

ORGANIZATIONAL PARTICIPATORY RESEARCH Practice Guide

Written by
Paula L. Bush, Marie-Claude Tremblay
and the OPR recommendations working group*

July 2018

Copyright 1144569
ISBN: 978-1-7751842-0-1

To cite the Organizational Participatory Research (OPR) practice guide:

Bush, P. L., Tremblay, M.-C., & The OPR recommendations working group. (2018). *Organizational Participatory Research Practice Guide*. Registration of Copyright for the English version (#1144569), Canadian Intellectual Property Office, Industry Canada. Retrieved from <https://soutiensrapmetho.ca/mieuxservir/>

TABLE OF CONTENTS

WORKING GROUP MEMBERS AND ACKNOWLEDGEMENTS	4
FOREWORD	5
INTRODUCTION	7
DEFINING ORGANIZATIONAL PARTICIPATORY RESEARCH	10
RECOMMENDATIONS	14
FORM AN OPR WORKING GROUP AND COLLECTIVELY ESTABLISH WORK PROCESSES	16
COLLECTIVELY ESTABLISH OBJECTIVES, ANALYZE DATA AND DETERMINE HOW TO USE OPR RESULTS	22
ADAPT THE OPR PROCESSES TO THE NEEDS OF THE WORKING GROUP MEMBERS	24
COLLECTIVELY ENSURE THE DEVELOPMENT AND NURTURING OF RELATIONSHIPS WITHIN THE WORKING GROUP	26
MODEL OF ITERATIVE PROCESSES AND OUTCOMES OF OPR	32
REFERENCES	33

* OPR recommendations working group members (practitioners, managers, patients, researchers), in alphabetical order

René Benoit	Vanessa Michaud
Mathieu Bouchard	Shandi Miller
Beatrice Débarges	Philippe Ouaknine
Mario Di Carlo	Sharon Parry
Benjamin Gaudet-Fex	Jennifer Reoch
Catherine Lemyze	

Acknowledgements

We are grateful to the insights of the Delphi group. Below, in alphabetical order, are the names of those who wished to be acknowledged.

Jan Dewing, Professor, Sue Pembrey Chair in Nursing QMU Edinburgh (Scotland)

Hanne Kaae Kristensen, PhD, Associate Professor, University of Southern Denmark and University College Lillebaelt. (Denmark)

Joseph W. LeMaster, MD MPH; Associate Professor, University of Kansas School of Medicine, (United States of America)

Brian Lucas, RN, PhD, Associate Lecturer, The Open University, (England)

Ann C Macaulay CM MD FCFP FCAHS FRCPC (Hon), (Canada)

Pierre Pluye MD, PhD Full Professor, FRQS Senior Research Scholar Director, Method Development, Quebec SPOR SUPPORT Unit Department of Family Medicine, McGill University, (Canada)

Profesor Nicola Spalding, EdD, MA, BSc(Hons), DipCOT, Professor of Occupational Therapy, University of East Anglia, (England)

Ellen Westh Sørensen, M.Sc.Pharm, Associate Professor (retired) at Department of Pharmacy, Section for Social and Clinical Pharmacy, Copenhagen University (Denmark)

Dean Whitehead – PhD, MSc, BEd, RN, FCNA, Senior Lecturer (New Zealand)

Anna-Leila Williams, PhD, MPH Frank H. Netter MD School of Medicine at Quinnipiac University (United States of America)

In addition, we thank the following doctoral students from McGill University for their comments on the penultimate version of this Practice Guide: Nadia O’Brien (MPH), Vera Granikov (MLIS)

FOREWORD



The Quebec Support Unit for Public and Patient Oriented Research and Trials (SUPPORT) is part of the larger Strategy for Patient Oriented Research (SPOR) of the Canadian Institutes for Health Research (CIHR), in partnership with the Ministry of Health and Social Services (MSSS) and the *Fonds de recherche du Québec - Santé (FRQ-S)*. Patient-oriented research recognizes not only the expertise of patients, but also that of the clinicians and managers who are working in the field every day to meet population needs. Patient-oriented research also favors conducting studies in real-world practice settings and making good-quality data accessible to guide decision-making. The mission of the methodological SUPPORT units is to foster a change in culture and to provide guidance to researchers and other actors in the health network as this transformation unfolds.

There has been a lot of interest in inter-professional collaboration as team-based care has become a cornerstone of health care delivery. However, most of the time, care is not provided by a team working within the same walls but by “virtual teams”, working in different organizations. Indeed, many care trajectories involve different organizations, and fragmentation of care is one of the biggest challenges we face. As we talk of inter-professional collaboration, we must also talk about inter-organizational collaboration and be interested in research on how to foster better inter-organizational collaboration and coordination. Hence, the concept of participatory research must extend to “participatory research with organizations”. But how do you effectively engage with organizations as a researcher? This is also part of the skills in the tool box of Patient Oriented Research.

Thanks to Dr Pierre Pluye, Dr Paula Bush and their team, the Quebec-SPOR SUPPORT Unit is proud to be able to offer researchers and also managers and decision-makers and patient-partners this practice guide on conducting organizational participatory research.



Marie-Dominique Beaulieu, MD, FCMF, M.Sc.
Scientific Director of the Quebec-SPOR SUPPORT Unit



Action research and participatory research have a longstanding history. While there are guidelines for community-based participatory research, few studies and no specific guidance exist on how to plan, implement and assess organizational participatory research (OPR), specifically OPR with health organizations. Organization and management studies demonstrate that organizations have specific principles (e.g., aim to be as efficient as possible), practice rules and power characteristics, in particular health organizations (professional bureaucracies). Therefore, OPR differs from other types of participatory research, and developing an OPR practice guide was set as a priority of the Method Development component of the Quebec-SPOR SUPPORT Unit.

