipline registrants who are non-compliant. Yet Bernhard and Oliver (2019), in their discussion about the functionalist approach to organizational problem-solving, noted that all relevant stakeholders must be involved in addressing complex problems, to ensure that stakeholders can contribute their expertise and financial resources as appropriate. This research suggests that Health Alliance would do well to engage stakeholders from across the pharmacy ecosystem to address the PoP.

As an agent of change, I must be mindful of the organization's leadership approach, as well as its tendency towards the tenets of functionalisms. These two frameworks will need to be balanced with my personal leadership position and lens, which are discussed in the next section.

Leadership Position and Lens Statement

The leadership position and lens present a philosophy of practice from a personal perspective. I will outline this philosophy from a macro- to micro-perspective, beginning with my world views, then my leadership style. My ethical and value-based perspective will also be embedded in the discussion.

Personal Leadership Position

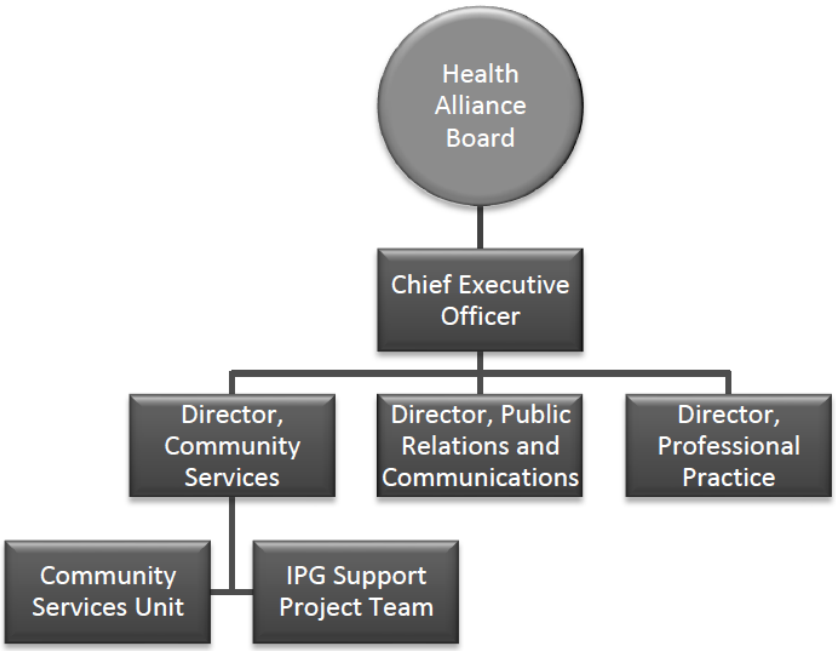
Health Alliance is a small non-profit organization consisting of three departments. Two departments are dedicated to regulatory affairs and to public relations and communications. The third department, where I work, is the Community Services Unit, outlined in Figure 2. This unit provides facilitative programs and services to licensure candidates. This until also houses the candidate access portal, which is a repository for administrative data on candidates seeking licensure to practice in Canada. Enrolment in the portal is a mandatory first step towards licensure.

I manage a three-year, government-funded pilot project to help IPGs overcome some of licensure's barriers. As the project manager, I report to the Director of Community Services. With a grant from the federal government, the Community Services unit develops resources to assist IPGs in better understanding Canadian workplace cultures and clinical settings. I oversee the development of the resources, manage processes to encourage participation, liaise with the external evaluator to ensure that evaluation data is available, and lead the communication efforts related to the project. My role as the project manager within the organization gives me a voice at

the leadership table with only limited authority to enact change, as I am only directly empowered to change the activities, processes, and policies within the scope of my project.

Figure 2

Health Alliance Organizational Chart



Role in the Potential Change Process

Aside from my core operational responsibilities of implementing a project plan while monitoring and addressing risks and ensuring that milestones are met, I am responsible for a program that offers tools and resources to assist IPGs in assessing their skills gaps and readiness to practice in Canada. Therefore, it is within my agency in the program to be a change initiator. A change initiator acts as a facilitator and team builder by stimulating change for the organization's improvement (Deszca, 2020; Kumar, 2013). As a change initiator at Health Alliance, I can provide vision and direction to this type of change. My role will be to bridge my department and senior management, until a change leadership team is established. This will be further discussed in Chapters 2 and 3. Once the change leadership team is in place, I will

continue to act as a change facilitator as a champion and critical friend without being the driver for the project.

I work directly with IPGs, interviewing candidates for the Community Services unit's program. I am passionate about helping people, regardless of age, ability, or country of origin to meet their potential and contribute to the Canadian workforce. As such, I am well-positioned to launch a shared leadership grassroots movement that is required to make the envisioned change.

Leadership Lens Statement

As a leader, my world views tend to be liberal and critical in nature. Plazek (2012) describes the liberal world view as having six attributes: "belief in progress/change, skepticism of tradition, optimistic appraisal of the human condition, fear of aggressive nationalism, human rights promotion, and emphasis on incentive (i.e., the carrot)" (p. 174). These tenets manifest themselves in my daily professionalism and personal leadership and, at times, can create tensions with the organization's functionalism perspective. My optimism in the human condition and belief in progress fuels my work in program development and quality improvement. My fear of aggressive nationalism influences my commitment to ensuring that every candidate, regardless of race, country of origin, ability, or gender has access to supports that allow individuals to reach their full potential. The only tenet with which I feel tension is the mistrust of tradition. In a political sense, where the word "tradition" is used as a euphemism to uphold institutions that are systematically discriminatory, there is indeed mistrust, but I do support cultural traditions and religious rights and freedoms. Here Plazek (2012) clarifies that having a liberal world view "does not mean that liberalism is entirely iconoclastic of existing institutions. Traditions that comport with positive visions of the future can remain, but those that do not must be altered or abandoned" (p. 174). It is my liberal worldview that supports my desire to work with the

traditional regulatory colleges and to facilitate a shift to a more innovative and socially just mandate in supporting IPGs.

As a secondary lens, I am also inclined toward a critical world view, which means accepting a moral responsibility "to imagine social scenarios through which people can deliberate and construct mechanisms of participation that may expand the workings of democracy and a political commitment to create an autonomous sphere of public debate" (Rexhepi & Torres, 2011, p. 690). What I value about a critical world view is the opportunity to interrogate problems from social and intellectual perspectives and to understand the power dynamics of the context in which problems exist. Extended to my professional role, the critical lens is the view through which I create spaces for serious debate and collaborative problem-solving. It is with this critical perspective that I can examine the discourse around deepening inequalities and create counter narratives for the disenfranchised (Apple, 2016), helping me understand the downstream implication of making this project viable. Taking a critical view also lends to the consideration of social policy where pervasive injustices exist and can be addressed by challenging dominant discourses (Freeman & Vasconcelos, 2010; Rexhepi & Torres, 2011). My liberal and critical world views frame my understanding of the gaps between the organization's efforts to respect their mandate and their IPG constituents' needs.

My leadership style can be considered from two perspectives: authentic and servant leadership. First, authentic leadership examines the genuineness of interactions between leaders and followers. George's (2003) seminal work on the approach described how authentic leaders are disciplined, self-aware, have a strong sense of passion and purpose, and lean on personal values to guide their leadership. Authentic leaders demonstrate transparency in their actions which allows them to establish trusting relationships (Avolio & Gardner, 2005). George drew

heavily on Kernis's (2003) description of authenticity as the ability to reflect true self, motivations, desires, emotions, and flaws. Authenticity as presented by Kernis (2003) reflects how I lead, parent, volunteer, and collaborate. My need to stay true to my values of inclusion, empowerment, and equity allow me to take interpersonal risks, and take personal responsibility (Liu et al., 2013) for how I interact with my peers, team, and family.

A criticism of authentic leadership is that it lacks an empirical base and, more specifically, requires some additional research on whether millennials born between 1977 and 1995 will respond well to the approach. Northouse (2022) cautions that this demographic's individual mindset with regards to compensation, recognition, and work-life balance are "potential stumbling points for effectively leading millennials as followers using the model of authentic leadership" (p. 234). This is notable, as Health Alliance leads interdisciplinary, cross-cultural, and intergenerational teams; any insight into demographic mindsets should be considered in implementing the chosen solution to address the PoP.

I am also drawn to servant leadership, which focuses on empowering and helping others determine and achieve their personal goals (Greenleaf, 2007). As Allen et al. (2016) noted, "a servant leader shares power, puts the needs of others first, helps individuals develop and optimize performance, is willing to learn from others, and forsakes personal advancement and rewards" (p. 2). The 10 key characteristics of servant leadership are noted as communication through listening, empathy, a view to healing, situational awareness, persuasive communication, conceptualization, foresight, responsibility, commitment to growth, and community building (Spears, 2002). These characteristics are critical in addressing the barriers faced by IPGs. At the core of servant leadership is a deeply rooted commitment to caring for, advocating for, and serving the needs of others (Maglione, 2022; Parris & Peachey, 2013). I use a servant

leadership approach as a social mechanism to build confidence among team members and to build trust between myself as a leader, my team members, and the administration of the organization. My team members and I meet individually to allow for confidential discussions about challenges that affect their work, and we meet collectively to allow team members to use their strengths for problem-solving.

A study on the correlation between servant leadership and trust found "a positive correlation between perceptions of servant leadership and leader trust, and between servant leadership and organizational trust" (Joseph & Winston, 2014, p. 15). As a servant leader, I am called to influence others towards a mutually accepted goal by empowering and nurturing the strengths of team members/followers. Empowering employees is a value close to my heart, as I feel the most accomplished as a leader when I see skills nurtured and developed; I feel privileged when I am able to help team members meet and surpass their goals. A caution to this leadership style, as Ciulla (2014) states, is that servant leaders often use language that creates unrealistic expectations around the employee's control over their role in the organization (p. 95). I am mindful of this, for example, in performance reviews when I ask team members what personal and professional goals they have, whether my team members understand that I will support them within my power, and if their goals are not in conflict with the employer. This transparent approach to clarifying expectations helps build trust as a pillar of servant leadership. There are challenges to servant leadership, such as the paradoxical dilemma of leading and serving, as well as the significant conceptual overlap between servant, transformational, and ethical leadership (Eva et al., 2019). I am aware of these criticisms and mindful that is necessary to balance leading my team, serving program beneficiaries, and fulfilling my role as a manager within the

organization. My personal leadership position and lens, influenced by authentic and servant leadership, shape my management and leadership style as a change facilitator for the PoP.

Leadership Problem of Practice

This OIP is an opportunity to examine one of the challenges faced by IEHPs seeking licensure in Canada. Specifically, there is minimal opportunity for IPGs to familiarize themselves with clinical workplace settings prior to licensure. Already at a disadvantage on the licensure journey, IPGs also do not have an opportunity for professional psychosocial support, have no opportunity to develop social capital, and cannot adequately understand workplace cultures prior to being assessed for licensure.

IEHPs wanting to become licensed to practice in Canada must go through a rigorous process of training and assessment before provincial regulatory authorities will grant them a professional designation. In the case of pharmacy this process includes two Pharmacy Examination Board of Canada (PEBC) exams, language proficiency assessments, a jurisprudence exam, and a standardized practical assessment of clinical skills that would typically take place in a clinical setting.

As noted in the organizational context, this PoP is situated within a complex bureaucratic structure, which is nested in an ecosystem of stakeholders including healthcare regulators, professional associations, micro-lenders, immigrant serving organizations, employment support services, educators, and IEHPs. Although this sector includes a diverse set of stakeholders, each with a specific role to play in supporting IPGs on their licensure path, none of these organizations have a mandate that extends to providing psychologically safe, culturally sensitive support to IPGs in the pre-assessment phase of the licensure process. Therein lies the gap.

The regulatory boards that govern specific regulated occupations in each territory/province are collectively called pharmacy regulatory authorities (PRAs). Anecdotally, PRAs have reported that IPGs often arrive at their mandatory practical assessment unprepared to begin their evaluation because their path to licensure has not afforded them same the opportunity for experiential learning in a pharmacy setting that their Canadian-trained counterparts received. IPGs therefore often require additional support to have access to licensure and gainful employment in Canada, causing IPGs to be unsuccessful in their assessment attempts, delaying their progress and adding time and cost to their licensure process. This represents an opportunity for all agencies working with an internationally educated talent pool to provide additional interventions to support the bridge between pre-arrival professional experience and Canadian credential recognition and licensure policies. Further, regulators are uniquely positioned to address this PoP as it relates to challenges that occur on the path to licensure.

Framing the Problem of Practice

The PoP is underpinned by Bolman and Deal's (2017) framework, which suggests moving beyond the narrow examination of the organization, to taking a broader approach to understanding the dynamic aspects of the organization and its environment. This framework guides the user through a multi-framed perspective: a structural, human resource, political and cultural examination of the organization. The end result is a more comprehensive analysis of the various dimensions of the organization, to look for factors that may impact the PoP and the proposed solution.

The Structural Frame

The structural frame allows for an examination of the coordinated individual and team efforts in reaching organizational objectives. Bolman and Deal (2017) noted that through a

structural lens we see how “conscious attention to lines of authority, communication, responsibilities and relationships can make a huge difference in group performance” (p. 111). For this reason, a brief exploration of the structural frame is required. As Health Alliance is a functional organization with clean lines of authority and distinct responsibilities, the structural lens reminds change agents to respect reporting structures and ensure that communications follow the lines of authority while remaining transparent. In Health Alliance, this would manifest itself as having the change team developing communications for implementation, sharing those plans with senior leadership for approval, and then disseminating information through the appropriate vertical channels.

The Human Resources Frame

While the structural frame looks at lines of authority, the human resource frame examines the PoP by investigating whether the right people are in place to guide, facilitate, and communicate change. It allows change leaders to take an appropriate skill inventory when examining potential members of the change leadership team and encourages egalitarianism, diversity, self-management, and empowerment to be core values for the team. To this end, the human resources frame outlines core strategies such as hiring appropriately, establishing a retention strategy, investing in people, empowering staff, and promoting diversity (Bolman & Deal, 2017). Notably, Health Alliance is committed to providing financial support to its employees for skills that will improve the ability to perform current tasks, or to prepare employees for future roles within the organization (Health Alliance, 2019). Investing in training around diversity, inclusion and belonging is an opportunity for Health Alliance to link its retention strategy to its promotion of diversity.

Health Alliance does not have a human resources department; their senior management team holds annual performance reviews to gain an understanding of staff strengths, areas of talent, and topics of interest that may fall outside of their specific role. This is part of Health Alliance's retention strategy, but within the context of this OIP, it also allows change agents, with support and input from senior managers, to access this information to build a diverse, cross-departmental change leadership team of individuals to produce movement, build momentum, and align the change to the organization's strategic objectives (Kotter, 1996). Health Alliance is a bureaucratic organization that has a fairly hierarchical structure, but it will need to foster a culture of cross departmental cooperation and reiterate its commitment to diversity and inclusion if staff members are to feel empowered to play an active role in addressing the PoP. This can be examined through the perspective of the human resources frame.

The Political Frame

The political frame allows change agents to examine the political agendas, power dynamics, and the potential for support or conflict inherent in the problem of addressing barriers for IPGs on the path to licensure (Bolman & Deal, 2017). These are not necessarily negative constructs, but can be taken as opportunities to foster networking and coalition-building partnerships among employees, volunteers, and other stakeholders working towards a common goal. These dynamics can be used as signposts in choosing the appropriate response to the PoP.

At Health Alliance, it is the political frame that alerts change agents to the competing mandates of organizational members to protect the public and Health Alliance's own mandate to provide value-added service to pharmacy practice by providing a communication and collaboration vehicle for members. As with any organization, it can be challenging for board members to abandon their own agendas and work towards having a collective impact on peers.

The Cultural Frame

The OIP is heavily framed by a cultural lens, through which diversity is embraced as a competitive advantage, storytelling and the contributions of informal cultural leaders are celebrated, and personal relationships support community and professional success (Bolman & Deal 2017). Gabriele (2010) notes that "it is important that we recall that, from a particular perspective, healthcare is a culture. It has many constitutive parts. Like other cultures, healthcare organizations and communities have shared language, patterns of communication, abilities, vision, behaviors and approaches" (p. 62). To that end, examining the PoP through a cultural frame will seek cultural symbols that bring together the shared lived experiences of the IPGs served by the stakeholders involved in this PoP. At Health Alliance, the cultural lens reminds us that offering truly inclusive services means being mindful not to schedule information sessions for IPGs on spiritual days of observance and to monitor communications to ensure they recognize gender, faith, and neurodiversity. It means ensuring the creation of safe spaces for people with diverse backgrounds.

The PoP will also be framed by an equity lens, examining issues of equity and where the PoP may leverage codes of ethics in various provinces to strengthen the proposed OIP. This will be further discussed in the "Change in the Context of Equity, Ethics and Social Justice" section of this OIP.

Theoretical Frameworks

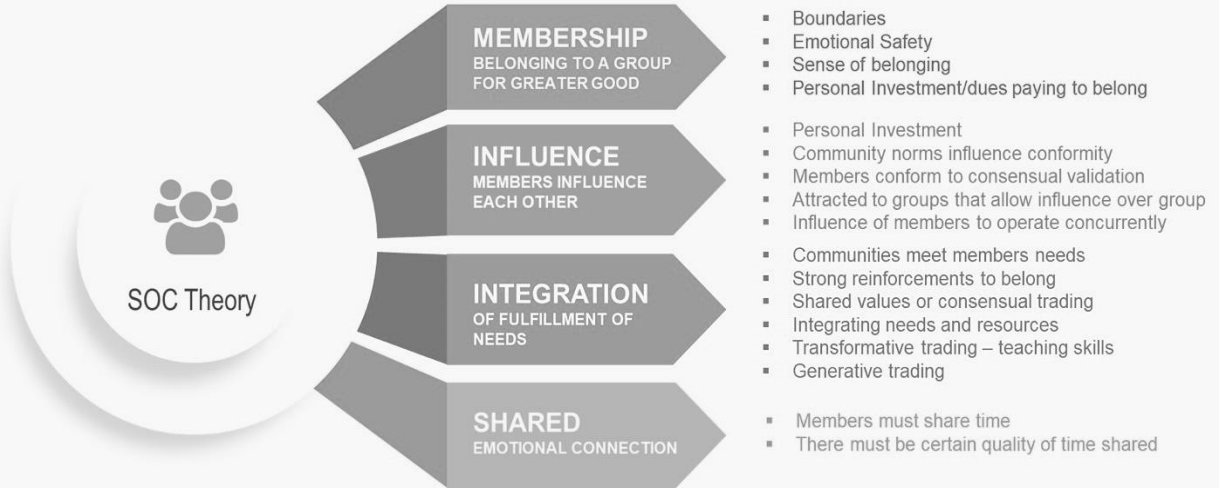
The theoretical frameworks that guide the PoP are a blend of critical theory's tenets and sense of community theory. Sense of community theory is the primary theory that underpins the examination of the IPGs' lived experience. Critical theory, critical race theory in particular, will also provide a focus on the benefits that can be gleaned from shared experiences.

