Patient & Community Partnership for Education
informed and shared decision making

THE UNIVERSITY OF BRITISH COLUMBIA
Office of the Vice-President, Health
UBC Health

PRACTICAL GUIDES TO THE INVOLVEMENT OF PATIENTS IN HEALTH PROFESSIONAL EDUCATION

GUIDE 1

Getting Buy-In and Institutional Support, Scaling-Up and Sustainability

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Before you begin

We recommend starting with the Introduction Guide, which provides essential context for getting the most out of this series.

All five guides are available at https://meetingofexperts.org/programs-activities/practical-guides/

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Getting Buy-In and Institutional Support, Scaling-Up and Sustainability

GUIDE 1

1. Introduction

Patient involvement in health professions education (HPE) is frequently initiated and sustained by passionate individuals or small groups without institutional support, at least initially. As time goes on, they look for arguments, strategies and examples to help convince senior leadership to get patient involvement embedded, supported and sustained at the institutional level. Institutional support may be needed for infrastructure, resources, policies, and/or creating a supportive culture. Even those of us who have been involving patients in HPE for many years cannot assume that this work is secure as institutional priorities, finances and leadership change. This guide provides a collection of ideas and examples for i) growing patient involvement beyond the initial enthusiasts and getting the attention and support of senior leaders and decision makers in your institution; ii) sustaining patient involvement in HPE once some level of institutional support has been obtained. Choose the ideas that most resonate with you, your context and the stage of the work at your institution.

2. Understanding the Case for Patient Involvement in HPE (Rationale)

Leaders in academic institutions often want evidence in order to support the implementation of new ideas. Here are some points you can make when you want to convince others of the importance of involving patients in HPE. Find out what matters to those you wish to convince, e.g., benefits to student learning or a desire to be a world leader, and choose your arguments accordingly. Support your arguments with published papers and reports—we have given examples of some of these below and foundational documents are referenced in the Introduction to the Guides. Familiarize yourself with these resources if you need more background.

2.1 A growing movement

Patient and public involvement (PPI) in health care has been around for several decades. Recognition of the importance of PPI in health research has followed and many granting agencies now require evidence of patient involvement in grant applications as well as in the research process. Patient involvement in HPE is more recent but is a logical progression and is now a growing world-wide movement,

not just at a few institutions. The amount of published research increases every year and there are several useful reviews summarizing the progress that has been made, e.g., Dijk et al. 2020, Gordon et al. 2020, Nowell et al. 2023, Towle et al. 2010. The Vancouver Statement, arising out of an international conference in 2015, summarizes the state at that time and identifies calls to action that are still relevant (Towle et al. 2016). Most institutions want to be seen as leaders in the field and the leaders in your institution may not be aware that they are lagging behind.

2.2 Enrichment of education

Patients bring experiential knowledge that helps align HPE with real-world needs and educates students for authentic patient-centred care. Although most educators can easily see the value of students learning from a patient's story, and indeed may bring one of their patients into the classroom to illustrate a particular condition (bringing textbook learning to life), patients have many kinds of experiences that can enrich HPE. Through a review of the literature, Dumez and L'Espérance (2024) identified six categories of knowledge which are acquired progressively over the course of a patient's journey: embodied knowledge, monitoring knowledge, navigation knowledge, medical knowledge, relational knowledge and cultural knowledge. As well as having knowledge about their own health conditions and how to manage them, patients are key informants and expert witnesses of the health care system. We are still discovering the many ways in which patients can enrich HPE for individual learners and at the institutional level.

In terms of learning outcomes, there are several good quality studies that demonstrate how learning from patients leads to transformative learning and other educational benefits for students. See, for example, Gordon et al. 2020, Nowell et al. 2023 and examples in Guide 5. This can be the most compelling argument for leaders in institutions of higher education. There is strong evidence that patients also benefit from being involved in HPE. That may not be a compelling argument for leaders focused on institutional quality, but it is one way for institutions to demonstrate their impact on community (see next section).

2.3 Alignment with institutional missions

Most institutional mission statements or strategic plans have some language that you can use to connect them with patient involvement in HPE. Where possible use the framing and words that are used in these documents. For example, most institutions of higher education have in their mission statements references to social responsibility, social accountability or community engagement. Involving patients in HPE embeds a culture of accountability to the people that health professionals serve, helping institutions become more transparent and socially accountable. Long-term, involving patients in the education of future professionals, who will be in a position to influence health and social care, can help address the greater health disparities experienced by specific populations or communities and counter the epistemic injustice that remains pervasive in health and social care. Short-term, involvement in education yields benefits to the community as patients report increased personal growth and self-efficacy (Kline et al. 2022, Romme et al. 2022).