The Method Development component supports patient-oriented research stakeholders (clinicians, decision/policy-makers, patient-partners, and researchers) for (i) producing methodological tools such as the present OPR practice guide, (ii) monitoring research trends collaboratively, (iii) adapting methodologies and methods in a primary care, or integrated care, context, (iv) creating new methodologies and methods. We also offer methodological consultations, peer-review and workshops. The component is located in the Department of Family Medicine, McGill University, which has a long tradition and significant expertise in participatory research via *Participatory Research At McGill (CIET-PRAM)*. Indeed, we are indebted to the team who carried out the CIHR-funded systematic mixed studies review that served as the basis for the work that led to this practice guide. As Director of this component, I am convinced that this practice guide will be useful to OPR practitioners. It is grounded in OPR projects with a broad range of objectives, conducted in various health organization contexts on all continents, and validated by experts including authors of these projects; thus, we hope this practice guide will be applicable across multiple contexts. Moreover, the application of the recommendations in this guide and the study of their effects can help us to better understand the value, and challenges, of this approach.

In conclusion, this OPR practice guide is an innovative easy-to-read, engaging work that will be of interest to all OPR stakeholders. It should be required reading for all researchers involved in academic collaborative partnerships with health organizations, their decision/policy-makers, professionals, staff, patients and their relatives and care givers.



Pierre Pluye, MD, PhD

Full Professor, FRQS Senior Research Scholar
Department of Family Medicine, McGill University
Director, Method Development, Quebec SPOR SUPPORT Unit
Fellow of the Canadian Academy of Health Sciences (CAHS)

INTRODUCTION

Guidelines and principles for community-based participatory research and participatory evaluation exist (Israel, Schulz, Parker, & Becker, 1998; Mercer et al., 2008; Shulha, Whitmore, Cousins, Gilbert, & Hudib, 2016), but this practice guide addresses aspects of participatory research that are unique to Organizational Participatory Research (OPR). The hierarchy, power, and rules present in all organizations lend a context to participatory research that is different from that found in community settings. This Practice Guide is meant to help all stakeholders (academics, health organization members, and health service users) participating in an OPR project to navigate this context successfully.

.....
ACCORDING TO FRIEDBERG (1997), AN **ORGANIZATION** IS A “CONTEXT OF ACTION IN WHICH RELATIONSHIPS OF COOPERATION, EXCHANGE, AND CONFLICT BETWEEN ACTORS WITH DIVERGENT INTERESTS ARE BEING ESTABLISHED AND MANAGED” (P. 43), AND WHICH FLUCTUATES IN RESPONSE TO CHANGES IN THE ENVIRONMENT.

HEREIN, WE CONCEIVE OF A **HEALTH ORGANIZATION** AS ANY ORGANIZATION OFFERING HEALTH-RELATED SERVICES. FOR EXAMPLE, THE ORGANIZATION COULD BE A HOSPITAL OR HOSPITAL WARD, PRIMARY CARE CLINIC, PHARMACY, LONG TERM CARE FACILITY, COMMUNITY ORGANIZATION, AMONG OTHER EXAMPES.
.....

OPR blends research and action to produce knowledge that can inform healthcare practices, services, and organizations. While it can be time consuming to develop the partnership (e.g., relationship and trust building, partnership agreement development), this up-front investment is valuable because when health organization members act as decision makers *with* academic researchers, throughout the research process, the likelihood research findings are relevant to, and used by, the health organization, and its members, increases. Moreover, OPR often results in benefits for the organization and its members that go beyond the research aims. These extra benefits are four times as likely to occur when the organization initiates the OPR (Bush et al., 2017).

.....
HEALTH ORGANIZATION MEMBERS REFERS TO ALL THOSE WHO DEVELOP, IMPLEMENT, OR ARE AFFECTED BY HEALTH ORGANIZATION PRACTICES. THIS INCLUDES ALL LEVELS OF **MANAGEMENT** AS WELL AS **ADMINISTRATIVE** AND OTHER PERSONNEL. **PRACTITIONERS** (PHYSICIANS, NURSES, PHARMACISTS, SOCIAL WORKERS, ALLIED CARE PROFESSIONALS AMONG OTHERS), VOLUNTEERS, AND **SERVICE USERS** INCLUDING PATIENTS, THEIR FAMILY, THEIR CARE GIVERS, AND THEIR REPRESENTATIVES.

IN ANY OPR, ALL HEALTH ORGANIZATION **AND** ACADEMIC STAKEHOLDERS ARE TREATED AS EQUALS. ALL STAKEHOLDERS ARE ON EQUAL FOOTING: NONE SHOULD EXERT MORE INFLUENCE THAN ANOTHER REGARDING THE RESEARCH PROCESSES AND OUTCOMES.
.....

This Practice Guide is addressed to all members of teaching and research institutions (hereafter, “academics”) and of health organizations who wish to work together to improve existing organizational practices or to design and implement new practices for the benefit of the health organization, its members, its service users, and the academics. Specifically, this document is for all types of OPR stakeholder groups who come together as an “OPR working group” to collectively address a common concern regarding health organization practices or policies. This working group includes managers, practitioners and staff working in health organizations; patients and their family, friends, representatives, or caregivers who use health organization services; academics. Throughout this guide, examples are provided for some, but not all, stakeholder groups. This has been done for the sake of parsimony and in no way implies that the stakeholder group for which an example is provided is more important or influential. All recommendations apply to all members of the OPR working group.