Sense of community theory

Sense of community theory is a belief system derived from McMillan and Chavis's (1986) work that determined that sense of community exists and serves as a driving force for people and communities. McMillan and Chavis explained that "sense of community is a feeling that members have of belonging, a feeling that members matter one another and to the group, and a shared faith that members' needs will be met through their commitment to be together" (p. 9). The theory is therefore based on the four elements of: (a) membership, (b) mutual influence, (c) integration and mutual reinforcement, and (d) shared emotional connections (Herman et al., 2005). These tenets are further defined in Figure 3.

Figure 3

Sense of Community Theory



Note. Four tenets of sense of community theory (SOC) and the principles that support them. Adapted from McMillan (2011).

Sense of community theory posits that once these four tenets are achieved, a functional community is formed. Prati et al. (2016) noted that there is a relationship between sense of community and social well-being, and social well-being contributes to behaviours that increase

quality of life. Related to the lack of opportunities for IPGs, sense of community theory acknowledges their feelings of psycho-social isolation and considers that any solution to the PoP is more likely to be effective if it facilitates an IPG sense of belonging and ability to rely on the connectivity of the community to meet goals.

Lin and Luyt (2012) noted how the National Library of Singapore became a community beacon to its members and how "entitlement of membership and a feeling of belongingness created a feeling of emotional security among the local multilingual, multiracial populace as they used the neutral nature of the library to meet and interact with each other," (p. 664) as evidence of how an otherwise disconnected, disparate group of individuals may be engaged by a shared experience and motivated by a common goal. In this sense, sense of community theory provides a strong foundation to support the need for IPGs to be empowered to articulate some of their own learning and support needs and to set their own learning goals.

While sense of community theory supports the shared and lived experiences from among and within the IPG community and speaks to the need for this community's empowerment and self-determination, it does not examine as deeply external factors, including barriers that shape the experiences shared by IPGs. For this reason, critical race theory (CRT) is also proposed as a theoretical framework from which to position the PoP.

Critical Race Theory

Critical theory presents an opportunity to test norms, with a view to challenging dominant discourses and reflecting on power structures and imbalances. CRT in particular uses the lens of race and ethnicity to critically examine the social, political, economic, and legal structures of policies and procedures to determine whether and how they are unfairly biased against people of colour (Schmidt & Block, 2010). CRT emerged from the early writings of Bell (1973, 1980) and

Crenshaw et al. (1995). It allows the lived experience of people of colour to elucidate structural and systemic barriers faced by IEHPs. CRT also provides an analysis framework that extends beyond legal structures to educational institutes, health policy, workplace practices, etc. (High, 2020). CRT "seeks to analyze the experiences of racial minorities while examining existing power systems like white privilege" (Boyd, 2018, p. 13). Additionally, it encourages dialogue to examine traditional research paradigms to uncover the effects of overtly racist policies (Solórzano & Huber, 2020).

CRT has five key tenets (Zaami, 2020) outlined as follows. The first tenet is racism is a normal, "structured part of everyday life in the U.S. as opposed to an aberration or a function of a few racist individuals (e.g., Neo-Nazis)" (Cabrera, 2018, p. 211). This recognizes that racism forms an on-going mantle borne by people of colour as they walk through life and undertake daily activities, extending to the IPG experience with the immigration processes, licensure journeys, and applications for employment. Some experiences with racism may be overt and some may be much more subtle, but the experience is constant. This tenet explores and challenges the notion that North America is a meritocracy, promising fair and equal access to opportunities (Zaami, 2020), countering the narrative of North America as a colour- and race-blind society and one without biases regarding orientation or ableism.

The second tenet is termed interest convergence, which describes that "only when an interest benefits the dominant group are minority groups allowed to strive or succeed" (Bernier, 2013, p. 72). This principle is of particular importance to this PoP because tension arises as regulators are not responsible for providing learning opportunities and, in some provinces, are required to maintain a demonstrable "arms-length" relationship with universities and associations that offer training, professional development, and member services. Nonetheless, regulators do

have a responsibility for workforce planning and a role to play in the quality of pharmacists, at arms-length. As economic and workforce planning drivers become more critical and the interests of IPGs and the greater community converge, there may be more support for addressing barriers to licensure. The COVID-19 pandemic has been an example of interest convergence as healthcare professionals have been fast-tracked through licensure or have received emergency licenses to support an overwhelmed healthcare system.

The third tenet is that race is a social construct, which McCray (2020) defines as the concept "of something based on the collective views developed and maintained within a society or social group; a social phenomenon or convention originating within and cultivated by society or a particular social group, *as opposed to existing inherently or naturally*" (p. 34). This definition explains that genetically, there is very little variation that divides human beings; race classifications were developed solely to categorise, assign attributes, and assume supremacy by one group of people over another.

The fourth tenet is intersectionality. It acknowledges that there are many forms and dimensions of oppression, such as marginalization, exploitation, and cultural oppression. Intersectionality is how oppression, power, class, ethnicity, and privilege intersect to contextualize the lived experiences of people of colour (Cabrera, 2018; Zaami, 2020). This principle is particularly salient to the IPG community, who unite through their shared path to licensure, but who each bring unique experiences, cultures, and backgrounds. Intersectionality acknowledges the confluence of existence as a person of colour and the additional burdens experienced by newcomers to Canada, particularly visible minorities, struggling to navigate cultural, workplace, and social norms. Their stories of intersectionality make this community rich, but also make their journeys and their burdens distinct.

The fifth tenet is storytelling. Here Bernier (2013) describes educational research that includes "using personal narratives, composing counter storytelling to negate the stock stories in education, considering interest convergence, examining Whiteness, and contextualizing race, racism, and educational polices," (p. 72) not just to create a counter narrative, but to contribute to the healing and empowerment of the storyteller. This aligns with sense of community theory's principle of influence, where members of a group can use their personal stories and lived experience of triumph over challenges to uplift and motivate each other to work against the dominant discourse.

Taylor (1998) raises two cautions regarding the CRT lens. The first is that "CRT may be criticized as too cynical, nihilistic, or hopeless. Indeed, its assumption of the permanence of racism and its prediction of continued subordination of Blacks can be read as excessively negative" (p. 4). The second caution noted is that CRT was born out of the civil rights movement when the two races in contention were African Americans and White Americans. Therefore, it is built on the premise that Black and White communities think in a homogenous and predictable manner, and it does not account for political and ideological blurring of more modern and diverse communities (Taylor, 1998). Further, research often confounds race and ethnicity, forcing some ethnicities to be racialized and adding an element of confusion to broad categorizations of people into the generalized term of people of colour (López & Hogan, 2021).

Taken together, CRT and sense of community theory complement each other as the theoretical underpinnings for this PoP. Sense of community theory draws on the self-interests of a particular group of racially diverse individuals who are brought together through shared experiences (Peterson et al., 2008). In the case of IPGs, these include displacement, immigration,

licensure, and the search for employment. These theoretical frameworks will help in examining the guiding questions emerging from the PoP and in considering the most effective solution.

Guiding Questions Emerging from the Problem of Practice

Questions arise when contemplating the PoP, as there are a number of evidence-based or emerging strategies to support international healthcare professionals overcome the barriers they face on their path to licensure in Canada. The questions are formed by considering the main challenges emerging from the PoP and by contemplating its effects. Coupled together, these two aspects will guide emerging research questions and the proposed solutions to the PoP.

Main Challenges Emerging from the PoP

The first challenge in addressing this PoP is that qualitative data on the barriers faced by IPGs on their licensure journey is difficult to secure and collate, as there are many aspects to the process. Immigration to Canada presents its own set of challenges, and information related to immigration is housed by the Canadian government. The licensure journey may be initiated with an alliance of regulators, but the licensure examination board is a separate entity. If candidates are required to participate in bridging programs, this introduces another organization. It becomes easy for organizations to step back from supporting IPGs if they believe other organizations have the resources, power, or authority to do so. A second challenge of the PoP is that regulatory authorities are empowered by their provincial/territorial governments to act as gatekeepers to the profession and to protect the public within their respective jurisdictions. Therefore, while participating in national initiatives is not unheard of, funding national initiatives out of provincial or territorial coffers can be more challenging to negotiate.

Based on the preceding discussion, questions arise when contemplating the PoP, as there are a number of evidence-based or emerging strategies to support international healthcare

professionals overcome the barriers they face on their path to licensure in Canada. As mentioned earlier, any national solution must be equally beneficial to each jurisdiction.

What are the Barriers Faced by IPGs?

The barriers faced by internationally educated professionals seeking licensure or registration with regulatory colleges or professional associations in order to have gainful employment in their field of choice are central to the challenges emerging from the PoP. Structural barriers noted by Grant (2007) include systemic discrimination against internationally trained workers, and personal situations alongside restrictive regulatory systems that make it challenging to bridge internationally acquired skills with Canadian workplace requirements. Cheng et al. (2013) also highlighted challenges in meeting Canadian professional and language standards as individual barriers. Internationally educated nurses (IENs) were also noted to face barriers such as "length of time involved in assessing credentials and competencies and then meeting outstanding requirements for licensure, costs associated with educational upgrading, variability among jurisdictions, accessibility and effectiveness of programs" (Ogilvie et al., 2007, p. 229). These challenges are reflected in the experiences of IPGs who are seeking licensure in Canada. In a study of 264 IPGs, Austin and Marie (2004) noted some IPGs struggle to become licensed to practice pharmacy in Canada due to a lack of experiential opportunities that would allow them to be more successful in objective structured clinical examination (OSCE) settings, as well as other barriers noted above.

What are the Effects of the PoP and Barriers Faced by IPGs?

One of the effects of these barriers is a delay in the ability of many internationally educated professionals to successfully integrate into their chosen profession. The delay in licensure and credential recognition can further result in socio-psychological isolation and

additional financial challenges (Cheng et al., 2013). Literature also revealed underutilization's cost to society. Here we remember that Canada faces a labour shortage in the healthcare field of as many as 43,000 workers. Human capital theorists believe that "the human capital that immigrants bring to the host country often offsets the costs of population growth" (Umut, 2018, p. 369), and the effects of underutilization include the employment of highly skilled professionals in low-skilled or unskilled jobs, and lower income and opportunities for internationally educated professionals. It is also noted that newcomers to Canada are substantially underpaid compared to native-born Canadian of similar ages, linguistic profiles, racial backgrounds, and qualifications (Reitz et al., 2013). Further, from 2001 to 2006, although the proportion of skilled immigrants in Canada and the U.S. continued to grow, this group of professionals saw declining rates of success in accessing managerial roles in their chosen professions over time (Reitz et al., 2013; Shapiro, 2017).

What supports can licensed professionals provide to skilled immigrants seeking licensure in the field of their choosing?

Licensed professionals, particularly those who were once IPGs themselves, can take a leadership role in providing assistance to IPGs on their path to licensure. They can act in formal roles such as assessors and preceptors, providing guidance and assessing whether IPGs have met entry to practice competencies and determining whether they are ready for independent practice. They can become involved in the development of the processes and tools used in mandatory clinical assessments (developing standards and clinical scenarios, for example) that are free of cultural bias. They can also act as coaches and mentors, providing safe and low-stakes opportunities for IPGs to practice their clinical and soft skills before they have to be assessed in a high-stakes environment. These opportunities to assist IPGs will be considered.

Leadership-Focused Vision for Change

The leadership-focused vision for change explores the gap analysis between present and future state. It is well described by Lavender (2009) who noted that in clearly defining the trajectory linking change from the past, present, and future, it was important to create urgency, providing an impetus for change. Lavender suggested that "in order for change to occur 'the present' has to be considered untenable and/or unacceptable, 'the vision' needs to be clear but not perfectly painted, and 'the resources' identified and available to move from the present towards 'the vision" (p.24). This premise underpins the discussion and vision of change that will be further explored.

Vision for Change

As regulators in many countries begin to revisit their approaches to maintaining public trust, regulated occupations are reflecting on what best practices in self-governance and regulation are to be considered to ensure their existing processes are appropriate mechanisms to protect the public. As Lahey (2011) wrote: "the traditional model of self-regulation can no longer be taken for granted. There are forces driving change, including a trend toward deregulation, which have little or nothing to do with the quality of regulation that is currently happening…" (p. 13). Organizations are being called to transition from strict patriarchal observance of its mandate to a more empathetic approach, allowing for a balance to be found "between the transactional/technical mandate and the human interactions/relational aspects that come to the forefront in the process of collecting information" (Canadian Network of Agencies for Regulation [CNAR], 2020, p. 11) for licensure.

Health Alliance continues to work with its regulatory members to re-examine their functions in self-regulation and how they protect the public. The OIP is meant to encourage the

organization to leverage its interactions with IPGs, through the IPG portal, to create formal opportunities to help them succeed. The vision for change, then, is for Health Alliance to renew its commitment to regulatory excellence with an additional assurance of creating formal opportunities to help IPGs succeed in Canada.

Gap between Current and Future States

In its current state, Health Alliance is an association of regulators. It houses a portal which is a mandatory first step on the path to licensure for all IEHPs in the sector. Regulators who form Health Alliance's membership and endorse the portal are mandated by their provincial governments to set and enforce licensure standards, licensing only those who meet entry to practice competencies. Regulators are not responsible for providing learning opportunities and, in some provinces, are in fact required to maintain a demonstrable "arms-length" relationship with universities and associations that offer training, professional development, and member services. As previously described, the pharmacy sector suffers from a lack of opportunities for international graduates to become familiar with Canadian workplace culture and clinical settings that impedes their path to licensure and employment. At the same time, regulators recognize that "organizations need to consider claiming responsibility beyond the scope of a regulator's mandates, expanding accountability for upholding the dignity of all stakeholders within regulated professions – beyond accountability solely for the public interest" (CNAR, 2020, p. 5).

This tension precludes a clearer connection between the regulator's public protection mandate and the IPGs' need for more inclusive processes and additional, accessible support. It also describes the gap that needs to be addressed. Further, although regulators create and aspire to uphold their own codes of ethics and professional conduct, few of those policies specifically

speak to helping IPGs integrate or re-integrate into the profession. In its desired state, Health Alliance can transform itself into a facilitator of IPG opportunities, as it has the capacity, resources, and infrastructure to leverage partnerships, relationships with stakeholders, and membership to reduce some of the barriers faced by IPGs.

Priorities and Drivers for Change

The intersection of the COVID-19 pandemic, the murder of George Floyd and the ensuing rise of the Black Lives Matter movement, and the Truth and Reconciliation Calls to Action (Truth and Reconciliation Commission of Canada, 2015) have helped uncover the depth of inequalities for marginalized communities in housing, health, education, and professional development (Armenta, et al., 2022; CNAR, 2020; Cross et al., 2022). Social justice issues continue to drive conversations among regulatory colleges about creating and supporting more inclusive processes and programs, increasingly causing them to realize that "combatting discriminatory practices is largely a task at the organizational level (e.g., fostering the acceptance and culture of diversity in addition to facilitating mentorships)" (Newton et al., 2012, p. 540). The sector is awakening to the need to address discriminatory practices and historical barriers that impede the licensure journey for professionals. As well, Canadians are calling for increased government oversight to compel regulators to be increasingly "accountable for the privilege and trust granted by [government] to the profession in self-regulation" (Yam, 2005, p. 95).

In November 2020, the CNAR held a workshop on diversity and inclusion. The three themes that emerged perfectly summarized the priorities for change, while also answering the question, "why now?". These themes were: (1) a need for inclusion that extends to the development of protocol and practices and a staff that is reflective of the community and stakeholders; (2) a realization that only through continued dialogue can organizations create

empathetic action; and (3) that there is a need to consider responsibility beyond regulatory mandates (CNAR, 2020). This is a promising step towards the ongoing discourse necessary to provide the foundation for this OIP and speaks to the readiness of regulators to begin looking beyond the strict parameters of their mandates.

Organizational Change Readiness

Before considering and selecting an appropriate solution to address the PoP, it is important to determine the organization's attitude towards it and to assess the organization's appetite for change. Diagnosing a readiness for change must be conducted close to the time of change, and, depending on the drivers, the change management process and communication will need to be adapted. Health Alliance's readiness for change will be informed by a PESTLE analysis to understand the environment surrounding the organization and will be diagnosed using Armenkasis's readiness for change model.

A PESTLE analysis is used to evaluate "the impact that the external environment might have on a project. It clusters external parameters into various factor categories under the broad headings of Political, Economic, Social, Technological, Legal and Environmental (PESTLE) considerations" (Cullinane, 2019, p. 4). A PESTLE analysis can further contextualize and diagnose the program, symptoms, and effects of the PoP. As a non-profit, it is critical to analyze external factors that ultimately affect the OIP's successful implementation and sustainability.

Political Factors

Deszca et al. (2020) noted that "the politics of the world are not the everyday focus for managers, but change leaders need to understand their influence on market development and attractiveness, competitiveness, and the resulting pressures on boards and executives" (p. 17). This is true for Health Alliance, whose revenue is affected by the number of IPGs who register via

the candidate access portal. Following the 2016 U.S. presidential elections, for example, Health Alliance saw a rise of almost 40% in portal enrolment revenue (Health Alliance, 2018). Additionally, the access portal allows Health Alliance to see that most IPGs entering Canada are coming from three main areas of the globe: Southeast Asia, North Africa, West Africa (Health Alliance, 2021). Understanding the political events in certain countries can help anticipate waves in applications from those areas. Housing this information also provides information about the scopes of pharmacy practice in the most active countries of origin. This can help Canadian regulators anticipate where the greatest learning needs will be.

Economic Factors

Economic factors such as inflation rates, employment levels, and interest rates impact the PoP in various ways. The state of the economy affects how many IPGs emigrate to Canada and begin the licensure journey. Canadian immigration programs such as the Express Entry profile allow candidates to apply using a point system. Some provinces rank certain professions above others to control the balance of demand and supply of the talent pool. Where there are fewer jobs, a province may rank a profession lower than it might if there are shortages, making it more difficult for candidates to become naturalized in that province. Add to this that people of colour and "immigrants, tend to be employed in sectors very sensitive to business cycles. When the general economy is doing poorly, populations concentrated in those sectors feel the effects more quickly and find that these effects last longer" (Shapiro, 2017, p. 109). Among Health Alliance's members, some jurisdictions are smaller than others. The smallest jurisdictions have the least number of IPG seekers and the lowest number of staff to address regulatory and operational issues. As such, smaller jurisdictions may have competing priorities that divert attention away from providing additional support to a handful of registration candidates. Since these jurisdictions

rarely receive requests to assess and support IPGs, forecasting to integrate requests into their workflow is impossible. Therefore, Health Alliance pays close attention to the social and economic climate to proactively offer support to its members and the IPGs it serves.