2.4 Accreditation standards

Accrediting agencies, as the regulatory authorities for health professions education, develop policies that impact every program. Accreditation requirements for patient involvement across various levels in the institution may provide the impetus for systems-level reform (Tackett et al. 2024). Although relatively recent, some health professions across the world have made patient involvement an accreditation standard, and others are likely to follow. All the signs are that this will increase and be a powerful lever for change. Examples include:

- Accreditation Council for Continuing Medical Education (USA): "Patient / public representatives are engaged in the planning and delivery of CME." accme.org/wp-content/uploads/2025/08/626_20251010_Accreditation_Requirements.pdf
- The Canadian Health Standards Organization is developing a new National Standard of Canada on Healthcare Education, CAN/HSO 40001:2026 with some references to supporting the involvement of people with lived experience. healthstandards.org/standard/healthcare-education/
- In 2023, the Australian Medical Council implemented new accreditation standards for primary medical education that significantly increased the focus on patient involvement, particularly through the lens of cultural safety and health equity. www.amc.org.au/wp-content/uploads/2023/08/AMC-Medical_School_Standards-FINAL.pdf



3. A Conceptual Model for Embedding Patient Involvement

For those of you who like conceptual models and a structured approach, the work of Paxino and colleagues may be of interest (Paxino et al. 2025). They introduce normalization process theory (NPT) as a framework to understand how patient and public involvement (PPI) may become embedded in HPE settings. Whilst presented as a linear sequence, the authors caution that this does not occur linearly in practice. In reality, progress is non-linear, emotional, and shaped by trust and relationships. However, NPT provides a framework for understanding routine adoption of a new practice and associated workforce and institutional dynamics. NPT has four core mechanisms, each of which focuses on the types of work people do to embed new practices. Here these mechanisms are presented as conditions that can enable or support meaningful PPI in HPE:

Coherence (conceptual work):	understanding PPI as a different way of knowing and working; collective agreement about the purpose of PPI; individuals understand what PPI requires of them; individuals construct the potential value of PPI for them.
Cognitive participation (relational work):	a key individual is willing to drive PPI forward; there is individual agreement that PPI should be part of work; academic and patient / public participants buy-in to PPI; there is continued support for PPI.
Collective action (operational work):	the necessary tasks for PPI are performed; trust in each other's PPI work and expertise is maintained; allocation of PPI work to individuals is appropriate; suitable support for PPI is provided by the host organization.
Reflexive monitoring (evaluative work):	information about the impact and outcomes of PPI is systematically assessed; PPI is collectively appraised as being worthwhile; PPI is individually appraised as being worthwhile; PPI approaches and work are changed in response to the appraisal.

4. Practical Steps to Getting Buy-In

Building on the ideas described in Sections 2 and 3, here are some practical suggestions for building and maintaining institutional support for patient involvement in HPE.

> *"Start slow to move fast. Laying strong foundations for patient involvement in HPE early on can lead to more efficient, meaningful and sustainable involvement over time."*
> **Julia Paxino**

4.1 Finding allies and building your community

Create space for a conversation, a new idea, a new principle. Start conversations at the watercooler or other informal gathering spaces. Start with a fellow colleague and casually throw patient involvement in HPE into a conversation and wait to see their reaction. Do they know about your work already? Are they interested? Are they already doing something similar?

Find champions and create allies. Create space for conversations to start percolating around the office and outside. Use your networks within the institution to discover hidden or unknown passion for the work. Find out what networks your patient and community partners have and can use: patients cross many boundaries, and are not caught up in, or intimidated by, institutional hierarchies.

Conduct an environmental scan. Use existing communication channels and platforms to find out who else is doing this work at your institution and beyond, e.g., digital bulletin boards, social media, newsletters, circulating a simple questionnaire. Publicize the work that is happening: which conferences are people doing this work attending, and where are they publishing their work?

Connect with relevant units at your institution. Is there a unit responsible for HPE at your institution? Do they have a newsletter or forum where you can present your work? Are there other units who might be interested? For example, an office of community engagement.

Collaborate with others outside your institution. You are not alone. Get advice from those who might be one or two steps further ahead than you. Collaboration with others on projects and grants may add capacity, bring in external funding and get institutional recognition for your work. Widespread access to virtual meeting technology means that patients can also be involved in inter-institutional collaborations and educational initiatives.