This practice guide was developed with academics and health organization stakeholders in three steps. Step 1: A systematic review of OPR (Bush et al., 2015; Bush et al., 2017) was used to draft an initial version of this guide. This review identified, described, and explained OPR processes and outcomes. Step 2: Two meetings were then held with an academic, a clinician, two managers, and a patient, all with experience in OPR, to review, modify and refine the initial draft. The systematic review of OPR only identified 15 studies with patient or caregiver participation (15 out of 105 OPR studies, i.e., 14%). The initial draft was, thus, missing an important element of OPR. To account for this, a group of seven patients and one academic met twice, and also worked collaboratively online, to develop recommendations for OPR that includes the patient perspective. This group began its reflection with a summary document based on patient engagement literature, prepared by the academic partner (Tremblay) (INVOLVE, 2013; Kotecha et al., 2007; Pollard et al., 2015; Telford, Boote, & Cooper, 2004). A final meeting was held with the two groups to discuss how to integrate the two sets of recommendations. Step 3: The project lead (Bush) carried out the integration to produce a new version of the practice guide which was submitted to 18 national and international experts in a Delphi study. The results of this study led to the version of the practice guide presented herein.

DEFINING ORGANIZATIONAL PARTICIPATORY RESEARCH

In OPR, all stakeholder groups are considered equally influential and important throughout the research process including the diffusion, dissemination and the implementation of results.

Working group members must seek to balance power relationships between service users, academics, health care practitioners, managers, and any other stakeholder group involved in the OPR.

This involves enabling all working group members to engage and participate meaningfully in the OPR process, contribute their experiential, clinical, managerial, and research knowledge, and to promote the distinctive and complementary value of their knowledge to address the OPR objectives.

Among others, stakeholders may contribute knowledge regarding:

- the feasibility of implementing a new clinical practice
- how current practices are experienced by service users
- change management
- rigorous and systematic research methods.

As equals, all working group members have the same rights, obligations, and responsibilities throughout the OPR process, including those related to raw data and dissemination of results.

.....
SERVICE USER REFERS TO ANY MEMBER OF THE PUBLIC WHO ACCESSES OR USES HEALTH SERVICES. THIS INCLUDES PATIENTS, THEIR CARE-GIVERS, OR THEIR FAMILY MEMBERS, AS WELL AS INDIVIDUALS WHO ACCESS SOCIAL SERVICES WITHIN THE HEALTH SYSTEM.
.....

Working group members may choose not to take advantage of some of these rights, or to distance themselves from certain obligations or responsibilities.

What is important is that working group members have the right to choose the extent to which they wish to be involved at various stages.

These decisions, and their rationales, should be openly discussed within the working group and agreed upon, and be transparent and respected.

According to a systematic mixed studies review of OPR in health (Bush et al., 2015; Bush et al., 2017), OPR requires regular, structured working group meetings that assemble a broad variety of health organization and academic stakeholders. and provide a supportive environment with the promise of confidentiality, such that working group members can voice their varied experiences, ideas for change, and fears and concerns; discuss and debate; accept compromises; gain confidence to effect the changes deemed necessary. Establishing objectives quickly helps to increase the unity of the working group. Circulating meeting notes (and other documents that may be produced) between meetings is crucial for subsequent deliberations, to correct misunderstandings, and to help engage working group members who are unable to attend some meetings.

The systematic review of the literature revealed that working group meetings are the crux of the OPR process. These meetings provide invaluable time and space to working group members.

These meetings:

- enable the working group to come to consensus regarding which issue to pursue via an OPR, and to systematically reflect on their objectives. Through this reflection, working group members identify needs, gain awareness of constraints to addressing those needs, gain confidence (which, in turn, leads to a drive to do the research), and become agents of change;
- help to increase working group members' awareness of practices and policies of the organization, and to anything that can contribute to improving care practices;
- allow working group members to learn from one another;

- increase or improve communications among working group members; in turn, this can improve communications with organisation members, or even to help improve or develop new skills (leading to feeling empowered), improve job satisfaction and team work, gain confidence to effect change, and diminish resistance to change;
- allow the working group to develop a cohesive identity, improve or increase the team-working and commitment of members. Working group members' commitment contributes to their increased involvement in the project, improved understanding of one another, improved care and sustainable change;
- improve coordination among organization members.

Specifically, working group meeting activities generally include planning and implementing the OPR, collectively analyzing data, and discussing results and how to act on them. Planning includes formulating the research question and specific research objectives, activities which are fundamental to all research. Moreover, working group members who are also organization members can help to plan and implement data collection (without needing to collect the data themselves) given they know what is and is not feasible in their organization. The collective data analysis process promotes dialogue and helps the group to gel. This process is also an opportunity to reflect and to make modifications to the project when this is appropriate and necessary. It is also important to discuss the findings within the working group because the research results often confirm perceptions and raise awareness. They also increase the motivation to make change and allow the group to identify additional needs and/or modify project plans. Finally, discussing research results increases working group members' understanding of how to use them to inform changes and enable joint problem solving. Communicating the findings outside of the working group (to managers and other organization members) gives the group legitimacy, enhances buy-in of other organization stakeholders, and stimulates reflection.

Finally, the changes the working group implements have a positive effect on the organization and its stakeholders. Moreover, they often pave the way for subsequent changes.

A diagram illustrating the processes and outcomes of OPR is included at the end of this practice guide.

.....
NOT ALL WORKING GROUP MEMBERS HAVE TO PARTICIPATE IN PLANNING AND IMPLEMENTING THE DATA COLLECTION. SOME MAY ABSTAIN TO NOT INTRODUCE BIAS OR TO AVOID CONFLICT OF INTEREST.

IN SOME OPR WORKING GROUPS, ORGANIZATOIN MEMBESR HELP ACADEMICS DETERMINE WHAT DATA TO COLLECT FROM WHOM, BUT DO NOT COLLECT THE DATA THEMSELVES. IN OTHER GROUPS, ORGANIZATION MEMBERS PARTICIPATE ACTIVELY IN DATA COLLECTION.