Social Factors

Population trends, as described earlier mean, that Canada will continue to address its aging population and declining birth rate with immigration. This creates a challenge for employers and managers to lead, hire, and train, with greater inclusivity and diversity strategies. Additionally, human capital theorists believe that "the human capital that immigrants bring to the host country often offsets the costs of population growth" (Umut, 2018, p. 369). The pervasive issue of underutilization of foreign trained professional talent in the workforce underscores the importance of examining the PoP from a social perspective to address some of the systemic and psycho-social barriers described earlier.

Technological Factors

Shatskaya (2016) noted the importance of a technological assessment of the organization's environment "in assessing and listing issues that could have a potential impact on its operations and that could be critical to its long-term future" (p. 49). There are two technological factors affecting this PoP. The first is that, while the licensure journey can be long and arduous, there is an opportunity to create or adopt technology that would allow IPGs to begin some of their process pre-arrival. Since language-specific communication and an understanding of Canadian scopes of practice can facilitate success in licensure (Covell et al., 2017), technology, such as learning management systems for low-stakes learning, e-badge platforms, and online secure testing services for higher stakes examinations, should be

considered when addressing the PoP. Gamified pharmacy simulation has also assisted with virtual education delivery during the COVID-19 pandemic (Hope et al., 2020).

Second, a portal housing administrative data related to IPGs and the success of their licensure journey already exists. The database was designed to support the regulatory authority's needs by providing information on how many IPGs currently aspire to become practicing pharmacists, and how many might apply to practice within a jurisdiction at any given time. It also acts as a repository of personal information, training, immigration, and language proficiency that can easily be accessed by any regulatory body, with the candidate's permission.

Environmental Factors

While environmental offsets and climate change could affect the supply chain and create challenges for practicing pharmacists, this would have little implication for this PoP. Additionally, post-COVID-19 realities (belonging equally to economic and technology, but listed here) mean that the environmental footprint normally inherent in implementing and monitoring change will necessarily be reduced, through remote monitoring and electronic data collection. Therefore, there are no discernable *environmental* threats posed by this PoP at this time.

Legal Factors

Legal variables that affect this PoP include legislation relevant to the pharmacy practice and immigration laws/systems that impact the ability of immigrants to become naturalized and access programming to facilitate their licensure. Provincial health care acts strictly govern who can perform regulated acts under which levels of supervision. A pan-Canadian approach would require adherence to these regulations. If, as part of the OIP, IPG learning needs are addressed in a clinical setting, proper status as either a registered student or employee will be required to ensure appropriate workplace liability and occupational health and safety training coverage for

the workplace and the IPG. Further, the setting would require some documentation to ensure that IPGs understand and respect legislation around the protection of personal health information, patient confidentiality, and the Canadian Charter of Rights and Freedoms. Practicing pharmacists, whether trained in Canada or internationally, must pass a jurisprudence exam prior to licensure, which addresses these areas of liability.

All of these factors above contextualize the findings from the readiness to change exercise that is explored in the next section.

Diagnosing Readiness for Change

The model used to diagnose readiness to change is the readying an organization for change model (Armenakis et al., 1999). The need for change is identified in terms of the gap between the current state and the desired state. The model suggests that the organization is ready to fully commit to change when people within the organization believe that the change appropriately responds to the problem, organizational members feel confident that the organization can sustain the change, the leadership and key decision-makers endorse the change, and leadership feel the organization benefits from the change (Armenakis et al., 1999).

In terms of the organization's belief in the change, Health Alliance has already set precedence for providing programs that assist IPGs. Currently, an innovative pilot project is underway that was deemed necessary by Health Alliance's regulatory authority members and financially supported by a grant from the Government of Canada, who also believed it to be necessary. Health Alliance's senior leaders are interested in the project's outcomes and its long-term impacts on IPG licensure.

Related to sustainability, most of the regulatory authorities nominated a member to a steering committee that guides the project and explores IPG assistance, as they felt invested in its

success. Some regulators have already begun exploring ways to further support IPGs in partnership with Health Alliance. The project has also captured the interest of employers who recognize IPGs as an important part of the talent pipeline and non-profit lenders who provide micro-loans to support IPGs with their pre-licensure expenses. Health Alliance also benefits from its involvement in the project as a key collaborator and a valued partner in building the international talent pool for the Canadian workforce.

Health Alliance exists in a dynamic health system where its regulatory members experience various levels of regulatory reform. The organization and its members are poised for change, and according to Armenakis et al.'s (1999) model, Health Alliance is ready for change. Still, the theoretical frameworks that drive the organization, a clear examination of its leadership PoP, and a solid vision for change will all help to prepare the organization for the planning and development needed to select and implement an organizational improvement plan that will facilitate the organization moving to its desired state. This will be discussed in the next chapter.

Chapter One Summary

It is clear that there are complex and challenging barriers facing IPGs, but they are not insurmountable. Chapter 1 examined the PoP within the organization and explored some of the questions that emerge from the PoP. The vision of change was determined, and the organization has proven itself ready to undertake it. Chapter 2 will build on the organizational context and leadership approaches to determine the appropriate response to the PoP.

Chapter 2: Planning & Development

In the first chapter, the problem of practice (PoP) was introduced and the organization presented in the dynamic system context in which the problem exists. The leadership position and focussed vision for change were presented in order to appropriately frame the PoP. This chapter critically examines some of the options for change: the leadership approach, the change management models, and various solutions to address the PoP. The social justice implications for the selected solution will also be discussed.

Leadership Approaches to Change

Taylor (1988) noted that a "leadership approach to change requires thinking about how to influence followers to work towards and achieve a desired outcome" (p. 9). With this in mind, the leadership approaches to change must be examined before considering options to address the PoP. Some of the commonalities between the proposed shared leadership approach supporting this OIP, the collaborative leadership approach currently embraced by Health Alliance, and the servant and authentic leadership approaches I embody as the change agent, will be explored. Here it is important to note that, in the literature, researchers often use terms intended to describe post-heroic, more democratic types of leadership, such as shared, distributed, collaborative, democratic and participatory leadership, interchangeably. Indeed, Bolden (2011) cautioned that there are dangers in assuming the synonymity of these terms. He noted that the clear overlap between some principles of these various styles of leadership does not necessarily imply that everyone is equally a leader in each one. This OIP clarifies the impetus for the suggested change from Health Alliance's collaborative leadership approach to shared leadership.

Collaborative Leadership Approach

Chrislip and Larson (1994) authored the term collaborative leadership to describe a leadership style that creates non-judgemental spaces for dialogue, requires team members to hold up their ideas to the scrutiny of other members, and that is open to new ideas that may transform organizations (Raelin, 2006). Additionally, collaborative leadership allows all team members to be on equal footing and to have equal agency in contributing to problem-solving, ensuring no-one feels a sense of loss or gain at the expense of others (Avery, 1999). Health Alliance embraces collaborative leadership, and in doing so, strives to create an environment for peer problem-solving, and to ensure broad-based involvement of a variety of stakeholders. Health Alliance is governed by the strong leadership of its board of directors and supported by the leadership of the senior management team. The collaborative leadership approach in this context is meant to facilitate the sharing of accountability, resources and responsibility for problem-solving (Rawlings, 2000). Health Alliance engages collaborative leadership in its board structure as well as its stakeholder consultations, where leaders are responsible for guiding the process to address the problem at hand.

Shared Leadership Approach

The OIP will be supported by the shared leadership model, a term originally coined by Pearce and Conger (2003) who described it as "a dynamic, interactive influence process among individuals in groups for which the objective is to lead one another to the achievement of group or organizational goals or both" (p. 1). Similar to collaborative leadership, shared leadership requires all team members to have positive, lateral influence over each other, to contribute constructively to problem-solving, and to have team members step into leader and follower roles at certain times (Bligh et al., 2006; Northouse, 2019). The commonality with collaborative

leadership extends to these two key tenets: the mutual influence between leaders and followers and the fluidity of roles (Sivasubramaniam et al., 2002). Finally, as with collaborative leadership's democratic decision-making, shared leadership occurs when the leadership role is distributed across the change team rather than having a designated leader (Fláviade Souza Costa & Fábio, 2021).

There are challenges to both models. Herbst et al. (2019) produced a qualitative analysis of shared leadership environments from which they highlighted possible drawbacks to the shared leadership approach, including a lack of facility in using the model, the potential for the lack of acceptance among users, and the possibility that not all team member voices would be heard. Further, shared leadership requires an adjustment period in order for some members to be comfortable with their roles as leaders or followers; this may add complexity to internal social structures, and cause loss of momentum in propelling the change forward (Fláviade Souza Costa & Fábio, 2021). Similar critiques regarding leadership exist for collaborative leadership: without formal organizational authority, if there is a rivalry or lack of belief in the cause or the process, perceived political allegiances may overtake collaborative efforts (Avery, 1999), slowing or interrupting change.

Both leadership styles have challenges that may make the differences between them appear insignificant. However, it is important to note that shared leadership can be further divided into two sub-styles: task-oriented vs. relationship-oriented shared leadership. Task-oriented shared leadership refers to a concern for achieving a performance standard while respecting prescribed rules and processes. Task-oriented shared leadership behaviours, such as monitoring and delegating of tasks, can have a negative effect on team performance (Han et al., 2021; Waldersee & Eagleson, 2002). Relationship-oriented shared leadership is a more person-

centred approach that focuses on mutual social support and fosters group cohesion (Han et al., 2021). Relationship-oriented shared leadership focuses on the emotional strength of the team, which correlates positively to team performance, particularly in the area of creativity (Han, et al., 2019). The distinction between task- and relationship-oriented shared leadership is critical to understanding why the shared leadership approach is appropriate to address this PoP, which calls for Health Alliance members to assume leadership roles in assisting IPGs, and for IPGs to take a leadership role in articulating their own learning needs. Relationship-oriented shared leadership allows different leaders with different leadership styles to play a role in creating organizational change. The shift between collaborative and shared is not monumental, but the important area of difference is relationship-oriented shared leadership's commitment to team prosperity and feelings of unity. This distinct factor is crucial to the success of this OIP.

Further, the personal leadership statement described my leadership style as servant leadership, influenced by tenets of authentic leadership. The resulting approach, leaning heavily on servant leadership, is about prioritizing the needs of others, where "the emphasis on serving encompasses more than employees and their development; servant leaders make the needs of consumers, employees, and communities their top priority" (Allen et al., 2016, p. 3). From this perspective, I easily prioritize the needs of IPGs as consumers. Relationship-oriented shared leadership bridges the paradigmatic divide between my servant leadership approach and the organization's collaborative leadership approach. Herein lies the driver for the proposed shift from collaborative to shared leadership.

The shared leadership approach is therefore appropriate to addressing this PoP, as leaders in this context typically have separate but complementary responsibilities, support one another's unique perspectives, and focus on collaborative problem-solving rather than focusing on

authority structures (Cogen & Vaidyanathan, 2019). Freund (2017) further contributed that a shared leadership environment "can promote an enabling climate of psychological empowerment, trust and safety, and common purpose" (p. 13). Additionally, shared leadership has been noted as contributing to employee empowerment (Cobanoglu, 2020; Binci et al., 2014), trust and safety (Freund, 2017), and habits that lead to quality improvement (Zamboni et al., 2020).

The OIP's objective, as outlined in the vision for change, is for Health Alliance to expand its pursuit of regulatory excellence to include the creation of formal opportunities to help IPGs succeed in Canada. Such an environment would support IPGs in articulating their own learning needs, as well as leaders from Health Alliance providing insight and guidance related to the licensure journey. The intended result is collaboration between stakeholders and IPGs working toward IPG success. This level of collaboration is well supported by the tenets of belonging and shared mutual responsibility in the sense of community theoretical framework. The concepts considered in the shared leadership approach also align with the issues discussed in the challenges and evaluation components of the "Change in the Context of Equity, Ethics, and Social Justice" section of this OIP.

Framework for Leading the Change Process

Nadler and Tushman (1989) divided change into two dimensions: Anticipatory vs. Reactive, and Incremental/Continuous vs. Discontinuous/Radical. Understanding the spectrum between anticipatory and reactive change allows leaders to determine the level of preparation that recipients will need to absorb the change. Examining whether the change is incremental or radical allows change agents to understand the change's impact. Both of these dimensions affect the change's plans and its communication.

An anticipatory, discontinuous/radical type of organizational change is considered for this implementation. Deszca et al. (2020) suggested that this type of change occurs when organizations undergo "strategic proactive changes based on predicted major changes in the environment," and when there is a need for "positioning the whole organization to a new reality" (p. 22). For Health Alliance, this change is considered anticipatory because, although the organization is reacting to social, systemic, and personal barriers faced by IPGs, the change is being approached from a voluntary desire to support IPGs rather than reacting to a mandate. It is further considered a discontinuous/radical change because it would be a departure from Health Alliance's primary mandate of serving its members. This OIP focuses on serving IPGs, and its members will be secondary beneficiaries of the chosen solution.

Change Models Under Consideration

This type of shift in the organization's orientation towards shared leadership requires a change model that is adaptive and can align with the organization's values and theoretical frameworks. Therefore, there are three change models under consideration to support this OIP: the Peters and Waterman (1982) McKinsey 7-S model, the Beckhard and Harris (1977) change-management model, and the Kotter (1996) change management model.

McKinsey's 7-S Model

The first model being considered is the McKinsey 7-S model. Early theorists Peters and Waterman (1982) explained that there are seven key elements to an organization, consisting of three hard elements—structure, strategy, systems—and four soft elements—skills, staff, styles, and shared values. Hard and soft elements are compared to see how they are congruent, and the areas of misalignment require change. The goal of the model is to demonstrate where the seven elements would align to contribute to organizational effectiveness (Mehdi Ravanfar, 2015).

A disadvantage to this model is that the soft elements in particular are more difficult to assess and align. In general, Mehdi Ravanfar (2015) noted that, irrespective of whether they are hard or soft elements, individual elements that are each effective on their own may not work well together, leading to organizational challenges. Another limitation of this model is that "strategy, structure and systems are hard elements that are much easier to identify and manage when compared to soft elements. On the other hand, soft areas, although harder to manage, are the foundation of the organization" (p. 8). Looking at Health Alliance's strategy and systems elements, it is easy to determine if the IT systems did not support the strategy, and this would be where change would need to take place. But alignment between the soft elements of skills and shared values would be more difficult to diagnose before proposing change.

Beckhard and Harris's Change-Management Model

The second model is Beckhard and Harris's change-management model (Beckhard & Harris, 1977), which is straightforward in its structure and heavily focused on process. It tasks change leaders with "defining and describing a future state in contrast to an organization's present reality. This process is called a gap analysis" (Deszca et al., 2020, p. 51) and includes planning activities, planning for commitment, and developing change management structures as a playbook for successful organizational change (Hussain et al., 2018). Commitment planning examines whose obligations are required for a successful change. Change management structures identify leadership structures and priorities for change. This model allows for different manners in which the stages can be interpreted and presents three organizational states of change as the present, transition, and future state. Within each of these, there is substantial room to develop activities (Smith, 2010), the flexibility of which is one of the model's appeals. However, for the type of change required to address the PoP, leaders may require a more instructional or directive

"playbook" from which to build a change management plan and accompanying communications strategy than this model provides.

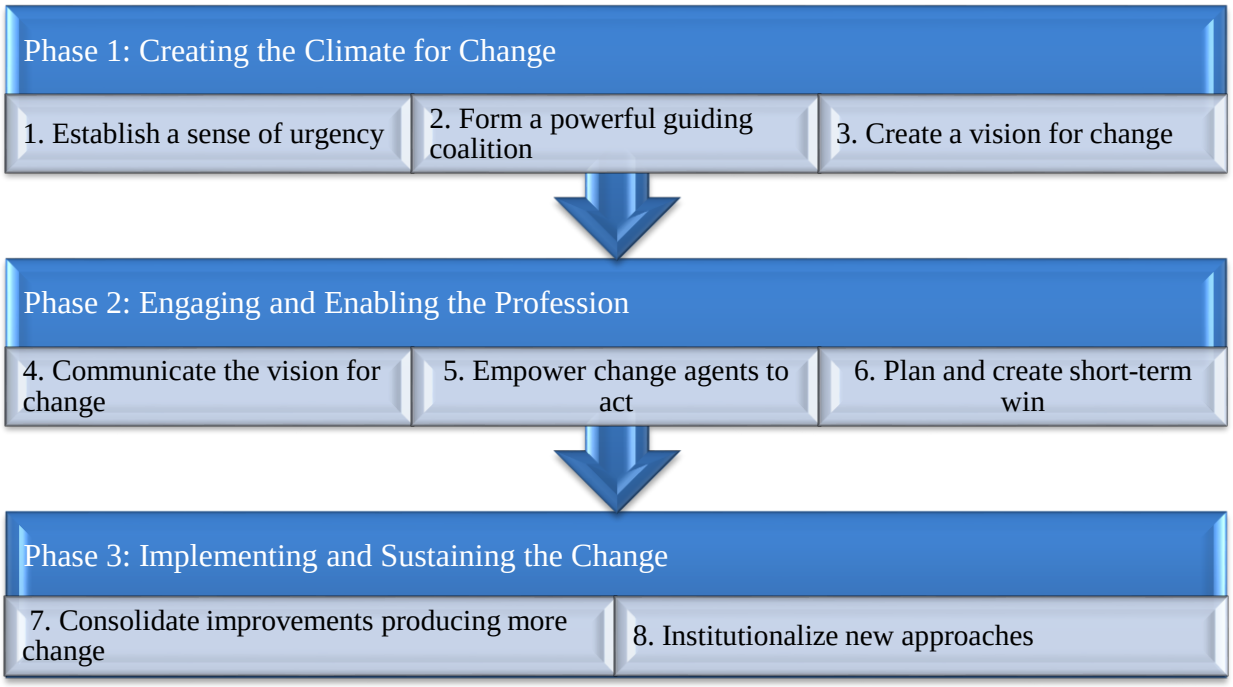
Kotter's Change Management Model

Because it is far more prescriptive than the Beckhard and Harris model, Kotter's (1996) change management model is the third considered for the level and depth of change required. Kotter's model comprises eight steps: establishing a sense of urgency, forming a guiding coalition, creating a vision for change, communicating the vision, empowering change agents to act, creating short-term wins, consolidating improvements to create more change, and institutionalizing new approaches (Kotter, 2003).