> *"Just look for champions and people that think this is important. It takes a lot of time. I think we've been trying to introduce this change for a long time until you find the right people. You don't always have institutional back-up or accreditation standards that will help, but also waiting for that to happen in order to start making change, that doesn't work either. So just start small."*
> **Paula Riganti**

Join a network. Several countries have a network or community of practice that you can join to get ideas, support, resources and, perhaps, institutional recognition. For example, in the UK there is the Doubleday Medical Schools Patient Partnership Collaboration (sites.manchester.ac.uk/doubledaycentre/patient-partnership-medical-schools-collaboration/) and in Canada the Association of Faculties of Medicine of Canada Network on Patient Partnership in Health Professional Education (www.afmc.ca/about).

4.2 Engaging institutional leaders

Do your homework. Identify the key leaders in your institution and assemble the case for patient involvement in HPE which you think will resonate most strongly with them using the ideas in Section 2. From your environmental scan results, review the current situation (Strengths, Weaknesses, Opportunities, Threats): identify strengths, room for improvements, gaps when compared with strategic plans or annual work plans.

Start conversations with leaders. Frame the work forward in a positive manner, cost effective and cutting edge. Position patient involvement in HPE not as a problem they have to solve, but an opportunity to showcase existing achievements, to make senior leadership and the institution look good (nobody at senior leadership levels likes to be a follower). Show that i) these are successes they can make use of, for example, with news stories for the general public, and the tables they sit at; ii) it meets the goals of the strategic plans of the unit and institution; iii) it is the gold standard, and we are leading not following.

Find ways to involve patients in educational activities. Frame patient involvement as a way to meet intended learning outcomes to get buy-in from education program leads. For example, review the curriculum to find where there are learning outcomes that could be met in a more tangible way by patient involvement (e.g., understanding conditions from a biopsychosocial perspective). Involve patients in committee meetings (not necessarily at the curriculum level but at the module, course or individual program level) to normalize involvement and help leadership view patients as valued members of the educational team.

"I would suggest if you were in a situation where you're trying to set up patient involvement, that you work with somebody else, maybe not even in your institute, but make a friend somewhere else that's done some patient involvement, take guidance from them, and run a small piece of work with some patients and carers, and then you can go and present that to the senior management and give them a visible, tangible example that they can understand and let them ask questions. You're more likely to get a yes if you give them something in the first place, rather than just going with an idea." **Jools Symons**

Demonstrate value: the pilot project. Arguments and evidence are useful, but demonstration projects give people a chance to experience what patient involvement actually looks like in practice and can be worth a thousand words. Successful pilots will demonstrate the quality of patient contributions and enthusiastic feedback from students. A well-chosen, carefully designed and rigorously evaluated pilot project may not only convince leaders of the value of this work, but lay the foundations for embedding patient involvement in HPE (See Case Studies in Section 5)

The advice to those starting out:

- Start small, even though your ambitions may be great.
- Seek advice and resources from people with experience.
- Borrow and adapt existing models to your own context. Don't be too worried about being able to implement the exact program in your setting: fidelity to purpose rather than form is key.
- Involve students, faculty and patients in the planning, implementation and evaluation of any pilot project.
- Document as you go: what you do, what goes well, what needs re-thinking. Then publish it for others to learn from, present at conferences, give in-person and virtual talks.
- Create an artefact (article, video, website) that you can promote, share and apply as a lever for building networks and communities of practice.
- Summarize and report evaluation data from all participants in the pilot, which may include data from routinely collected student feedback. For more ideas about evaluation and research see Guide 5.

4.3 Consolidating success

Anticipate roadblocks and reframe. When you start taking it up the leadership ladder you will run into people who feel threatened and respond that: "We don't do that, we've never done that, that's not our way". Create space for them to feel comfortable, to stop thinking negatively and open their ears. Create the buy-in: what's in it for them, make visible what is already happening that they may be unaware of, invite them to be a champion.

Be realistic about costs. Highlight that although patient involvement in HPE does require resources—time, staffing relational work, and money for patient expenses and remuneration—these investments are well justified by the longer-term gains. Being explicit about initial costs maintains transparency and avoids sugar-coating the effort needed, but also allows you to emphasize that thoughtful early investment can ultimately enhance quality, relevance and impact of education.

Identify and address concerns. Separate out perceived (imaginary) and real barriers. Provide examples of how other institutions have overcome them, i.e., provide solutions, refer to examples and case studies in the literature and these guides. Give leadership opportunities to meet students who are enthusiastic about learning from patients and to meet patients who have a wealth of experience to contribute.