THE DISCUSSION AND DEBATE THAT OCCURS DURING THE DATA ANALYSIS AND INTERPRETATION OF RESULTS PHASES ARE IMPORTANT (BUSH ET AL 2015).

THE WORKING GROUP DECIDES WHO WILL PARTICIPATE IN WHAT PHASES OF THE STUDY.

THE ACADEMICS DO NOT DECIDE FOR THE OTHER STAKEHOLDER GROUPS.
.....

RECOMMENDATIONS

This Practice Guide includes four sections of recommendations listed below. Explanations of each recommendation follow the list.

1. FORM AN OPR WORKING GROUP AND COLLECTIVELY ESTABLISH WORK PROCESSES.

- 1.1. Recruit stakeholder representatives known to work well in groups.
- 1.2. Recruit working group members of all stakeholder types, including management.
- 1.3. Assess and respond to working group members' training needs.
- 1.4. Establish project management processes.
- 1.5. Schedule and hold meetings at regular intervals.
- 1.6. Ensure meetings are structured, focussed and evaluated.
- 1.7. Agree upon communication mechanisms.
- 1.8. Establish mechanisms for continuity.

2. COLLECTIVELY ESTABLISH OBJECTIVES, ANALYZE DATA AND DETERMINE HOW TO USE OPR RESULTS

- 2.1. Establish objectives quickly to help build the commitment of working group members.
- 2.2. Analyze data and interpret results.
- 2.3. Implement changes based on results.

3. ADAPT THE OPR PROCESSES TO THE NEEDS OF THE WORKING GROUP MEMBERS

- 3.1. Adapt OPR processes to schedules.
- 3.2. Adapt OPR processes to language and literacy needs.
- 3.3. Adapt communication tools to needs of working group members.
- 3.4. Adapt OPR processes to working group members' skills.

4. COLLECTIVELY ENSURE THE DEVELOPMENT AND NURTURING OF RELATIONSHIPS WITHIN THE WORKING GROUP

- 4.1. Ensure reciprocity, trust, and respect within the working group.
- 4.2. Recognise, explicitly, what working group members learn from one another.

- 4.3. Ensure potential, actual, or perceived power differentials among working group members are acknowledged and addressed.
- 4.4. Ensure each working group member's expectations are expressed and understood
- 4.5. Discuss, define and clarify the OPR-related roles and responsibilities of each working group member.
- 4.6. Discuss, define, and clarify ethical rules for collecting, using, and storing data.
- 4.7. Discuss, define, and clarify rules for accessing and disseminating scientific research materials and publications.
- 4.8. Discuss and clarify benefits of participation in the OPR, for all working group members, from the outset.
- 4.9. Be transparent about challenges that may occur and determine how to address them.
- 4.10. Discuss, define and clarify how working group members should be compensated.
- 4.11. Draft an OPR guiding principles document at the outset of the OPR.

1. FORM AN OPR WORKING GROUP AND COLLECTIVELY ESTABLISH WORK PROCESSES.

Organizational Participatory Research (OPR) is carried out by a core working group of health organization and academic researcher stakeholders.

Health organization stakeholders participating in the working group ought to be representative of all organization stakeholder groups. That is, representatives of those who will need to implement the changes addressed by the OPR, as well as representatives of those who will be affected by the changes (and their potential effects), should participate in research-related decisions, with the academic researcher(s), throughout the OPR.

Literature reviews suggest health organization stakeholders' participation in the decision-making may take the form of being consulted by the academic researcher(s) or co-constructing the OPR with the academic researcher(s) (Bush et al., 2015; Munn-Giddings, McVicar, & Smith, 2008). The decision regarding extent of participation should be that of the working group.

1.1. RECRUIT STAKEHOLDER REPRESENTATIVES KNOWN TO WORK WELL IN GROUPS.

working group members should be willing collaborators, open to listening to others and to compromise.

working group members with divergent opinions, or who challenge the objectives and processes of the OPR may provide relevant contributions.

1.2. RECRUIT WORKING GROUP MEMBERS OF ALL STAKEHOLDER TYPES, INCLUDING MANAGEMENT.

Variety within stakeholder types is also important. This may mean recruiting patients with different socio-economic characteristics, age, and health status; academic researchers from qualitative and quantitative backgrounds.

Stakeholder types should be represented in equivalent numbers.

It may be difficult to achieve such fair representation of all stakeholder types, but this should not stop the OPR process. Some projects begin with a few individuals and recruit others as the OPR gains traction within the organisation.

Relevant management participation is required for the approval of the OPR and change implementation activities, and for the allocation of required resources.

.....
TO RECRUIT SERVICE USERS TO THE WORKING GROUP, PATIENT GROUPS MAY BE A FRUITFUL AVENUE. MOREOVER, HEALTH ORGANIZATIONS MAY CONSIDER MAINTAINING A LIST OF SERVICE USERS INTERESTED IN PARTICIPATING IN OPR ENDEAVOURS.

HEALTH ORGANIZATIONS COULD SET UP COMMITTEES OF ALL TYPES OF ORGANIZATION STAKEHOLDERS, TO RECOMMEND SERVICE USERS FOR OPR WORKING GROUPS.

SERVICE USERS MAY WANT TO ESTABLISH THEIR OWN COMMUNITY OF PRACTICE FOR OPR. IT MAY BE TO THE ADVANTAGE OF FUTURE OPR FOR THE ORGANIZATION TO SUPPORT THIS ENDEAVOUR.
.....

1.3. ASSESS AND RESPOND TO WORKING GROUP MEMBERS' TRAINING NEEDS.

It is essential that all working group members have the necessary skills and knowledge (or the opportunity to get training and improve) to be able to contribute effectively to the OPR.

At the outset of the OPR, working group members should express their needs and determine how to address them.

This may mean providing a research literacy workshop for the non-academic members of the team, OPR training for the academic members, meeting facilitation skills training, or a meeting decorum seminar, to name a few examples.