Teixeira et al. (2017) furthered Kotter's work by categorizing the eight steps into three phases: that are divided into three phases: Creating a Climate for Change, Engaging and Enabling the Profession, and Implementing and Sustaining Change as outlined in Figure 4. The resulting three phases mirror the present, transitional, and future state in Beckhard and Harris's model. However, the strength of this model lies in Kotter's individual steps. Some of the eight steps will resonate with change leaders more than others. In this case, one set of recommendations that resonates within pharmacy regulation change are the recommendations to create a change leadership team. Because pharmacy regulatory bodies usually consist of practicing pharmacy professionals (pharmacists, pharmacy technicians, and pharmacy assistants) as well as public appointees, staff, board, and volunteers from other professional disciplines (i.e., law, accounting, administration, project management, etc.), Campbell (2008) suggested that using this model should involve candidates "selected from horizontal and vertical positions of the organizational chart" (p. 26). This process is consistent with the inter- and intra-professional nature of pharmacy regulatory bodies.

Figure 4

Kotter's Change Management Model



Note. Adapted from Kotter, 1996; Teixeira et al., 2017

Teixeira et al.'s (2017) exploratory study examining pharmacists' agility in responding to the profession's rapid changes noted that specific steps of Kotter's model have been effective and seem to be well accepted by pharmacists, particularly creating a climate for change. In this study, participants also expressed skepticism in the sometimes-contradictory presentation of proposed changes using the framework. It was also noted that the credibility of Kotter's model could be questioned if the implementation of the model was compromised by not applying each stage fully, particularly if moving from creating the vision directly to implementation. Kotter (1996) noted that change efforts are often compromised when change leaders attempt to skip any of the eight steps during implementation of the change model. The potential risks of an ineffective implementation would need to be mitigated by a strong show of leadership support,

as well as a solid communication plan. Having a vertically and horizontally representative change team in place also helps to address this concern.

Overall, all of these models seem to address the complex and discontinuous change identified for the PoP. The dilemma in choosing a change management type is the varying levels of capacity among regulators to address the issue, which underscores the need for a prescriptive, well-structured change management model. Despite its drawbacks, Kotter's eight stage change management model has the flexibility to allow for adaptive approaches that are appropriate for the dynamic environment in which the regulators exist. The context related to regulatory reform will be further discussed in the next section.

Critical Organizational Analysis

The organizational analysis tool selected to "diagnose" the organization and frame the OIP is Nadler and Tushman's (1989) organizational congruence model outlined in Figure 5. This model was selected for its varied and multidisciplinary approach to organizational review. De Moville (1999) noted that "reviewers who have used the model found that it also helped them explore the changes in results when modifications are made to the values of the variables. This is the primary value of any model" (p. 117). Part logic model and part strategic review, it is useful as a comprehensive launch point from which to begin framing an OIP that occurs in such a dynamic and complex environment. It also makes efficient use of the PESTLE review, which can inform the "inputs" and "informal organization" components of the model.

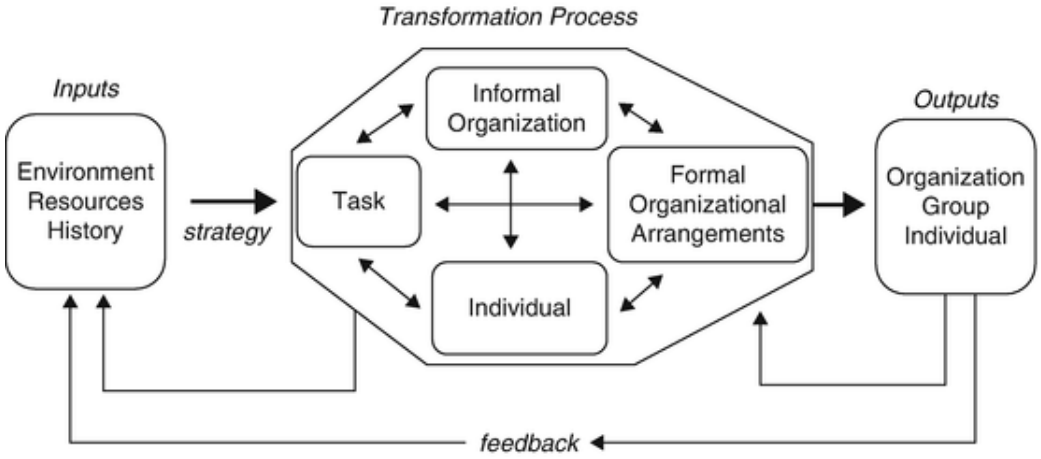
Inputs

Nadler and Tushman (1980) describe inputs as factors that, at any point in time, make up the "givens" facing the organization. They are the materials the organization has to work with (p. 39). The PESTLE analysis undertaken in Chapter 1 provides an understanding of the

organization's external environment. It is also necessary to examine the organization's internal environment, including its history, culture, and resources, which will further described.

Figure 5

Key Components of the Congruence Model



Note. From D. A., Nadler, & M. L. Tushman. (1980). A model for diagnosing organizational behavior. *Organizational Dynamics*, *9*(2), p. 47. (http://dx.doi.org/10.1016/0090-2616(80)90039-X) Copyright 1980 by AMACOM, a division of American Management Associations.

PESTLE: Examining the External Environment

Briefly, the PESTLE analysis provided earlier revealed that Canada's regulated occupations have several variables that affect their ability to meet their mandate "to 'protect' the public, foster the 'safety' of patients, and increase the 'competence' of medical professionals" (Ahmed, et al., 2018, p. 141). It is also a challenge for regulators to evolve "to keep pace with many changes in the health system, including: 1) changing public expectations; 2) growing concern among citizens about the system's ability to deliver high-quality, patient-centred care; and 3) changing care-delivery models (e.g., interprofessional team-based care)" (Waddell et al., 2017, p. 11).

History and Resources of the Organization

Health Alliance is an organization that has been in operation for over 25 years. As a member-driven organization, it is largely funded by membership dues, but also receives revenue from programs, its portal, and, periodically, project funding, which are used to cover human resource and overhead/operational costs. Health Alliance has a communications department but also disseminates key messages through its member organizations, which cover their own costs to participate in meetings and agree to diffuse communications as necessary. Health Alliance also maintains collegial relationships and collaborates as necessary to exchange information about key pharmacy competencies and standards of practice with educators, the pharmacy examining board, and other pharmacy associations. As such, Health Alliance is well resourced and positioned to address the PoP.

Transformation Process

The Nadler and Tushman (1980) model defines the transformational process as occurring where "the organization and its major component parts are the fundamental means for transforming energy and information from inputs into outputs" (p. 43). Analysis of Health Alliance can include an assessment of the organization's (board) membership components or its internal (departmental) components.

The Work

Health Alliance's work is primarily administrative. The organization is supported by a strong senior leadership team, consisting of directors of three departments:

- Professional Practice, which determines entry to practice guidelines and coordinates standards of practice between jurisdictions;

- Communications and Public Relations, which represents the public-facing part of the organization, coordinating media communication, social media, website, and internal formal and informal messaging;
- Community Services, which provides programs and services to IPGs, as well as to member organizations and other sister organizations.

Department managers oversee the workload and task distribution to their team members and are responsible for sharing and supporting work organizational mission, vision, and strategy.

Individuals

The organization is staffed by a small, dedicated team with a mix of project management, administrative, and pharmacy leadership backgrounds. All staff, particularly at the frontline level, are expected to be fluent or conversant in English and French and must be at ease in a digital environment as well as with basic data analysis. The organization provides opportunities for each staff member to raise concerns and contribute to the organization's operational and strategic direction via staff consultation on areas such as strategy, risk, and governance, and via individual performance appraisals. The leadership approach to staff engagement reflects its commitment to collaborative leadership.

Formal Organizational Arrangements

Tasks at Health Alliance are packaged by department siloes, seldom engaging in cross-departmental activities. In addressing the PoP, the Professional Practice team's role will be to ensure that any proposed solution is underpinned by the tenets of professionalism to which pharmacies adhere and that the solution is aligned with entry to practice guidelines for independent practice. The Community Services unit would assure that the proposed solution takes a programmatic approach, that it can be integrated into the department's workflow, and that

it aligns with the organization's strategic goals. The Communications and Public Relations department would assure that the change leadership team is advised on the vision of change so that consistent messaging can be shared within the organization and with other stakeholders within the pharmacy regulatory ecosystem. Human resources within the organization are decentralized, such that there is no HR department; instead, department leads hire, train, and manage their own staff.

The organization is non-unionized, and salaries vary based on attributed levels of experience, not by established salary bands. There is a great deal of predictability (these past two years of COVID-19 instability notwithstanding) as the organization adheres closely to its priorities outlined in the strategic plan. Since Health Alliance provides a collegial work environment; a safe, clean, and respectful workspace; health and wellness benefits; and a healthy work-life balance, there is little turnover and few constraints to the work environment.

Informal Organization

Informally, Health Alliance maintains a collegial work environment, and several friendships extend outside the office. Colleagues relate to each other professionally via meetings and other appropriate means, but maintain an informal network through chat, text, and social media functions. Informal structures also exist to support IPGs. Because Health Alliance houses a portal to collect administrative data on IPGs and maintains a call line during regular business hours, IPGs often reach out to Health Alliance employees via telephone or email, sometimes about to issues unrelated to the regulatory function. Because Health Alliance is a central point of contact, employees have gained sufficient knowledge about other stakeholder organizations to act as a resource for IPGs. Although Health Alliance employees would not speak on behalf of

other organizations, they can often point IPGs in the appropriate direction for their questions, and this makes the IPG community comfortable in seeking out answers from Health Alliance.

Outputs

Outputs speak to the performance, effectiveness, and efficiency of the organization (Nadler & Tushman, 1980). Health Alliance produces a number of products to support their organizational members. Standards of practice help outline best practices for pharmacy professionals that jurisdictions may choose to adopt or adapt. New products to address emerging situations such as developing a pan-Canadian COVID-19 protocol repository are also outputs for Health Alliance. Additionally, Health Alliance representatives often act as consultants or advisory committee members for other stakeholders, such as federations of faculties of pharmacy or Health Canada. Finally, Health Alliance provides a hosting service for the IPG administrative data portal. These outputs are ongoing and fit within Health Alliance's mandate and strategic plans. For this reason, the selected solution to address the PoP should also conceivably respect the organization's conservative culture, its history entrenched in facilitating labour mobility, and their operational efforts in supporting IPGs.

What Needs to Change?

As the regulatory environment continues to evolve in Canada, there is an increased need to critically analyze the licensure processes across jurisdictions to determine whether they are transparent, fair, culturally sensitive, and effective. Regulators must continue to self-assess or be assessed on their ability to help candidates integrate or re-integrate into the profession. This is supported by the change readiness model, which reveals that developing a culture that rewards change, and fosters measures for change and accountability should be areas of focus for change agents implementing the OIP. In particular, the needs of the IPGs themselves must be considered

by building useful organizational data, evaluating IPG satisfaction with services, and ensuring that appropriate measures exist for monitoring progress. These will be described in the "Plan to Implement Change," which will address key communication messages for all stakeholders.

Solutions to Address the Problem of Practice

This section will explore viable solutions to address the PoP. It considers the stakeholders who are affected by the PoP, and those who have agency to contribute to the change, from a time and resource perspective. The strengths and weaknesses will also be examined to better draw comparisons to allow a natural and discernable solution to emerge. It is important to understand the various options for addressing the PoP. The following discussion will introduce the stakeholders who will help to address IPGs' unique needs. A preferred solution will be identified and then justified.

Considering the Status Quo

In considering potential options for addressing the PoP, the first is to contemplate what might occur if Health Alliance were to take no action. This is a reality, as the organization continues to consider its role in the regulatory environment. Hacker (2020) suggested that in contemplating maintaining the status quo, regulators ask themselves: "Does your governance and organizational structure leave you vulnerable to not meeting your mandate? To ministerial/governmental directed review and/or change? What is the appetite for change (yourself, staff, board, committees, registrants, public)?" (p. 30). The inference is that if the regulatory environment has not changed, and the trends continue, it is impossible to maintain the status quo. For Health Alliance, maintaining the status quo would bring the organization no closer to addressing the PoP.

Option 1: Micro-credentialing

There are a number of interventions that can facilitate the path to licensure for IPGs. As an example, bridging programs that have prescribed courses meant to bridge the divide between the scope of practice in other countries and those in Canada are available to many IEHPs. Another lesser-known but increasingly popular learning opportunity is micro-credentialing, at times used interchangeably with the term micro-certification. A micro-credential is "a credential recognizing a distinct skill or accomplishment. Micro-credentials come in a variety of formats including certificates, nanodegrees, digital badges, and open badges" (Clements et al., 2020, p. 157) that allow learners to customize their professional development based on their needs. Digital badges are visual representations of the credentials, embedded with verifiable metadata about the recipient, the badge provider, and the competencies acquired with the credential (Besser & Newby, 2019). Such credentials are portable, verifiable, less time-consuming, and, therefore, considerably more affordable. As such, they may be a viable option to provide better learning opportunities to skilled immigrants on their path to licensure and employment. Micro-credentials are typically offered by post-secondary institutions, such as community colleges, in partnership with industry, making the credential more valuable to both employers and the learner (Gauthier, 2020).

Decisions regarding the development of micro-credentialing framework require discussion with stakeholders that support professionals to determine the usefulness of certain micro-credentials as preparation for employment. Funding structures must also be examined to determine the necessary requirements for micro-certifications to qualify for micro-loans. As an example, the province of Ontario now allows micro-certifications to qualify for Ontario Student Assistance Programs (OSAP) if offered by a recognized post-secondary institute.

Strengths of Micro-credentialing

There are a variety of contexts that showcase the versatility of micro-credentials. For example, they may be paired with other learning opportunities, such as mentorship or peer evaluation. Implementation science could provide some evidence-based direction on which of these or other environments are best to support IPGs obtain skills that support their success on their journey to licensure.

There is also a certain appeal to micro-credentials: they a support diverse range of learners because they are easily accessible. Learners can tailor the pursuit of their learning goals to their availability (Farmer & West, 2016). This intervention preserves the dignity of the learner and creates a more accessible environment for success, which translates into success for the Canadian workforce.

Micro-credentialing can be an opportunity to provide continuous rewards for learning. Lexman et al. (2020) described a micro-certification in teacher training in Israel, where teachers went through competency-based learning and reflections, which were shared with peers for comment and discussion. The "micro-credential model allowed flexibility in learning, within the boundaries of assigned course time and pace of individual learning" (p.194), and the peer-reviewed reflections allowed for peer interaction and collaboration. Digital badges offer the opportunity to build interdisciplinary expertise to complement traditional academic pathways.

Weaknesses of Micro-credentialing

One challenge linked to micro-credentialing is that they are often offered through virtual delivery in an effort to make them more accessible to learners. Completion rates of online courses are known to be dismally low due to contributing factors such as lack of peer interaction, waning enthusiasm for course content, adaptation to technology, and longer-than-anticipated

completion times (Lexman et al., 2020). Consider that the Bachelor of Medical Science program at the University of the West Indies (UWI) introduced a digital badge in a micro-credentialing program to encourage students to learn more about public education related to resistance to antimicrobial drugs. Thirty-one students were registered for this program, and only ten completed the badge, leading researchers to question the students' motivation (Gossell-Williams, 2020). Personal motivation also contributes to the perception of the value of this type of learning. Amotivation, for example, can also create negative attitudes towards micro-credentials (Pangaribuan, 2019), and this negative perceived value may also affect completion rate. At the same time, Risquez et al. (2020) note that there is no straightforward relationship between motivation and this type of credential, making it difficult to know how best to encourage completion of online programs.

There are mitigating strategies for these challenges. Micro-credentialing was selected as an option because it can be used to provide a foundation for learning with Canadian content and can provide scenario- and simulation-based learning. As well, peer evaluation can be included in the structure of the credentialing process to counteract experiences of low peer interaction and lack of enthusiasm for content. Besser and Newby (2019) noted that as students gain more exposure to giving and receiving feedback, they have a corresponding increase in self-regulation and confidence with the process. They begin to see feedback as a learning opportunity rather than a form of criticism. This suggests that, should Health Alliance choose to pursue this option, it would need to consider embedding opportunities for peer learning.

Resources Needed

One of the costs associated with micro-credentialing is the subject matter expertise necessary to develop the competency blueprint and the content for the credential. Other costs to

developing and administering micro-credentials are those of grading the assessments if not online/multiple choice assessments, the subscription fees for the online platform to make information about the credentials visible to potential employers, and those to update the content based on industry innovations. The subject matter expertise to develop and update content may be negotiated as in-kind contributions from industry, but the subscription fees and cost of instructors for course delivery would be passed along to the student via tuition.

Option 2: Develop a Mentorship Program

Mentorship can also assist IPGs in overcoming some of the barriers to licensure by providing opportunities for experienced pharmacist mentors to be paired with IPGs. Bozeman and Feeney (2007) defined mentorship as "a process for the informal transmission of knowledge, social capital, and psychosocial support perceived by the recipient as relevant to work, career, or professional development; mentoring entails informal communication, usually face-to-face and during a sustained period of time" (p. 731). Unlike assessors or preceptors, mentors are not responsible for reporting against entry to practice standards. Instead, mentors are meant to create a safe space for their mentees to work, learn, and ask questions. In mentorship, mentees are encouraged to practice self-reflection, an important part of professional practice in pharmacy.

Strengths of Mentorship

Mentorship can take many forms. It can involve informal discussions over coffee, or more formal demonstrations, job shadowing, and role-playing in a clinical setting. Students in these settings benefit from real world experiences, where they receive coaching, support, and practical application of skills in problem-solving (Crossan et al., 2013, p. 295). Newton et al. (2012) noted that interventions to integrate IEHPs into the workforce, such as mentoring, are concerned with "fostering a culture which applauds diversity and facilitation of professional

mentorships" (p. 541). This aligns with the sense of community theory, which will underpin the examination of the IEHPs' lived experience, and the contributions to the experience made by mentor leaders. Done well, mentorship programs can be created that allow mentors and mentees to celebrate lived experiences and the exchange of knowledge between them.

Health Alliance has the additional advantage of access to rosters of IPG mentees through its existing portal. While the existing portal may need to be redesigned to ensure that electronic data gathering to determine the impact of any initiative undertaken will be collected, doing so would allow Health Alliance to establish benchmarks about the licensure pathway. This also would afford Health Alliance to enable push technology to automate messaging to candidates, to connect them with mentors, and to keep them informed of learning opportunities that may assist them in becoming licensed.

Weaknesses of Mentorship

Educators and pharmacists who play a supporting role in the IPG licensure process must be clear on the difference between assessor/preceptor roles and the intended role of mentors. Assessors and preceptors have a more evaluative role, while mentors are meant to be concerned with IPG improvement, not assessment. This distinction can be difficult for some pharmacist mentors to absorb. Those who are accustomed to acting as assessors, preceptors, or teachers may not be comfortable providing psychosocial support that is sometimes inherent in the mentoring function. Mentorship can also be unstructured compared to other types of support and, thus, can be difficult to evaluate the content of the program because there would be no comparable evaluative data from which to draw conclusions regarding the mentorship experience. For this reason, efforts to sustain such mentorship programs could be problematic.