Anticipate changes in senior leadership. This is inevitable and can slow down your progress. Mitigate changes in leadership by ensuring you close the loop after any meetings or informal verbal discussions by sending a follow-up e-mail outlining the points discussed—then if leadership changes you have evidence of previous support. Gather information about the incoming leader: know what they have done in the past, what their interests are. Can you reframe your story to connect to their past experiences, vision and priorities?
(See Section 7 on Sustainability).

"Start small, but never stop. It's about showing what difference you can make. Of course, you can aim for the stars. But if you can start with a small group, get your faculty on board there, or your institution on board there, and the story will tell and sell itself." **Matthijs Bosveld**

5. Growing and Sustaining Patient Involvement: Four Examples of Journeys over Time or How One Thing Leads to Another!

5.1 Case Study: Université de Montréal

Annie Descoteaux and colleagues at the Université de Montréal describe the changing role of patients in the program from providing one-off idealized testimonials to sustained, reflexive, real conversations that bridge the student-patient gap (Descoteaux et al. 2025). Patient partners who were initially matched to disciplines based on their lived experience are now paired more flexibly to support interprofessional learning. With clinical co-facilitators the patient's role has evolved from reactive participation during workshops to active co-creation, promoting the democratization of exchanges and shared responsibility for the program's educational content. Factors that enabled this shift included sustained institutional trust and commitment, and long-term involvement of patient partners, some of whom have been involved longer than most course teachers. The Faculty of Medicine Patient Partner Office has played a key role, recruiting patient partners, offering training, and providing ongoing support. Long-term involvement of patient partners allows cross pollination across the 13 disciplines involved, through sustained and interdisciplinary engagement (navigating silos in education as they navigate silos in health care). The evolving role of patient partners requires the acquisition of new skills: delivering a well-rehearsed story is one thing, facilitating dynamic unpredictable sessions is another—but the shift mirrors real-life situations. Progress has been largely through trial and adjustment, learning from each other and allowing productive mis-steps.

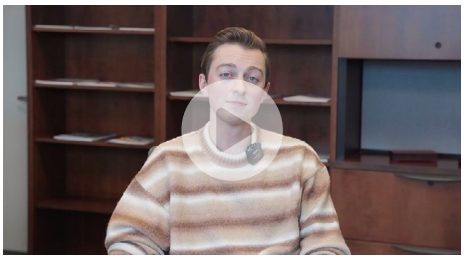
TIP:

We must allow ourselves time to 'grow together'. Continuity enables trust to be built, leading to increased confidence and creativity, courage to experiment and boldness in continuous quality improvement processes. (Descoteaux et al. 2025)

5.2 Case Study: University of Maastricht

In this video clip Matthijs Bosveld describes how the patient partner program was started by students, how it grew and how they got buy-in from the institution. mensachterdepatient.nl/english/default.aspx

VIDEO: learning.media.ubc.ca/media/Guide+1%2C+Clip+1+-+Matthijs+Boseveld/0_ocer2s4r



TIP:
Harness the power of student enthusiasm and learning. (Bosveld et al. 2023)

5.3 Case Study: Stanford University

(Kim Osborn, Jesse Rokicki-Parashar, Erika Schillinger)

The Patient & Family Engaged Medical Education program is the administrative home for innovations in patient involvement in elective courses and programs at the School of Medicine. Our goal is to include patient and family perspectives at the exploration, development and implementation stages of curriculum design. We focus on small, controllable pilots that have the potential to scale within required courses or across the medical education continuum. The program maintains a flexible administration and planning approach that is responsive to stakeholder feedback and changes in internal and external environmental factors.

The program developed from a Dean's Office mandate to increase early clinical exposure for medical students. Medical students were placed into community and university clinics and would participate in care as they learned through health coaching, scribing, conducting home visits and population health e-management. These pilots showed the importance of relationship-building with internal and external community partners, and revealed challenges of sending learners into the community. However, limited clinical capacity affected our ability to responsibly scale these efforts while maintaining clinical-education program relationships and minimizing impact on patient care. Subsequent innovations were developed in response to student feedback that these experiences were valuable but provided limited opportunities for authentic interactions with patients, families and caregivers, and there was still an unmet need for settings in which they could discuss the lived experience of navigating a complex health care system while living with chronic illness.