.....
FOR OPR PROJECTS FOCUSED ON IMPROVING ORGANIZATIONAL PRACTICES
ASSOCIATED WITH A **SPECIFIC HEALTH ISSUE**, IT IS RECOMMENDED TO
RECRUIT SERVICE USER REPRESENTATIVES WITH RELEVANT EXPERIENCE
REGARDING THE HEALTH ISSUE, BUT ALSO AN ABILITY TO TAKE A STEP BACK
FROM THIS EXPERIENCE TO CONSIDER THE HEALTH ISSUE AND ASSOCIATED
ORGANIZATION PRACTICES.

IT IS NOT NECESSARY FOR SERVICE USERS REPRESENTATIVES TO HAVE
EXPERIENCED THE SPECIFIC HEALTH ISSUE, BUT RATHER, TO HAVE HAD
EXPERIENCE WITH IT.

A CARE GIVER FOR AN INDIVIDUAL AFFECTED BY THE HEALTH ISSUE
ADDRESSED IN THE OPR COULD ACT AS A SERVICE USERS REPRESENTATIVE
.....

1.4. ESTABLISH PROJECT MANAGEMENT PROCESSES.

OPR projects require a certain amount of management and coordination to, for instance, call meetings, prepare agendas, write and circulate meeting notes, follow up with people regarding their OPR-related tasks.

Ideally, these responsibilities should be shared between an academic working group member, a member who is from the health organization and one who is a service user. These leaders must have relevant skills and knowledge and be committed to the success of the OPR. This is particularly important for OPR projects that lead to additional projects in the health organization.

Managing OPR in this way is not always possible, nor practical, and academics often assume the project management. It is recommended to develop to a succession plan to transfer project management responsibilities to an individual embedded in the organization and a service user to facilitate the continued work.

Management needs to support these leaders to ensure they have the time and resources to do the work.

Support for the service user leader is also required in the form of financial compensation and material resources (office space and supplies, computer-related resources, etc.).

1.5. SCHEDULE AND HOLD MEETINGS AT REGULAR INTERVALS.

Working group meetings are central to OPR as they provide valuable opportunities for members to discuss, debate, reflect, and develop relationships, helping to drive the OPR and to ensure its relevance to the organization and its members. Working in a participatory way, from the project planning phase and holding meetings regularly is an important part of the overall OPR process and helps to generate benefits over and above the OPR project objectives.

1.6. ENSURE MEETINGS ARE STRUCTURED, FOCUSED AND EVALUATED.

Working group members need to feel the meeting time is productive. This may mean, among other possibilities, beginning each meeting by reviewing OPR actions and results, followed by making informed decisions for subsequent actions.

Meeting agendas should be set and circulated prior to each meeting, and all members should have the opportunity to make modifications or additions.

It is essential to produce and circulate a summary of the working group's discussion and reflections soon after each meeting. Include a summary of decisions and action points that provide precise instructions for specific people, and a timeline.

Ensure working group members regularly complete an OPR process evaluation survey, reflect on results, and implement means to improve their working group processes, including meetings.

1.7. AGREE UPON COMMUNICATION MECHANISMS.

All OPR-related decisions and actions need to be made explicit, written down, and verbally validated with all working group members. One cannot assume that because information has circulated, it has been understood the same way by all members.

Continual checking for understanding is necessary. This may mean beginning each meeting by reviewing the notes from the previous meeting.

It is important to establish how to communicate with working group members who miss meetings, or with organization members not engaged in the OPR. Among other possibilities, this may mean making a log book available in the health organization or posting information on an online message board.

1.8. ESTABLISH MECHANISMS FOR CONTINUITY.

Competing obligations may make it impossible for some working group members to attend every meeting. Also, some may be more likely to get involved if they know they do not have to attend every meeting. Some OPR studies report the value of allowing new members to join the working group during the OPR process, while others report this as disruptive. The working group should discuss and decide what is most appropriate for them and their OPR.

The working group should establish communication means to ensure all working group members remain abreast of activities and engaged in decisions.

Among other options, this may mean videorecording meetings and making them available online or distributing meeting notes soon after meetings.

From the outset of the OPR, the working group should decide how to manage losing members (including academic members) in the midst of a project (due to, for instance, staff turnover, work constraints, health issues, or dissatisfaction with the OPR).

Should the working group decide to replace members who leave, recruiting individuals with equivalent expertise, as well as from the same stakeholder group, is warranted.

2. COLLECTIVELY ESTABLISH OBJECTIVES, ANALYZE DATA AND DETERMINE HOW TO USE OPR RESULTS

A systematic review of the OPR health literature suggests that the research decisions that must be made in a participatory manner pertain to the research question and specific objectives of the OPR, the data analysis and the use of results are crucial (Bush et al., 2015). Participation in other research phases, while not addressed explicitly in this document, can be addressed collectively by the working group, as well. This may mean, for instance, that the working group plans the data collection, identifying, for instance, participants to recruit and how to recruit them, or the type of data to collect and by which means.

2.1. ESTABLISH OBJECTIVES QUICKLY TO HELP BUILD THE COMMITMENT OF WORKING GROUP MEMBERS.

A systematic review of the OPR health literature suggests that if the OPR is initiated by the organization, then the likelihood the OPR will lead to benefits beyond those sought is quadrupled (Bush et al., 2017). All working group members should contribute to defining the precise nature of the OPR to ensure objectives are pertinent to all stakeholders who will be affected by the changes or who will need to implement the changes.

22

2.2. ANALYZE DATA AND INTERPRET RESULTS.

Analyzing data and interpreting results are essential parts of the OPR process. The diversity of the working group members will lend depth and rigour to the process. The academics contribute, among other things, data analysis expertise, whereas, other members contribute, among other things, practical expertise.