Finally, it can be challenging to identify and/or train high-quality mentors. Mentors must be equipped to provide mentees with opportunities to observe, to engage and, at times, to fail. In a survey of mentees in a children's healthcare program, Mutambo et al. (2020) remarked that "participants specified that the mentorship process was inadequate and that they would prefer that mentors demonstrate cases to give the mentees an opportunity not only to learn, but also to gain more confidence" (p. 6). Mentorship participants appreciate opportunities to test acquired skills in a clinical or simulated setting, so that they can gain confidence in their ability to provide real-world patient care. There is a quality assurance component required in training and monitoring mentors so they have the knowledge and attributes to improve the likelihood of mentee success, but retaining mentors who acquire these skills can prove difficult, particularly as the demands for pharmacists increase due to public health issues.

Resources Needed

Mentorship is a scalable activity that can be adapted to balance the demand for support with the human resource capacity of the administering organization. Generally, a dedicated administrator is required to ensure qualified mentors are matched with mentees who meet the designated criteria. Mentorship can be as customized or as structured as the organization wishes, but for more structured learning experiences, subject matter experts may be required to develop core learning goals on which the mentorship placement will focus. The cost associated with mentorship is therefore generally related to human resources. In terms of technology, several platforms exist to support mentorship pairings that are subscription-based and would house information about the mentors, such as location of placement, areas of expertise, years of experience, and about the mentee such as interests, goals, and home address (for proximity of placement). The subscriptions could cost thousands depending on the number of mentor/mentee

matches or less if mentorship can be added to the organization's customer relationship management system.

Option 3: Clinical Simulation

Clinical simulation involves creating a clinical setting that simulates a real-world work placement, which could include virtual reality, case competitions, patient simulations, or simulated clinical tasks. Lillekroken (2019) noted that the "diversity of simulations and scenarios are designed to encourage students to focus on the comprehensive picture surrounding each patient and situation, rather than focusing on singular problems" (p. 1). Clinical simulations are now widely acknowledged for their usefulness in teaching: clinical simulations are no longer considered "just an innovative form of teaching in the health professions. It is becoming conventional practice and is already recognized by national medical and nursing organizations as comparable to direct patient care experience and a valuable teaching and assessment tool" (Lin et al., 2011, p. 5). Flott and Linden (2016) and Husebø et al. (2018) also discuss the importance of creating safe and supportive learning environments for students that replicate a clinical setting.

Strengths of Simulation

Clinical simulations have numerous advantages for the trainee and learning process, and its merits have been argued extensively: simulation can boost student confidence, fill gaps in clinical knowledge, and provide a controlled learning environment" (Lin et al., 2011, p. 6). Communication between students, between student and teacher, and between student and simulated patients is also a positive outcome of simulation. Gruenberg et al. (2015) noted that many students presented with confidence in their ability to communicate with patients, but struggled when placed in a simulated setting and tasked with demonstrating interpersonal and interprofessional communication skills. This experience was common among students from a

range of healthcare settings, including pharmacy, nursing, and medicine. Clinical simulation can provide a safe environment for practicing interprofessional communication.

Additionally, clinical simulations provide the benefit of time: students are often able to repeat clinical tasks until they reach a level of comfort or proficiency, and feedback can be provided and challenges addressed in real time. Students in simulated clinical settings feel welcomed to bring their concerns forward in real time, develop communication skills with their peers, recognize their peers' limitations and skills, and provide constructive feedback. This fosters peer learning, mutual support, and a collaborative approach to patient care (Lillekroken 2019; Oade et al., 2019).

Weaknesses of Simulation

Lin et al. (2011) also noted that "a significant disadvantage of the use of simulation in health professionals' education is the cost of sophisticated equipment," and that "the most talked about disadvantage of simulation is its questionable return on investment" (p. 4). Additionally, simulated settings are never fully able to compete with real patient interaction even from the instructor's perspective: "the lack of real situations to relate to when teaching some skills could contribute to less understanding of how to perform the skill and possibly delay the development of the students' skills" (Lillekroken, 2019, p. 5). And while time was an advantage of simulation, Lillekroken (2019) also offered the counterpoint that due to time restrictions, not all students have the opportunity to play the role of the healthcare professional in every clinical simulation session. One final weakness to note is that while simulation is considered a safe and effective learning tool due to the limited potential for patient harm, it is often not selected as an educational option due to prohibitive costs and labour capacity (Wright et al., 2019). Indeed,

patient and clinical simulations can be an excellent adjunct to learning, but come with significant resource demands.

Resources Needed

Clinical simulations are quite resource intensive. As with all options, subject matter expertise is required for content development and for continual updating of the content. With clinical simulations, new and emerging technology upgrades can also add cost to the program. Salary is also required for administrators and for mentor trainers. Simulation trainers and assessors must be monitored to ensure inter-rater reliability in order to create simulated environments where learners are accessing consistent information.

Comparing Options

In order to determine the most viable answer to the problem, Table 1 compares the three solutions in terms of how well they address the PoP, the psychosocial, financial, and systemic barriers faced by IPGs. The table also compares the potential costs of the solutions to the organization, as well of the need for technology and other elements that Health Alliance will need to consider in its decision making.

From the PoP perspective, the barriers to success that exist for IPGs, and the cost to the organization, it is clear that Option 2: Mentorship is the solution that addresses most IPG needs, while being most accessible to Health Alliance. Mentorship also builds capacity in both the mentor and the mentee, allowing leadership opportunities for the mentor as a guide and for IPGs to become leaders. This opportunity to leverage the expertise and diverse skill set of the mentor and mentee resonates with the tenets of empowerment and capacity building in shared leadership and builds on strength of drawing on diverse skillsets using collaborative leadership. For these reasons, Option 2 is the selected solution.

Table 1

Comparison of Solutions

Consideration	Option 1: Micro-credentialing	Option 2: Mentorship	Option 3: Clinical Simulation
Addresses Problem of Practice	✓ Addresses the PoP through upskilling of IPGs.	✓ Addresses the PoP by providing direct clinical setting experience.	✓ Addresses the PoP by providing simulated clinical setting experience.
Addresses Psychosocial Barriers	× Does not address psychosocial barriers, and may contribute to barriers if delivered online, as this has been shown to be isolating.	✓ Provides psychological safety and feelings of acceptance, important by-products of a successful mentor/mentee relationship (Prouty, 2016).	✓ Addresses psychosocial barriers by creating safe learning environment and opportunities to learn from and with peers (Flott & Linden, 2016; Husebø et al., 2018).
Addresses Financial Barriers	✓ Does not greatly contribute to financial barriers as courses are designed to be financially accessible.	✓ Does not greatly contribute to financial barriers as most mentorship programs request volunteer services from mentors.	× Clinical simulations are extremely costly to produce and administer, and these costs are absorbed by the learner in the form of tuition, contributing to financial barriers.
Addresses Systemic Barriers	× Does not address systemic barriers.	✓ International healthcare professionals benefit from mentorship and peer support in confronting microaggressions and systemic barriers.	× Does not address systemic barriers.
Costs (to the organization)	✓ Costs include salary for an administrator and support for committee/content experts. Costs are moderate compared to other interventions such as simulation and	✓ Costs include salary for an administrator and support for upfront content development and training for mentors. Costs are moderate compared to other	× Costs include development costs, costs to maintain, salary for administrators, training, and quality assurance for instructor/assessors

Consideration	Option 1: Micro-credentialing	Option 2: Mentorship	Option 3: Clinical Simulation
	bridging programs.	interventions such as simulation and bridging programs.	to ensure inter-rater reliability.
Technology	✓ Technology required is a subscription to a service that makes the credential visible to employers. Cost is moderate and the technology is not difficult to learn.	✓ Technology required is a subscription to an online mentorship platform. The platform is not difficult to learn, and is optional and unnecessary for small-scale mentorship programs.	× Technology can be onerous depending on whether the program involves robotic patients, virtual reality, medical equipment, etc.
Other Considerations	✓ Post-licensure implications for micro-credentialing are positive, as partnerships with industry make the credential more valuable to both employers and the learner (Gauthier, 2020). × Creates greater tensions for PRAs, whose mandates are not to train individuals.	✓ Post-licensure implications for mentorship are positive, as mentor/mentee pairs often stay in contact after placement. × Creates greater tensions for PRAs, whose mandates are not to train individuals.	× Health Alliance has no agency in the simulation space to enact change through this mechanism.

Leadership Ethics, Equity, and Social Justice Challenges in Organizational Change

The context for ethics, equity, and social justice challenges begins with the reminder that Canada's Multiculturalism Act (1990) "assures protections against racial discrimination and, in conjunction with other legislation, lays the foundation for improved access to political and economic opportunities" (Roth, 1998, p. 6). Canada has opened its borders to internationally educated talent to address a growing skills and labour shortage, implying that these "economic opportunities" are available to newcomers, but underutilization is a symptom of insufficient supports for newcomers to Canada. From a social justice perspective, internationally educated

professionals provide Canadians with labour that supports our healthcare system, contributes to our economic growth, and provides contributions to our richly diverse culture. Understanding that internationally trained professionals (IEPs) are subjected to many "regulatory, logistical, and financial barriers" (Austin & Marie, 2004, p. 3), it is also important to recognize the ethical obligation of all organizations to assist newcomers. Advocating for the profession means acknowledging and not discounting the experience of a diverse talent pool of healthcare professionals (Patel, 2019). This OIP aims to harness the strengths of the IEHP community and empower them to overcome their barriers.

Addressing the Ethical Responsibilities of the Organization

The ethical responsibilities of Health Alliance and its member organizations will be addressed by conducting a cross reference of each of the value statements of the pharmacy regulatory authority members, for a reinforcement of the OIP's objectives. The value statements can provide some guidance on how the organizations can apply their own behaviour towards supporting IPGs. To address the PoP, it is imperative for leaders at Health Alliance to consider various types of accountability, and this includes consideration of this issue from an ethical perspective (Ehric et al., 2015). The OIP will also lean heavily on Tuana's (2014) ethical leadership development framework, in which she describes moral literacy as "the type of literacy I espouse in order to distance it from the typical focus on ethical reasoning training common in philosophical approaches to ethics or the rule-based approach common to codes of ethics" (p. 154). Of the ten PRAs that license pharmacists (the Territories do not license pharmacists directly but will accept pharmacists licensed by other jurisdictions), six have integrity and ethics within their core values (Pharmacy Regulator 1, 2022; Pharmacy Regulator 2, n.d.; Pharmacy Regulator 3, 2022; Pharmacy Regulator 4, 2021; Pharmacy Regulator 5, n.d.; Pharmacy

Regulator 9, n.d.). The other most common values are accountability, transparency, respect, and collaboration. The intent is to use the tenets of this framework—ethical sensitivity, decision-making, and motivation—to guide the actions of the organization, providing a moral compass toward the "right" thing to do in addressing the PoP.

Ethical Sensitivity

Ethical sensitivity is described as "the interpretation of situation in determining who is involved, what actions to take and what possible reactions and outcomes might ensue" (Tuana, 2014, p. 158). She goes on to note that components of ethical sensitivity include preventing social bias and considering the consequences of actions and responses. Here is where Health Alliance can determine whether the proposed solution (a) violates the mandates of either Health Alliance or its members, or (b) aligns with its members' common core values.

Ethical Decision-Making

Ethical decision-making is a process that occurs when "the action or decision must have consequences for other people and involve[s] choice on the part of the decision maker" (Selart & Johansen, 2011, p. 129). The ethical leadership framework notes that ethical decision-making involves identifying salient facts related to the issue, identifying which stakeholders could assist in addressing the issue, considering the values related to the decision, and pondering the options (Tuana, 2014). For Health Alliance, this means looking at the stakeholder ecosystem to determine which organizations have the most agency to address the PoP, and how it can collaborate with other organizations while staying as close to its mandate as possible.

Ethical Motivation

Ethical motivation is informed by moral literacy, ethical reasoning and moral imagination (Tuana, 2007). It is created by the purpose behind the issue or potential for change, the courage

of the change agent to initiate and support change, and the hope or belief that change is possible (Tuana 2014). Here, the PoP is the ethical motivation driving change at Health Alliance.

Social Justice Context of the PoP

Canada relies on immigration for population growth, and yet "immigrants are paid considerably less than the native-born even when they have similar qualifications, are at similar ages, live in the same cities, have similar language knowledge, have similar racial backgrounds, and even work in the same occupational levels" (Reitz et al., 2014, p. 17). The challenges of equity and social justice will be carefully considered for communication and change planning.

Challenges of Equity and/or Social Justice Considered in Change Planning

There are a number of equity and social justice challenges inherent in this PoP. First, there are very few protections for racialized individuals from discriminatory hiring and placement practices.

Second, the IPG community is very fragmented, as there are few formal networks to support workplace acculturation and exchanges of cultural knowledge. Professionals from underrepresented communities can play significant leadership and mentorship roles in the journey towards credentialing of IEPs (Antonio, 2002; Lanari, 2022), acting as assessors, trainers, advocates, mentors, and coaches to facilitate learning and create opportunities for international talent to succeed. Creating opportunities through interventions, such as mentorship, would require an intentional, programmatic approach.

Additionally, the societal issues that impede successful access to licensure and practice must be explored through a diversity and inclusion lens. A growing number of women are principal applicants for families entering Canada (Immigration, Refugees and Citizenship Canada [IRCC], 2018). Therefore a gender-based review would elucidate the specific and unique

challenges faced by women who are emerging as primary applicants in the immigration process (Ogilvie et al., 2007).

Chapter Two Summary

This chapter reviewed the OIP's planning and development, including the leadership approaches, the characteristics of the change to be undertaken, and an organizational analysis to inform the selection of a proposed change. Mentorship has been selected as the proposed change for its ability to address the problem in a manner that does not represent onerous costs to the organization, is accessible for IPGs, and can have positive immediate and downstream (i.e., post-licensure) implications for IPGs. In the next chapter, an implementation plan for mentorship will be discussed. Supporting activities for the implementation, i.e., an evaluation and change management plan, will also be explored and framed within the context of ethics and social justice issues that impact the PoP.

Chapter 3: Implementation, Evaluation, and Communication

The first two chapters of this organizational improvement plan (OIP) articulated the barriers faced by international pharmacy graduates (IPGs) on their path to licensure and explored leadership and theoretical approaches required to implement a menu of solutions related to the problem of practice (PoP). Social justice issues that inform the PoP were also examined. Developing a national mentorship program was selected as the solution where Health Alliance had the greatest agency to affect change. In Chapter 3, the change implementation plan will be introduced to bring mentorship from a theoretical concept to a tangible and viable program. Once implemented, it will be necessary to monitor and evaluate the program to ensure its ongoing success. The selected approaches for monitoring and evaluating the program, as well as the monitoring tool and theories, will be presented. Additionally, the plan to communicate the change and its alignment with the monitoring and implementation plans will be introduced along with considerations for future research to be explored to support IPGs on their path to licensure.

Change Implementation Plan

This change implementation plan will take a pragmatic approach that aligns communications with the organizational strategy and its vision for change, allows stakeholders to feel vested in the process, and ensures that stakeholder concerns are considered and mitigated. The change implementation plan discussion will move from macro considerations, such as revisiting the need for change and how the change fits within organizational structures, to more micro processes, such as engaging stakeholders and anticipating resistance. It will highlight how adopting a shared leadership approach will call on all change agents to communicate the key messages and evaluate the program, during the mentorship program’s development.

Change Plan within the Overall Organizational Strategy and Structure

As a reminder, Health Alliance is an organization that supports pharmacy regulators by housing a portal that streamlines the application process for IPGs looking to become licensed in Canada. Any IPG wishing to become licensed must register through this portal, providing Health Alliance with early access to all IPGs. Health Alliance's vision for change is to renew its commitment to regulatory excellence with an additional assurance of creating formal opportunities to help IPGs succeed in Canada. The change implementation plan for mentorship supports the organization's mission, as well as its vision for change. The change plan will take into account how management aligns with leadership's approach.

Planning For System Improvements and IPG Success

The change management plan was designed to create an improved situation for IPGs and other stakeholders. Mentorship is an opportunity for licensed professionals to give back to the profession, to access professional development, and to continue to practice empathy and critical self-reflection, both of which are required skills for any healthcare professional. For mentors who were once IPGs themselves, it is a unique opportunity to share their lived experience and expertise. Mentors fill a role in the lives of their mentees that falls outside of the just professional practice and that often makes the relationship far less intimidating. This relationship can endure beyond the mentorship placement.

This lasting relationship is a desirable by-product of mentorship for practical reasons. IEHPs, not just pharmacy graduates, are particularly vulnerable to patient complaints and are disproportionately disciplined in Canada and many other western countries (Elkin et al., 2012; Bonnell 2008). Mentor leaders with the same lived experience as IPGs can lean on authentic and servant leadership to use empathy to build trust with their mentees. Although outside of the

scope of this OIP, it is anticipated that once licensed, mentees may feel safe in bringing challenges to their previous mentors before they lead to disciplinary action.

Mentorship also empowers mentees to take a leadership role in their own development, allowing the IPG perspective to figure prominently: in no other stakeholder does the IPG voice appear at the leadership or decision-making table. The model of decision-making for the mentorship program is a precedence for some stakeholders, as is the mentorship program itself. This model is supported by sense of community theory, which recognizes that mentees will be more successful if they are supported by a caring community and feel vested and empowered in their own learning and success (McMillan & Chavis, 1986).

Plan To Manage the Change

The plan to manage change outlines the transition between the current and the future state that would involve leveraging existing resources to develop a fully sustainable mentorship program as part of the organization's existing offerings. Implementation of the change will be housed in Health Alliance's Community Services business unit. This department already provides services to IPGs seeking licensure and actively engages with other stakeholders such as regulators, the examining board, and immigrant serving organizations that provide pre- and post-licensure employment supports for IPGs in their areas. The implementation plan aligns with Kotter's change management model, and Appendix A summarizes the implementation plan.

Phase One, creating the climate for change, will occur in Months 1–6. Within this timeline, Health Alliance will review the infrastructure that supports existing products such as learning resources, the enrolment platform, invoicing processes, etc. In alignment with a shared leadership approach, Health Alliance would arrange consultations with stakeholders to discuss the mentorship program and to hear any challenges, concerns, or suggestions that stakeholders

may have to contribute to IPG success. This includes consultations with Health Alliance staff to determine any capacity, reputational, or strategic concerns that are anticipated by staff. Here, an authentic leadership approach will help build trust between change leaders and staff (Farid et al., 2020). During consultations, change agents and senior leaders will acknowledge concerns as risks and record them on the risk register for management.