In 2017, we developed the *Walk with Me* course which became the flagship offering and 'front door' to learner, student and faculty engagement with the Patient & Family Engaged Medical Education program. This course pairs first-year medical students and physician assistant students one-on-one with a patient over the course of three academic quarters and is aligned with an MD program Early Clinical Experience graduation requirement. It has since transitioned to a selective course that students may choose to meet this requirement. This alignment has provided enrollment stability and continued leadership support. We have sustained leadership engagement through thoughtful cost-sharing across business units, shared best practices and administrative support. Particularly useful has been a 'follow the faculty' model of administration, which leverages a flexible, lean staffing structure in the division to support faculty efforts to include patients across administrative silos, in division-supported elective courses and improvement efforts, and in their patient-involved teaching and improvements in other departments.

Patient & Family Engaged Medical Education programing now serves as the education pillar of the *Patient & Family Involved Innovations* strategic initiative within the Division of Primary Care and Population Health. Early work to involve patients in education has been supported and championed by division leadership and has been elevated to a stated value in the division, with active projects in pre-health education, faculty professional development, quality improvement and medical education research that aim to involve patients, families and community members across these domains. One exemplar innovation is the Patient & Family Involved Medical Education Seed Grants program, which serves as an innovation incubator by providing small financial incentives and administrative guidance to faculty who wish to update a course or program to include authentic patient involvement. These grants have resulted in increased faculty and learner involvement and broader uptake of patient and family involvement within the division and the school.

This work has also catalyzed conversations and new partnerships focused on transparency in health care and destigmatizing language in medicine. The program is not the only effort to involve patients in teaching, but such practices have historically existed in isolated pockets of engagement across the school. Over a decade since its first pilots, the program is now showing a return on that investment as those students and faculty who have been involved in our programs continue their practice as collaborators and capacity-builders for patient involvement across our school and at other institutions.

TIP:

Small seed grants encourage innovation, build capacity and raise the profile of the work.

5.4 Case Study: University of British Columbia (UBC)

The Interprofessional Health Mentors Program (HMP) is a longitudinal elective program for students from ten different health professions who meet in small interprofessional groups eight times over the course of an academic year with a health mentor who is someone living with a chronic condition or disability, or is a caregiver (Towle et al. 2014). We borrowed the idea from Dalhousie University, who generously shared their successes, challenges and lessons learned. We adapted the program to give greater autonomy to the health mentors, minimize the influence of faculty, expand the range of topics for discussion, and limit the number of students participating by making it an elective. We set up a planning committee of students, patients and faculty and ran the first pilot in 2011. It has proved to be a flagship project that keeps giving. From the beginning, the program powerfully demonstrated transformative student learning to the faculty who read the students' reflections after each meeting and came to the end-of-program symposium where students shared their learning and enthusiasm through creative displays. It also helped to fill curriculum gaps in interprofessional learning and health advocacy. This buy-in by faculty champions was key to ensuring ongoing funding and institutional commitment, not only to the HMP but to patient involvement in education more broadly and, more recently, in other roles at the institution.

The degree of autonomy given to the health mentors to make the program their own, and evidence that they have an important role in shaping the hearts and minds of the next generation of health professionals has led to long-term commitments. Many health mentors have been with the program for years and have also got involved in activities beyond teaching students, such as curriculum development, adjudicating awards, planning a new team-based teaching clinic, sitting on hiring committees and co-presenting at conferences. The longevity of the program, now in its 15th year, has allowed us to study and publish research to demonstrate the lasting benefits to students and patients. Beyond UBC, we have supported dissemination of the HMP model and witnessed its successful adaptation to other countries and contexts, including Brazil, Argentina and Switzerland.

TIP:

Borrow and adapt good ideas: "steal shamelessly".

6. Scaling-Up Patient Involvement in HPE

If you are successful in getting patient involvement recognized as important and beneficial for student learning you may find yourself faced with increasing demands. In some countries, HPE programs are seeing increased numbers of students, and often this means that education has to occur across wider geographic areas in order to provide capacity for clinical education. So, you may be faced with the double challenge of increased numbers of students and distributed education. This may lead to a tension between quality and quantity, but there are also opportunities. Having learners in sites other than the main campus creates a need to recruit patients from local communities. Their experiences may be quite different from patients who have been involved previously and so expand the range of perspectives. The use of on-line virtual meetings has facilitated learning across distances, and makes it possible to include those living in rural and remote areas.