Collective data analysis does not necessarily mean that all working group members participate in the technical work of the analysis (e.g., coding qualitative data, performing statistical analyses). With the support of the academics, the working group may decide which types of

analyses are needed (e.g., comparison of groups of participants, changes in variables over time) or comment on qualitative categories such as preliminary themes to help direct the analysis which may be performed by the academics.

Working iteratively, discussing, debating, and reflecting as a group, is necessary. This entails validating, confirming and understanding different points of view, and documenting reflections and decisions.

2.3. IMPLEMENT CHANGES BASED ON RESULTS.

An important advantage of the OPR approach, is that practice changes may be made in the organization as soon as the working group has research results.

Depending on the research methodology used, it is possible for the working group to take actions intended to improve practices based on preliminary results.

The participatory processes can lead to changes in the practice environment and the organization members, which may in turn influence the OPR.

The working group must document changes that are made or occur; reflect on their impact on the organization, its members, and the research itself; reassess the OPR objectives, and determine new ones if necessary or desired.

The working group should also plan and implement a process to evaluate the changes made.

3. ADAPT THE OPR PROCESSES TO THE NEEDS OF THE WORKING GROUP MEMBERS

All working group members must be able to express themselves equally. This means the group should implement informal processes or clear procedures to ensure all members feel at ease and comfortable to express themselves during meetings. It is necessary to adapt OPR-related work to the knowledge, skills, and needs of all working group members. This may mean submitting suggestions in writing prior to meetings.

3.1. ADAPT OPR PROCESSES TO SCHEDULES.

The working group must negotiate how best to accommodate members' different schedules. This could mean (among other options) using video/teleconferencing platforms to enable participation of working group members who are unable to attend the meeting onsite.

3.2. ADAPT OPR PROCESSES TO LANGUAGE AND LITERACY NEEDS.

It is important to share and clarify any specific terms that will be used in the OPR (jargon, symbols, acronyms, for instance). No one stakeholder will understand the technical lexicons of all the other stakeholders, for example.

Steps should be taken to ensure all group members understand what is discussed during meetings and can, thus, participate fully in these discussions.

This recommendation could take the form of several suggestions such as: discouraging the use of acronyms; adapting written and oral language for those whose first language is different than the one used during meetings, or who may have low research or health literacy; using diagrams or any other visual aid such as videos; or any other option the group deems necessary.

3.3. ADAPT COMMUNICATION TOOLS TO NEEDS OF WORKING GROUP MEMBERS.

Some members may have functional limitations (e.g., visual, hearing, or cognitive impairment), others may not have access to computing equipment or the internet. The working group must verify members' communication needs and address them accordingly. To this end, one relevant resource to consult is the Centre for Community organizations (COCO) [Accessibility guidelines for organizers and facilitators](#).

3.4. ADAPT OPR PROCESSES TO WORKING GROUP MEMBERS' SKILLS.

It is not necessary for all working group members to have research skills, but the capacity to analyze and synthesize ideas is an asset. While research skills are not a pre-requisite to participation, they are important to the OPR process.

It may be pertinent to support the development of all working group members' skills in terms of research and the context of the project.

This may mean offering research and OPR literacy training to ensure all working group members understand key concepts, general research processes and methods (e.g., basic statistics, qualitative themes), ethical considerations, publication processes, and requirements for academic promotion.

Academics may need to learn the value of working with non-academics as well as how to respectfully and meaningfully engage with all working group members.

4. COLLECTIVELY ENSURE THE DEVELOPMENT AND NURTURING OF RELATIONSHIPS WITHIN THE WORKING GROUP

Developing and nurturing relationships among working group members can be a lengthy process and requires constant effort. However, this step is key. It is not always possible to devote a lot of time and energy to build these relationships due to conflicting schedules and the demands of research (e.g., funding cycles and timelines). It is therefore, important to incorporate relationship building and maintenance activities into the OPR processes.

4.1. ENSURE RECIPROCITY, TRUST, AND RESPECT WITHIN THE WORKING GROUP.

The working group members must cultivate and nurture an atmosphere of awareness and understanding of one another.

The working group climate must be such that members feel safe to express any thought or feeling they may have regarding the OPR.

To help achieve this, options include: signing confidentiality agreements; conducting team building exercises; enjoying a meal together for fun and fellowship before, during, or following meetings; or using given names, rather than titles (e.g., 'Dr.', 'Professor').

4.2. RECOGNISE, EXPLICITLY, WHAT WORKING GROUP MEMBERS LEARN FROM ONE ANOTHER.

To foster engagement, working group members must regularly express their appreciation for members' contributions and explicitly state what they have learnt from one another.

To this end, some suggestions include: allotting specific time for this in meeting agendas, tasking a group member to note particular strengths of other members and sharing these at selected meetings, or thanking members with greeting cards and phone calls.

4.3. ENSURE POTENTIAL, ACTUAL, OR PERCEIVED POWER DIFFERENTIALS AMONG WORKING GROUP MEMBERS ARE ACKNOWLEDGED AND ADDRESSED.

Power differences among working group members, be they actual or perceived, are inevitable. The group must put all members on the same level and strive to achieve equity in terms of participating in discussions, for example.

The group must address explicitly that all members are on equal footing in terms of their expertise (academic, professional or experiential) and benefit from the same degree of power and influence in the context of the OPR, regardless of the roles they hold outside of this research.

The working group should conduct assessments of its transparency and equity, with validated tools, during the OPR with a goal of continuous improvement.