Phase 2, engaging and enabling the profession, would occur in Months 7–15 of the transition. This phase sees the guiding coalition beginning to share the vision for change among stakeholders and the public through the change communication/knowledge mobilization strategy outlined in Appendix B. At the same, staff allocated to this file would begin to recruit, match, and place mentor and mentee pairs. This phase is also where senior leadership begins to step back from leading this initiative and empowers the implementers to continue to execute the communications strategy. Members of the steering committee and change agents, including IPGs themselves, become champions of the change and find opportunities to support and promote mentorship placements. This phase requires shared leadership among the steering committee/guiding coalition and change agents to find opportunities to celebrate short-term wins, such as looking at the number of participants recruited and the number of mentorship placements completed to date.

Phase 3, implementing and sustaining the change, will occur in Months 16–24. It is during this phase that change becomes institutionalized. Past challenges and lessons learned are scrutinized to allow the guiding coalition to course-correct and make adjustments to sustain the program. During this phase, the steering committee establishes the evaluation team for the IPG mentorship program. As will be discussed in the “Change Process Monitoring and Evaluation” section, the program will be evaluated using an empowerment evaluation approach. This phase

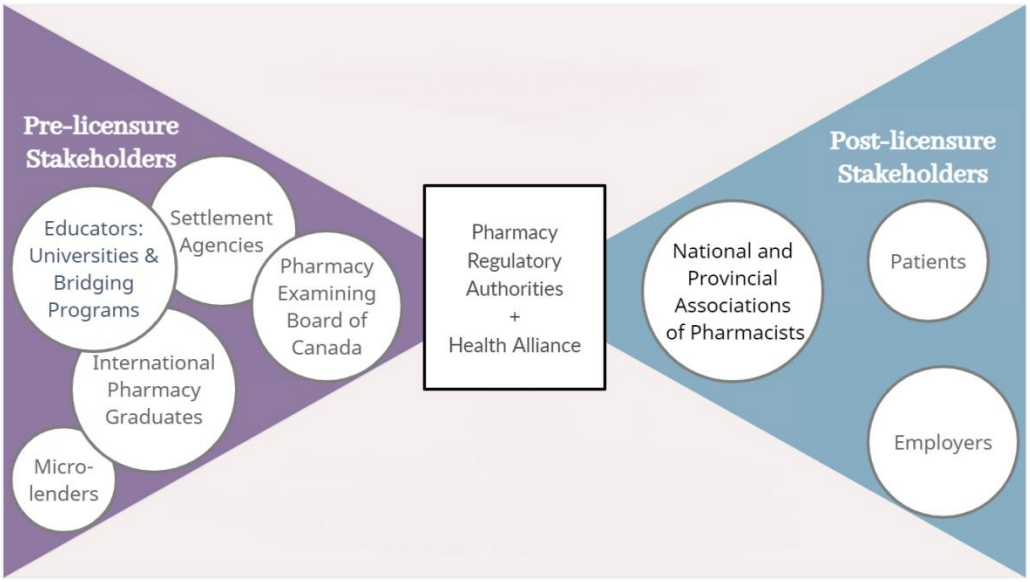
will once again require shared leadership from the steering committee, IPGs, mentors, and other stakeholders to engage team members to "take on leadership behaviours to influence the team and to maximize team effectiveness" (Northouse, 2022, p. 464). This is further supported by sense of community theory's tenet of mutual responsibility, where team members engage in activities as a matter of course of responsibility to one another. In preparing the evaluation plan, team members will assess data on IPG outcomes, and revise any policies required to ensure that changes continue to be "institutionalized." This can be achieved through Deming's four-step process for quality improvement, the Plan, Do, Study, and Act (PDSA) Cycle. The PDSA cycle will be further discussed in Chapter 3.

Engaging Stakeholders and Understanding Reactions to Change

Stakeholders in the pharmacy regulatory ecosystem can be divided into pre- and post-licensure stakeholders. Most of the pre-licensure stakeholders such as educators and settlement organizations have a role to play in IPGs becoming licensed and therefore could house a mentorship program. However, only two stakeholders—the portal housed at Health Alliance, and the Pharmacy Examining Board of Canada (PEBC)—are mandatory touchpoints for IPGs seeking to practice in Canada. PEBC's role as an assessment body would be substantially compromised if it were to undertake teaching, mentoring, or any activity related to assisting IPGs to gain licensure. All IPGs must enrol in the portal housed by Health Alliance, making it emerge organically as the best host organization for the program. For the mentorship program to succeed, support from four other stakeholder groups is key: IPG participants, settlement and immigrant-serving organizations, Pharmacy Regulatory Authorities (PRAs), and employers. Each of these stakeholders listed in Figure 6 has a role to play in IPG licensure, but this discussion will address the contributions of selected stakeholders and their resistance to change.

Figure 6

Stakeholders in the Pharmacy Regulatory Ecosystem



Note. The pharmacy regulatory ecosystem is a map of stakeholders in the IPG licensure journey.

International Pharmacy Graduates (IPGs)

IPG participants are required. Although Health Alliance's portal contains thousands of IPG registrants, some have enrolled pre-arrival and are still in their countries of origin, while others are still in the very early stages of their licensure journey. Candidates for the mentorship program will be those in the latter stages of their licensure journey; mentorship has been known to correlate positively with better development of interpersonal relationships, better understanding of workplace expectations (Powell et al., 2018), and worker retention (Bell, 2000). Many mentees ultimately find employment with the mentor post licensure. Little resistance to change is anticipated from this group, who have only to gain from the mentorship program.

Settlement Agencies

Within the settlement agency stakeholder group, International Employment Councils (IECs) in particular provide guidance in licensure and in connecting international talent

to employers. They can also support IPGs in their settlement process by assisting with housing, language training, and securing employment. Of note, these agencies are mandated to build job-readiness skills in candidates to prepare them for employment, not specifically for licensure. Additionally, IECs offer voluntary services; therefore, only IPGs who are aware of IEC services will receive them. The only anticipated reason for resistance to change from this stakeholder is the allocation of tasks related to supporting the IPGs. Health Alliance would ensure that it drafted a clear memorandum of understanding (MOU) with partner organizations to clarify the expectations of each partner.

Pharmacy Regulatory Authorities (PRAs)

Health Alliance is a coalition of regulatory authorities for the pharmacy profession. As such, legislation grants regulators "extensive rights to establish training programs, examine potential candidates, regulate many aspects of practice, and discipline practitioners" (Adams, 2009, p. 231). Regulators are also responsible for representing their members and advocating for the public through health policy reform. As pre-licensure candidates, IPGs fall outside of the strict regulatory purview and responsibility of pharmacy regulators. As anticipated in the results from the readiness assessment, this is where the greatest resistance to change is expected and where key messaging and transparency will be instrumental in communicating the change.

Employers

Corporate human resource representatives are increasingly recognizing IPGs as an untapped talent pipeline and offering workplace opportunities to IPGs pre-licensure with commitments to more lucrative opportunities post-licensure, particularly in rural and remote areas (D. Herschel, personal communication, February 8, 2022; D. Gables, personal communication, October 6, 2021). These hiring practices have the added benefits of early

workplace exposure, early access to corporate training, and inclusion in a professional network of future peers. However, pharmacies do not have easy access to IPGs outside of their individual, local recruitment efforts. As the search for viable talent becomes increasingly competitive, these interventions benefit employer recruitment efforts; therefore, no resistance to change is anticipated from this group.

Stakeholder Resistance to Change

Acknowledging that there will be resistance to organizational change is an important element in managing change. Kotter and Schlesinger (2008) suggest that resistance to change can be diagnosed and categorized into four different types of concerns: self-interest, mistrust or misunderstanding of the proposed change, a different assessment of the situation leading to change, or low tolerance for change. Understanding the distinctions of the various types of resistance is useful in addressing concerns.

Senior staff and leaders at Health Alliance may experience two of the forms of resistance described. The first is a different assessment of the situation leading to change. Kotter and Schlesinger (2008) caution that decision makers may "assess the situation differently from their managers or those initiating change and see more costs than benefits resulting from the change, not only for themselves, but for their company as well" (p. 108). In these situations, a communication strategy, discussed later in this chapter, is crucial to ensuring, rather than assuming, that change agents, senior leaders, and change recipients all have the appropriate level of detail regarding the change to assure buy in. For decision makers, the benefits of mentorship must be clearly reflected in the organization's bottom line and must be financially viable. Senior leadership will want to see evidence of mentorship's impact.

The second type of resistance to change anticipated is a low tolerance for change among leadership and some operational staff. Within a traditionally conservative bureaucracy such as Health Alliance this is to be expected. Kotter and Schlesinger (2008) noted that "even when managers intellectually understand the need for changes in the way they operate, they sometimes are emotionally unable to make the transition" (p. 109). As a key strategy in resisting change, managers will likely reference policy and procedure and may argue that this type of intervention falls outside of their standard processes and adds to or changes their scope of work.

Kotter and Schlesinger (2008) reference strategies to address resistance to change and note that a well-planned education and communication strategy can be key to change perspective if the resistance was originally based on misinformation or inadequate communication. Change will be best tolerated if change agents and leadership are well-briefed about anticipated changes and receive communications regularly. In selecting strategies, it is important to reference Health Alliance's collaborative leadership approach and its values of innovation and collaboration. This will assist in selecting an appropriate mix of change champions and resistors when organizing the change leadership team.

Selecting Agents of Change

Health Alliance has an established consultation process that will manage the proposed change. Any project at Health Alliance requires the identification of a project lead, who will be accountable for monitoring and reporting to senior leadership. The project lead, a role for which I was trained and will likely assume, will design a project charter that outlines the scope, timeline, and resources required for the project according to the principles of project management (Vachan, 2012), as well as a risk register that will be populated by consultations with relevant stakeholders. Once the project charter has been developed, members of the change

leadership team will be identified. The project lead will lean on the shared leadership tenets of mutual influence between leaders and followers and collaborative problem-solving to analyze the risks and concerns raised by stakeholders. The shared leadership approach will help bring change agents together to develop the project charter and the risk register.

As previously referenced, Health Alliance has three business units. The first is related to professional practice, the second to communications and public relations, and the third to community programs and services. Each department will be represented in a cross-departmental change leadership team. A representative from the professional practice department will be designated to ensure that tenets of professionalism entry to practice competencies (Health Alliance, 2014) are infused in the content of the mentorship program. This also involves ensuring that mentors are empowered with tools to assist through the licensure journey. Expertise from the communications team representative will guide the development of the communication strategy. The programs and services representative will advise on where additional services and supports can be leveraged during the mentorship for IPG success. Additionally, IPG and mentorship representatives will be invited to participate as part of the change leadership team. These positions will be voluntary as they are not employed by Health Alliance.

Supports and Resources Required

Creating a viable mentorship program to support IPGs on their path to licensure will require a number of supports and resources: technology, human resources, financial resources, and time.

Technology

Health Alliance does not need to invest heavily in a new technological system. A legacy portal exists to house administrative data regarding IPGs. The platform could be modified to

support a fully functional mentorship program. If the mentorship program were to expand beyond the capacity of the platform, there are other subscription software services available such as MentorCity that specialize in supporting mentorship programs. Additionally, Health Alliance may wish to leverage its existing teleconferencing subscriptions to support virtual meetings and webinars for mentees and mentors.

Human Resources

This program will require one half-time employee to coordinate the program for IPGs. This additional resource/time will be a complement to existing staff and would be responsible for administrative tasks, such as issuing an annual call for participants, intake, vetting and assistance with placement; liaising with the working group established to guide the program; and any virtual mentorship activities or community of practice managed by Health Alliance.

Financial Resources

Financial resources will be required to cover the salary for the coordinator position and periodic information technology support, including troubleshooting and upgrades to the IPG platform. Mentorship will be positioned as a professional development opportunity for mentors, where cross-cultural, operational, and leadership training will be provided. These funds could be generated by adding a nominal increase to the registration fee for candidates who enrol in the existing portal. IPG participation in the program will be self-funded, so there will be no additional costs to Health Alliance for IPGs, but IPGs may wish to access micro-loans to cover living expenses during participation.

Time

Hall (2013) noted that complex organizational change typically requires “three to five years, or even longer, depending on the organizational context” (p. 265). Indeed, a culture shift

required to fully embrace the vision for change would likely take that long. To develop a fully operational program, a change of this complexity and magnitude will likely require closer to 24 months to establish policies, finalize partnership agreements, recruit participants, launch the program, and conduct a full monitoring and evaluation exercise. This time frame excludes a secondary evaluation cycle and culture shift.

Framing Issues for Various Audiences – Challenges to Implementation

In developing a change implementation plan, it is important to take time to anticipate challenges so that they can be addressed. One area of difficulty will be to ensure that all participants understand the expectations of mentorship and the differences between mentoring (coaching, supporting, and providing feedback) and preceptoring (teaching, evaluating, and reporting) (Austin & Martin, 2011). Mentoring is an informal part of the licensure journey, and it is important that IPGs clearly understand this distinction. Further, mentees must be open to coaching and learning, and readiness will be assessed via a preparation interview. Occupying the role of a learner can be difficult for some who are already accomplished professionals in their countries of origin. Another aspect of Health Alliance's mentorship that must be appropriately framed is the language around meeting national and regional needs. As an example, over 50% of IPGs apply to settle and pursue licensure in Ontario; less than 1% opt to pursue licensure in Prince Edward Island (Health Alliance, n.d.). The scale of the mentorship placements will therefore be equitably, rather than equally, dispersed.

Change Process Monitoring and Evaluation

A well-structured monitoring and evaluation framework is critical to the success of the program's implementation. An evaluation framework enables evaluators to craft, investigate, and answer questions related to the program's appropriateness, effectiveness, efficiency, impact, and

sustainability (Markiewicz & Patrick, 2016). Systems are put in place to monitor program performance on an ongoing basis to ensure that data is collected at regular time intervals, in a consistent manner, with consistent tools and methods (Poister, 2015). Together, they form an overarching plan that outlines a comprehensive review of the program's performance and opportunities for improvement, and for this reason they will be often referenced in tandem in further discussions. The next section explores the monitoring and evaluation framework that will be created and the corresponding evaluation approach recommended to ensure progress.

Monitoring Change: PDSA Cycle

A robust monitoring system will include data that will allow the evaluation team to gauge progress and track change. The recommended monitoring tool for the OIP implementation will be the PDSA cycle. During PDSA cycles, practitioners ‘’’Plan’ a change to be tested, ‘Do’ the test, ‘Study’ the data they collected during the test, and ‘Act’ on what they have learned from the test by abandoning, revising, or scaling up the change” (Tichnor-Wagner, 2017, p. 466). Once the cycle is complete, it can be repeated to review the effect of changes. This cycle is a well-established and familiar tool in healthcare, which facilitates its implementation. Additionally, “PDSA cycles are useful to involve and engage participants in change” (Beattie et al., 2020, p. 3), and they align with my experience and training in project management. From a project management perspective, the “Plan” portion of the cycle will be considered complete when the organization's problem and readiness for change have been appropriately diagnosed, the OIP objective has been approved by the organization, and the change communication plan and evaluation framework have been developed. This cycle aligns well with the discovery stage of Kotter's change management framework. Once the cycle is complete, it can be repeated to review the effect of changes.

Table 2 provides a monitoring framework that will take place in Months 7–15 of the implementation plan, which the evaluation team can use to answer the evaluation questions. The program's activities, outcomes, and outputs help frame the program for the evaluator. Indicators will be established to "indicate progress in a specific area of program performance. Indicators demonstrate a type of change, event, or condition" (Markiewicz & Patrick, 2016, p. 131).

Four aspects of the mentorship program will be monitored and evaluated. The first will be a review of Health Alliance's staff activities and outputs, including how well staff members recruit participants, engage stakeholders, document policy, and provide other operational supports to the program. The second area of monitoring is Immigrant Employment Councils (IEC) activities and outputs. Here, the evaluation team will examine indicators that demonstrate the IECs' efficiency in matching mentors to mentees. The third area for monitoring and evaluation will be employer activities and outputs. The evaluation team will be tasked with reviewing how well employers promote the program to the pharmacists within their pharmacies, and how well they attract and retain mentors. The final area will be overall program outcomes, where the evaluation team seeks to understand whether mentorship has had a tangible impact on the licensure journey, including post-licensure employment and support. The monitoring framework can be supported by a shared leadership approach, where various change agents will step forward to provide stewardship of data-gathering within their own teams and organizations.

Table 2

Mentorship Performance Monitoring Indicators

Activities and Outcomes	Indicators	Data source	Frequency of measurement
Health Alliance Staff activities and outputs			
Call for participants	• # of IPGs recruited for mentorships, for use of the diagnostic tool, and for use of learning modules	• Roster of participants • Health Alliance staff	Quarterly
Administer diagnostic tool to vet and refer mentees	• # of mentors recruited • # of participants using self-assessment tool and reporting increased awareness of skills required for the workplace	• Health Alliance staff; administrative data from self-assessment tool	Quarterly
Develop and host steering committee	• Rate of stakeholders represented on committee	• Project Lead	Annually
Facilitate development of Terms of Reference for Steering committee	• Documented Terms of Reference approved by all members of steering committee	• Project Lead	Annually
IPG support: virtual mentorship with content based on FAQs and case studies from PRAs	• # of sessions organized • Percentage of participants attending	• Project Lead • Administrative/registration data	Semi-annually
Engaging IECs to receive potential mentees	• # of Memoranda of understanding signed between IECs and employers	• IEC representative	Annually
Immigrant Employment Councils (IEC) activities and outputs			
Review applications to match mentees and mentors	• % of candidates matched to mentors	• IEC administrative data	Quarterly
Liaise with employers	• # of documented touch points between IECs and employers per MOUs	• IEC administrative data	Quarterly
Review learning plans for progress and completion	• % of learning plans completed weekly	• IEC administrative data	Quarterly
Issue certificates of completion	• # of certificates issues • Rate of completion relative to matched mentors	• IEC administrative data • Mentorship survey data	Semi-annually

Activities and Outcomes	Indicators	Data source	Frequency of measurement
Issue pre- and post-mentorship surveys to participants	• % of surveys returned relative to # issued (response rate) • Satisfaction rate of mentors and mentees	• Mentorship survey data	Semi-annually
Employer activities and outputs			
Promote the program to pharmacies and identify mentors willing to volunteer into the program	• # and names of organizations contacted	• Employer administrative data	Semi-annually
	• # of pharmacists willing/available to be mentors	• Employer administrative data	Semi-annually
Identify incentives for mentors (continuing education hours, additional leave, etc.) where appropriate	• # of incentive packages sent to mentors • # of pharmacists willing to return as mentors	• Employer administrative data • Mentorship survey data	Semi-annually
Document mentee progress in learning plan	• % of learning plans completed weekly	• IEC administrative data	Semi-annually
Program Outcomes			
Greater IPG access to Canadian Clinical settings	• # IPGs participating in mentorship relative to eligible candidates	• Health Alliance administrative data	Semi-annually
Increased IPG preparedness for assessment of practical skills in the licensing process	• % of IPGs completing mentorship who report feeling more prepared for a formal assessment of their practical skills in a Canadian pharmacy	• Mentorship survey data	Semi-annually
Increased IPG ability to articulate their own learning needs	• % increase on diagnostic tool	• Diagnostic tool performance data	Semi-annually
Increased community commitment to assisting international healthcare professionals on their path to licensure	• Number and percent of mentors indicating that they are willing to again act as a pre-STP mentor	• Mentorship survey data	Semi-annually
Increased understanding by Health Alliance, PRAs IECs, and other organizations of barriers to IPGs pursuing a license to practice	• Number of people/organizations receiving mentorship reports on IPG use of mentorship components	• Project Lead	Semi-annually

Evaluation Approach

There are a number of evaluation theories that can be used to review a program. Generally, evaluation theories group into three main "branches" (Christie & Alkin, 2013) of focus: methods, valuing, and use. *Methods* theories "emphasize maximizing program effectiveness through measurement of results, and commonly use quantitative methods" (Markiewicz & Patrick, 2016, p. 162). The v*aluing* branch of evaluation theory is grounded in social inquiry and "focuses on those theorists who as a central feature of their evaluation theories consider the process of placing value on the evaluation as the essential component of an evaluator's work" (Christie & Alkin, 2008, p. 132). The opportunity to bring together a variety of perspectives and the emphasis on qualitative methods makes a valuing-based evaluation a possibility, as an opportunity to use the narratives of the IPG lived experience to inform some of the findings. The final branch of evaluation theories is *evaluation use*, "which refers to the potential utility of stakeholders' participation in the evaluation process" (Lemire, et al., 2020, p. S48). This use-focussed branch of evaluation is recommended due to its emphasis on stakeholder use and utility and its participatory nature.