In addition, once the value that patients bring to education is recognized, you may find an increased demand for patients to play roles other than simply sharing experiences with students. For example, for assistance with curriculum development, assessment, sitting on working groups, committees, etc. Having a dedicated person and/or unit is necessary to scale up and move beyond passionate individuals. Development of a community of patient educators will also become necessary to meet and sustain increased demands (See Guide 2, Section 7 Building a Patient Partner Community). Also important is to build the capacity of academic educators to include patients in their teaching through faculty professional development.

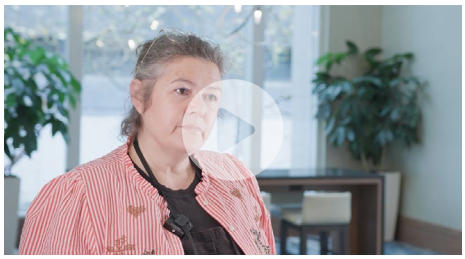
TIP:

Develop resources and policies that can be scaled-up and used across different contexts (e.g., geographical or different HPE programs) to promote quality assurance and reduce duplication of effort and workload as you scale-up.

7. Sustaining Patient Involvement in HPE

Sustaining patient involvement is an on-going process because of changes in institutional priorities, leadership, curriculum, finances and external factors in the environment. In this video clip Jools Symons from the University of Leeds summarizes the challenges and some solutions.

VIDEO: learning.media.ubc.ca/media/Guide+1%2C+Clip+2+-+Jools+Symons/0_2mxtxf23



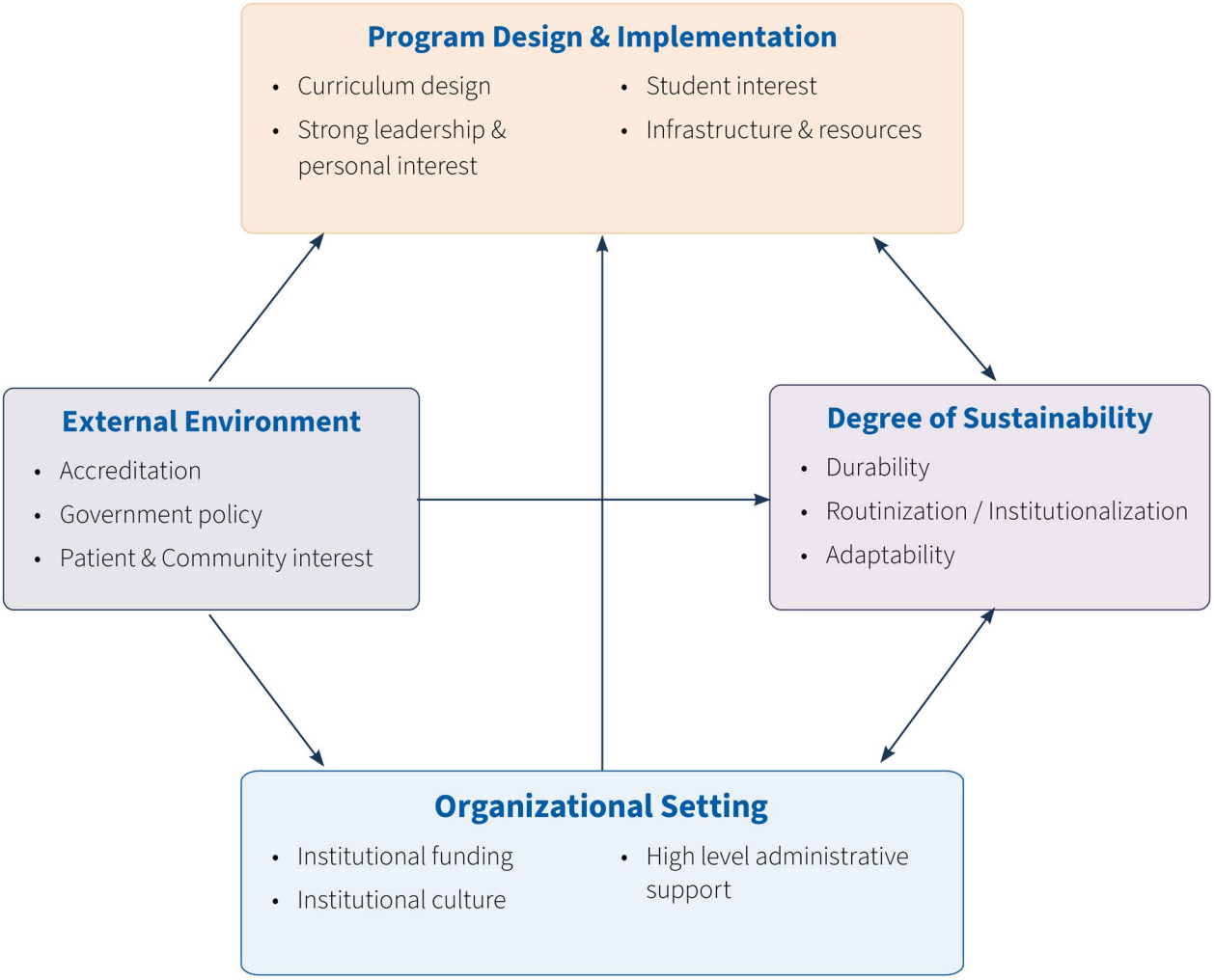
7.1 A Conceptual Framework for Sustainability