4.4. ENSURE EACH WORKING GROUP MEMBER'S EXPECTATIONS ARE EXPRESSED AND UNDERSTOOD

All working group members' expectations should be explicit and understood. This may include transparent discussions and decisions about project timelines, required time commitments, and how OPR activities will fit into the schedules of all those involved. The funding source and associated requirements should be made explicit, together with expected results and deliverables. It may be useful to set milestones and circulate them in writing, as needed. The working group must remain flexible and agile to modify or prioritize the specific objectives of the OPR to meet the group's expectations which may evolve overtime and with the renewal of group members

4.5. DISCUSS, DEFINE AND CLARIFY THE OPR-RELATED ROLES AND RESPONSIBILITIES OF EACH WORKING GROUP MEMBER.

The working group must define the roles needed for the OPR and their associated responsibilities.

28

This may include, among others, deciding who will take meeting notes and when they should be distributed; deciding who will analyse data and how results will be communicated; or deciding who will disseminate results, to whom, when and how.

It is not necessary for all working group members to take on a leadership role or to be responsible for specific tasks.

Overlapping or competing roles should be discussed openly and made explicit, together with conflicts of interest, if present.

4.6. DISCUSS, DEFINE, AND CLARIFY ETHICAL RULES FOR COLLECTING, USING, AND STORING DATA.

The working group should define and understand how to handle sensitive or confidential data. For instance, it is necessary to anonymize all aggregated data and the results of analyses before they are sent to the working group.

4.7. DISCUSS, DEFINE, AND CLARIFY RULES FOR ACCESSING AND DISSEMINATING SCIENTIFIC RESEARCH MATERIALS AND PUBLICATIONS.

All working group members must have access to research tools, documents, data, and other materials. It is up to their discretion whether or not they take advantage of this access.

Guidelines for publishing OPR findings should be developed and agreed to in a written contract, particularly when the group decides to not follow typical academic norms (e.g., [“The Tri-Council Policy Statement”](#) in Canada)

All working group members deserve the same recognition for their contributions to the OPR, if they want it

Requirements for intellectual property, collaboration and acknowledgement in publications and presentations (academic or otherwise) must be discussed and adopted by consensus in a meeting (consensus and decision written in meeting notes). They should be negotiated and agreed to in a written contract when the group decides not to apply typical academic norms.

All working group members’ contributions must be described in publications and presentations.

4.8. DISCUSS AND CLARIFY BENEFITS OF PARTICIPATION IN THE OPR, FOR ALL WORKING GROUP MEMBERS, FROM THE OUTSET.

OPR working group members benefit from their participation in myriad ways. For instance, patients may benefit regarding the knowledge they acquire through the OPR regarding their health condition and rationale for certain care practices, health care professionals may improve their working relationships with other organization members, the relationships patients and health care providers develop in the working group may benefit their patient-provider interactions, and all members may experience improved confidence or leadership skills.

Addressing what cannot be achieved through the OPR is also important. Among other things, this may mean clarifying that the OPR is not a context for addressing clinical or social issues of working group members.

4.9. BE TRANSPARENT ABOUT CHALLENGES THAT MAY OCCUR AND DETERMINE HOW TO ADDRESS THEM.

It is important to define a mechanism for working group members to express concerns or grievances they may develop as the OPR progresses, be they ethical, practical, theoretical, methodological, or otherwise.

Among others, challenges may include potential for conflicts of interest regarding patient-provider relationships, strained work relationships, or disagreements about the meaning of results.

Options for addressing challenges include: reporting more than one possible interpretation of results in publications (being transparent regarding diverging viewpoints), communicating with

the university ombudsman, or an ethical review board independent of the institution that approved the OPR.

The working group should determine mechanisms for dealing with dissension (ideally before any dissension occurs). Enlisting the help of an arbitrator may be required at times.

4.10. DISCUSS, DEFINE AND CLARIFY HOW WORKING GROUP MEMBERS SHOULD BE COMPENSATED.

Compensation must be fully addressed during the planning phase of the OPR (e.g., funding or ethical approval applications).

For instance, the following suggestion may be helpful: budget for service users to receive financial compensation for their time, as well as costs incurred for participation (e.g., parking, child care, meals), and plan for honoraria or costs associated with clinicians who are granted leave from professional duties to allow for time to participate in the OPR activities.