One such use-focused theorist is Dr. David Fetterman, who founded an approach known as empowerment evaluation (EE), "where evaluation supports stakeholders and program beneficiaries, through evaluation capacity building efforts, to evaluation their own program in order for them to achieve self-determination and empowerment" (Markiewicz & Patrick, 2016, p. 162). EE is based on Zimmerman's (1995) theory of empowerment, where empowerment is defined as "a construct that links individual strengths and competencies, natural helping systems, and proactive behaviours to social policy and social change" (p. 569). EE positions the evaluator as a guiding participant who will leverage and harness the lived experiences of the program

beneficiaries as the key knowledge holders in the process. In undertaking EEs, evaluator teams use this technique to shift the balance of presence and power to those who typically do not have a voice. EE places the evaluator in the "back seat" of the evaluation process to allow the stakeholders to be the key drivers, and for stakeholders to arrive at collaborative judgements about the program at hand. This emphasis on empowerment is one of three reasons it is the recommended evaluation approach for this mentorship program. This is one opportunity for IPGs to take an active role in understanding and improving the program designed to benefit them. EE requires leadership at the centre of servant and shared leadership, where leaders are empathetic and are concerned with capacity-building.

The second reason for selecting this approach is its emphasis on capacity-building, which can be embedded into any evaluation framework, with support from change leaders. For marginalized groups, EE has arguable strengths for capacity building to be explored. Capacity building is about transferring the knowledge and skills of evaluation to the stakeholders and empowering them to self-monitor and evaluate (Fetterman, 2001) and to take ownership and leadership on the use of the outcomes. Bremner (2019) noted that, "as responsible evaluators we need our work to address cultural repression and support cultural renewal. We have to give back the knowledge we have been taking from the communities" (p. 337). This highlights how EE further underlines the concept of evaluators as storytellers, building context to frame data for decision-making. In this project, IPGs would act as key knowledge holders and drivers for change and would actively participate in assessing mentorship's impact on their professional growth and development.

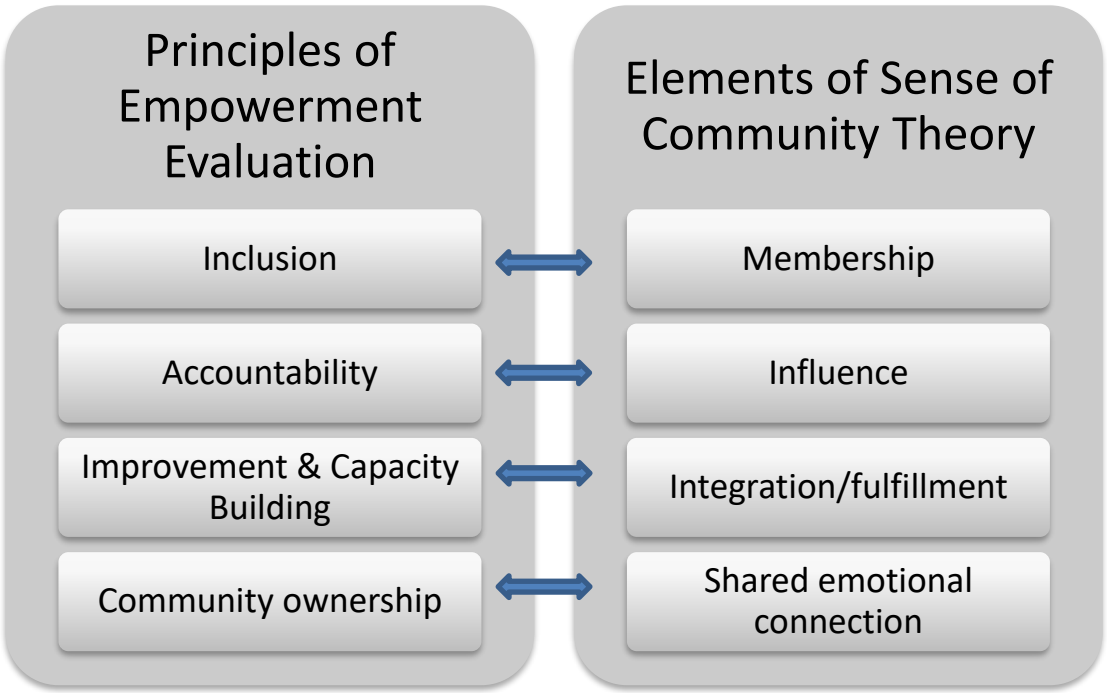
The third reason EE is recommended is due to its close association to sense of community theory. As Fetterman (2001) noted, "one of the most powerful strengths of EE is its

ability to pull people together toward the common good. The collaborative process is democratic and inviting. It emphasizes inclusion, rather than exclusion" (p. 143). The principles of inclusion, membership, and connection are underpinned by the core of sense of community theory, as illustrated in Figure 7. The three steps to EE are:

- Establish a mission: Determining the purpose of the evaluation
- Taking Stock: Reviewing the current context and status of the program, and
- Next steps: Planning for the future.

Figure 7

Empowerment Evaluation Alignment with Sense of Community Theory



Note. Adapted from Wandersman et al., 2005; Herman et al., 2005

In the first step, establishing a mission, program beneficiaries and other stakeholders would gather to determine the key objectives of the evaluation. Activities here involve collecting survey data from mentor participants to analyze their strengths and weaknesses, as well as

examining learning goals, allowing stakeholders to bring diverse voices to bear on the goals of the mission. This can be done during a workshop that fosters team building while preparing for next steps (Charoenchai et al., 2015). For mentorship, this is an opportunity for the evaluator(s) to create evaluation questions around program effectiveness by determining what information is required to showcase learning and progress along the licensure path. This first step in the EE process would take place in Phase 2 (Months 7–15) of the change implementation plan.

The second step of the EE process is taking stock, where the evaluator(s) review the context and status of the program, "prioritizing and identifying activities to achieve the group's mission, assessing their performance through ratings and/or group dialogue" (Haskell & Iachini, 2015, p. 166). The data related to the indicators in the monitoring and evaluation framework would guide this discussion. One important distinction between EE and other participatory forms of evaluation is the democracy of the process, where during the taking stock stage, the experienced evaluator acts as a facilitator. The group acts as key knowledge holders, producing content and ideas, while the evaluator "is responsible for making sure that everyone is given an opportunity to speak, and serves as a critical friend – challenging [participants] to clarify terms, ideas and judgements" (Fetterman, 2001, p. 25). For the mentorship program, this would involve the steering committee, including IPG mentor and mentee representatives as program beneficiaries, guiding and informing the discussion. The IPG voice is critical at this stage, to ensure that their shared lived experience complements the qualitative and quantitative data gathered. Charoenchai et al. (2015) noted that this stage consisted of "specifying objectives, work duties, evaluation tools and methods, time and place, evaluation criteria" (p. 2528), where IPGs would look at the task of gathering data, confirm the tools recommended in the evaluation framework, and agree on the evaluation criteria. This type of evaluation is an exercise consistent

with the shared leadership used throughout the OIP, as the stakeholders drive the agenda and must each take responsibility for various aspects of the evaluation.

The final stage of the evaluation is planning for the future. This is what Haskell and Iachini (2015) refer to as "identifying goals and implementing related strategies, determining what type(s) of evidence will be needed to monitor impact, and monitoring implementation in order to foster continuous improvement" (p. 166). There is overlap between these activities and the stages of Kotter's implementation: Creating a Climate for Change, Engaging and Enabling the Profession, and Implementing and Sustaining Change (Teixeira et al., 2017), in which the evaluation team would review the consolidation of recommended improvements to identify best practices and institutionalizing or formalizing new approaches and best practices. The second and third steps of the EE process would take place during the third phase of the change implementation.

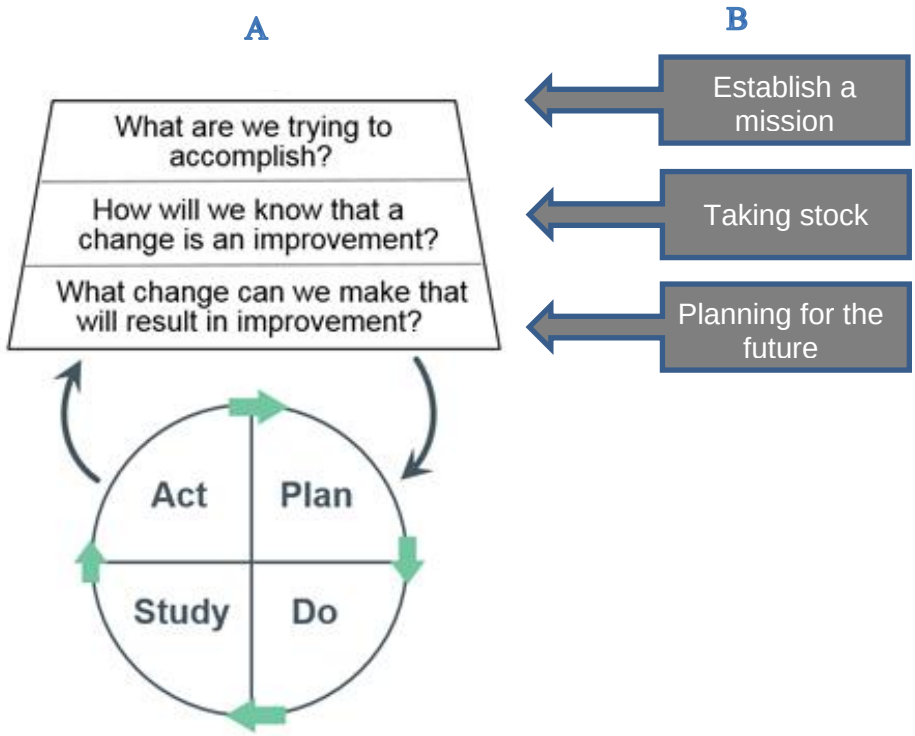
Taken together, Kotter's eight-step plan and the stages of EE align well to continuously monitor through the PDSA cycle. Each of these stages will be aligned with implementation as demonstrated in Figure 8.

Langley et al. (2009) propose a theoretical model to "illustrate how the model for improvement and EE supports the quality improvement initiatives and then describe how integration of these approaches has the potential to produce a whole that is greater than the sum of the individual parts" (p. 648). The EE questions in Langley et al.'s model align with Fetterman's (2001) stages of evaluation. The model demonstrates how the activities during the evaluation exercise can inform the PDSA cycle. Establishing a mission answers the question "what are we trying to establish?". The data gathering and context review activities in the taking stock stage will assist in determining whether improvements are taking place. Planning for the

future will happen as participants examine the changes they can make to bring about improvements moving forward.

Figure 8

How Empowerment Evaluation Informs PDSA



Note. Graphic portion A from G. J. Langley, R. D Moen, K. M. Nolan, T. W. Nolan, C.L. Norman & L.P. Provost. (2009). The improvement guide: A practical approach to enhancing organizational performance, p. 24. Copyright 2009 by G. J. Langley, R. D Moen, K. M. Nolan, T. W. Nolan, C.L. Norman & L.P. Provost. Graphic portion B adapted from Wandersman et al. (2015).

In the next section, how change will be communicated within the organization and among stakeholders to build awareness, support, and excitement about the mentorship program will be discussed. The timelines and key messages will accompany each stage.

Plan to Communicate the Need for Change & the Change Process

This section will examine how Kotter's model for change will guide the communication strategy through three phases and eight steps. The narrative will provide context for the visual representation of the communication tactics more fully addressed in the Knowledge Mobilization Plan in Appendix B.

Building Awareness of the Need for Change

It will be critical for any change management strategy to build awareness among change agents and recipients of the need for change. While various stages of the plan will address key messages and specific tactics that outline the media for the messaging, the themes guiding the messaging must be conveyed: the PoP of IPGs facing a myriad of barriers to success on their licensure journey, and the vision for change to address these barriers. Awareness of the barriers will guide the selection of tactics and messages throughout. Stroh (2015) also suggests that in addressing the PoP, change agents can ask powerful questions to raise awareness, such as, "why have we been unable to solve this problem despite our best efforts? How might we be partly responsible, albeit unwittingly, for the problem? What might we have to give up for the whole to succeed?" (p. 149). These are questions that change leaders will carry into the implementation and communications plans to ensure that change agents focus on the right areas and provide messages that reinforce the benefits and successes of implementation.

Phase 1: Creating a Climate for Change (Months 1–6)

The "Creating a Climate for Change" phase is where the plan for change is developed, tested, and used to craft an improvement plan. Following Kotter's model, where the first step is creating a sense of urgency, change leaders will revisit the drivers and priorities for change. These include the need to consider the financial and psychosocial barriers to success faced by

IEHPs. Messaging here will be related to “the fierce urgency of now” (King, 1963). In his “I Have a Dream” speech, Dr. Martin Luther King, Jr. noted that as we become increasingly aware of inequities and disparities facing marginalized communities, “we are now faced with the fact that tomorrow is today. We are confronted with the fierce urgency of now. In this unfolding conundrum of life and history, there is such a thing as being too late” (King, 1963). As a change leader, I will bridge the values of servant leadership: empathy, stewardship, and community building (Greenleaf, 1977), and the principles of shared leadership, embedding leadership in relationships, and remaining focused on collective goals (Chiu et al., 2016). Key messages, then, will involve three pillars: leaning on empathy to address the original barriers to licensure faced by IPGs that were raised by pharmacy regulatory authorities (PRAs); using relationships to address any concerns raised and corresponding risk management strategies documented in the risk register; and the call for collective efforts to assist IPGs to become licensed to allow more Canadians to access quality healthcare services. This will facilitate the ability to recruit champions to guide the implementation process.

Kotter’s recommendation to form a powerful guiding coalition is a call to action to change leaders to create a team that includes “individuals with the appropriate skills, the leadership capacity, the organizational credibility and the connections to handle a specific kind of organizational change” (Kotter & Cohen, 2002, p. 43). Key messaging during this time must include benefits to the organization, as change agents may be concerned with organizational justice, and will continue to be directed internally and will identify ways in which assisting IPGs will also assist Health Alliance and its organizational members. Messaging will respond to the “what’s in this change for me?” question, while also appealing to the employees’ sense of altruism.

Kotter's (1996) process also recommends that change agents create a vision which, for Health Alliance, is to re-center it strategic goals to include formal supports for IPGs. At this time, Health Alliance has been discussing and considering this objective for over a year, so although this vision for change was created out of step with Kotter's model, it will be revisited as the implementation proceeds, and therefore fits well within the framework. The activity in this stage will be to revisit the vision for change and build key messaging associated with it. Further, as is common for any change, it will be met with hesitation and emotion. It will be the guiding coalition's role (the steering committee, in Health Alliance's corporate language) to alleviate those insecurities by positioning the change as an intentional change in the organization's evolution, rather than as a crisis.

Phase 2: Engaging and Enabling the Profession (Months 7–15)

This second phase aligns with the "Do" of Deming's PDSA cycle, where those managing and monitoring change will begin to carry it out. Once the planning is finalized, it will be important to communicate the vision to stakeholders and direct recipients of change: employees of professional regulatory authorities, IPGs as mentees, employers who will assist in identifying mentors, and immigrant serving organizations who will help to identify employers/clinical sites. Communications at this stage will emanate from the guiding coalition outward throughout the organization and to key stakeholders. The recommendation around communicating change at various levels was a strength of Kotter's model. This was illustrated in Campbell's (2008) Communicate for Buy in Layered Model in Figure 9. He explained how "each successive layer represents a set of strategies to promote the vision statement, detect and overcome resistance, and build commitment toward the proposed changes" (p. 28). These layers can be used to infuse change throughout the organization and among stakeholders.

Figure 9

Communicate For Buy in Layered Model

Note. Visual of how to infuse the organization with the vision for change. From R. J. Campbell. (2008). "Change management in health care," *The Health Care Manager*, *27*(1), p. 28. Copyright 2008 by Wolters Kluwer Health, Inc.

For a complex change with multiple audiences, it is important to have a plan that adapts itself to each stage of change. Communications must vary in method and frequency during the preparation, implementation, and maintenance of the new order. Klein (1996) noted that the difficulties that arise with significant change can be "more easily dealt with if there is strategic thinking about what and how to communicate. The process should be based on a good grasp of some principles of communication, together with an understanding of the change process" (p. 44). Key messaging will relate to operational changes and to the system improvements that are realized by transitioning from a pilot project to a sustainable program.

The fifth step in Kotter's model is to empower the implementers to act on the vision. This stage is about finding allies that are receptive to change who become credible sources of information and can use communication tools created/adopted, to build and strengthen bonds between frontline workers and management. Implementers, if empowered, can facilitate change

by “selling” the project and acting as “cheerleaders” (Bolman & Deal, 2017) to build enthusiasm for the project and create safe spaces to air grievances and frustration. The main focus at this stage is ensuring that change agents are empowered with the appropriate tools and mechanisms to promote the program, support the change, and respond to any concerns raised. Tactics for this stage will carry messages of success and will include bite-sized narratives on participants, benefits of the program, and where other parallel sectors have seen success through mentoring. It will also highlight some of the learning goals of the mentorship program, to showcase how mentorship allows IPGs to hone their skills in patient-centred, collaborative health care.