Adapting Vogel's 2009 model of sustainability to patient involvement in HPE (Towle et al. 2020), we can identify three degrees of sustainability:

- **Durability:** the program continues without additional support at an institutional level; it survives but has not grown and may have shrunk.
- **Routinization / institutionalization:** the program continues within an organizational structure. Routinization occurs when a program has become a regular and stable part of an organizations' routine activities; institutionalization has the characteristics of routinization but also includes policy and infrastructure support.
- **Adaptability:** the program has led to other initiatives within the institution and beyond.

At UBC we have sustained patient and community involvement in HPE for over 20 years (see also Case Study 5.4). Adapting Vogel's 2009 model, we have identified three major groups of factors that are influential in sustainability: factors in the broader external environment; program design and implementation factors; factors within the organizational setting (Towle et al. 2020). Figure 1 illustrates how these factors interlink to lead to sustained programs of activity. We give examples of each of these factors below and illustrate how they have played a role in sustaining work at UBC.

Figure 1: Conceptual framework for sustainability of patient involvement in HPE (Towle et al. 2020)



7.2 Sustainability factors: external environment

- **Accreditation:** in the context of HPE this is the most powerful external driver for change (see Section 2.4).

> **UBC EXAMPLE:** the introduction of accreditation requirements for interprofessional education in several health professional programs in Canada provided an opening to design new curriculum that included patients.

- **Government policy:** are there policies that encourage or demand patient and public involvement in health care and/or health research that you can link to?

> **UBC EXAMPLE:** a movement relevant to our work has been increased public scrutiny of higher education which has led universities to reaffirm their commitment to preparing students for engaged citizenship, changing social and economic inequalities and to contributing to their communities as place-based institutions. In many universities, community engagement has become integrated into core missions of teaching and research, and is manifest through their strategic plans. Such has been the case in the last two UBC strategic plans.

- **Patient and Community interest:** ongoing interest from individual patients and community organizations is critical. Individual patients are motivated to 'give back', to improve care for others and/or to influence the future of health care (see Guide 2 for ideas on how to build and sustain a community of patients committed to long-term involvement in HPE).

> **UBC EXAMPLE:** we discovered that the mission statements of many patient advocacy organizations include reference to the education of health professionals. For community organizations engaging with the university can offer both short-and long-term benefits. However, many organizations are under-resourced and have other urgent priorities and they must decide how much effort to put into their participation in HPE—is it a one-off, or has it long-term potential that needs to be built into work plans? For sustainability, mutual commitment to reciprocal long-term relationships is essential.

7.3 Sustainability factors: program design and implementation

- **Curriculum design:** various aspects of curriculum design may be relevant, including purpose and philosophy; design and governance principles; variety and flexibility; and quality assurance. Some of these are not only important for sustainability of programs but for sustaining patient and community interest.

> **UBC EXAMPLE:** our work is underpinned by the philosophy and practice of informed and shared decision-making, both in health care and in the design and implementation of HPE. Putting shared decision-making into practice we follow the principle of involving students, faculty and patients in everything we do, although we are flexible in the ways we get input. Co-creation of the educational design ensures relevance and buy-in.

- **Strong leadership and personal interest:** strong leadership is an important factor in implementing all educational innovation. Most patient involvement in HPE comes from the enthusiasm and commitment of individuals or small groups, although this is not sustainable in the absence of other factors.

> **UBC EXAMPLE:** leadership came from two faculty members who were recognized in the field of shared decision-making. Through previous leadership roles they had forged connections with many faculty in the different health programs and earned credibility (social capital).

- **Student interest:** Students can be great advocates for patient involvement in HPE and play an important role in sustainability through their interest, motivation and feedback on positive experiences.