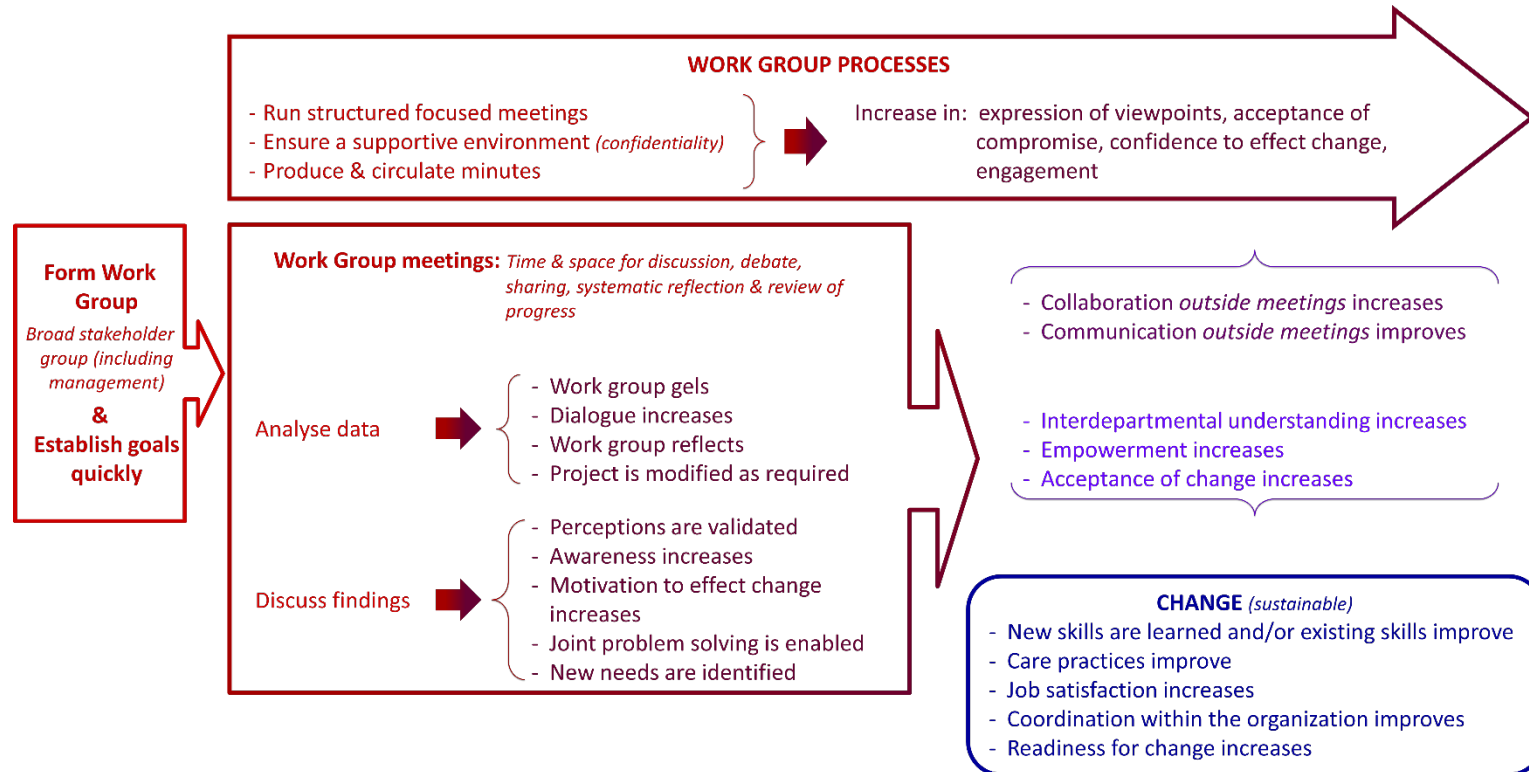
31

Compensation for different group members may be governed by institutional regulations and this should be made explicit at the outset.

4.11. DRAFT AN OPR GUIDING PRINCIPLES DOCUMENT AT THE OUTSET OF THE OPR.

The working group's decisions regarding the recommendations in this practice guide should be written in a document outlining the guiding principles of the OPR. All working group members should agree to the principles, in writing (or provide their informed consent during a meeting when the document is formally presented, discussed and indicated in the meeting notes. The guiding principles may be amended during the OPR, but it is important for the working group to produce a written document of principles, at the outset of their OPR project.

MODEL OF ITERATIVE PROCESSES AND OUTCOMES OF OPR



REFERENCES

- Bush, P. L., Pluye, P., Loignon, C., Granikov, V., Wright, M. T., Pelletier, J.-F., Bartlett-Esquilant, G., Macaulay, A. C., Haggerty, J., Parry, S., & Repchinsky, C. (2017). Organizational participatory research: a systematic mixed studies review exposing its extra benefits and the key factors associated with them. *Implementation Science, 12*(1), 119. doi:10.1186/s13012-017-0648-y
- Bush, P., Pluye, P., Loignon, C., Granikov, V., Parry, S., Repchinsky, C., . . . Macaulay, A. (2015). *How Does Organizational Participatory Research Help Improve Practices? A Participatory Systematic Mixed Studies Review*. Paper presented at the The 43rd annual North American Primary Care Research Group meeting, Cancun, Mexico.
- Friedberg, E. (1997). Local orders : dynamics of organized action. *Monographs in organizational behavior and industrial relations*(v 19), vi, 311 p.
- INVOLVE. (2013). *Briefing notes for researchers*. Retrieved from http://www.invo.org.uk/wp-content/uploads/2014/11/9938_INVOLVE_Briefing_Notes_WEB.pdf
- Israel, B. A., Schulz, A. J., Parker, E. A., & Becker, A. B. (1998). Review of Community-based Research: Assessing Partnership Approaches to Improve Public Health. *Annual Review of Public Health, 19*, 173–202. doi:10.1146/annurev.publhealth.19.1.173
- Kotecha, N., Fowler, C., Donskoy, A., Johnson, P., Shaw, T., Doherty, K., . . . Welton, S. (2007). A guide to user-focused monitoring. *London: Sainsbury Centre for Mental Health*.

- Mercer, S. L., Green, L. W., Cargo, M., Potter, M. A., Daniel, M., Scott Olds, R., & Reed-Gross, E. (2008). Appendix C: Reliability-tested guidelines for assessing PR projects. In M. Minkler & N. Wallerstein (Eds.), *Community-Based Participatory Research for Health: from practice to outcomes, 2nd edition*. San Francisco: Jossey-Bass.
- Munn-Giddings, C., McVicar, A., & Smith, L. (2008). Systematic review of the uptake and design of action research in published nursing research, 2000-2005. *Journal of Research in Nursing*, 13(6), 465-477. doi:10.1177/1744987108090297
- Pollard, K., Donskoy, A.-L., Moule, P., Donald, C., Lima, M., & Rice, C. (2015). Developing and evaluating guidelines for patient and public involvement (PPI) in research. *International journal of health care quality assurance*, 28(2), 141-155.
- Shulha, L. M., Whitmore, E., Cousins, J. B., Gilbert, N., & Hudib, H. a. (2016). Introducing Evidence-Based Principles to Guide Collaborative Approaches to Evaluation. *American Journal of Evaluation*, 37(2), 193-215. doi:10.1177/1098214015615230
- Telford, R., Boote, J. D., & Cooper, C. L. (2004). What does it mean to involve consumers successfully in NHS research? A consensus study. *Health Expectations*, 7(3), 209-220.