The sixth stage is to plan for and create short-term wins. As acceptance and enthusiasm for the change begin to grow, it will be helpful to continue to fuel the momentum by celebrating successes. The implementation of a mentorship program as part of the path to licensure will be new and suspicious to some. Here is where the greatest resistance to change will occur. Demonstrating that the shift is evidence-based and proactively setting up opportunities to act on the data will facilitate planning for short-term wins. Kotter (2014) noted that “These wins, and their celebration, can carry great psychological power and play a crucial role […] they give credibility to the new structure. This credibility in turn promotes more and more cooperation within the organization” (p. 32). As such, communication at this stage can draw from the low-hanging fruits of success. Key messages will continue to promote the mentorship program and build awareness via social media, will provide positive updates on the number of mentors and mentees recruited, and will celebrate any accomplishments, either within the team (for example, increasing numbers of employers interested in the program) or by the IPGs (for example, number of former program participants now licensed and practicing as pharmacists).

Phase 3: Implementing and Sustaining the Change (Months 16–24)

This phase of implementing and sustaining change aligns well with Deming's "Study" phase of the PDSA cycle, where the implementation of the change is measured for discrepancies between implementation and planning.

The seventh stage of Kotter's model recommends that change leaders consolidate improvements producing more change. At this stage, lessons learned from Phase 2 allow the change leadership team to examine emerging and promising practices that can be leveraged to continue the change. In the case of this OIP, the change leadership team will be preparing its evaluation data and will use some of the outcome findings to build key messages. At this stage, communications will revisit the growth in the number of mentorship placements completed in order to showcase the favourable experiences reported via survey from participants.

The final stage of Kotter's change management cycle is to institutionalize new approaches, and it is proposed here that this stage forms the beginning of the "Act" phase of the PDSA cycle. This is where change agents "make the change 'stick' by changing policies, procedures, regulations, and legislations to ensure the change will endure" (Teixeira et al., 2017, p. 199). A change to, or validation of, policies and procedures will legitimize the change and add support to the process before the PDSA cycle can be repeated to improve the framework. Health Alliance's intent is to move the implementation through the PDSA cycle once or twice, to ensure that the organization continues to learn from the process and provide the best support possible to the PRAs as they adjust to the framework. The PDSA cycle facilitates organizational learning by empowering change agents to be part of the full change, including its challenges and successes. Key messaging here will celebrate implementation achievements and will continue to build on

highlights from mentorship accomplishments, but will also report with transparency on opportunities for efficiency and improvement.

Next Steps and Future Considerations for the Organizational Improvement Plan

A deeper understanding of virtual mentorship as an adjunct to face-to-face interactions will broaden the reach of a traditional mentorship program, in the event that the pandemic leads to increasing restrictions that affect the operations of the program. It may also prove beneficial as well as for those mentors and mentees with accessibility issues or who have other limitations that would prevent them from fully participating in the program.

The societal issues that impede successful access to licensure and practice will continue to be explored with a diversity and inclusion lens. As women are increasingly principal applicants for families entering Canada (IRCC, 2018), this OIP highlights an opportunity to study professional women as the particular focus of greater research. Grant (2007) noted that, "the study of the problems faced by professionally trained women who emigrated have been neglected in the extant literature due to research concentration on the exploitations of women who are unskilled and often illegal immigrants and refugees" (p. 136). This is where Rao et al. (2016) suggest that their Gender at Work framework is useful in understanding "gender inequality and the power relationships between women and men in communities. We have also used the framework to analyze and strategize for change in gender relations within organizations" (p. 27). Regardless of the lens used for analysis, expanding the scope of existing literature allows for greater focus on barriers specific to women who may arrive as refugees or have experienced other forms of trauma. Challenges that may impede the success of the OIP implementation must be regarded as risks and mitigation strategies considered as part of the

project charter development and throughout implementation. This must be done in the interest of meeting public expectations around safety and confidentiality of patient information.

Practically speaking, although micro-credentialing was not selected to be the object of this organizational improvement plan, Health Alliance should not lose sight of the role that micro-credentials can play in supporting IPGs. The literature review for this OIP explored whether micro-credentialing is an effective strategy to assist international healthcare professionals in overcoming barriers to their journey to licensure in Canada. Additionally, though not directly related to licensure, micro-certification can provide candidates with a Canadian credential to present to employers who may be holding unconscious biases towards internationally trained candidates.

Further research is required to gain a firm understanding of how micro-credentialing has played a role in assisting foreign trained professionals in other sectors in their path to licensure. Additional literature could also be pursued on accessibility to courses, and whether technology is helpful or hindering in efforts to support newcomers to Canada. The use of technology to offer digital badges must be balanced against the accessibility and connectivity of newcomers to that technology. A deeper exploration of implementation science would reveal the contexts in which micro-credentials may be used appropriately. Implementation science could provide evidence-based direction on whether these approaches together will best help IPGs obtain skills that support their success on their journey to licensure.

Finally, underutilization of international talent remains a persistent issue in Canada (Reitz et al., 2013). The barriers faced by IPGs enumerated earlier are exacerbated for immigrants and people of colour. Even as the Canadian government continues to promote immigration through the Multiculturalism Act, North America is moving into a period of toxic inequality, “a powerful and

unprecedented convergence: historic and rising levels of wealth and income inequality in an era of stalled mobility, intersecting with a widening racial wealth gap, all against the backdrop of changing racial and ethnic demographics" (Shapiro, 2017, p. 18). More research is required to fully understand the effects of toxic inequality on the retention rate of IPGs who become licensed to practice in Canada.

Chapter Three Summary

This chapter has provided a tangible implementation framework to a theoretical base. Building on the PoP and theoretical frameworks introduced in Chapter One and the analysis of proposed solutions examined in Chapter Two, it has laid out a monitoring, evaluation, and communication plan for implementation. The chapter began with a discussion about the context within which this organizational improvement plan exists: a rich pharmacy ecosystem with a number of interdependent and complementary stakeholders. This chapter has also delved into how stakeholders can be engaged to support the program implementation, and how change leaders can seek to understand stakeholder needs and stakeholder reactions to change. This chapter also presented a monitoring and evaluation approach and positions EE as the approach of choice due to its close alignment with sense of community theory. Finally, the communications plan following Kotter's eight step system was presented and a knowledge mobilization plan (Appendix B) introduced.

Conclusion

There is a disconnect between the needs of regulators and employers to find skilled health professionals (Hou & Schimmele, 2020) and the availability of internationally educated workers. Much of this disconnect can be traced to the licensure journey. A rigorous licensure process for Canadian educated practitioners and IEHPs is critical to public protection. Nevertheless, it is important to note that internationally educated professionals provide Canadians with labour that supports its healthcare system, contributes to its economic growth, and provide contributions to Canada's richly diverse culture, yet there are thousands of IEHPs whose careers have been sidelined while they remain underemployed or working in jobs other than those for which they have been trained (Atlin, 2020). This OIP seeks to set IPGs up for licensing and professional success. Empowerment has been a value central to its development, supported by servant leadership, sense of community theory, and the evaluation approach. As a learning approach, the proposed mentorship program seeks to support IPGs on their path to licensure in a way that results in developing competencies and building capacity. In this model, both mentors and mentees develop valuable evaluation and leadership skills that will contribute to their career success.

As Patel (2019) noted in addressing the barriers to international graduates, "when we advocate for advancing the practice and the profession, we should always keep in mind where half of our pharmacists come from—we cannot afford to leave them behind" (p. 290). This addresses the importance of identifying the hurdles in the pathway to licensure and finding support to facilitate this part of the process.

Narrative Epilogue

This OIP started as a passion project, first as an academic and professional assignment, then as a personal exercise in growth and discovery. The immigrant experience has shaped me: my parents immigrated to Canada in the 1960s. They had many wonderful first experiences in moving to a colder climate, but also faced racism, sexism, and xenophobia. The details of their experiences are common; their stories are woven with other voices of common encounters shared, re-told, and relived in living rooms and around dinner tables in Caribbean expat homes across Canada. I have realized that this is why I am so heavily invested in ensuring that every person, regardless of ability, gender, race, or country of origin is empowered to meet their potential and live their best lives.

Mentorship is more than just a career experience. For the mentor, it is absolutely an opportunity for professional development, but it is also an opportunity to show professional leadership and make a lasting contribution to a colleague's personal and professional life. For the mentee, it is an opportunity to build friendships, develop a professional network, and a dignified way to learn in an authentic and safe environment. For the profession, it contributes to a sense of community and belonging and builds more diverse and equitable workplaces. The mentors and IPGs that I have been privileged to work with have humbled and inspired me. I am forever honoured to have heard their stories, amplified their voices, and played some part in their journey.

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Appendix A: Rating of the Health Alliance's Readiness for Change

Readiness Dimension	Possible Readiness Score	Actual Score
Previous Change Experiences		
1. Has the organization had generally positive experiences with change?	Score 0 to +2	2
2. Has the organization had recent failure experiences with change?	Score 0 to -2	0
3. What is the mood of the organization: upbeat and positive?	Score 0 to +2	2
4. What is the mood of the organization: negative and cynical?	Score 0 to -3	0
5. Does the organization appear to be resting on its laurels?	Score 0 to -3	-1
Executive Support		
6. Are senior managers directly involved in sponsoring the change?	Score 0 to +2	2
7. Is there a clear picture of the future?	Score 0 to +3	2
8. Is executive success dependent on the change occurring?	Score 0 to +2	0
9. Are some senior managers likely to demonstrate a lack of support?	Score 0 to -3	-2
Credible leadership and change champions		
10. Are senior leaders in the organization trusted?	Score 0 to +3	3
11. Are senior leaders able to credibly show others how to achieve their collective goals?	Score 0 to +1	1
12. Is the organization able to attract and retain capable and respected change champions?	Score 0 to +2	1
13. Are middle managers able to effectively link senior managers with the rest of the organization?	Score 0 to +1	1
14. Are senior leaders likely to view the proposed change is generally appropriate for the organization?	Score 0 to +2	1
15. Will the proposed change reviewed as needed by the senior leaders?	Score 0 to +2	1
Openness to change		
16. Does the organization have scanning mechanisms to monitor the internal and external environment?	Score 0 to +2	1
17. Is there a culture of scanning and paying attention to those scans?	Score 0 to +2	1
18. Does the organization have the ability to focus on root causes and recognize interdependencies both inside and outside the organization's boundaries?	Score 0 to +2	2
19. Does "turf" protection exist in the organization that could affect the change?	Score 0 to -3	-1
20. Are middle and senior managers hidebound or locked into the use of past strategies approaches and solutions?	Score 0 to -4	-1
21. Are employees able to constructively voice their concerns or support?	Score 0 to +2	1
22. Is conflict dealt with openly, with a focus on resolution?	Score 0 to +2	2

23. Is conflict suppressed and smoothed over?	Score 0 to -2	0
24. Does the organization have a culture that is innovative and encourages innovative activities?	Score 0 to +2	1
25. Does the organization have communications channels that work effectively in all directions?	Score 0 to +2	1
26. Will the proposed change be viewed as generally appropriate for the organization by those not in senior leadership roles?	Score 0 to +2	2
27. Will the proposed change be viewed as needed by those not in senior leadership roles?	Score 0 to +2	1
28. Do those who will be affected believe that they have the energy needed to undertake the change?	Score 0 to +2	0
29. Do those who will be affected believe that there will be access to sufficient resources to support the change?	Score 0 to +2	1
Rewards for Change		
30. Does the reward system value innovation and change?	Score 0 to +2	1
31. Does the reward system focus exclusively on short-term results?	Score 0 to -2	0
32. Are people censored for attempting change and failing?	Score 0 to -3	0
Measures for change and accountability		
33. Are there good measures available for assessing the need for change and tracking progress?	Score 0 to +1	0
34. Does the organization attend to the data that it collects?	Score 0 to +1	0
35. Does the organization measure and evaluate customer satisfaction?	Score 0 to +1	0
36. Is the organization able to carefully steward resources and successfully meet predetermined deadlines?	Score 0 to +1	1
Scoring		
• The higher the score, the more regular ready the organization is for change. • If the score is below 10, the organization is not likely ready for change at the present. • To increase readiness, change agents can use the responses to the questions to help them identify areas that need strengthening and then undertake actions to strengthen the readiness for change.	The scores can range from -25 to +50	Health Alliance's change readiness score: 25

Note. Adapted from Deszca, G., Ingols, C., & Cawsey, T. (2020). *Organizational change: An action-oriented toolkit* (4th ed.). SAGE.

Appendix B: Kotter's Change Management Model (1996) and Implementation Plan

Phase	Kotter's Steps	Responsible	Project Implementation
Phase 1: Creating the Climate for Change (Months 1–6)	1. Establish a sense of urgency: a "burning platform" where all recognize the importance and exigency of change	• Pilot project lead; senior leadership	• Review the vision for change and establish key outcomes • Conduct consultations • Build project charter and risk register
	2. Form a powerful guiding coalition: leaders and implementers who represent their constituencies, are trustworthy and credible and who inspire others	• Senior leadership	• Create steering committee
	3. Create a vision: a collaborative process of engaging all in shaping a future they will share	• Guiding coalition	• Draft the communications strategy • Finalize benchmarks and performance measures
Phase 2: Engaging and Enabling the Profession (Months 7–15)	4. Communicate the vision: within and outside the profession to create anticipation, manage expectations and produce enthusiasm about the future	• Guiding coalition	• Implement the communications strategy • Begin recruitment and placement
	5. Empower the implementers to act on the vision: learn how to make the vision a reality at the local level and despite context-specific hurdles and obstacles	• Guiding coalition and change agents	• Continue to implement communications strategy • Support mentorship placements
	6. Plan for and create short-term wins: allow immediate successes with change to become the fuel that fosters future, more difficult changes and provides a signpost for how to build capacity and reach of the change across different local contexts	• Guiding coalition and change agents	• Examine Short-Term Goals: ○ Promote mentorship program and build awareness via social media ○ Recruit X number of mentors ○ Identify X number of mentees ○ Celebrate team accomplishments
Phase 3: Implementing	7. Consolidate improvements producing more change: learn the lessons from	• Guiding coalition,	• Examine Medium-Term Goals ○ X number of mentorship

Phase	Kotter's Steps	Responsible	Project Implementation
and Sustaining the Change (Months 11–18)	phase 2 to identify the best and promising practices that can be spread across the profession	change agents and evaluation team	placements completed o Favourable experiences reported via survey from participants o Begin reviewing evaluation data
	8. Institutionalize new approaches: make the change "stick" by changing policies, procedures, regulations, legislations to ensure the change will endure	• Guiding coalition, change agents and evaluation team	• Examine Long-Term goals o Assess data on mentee outcomes – confidence, licensure, employment Complete Plan-Do-Study-Act cycle o Prepare evaluation plan o Review lessons learned

Note: Adapted from Kotter, 1996 and Teixeira et al., 2017

Appendix C: Change Communication Strategy: Knowledge Mobilization Plan

Phase	Kotter's Steps	Responsible	Key Messaging	Tactics & Audience
Phase 1: Creating the Climate for Change (Months 1–6)	1. Establish a sense of urgency: a "burning platform" where all recognize the importance and exigency of change	• Pilot project lead; senior leadership	• The original barriers to licensure faced by IPGs • concerns raised and corresponding risk management strategies documented in the risk register • asking "powerful questions" (Stroh, 2015) • The urgency of now: equity and social justice issues	• Senior leadership to build communication through existing internal communication vehicles – board reports, regular senior leadership reports; organizational newsletter • Audience: Internal
	2. Form a powerful guiding coalition: change agents who represent their constituencies, are trustworthy and credible and who inspire others	• Senior leadership	• Call to arms – request for participants to act as agents of change • Benefits to the organization: "What's in it for me?" • Need for more pharmacists as an integral part of the healthcare system	• Senior leadership to build communication through existing internal communication vehicles – board reports, regular senior leadership reports; organizational newsletter distributed to sister organizations to enlist participation in guiding coalition • Audience: Internal
	3. Create a vision: a collaborative process of engaging all in shaping a future they will share	• Guiding coalition	• Position the change as proactive and intentional, not mandated • Position change as evolution	• The guiding coalition to disseminate information via inter-departmental memos, outreach to • Audience: Internal to Health

Phase	Kotter's Steps	Responsible	Key Messaging	Tactics & Audience
				Alliance and potential stakeholder partners
Phase 2: Engaging and Enabling the Profession (Months 7–15)	4. Communicate the vision: within and outside the profession to create anticipation, manage expectations and produce enthusiasm future	• Guiding coalition	• Understanding operational changes and system improvements; fostering trust in the system and improvements	• The guiding coalition to use "layered communication" to foster buy-in: o beginning with communicating the vision to stakeholders, o using moderated forums to engage in continuous dialogue; and o using broader tactics such as social media platform to ensure project information continues to be shared through out the organization and pharmacy ecosystem o Audience: Internal and external
	5. Empower the implementers to act on the vision: learn how to make the vision a reality at the local level and despite context-specific hurdles and obstacles	• Guiding coalition and change agents	• Building enthusiasm for the project, highlighting support form leadership • Focus on the rigour of the program	• Bite sized narratives, suitable for twitter, versatility to be included in stakeholder newsletters, website news, etc. • Audience: Internal and external
	6. Plan for and create short-term wins: allow immediate successes with change to become the fuel that fosters future, more difficult	• Guiding coalition and change agents	• Continue to promote mentorship program • Provide positive updates on the number of participants recruited • Celebrate team and individual	• Bite sized narratives, suitable for twitter, versatility to be included in stakeholder newsletters, website news, etc. • Audience: Internal and external

Phase	Kotter's Steps	Responsible	Key Messaging	Tactics & Audience
	changes and provides a signpost for how to build capacity and reach of the change across different local contexts		IPG accomplishments	
Phase 3: Implementing and Sustaining the Change (Months 16–24)	7. Consolidate improvements producing more change: learn the lessons from phase 2 to identify the best and promising practices that can be spread across the profession	• Guiding coalition, change agents and evaluation team	• Continue to promote mentorship program • Provide positive updates on the number of participants recruited • Celebrate team and individual IPG accomplishments ○ Showcase favourable outcomes reported via participant data	• Bite sized narratives, suitable for twitter, versatility to be included in stakeholder newsletters, website news, etc. • regular senior leadership reports; organizational newsletter distributed to sister organizations • Audience: Internal and external
	8. Institutionalize new approaches: make the change "stick" by changing policies, procedures, regulations, legislations to ensure the change will endure	• Guiding coalition, change agents and evaluation team	• Continue to promote mentorship program • Provide positive updates on the number of participants • Celebrate team and individual IPG accomplishments • Showcase favourable outcomes reported via participant data	• Bite sized narratives, suitable for twitter, versatility to be included in stakeholder newsletters, website news, etc. • regular senior leadership reports; organizational newsletter distributed to sister organizations • Audience: Internal and external