> **UBC EXAMPLE:** student enthusiasm for transformative learning with and from patients is demonstrated in various ways, including through conventional evaluation surveys, reflective journals, creative artistic displays, video testimonials and student-initiated projects.

- **Infrastructure and resources:** Sustainability is greatly enhanced by having an institutional home for the work and a dedicated patient / community coordinator role who can span and bring together the two worlds of academia and community.

> **UBC EXAMPLE:** we have developed a number of approaches to build and maintain relationships in the community and university that foster long-term commitment for sustainability. A monthly newsletter keeps everyone connected and raises the profile of the work.

7.4 Sustainability factors: organizational setting

- **Institutional funding:** sustainability would be impossible without some degree of institutional funding. This may initially be in the form of small grants that are available for educational innovation or community-based initiatives. The challenge is to find ongoing funding to sustain successful innovations when project funding ends which requires commitment from senior leadership (see Section 4).

> **UBC EXAMPLE:** we have had some success working with university fundraisers to find support from corporate or alumni donors. For example, we were able to pilot a community engagement coordinator role as a proof of concept, which proved so valuable that it was subsequently core-funded by the university.

- **Institutional culture:** institutional culture is manifest through university policy, strategic plans and stated commitments, for example to social accountability or community engagement. Sustainability is enhanced if you can align your work with whatever relevant institutional policies there are, including adopting the same words as appear in strategic plans. Demonstrate how your work is a successful and practical demonstration of university policy. Two key indicators of institutional support and commitment are workload allocation (the recognition that patient involvement work is part of someone's job description and not off-the-side of their desk) and recognition of the importance of this work (through awards, academic promotion). See Appendix for examples from the University of Western Sydney related to community (patient) engaged learning.

> **UBC EXAMPLE:** UBC has made commitments through its strategic plan to community engagement and student transformative / experiential learning which we have used to legitimize the work we do.

- **High level administrative support:** perhaps you have succeeded in getting institutional buy-in and are fortunate to have a home and infrastructure for patient involvement in HPE. The challenge then is how to sustain this in the face of turnover of leadership, loss of champions (through retirement or relocation), institutional reorganizations and/or funding cuts. Sometimes the work can advance quickly and sometimes you are in a maintenance phase where your allies and champions become especially important.

> **UBC EXAMPLE:** over the years we have experienced many changes of leadership and re-organizations which have made it necessary to re-make the case for the work, and to re-align it with changing institutional priorities.

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Appendix

Examples of Best Practice Position Description and Recognition from the University of Western Sydney

Example 1: **Position Description:** School of Medicine Senior Lecturer, Community Engaged Learning

Selection criteria:

1. A PhD in a relevant area, or combination of relevant professional qualifications and significant experience in medical/health professional education.
2. Teaching expertise in one or more core areas relevant to community engaged medical education, including health professional training programs, public health, social sciences, medical humanities or research methods.
3. Demonstrated experience in quality teaching at tertiary level, including extensive experience in education programs relevant to community engagement; such as ability to facilitate learning in small and large groups; experience contemporary methods of curriculum design, development, delivery, and assessment (including the use of e-learning methods) and providing pastoral and academic support to students.
4. Demonstrated capacity for high quality research output and experience in applying for external research funding.
5. Excellent oral and written communication skills, including interpersonal skills, and the ability to work collegially and effectively in a team.
6. Demonstrated experience in working with the community sector or within a community development/ community engagement framework; including leadership skills in building positive relationships with a broad range of relevant stakeholders, or demonstrated capacity to undertake these activities.
7. An understanding of the complexity of the Greater Western Sydney community [i.e., the local region of the university] with demonstrated ability to network and consult effectively and to negotiate mutually agreeable outcomes.
8. Program management experience demonstrating an ability to effectively implement, manage and ensure the smooth running of a program.
9. Undertake risk management and actively support and participate in the risk management processes adopted by the University which include identifying, analysing and evaluating risks that may impact on the University.
10. Demonstrated understanding of the principles of anti discrimination, staff and student equity, occupational health and safety and other relevant legislation, and the willingness and capacity to implement equal employment opportunity and occupational health and safety plans, policies and programs.

Example 2: **Vice Chancellor's Excellence in Service Award** www.westernsydney.edu.au/excellence-awards

Selection criteria:

This award recognises an individual or team that has delivered meaningful impact. It encourages applications that demonstrate the importance and benefits of the University's outreach activities to the University, community, and business.