Article

A Descriptive Account of an Inter-Professional Collaborative Leadership Project

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Abstract: A collaborative project between an academic healthcare faculty and a professional development director resulted in the design, delivery and evaluation of an inter-professional collaborative leadership workshop with ongoing leadership development activities. The workshop attendees were five inter-professional teams from one large, urban cancer care center in Taipei, Taiwan. The workshop included didactic instruction complemented with team discussions and interactive exercises. Continued practice was encouraged, such as appreciative inquiry exercises and rotated team leadership. Evaluation involved the use of a cross-culturally validated collaborative practice tool and follow-up interviews and focus groups. Although the formal workshop was a 1-day session, continued organizational support and systematic approaches to collaborative leadership practice in clinical settings were necessary components for transfer of learning from the workshop to real life. This paper will include an overview of the foundational leadership concepts covered in the workshop. The instructional strategies, evaluation methods and outcomes will be discussed. The limitations

and strengths of this collaborative leadership project will be provided, as well as future plans for a collaborative leadership development program.

Keywords: inter-professional; healthcare; collaborative; teamwork; leadership development

1. Introduction

Leadership development is considered a wise organizational investment, but despite the billions spent on it, many organizations have little evidence of return on their investment [1]. A variety of explanations exist in the literature, including lack of executive-level engagement [2]. Healthcare organizations, for instance, are structurally rigid with hierarchical chains of command that are reinforced by the siloed role socialization that separates the healthcare disciplines from one another in training and practice [2]. Leadership development requires executive-level commitment to shift the pervasive culture to a new, collaborative way of thinking and doing. An aim of this leadership development project was to ensure executive-level engagement throughout the planning, implementation and evaluation phases. Approximately three years ago we began a conversation with executive leadership to identify the leadership development needs of one, large urban cancer center in Taipei, Taiwan. The CEO and President of the organization is a physician who oversees strategic planning, operations and budget. Two other individuals, the Director of the Palliative Care Team and the Chief of Psychiatry, were also involved in leadership development planning. A qualitative needs assessment was conducted with the organization's executive officers. Needs assessment is considered a leadership development best practice [3]. Organizational leaders should be engaged in developing clear objectives for leadership development that aligns with overall business strategy; and leaders should be queried to determine the organizational presence or absence of key elements associated with effective leadership. A qualitative approach was used whereby the executive leaders were interviewed to determine their vision for strategic leadership development; and they were asked to identify key leadership competencies needed at different levels of their organization. A content analysis of interview data was conducted to establish a consensus among executive leadership with respect to project goals and curricular content. Needs assessments should include internal and external perspectives [3]. In this instance, an internal analysis of executive leaders' perspectives of organizational needs was combined with external evidence from the literature of best leadership practices. Transfer to practice is "smoothed" when key internal stakeholders corroborate the organizational applicability of evidence-based leadership practices [3].

The content analysis revealed that executive leadership wanted to instill a values-based approach to leadership throughout the organization, focusing at the team level: "more collaborative leadership within teams." What was apparent was leaders' desire to return to their core values. They saw teams of healthcare providers as the vehicle for making a paradigmatic shift from acting in disciplinary silos to engaging collaboratively in the important work of the organization—"caring for patients and their families". To get there, we recommended a "scaffolding" approach to leadership development that is akin to the scaffolding or cognitive supports used by adult educators to promote deeper thinking and critical reflection [3]. We suggested starting with individual team members' self-development, followed by collaborative team development, then collaborative leadership development within teams, and finally

connecting teams in networks across the organization. As described in the literature, once a leader has an appreciation of their core values and is committed to this value set, it becomes easier to bridge individual meaning and purpose with collective values of a team or an organization [4]. The more an organization's core values are appreciated and shared, the stronger the culture of that organization—*versus* an organization with vagueness, inconsistency, and lack of shared purpose [5]. Changing a culture, therefore, requires that core values are identified, discussed and aligned, and this precedent needs to be set by organizational leadership [6].

A focused literature review of the healthcare and leadership literature was conducted with terms derived from the needs assessment, particularly "collaborative teamwork", "collaborative leadership", and "values-based leadership". Based on our review, we identified concepts that theoretically "fit" the needs assessment themes; concepts that we were able to map to our proposed continuum of leadership development from "I" to "we" leadership. The following section of this paper will provide evidence that links these concepts to collaborative leadership development (*i.e.*, leader self-development → collaborative teamwork → collaborative leadership within teams). The key concepts we chose to highlight are: emotional intelligence, authentic leadership, self-development, collaborative teamwork, and collaborative leadership (in teams and organizations). We designed a 1-day workshop to familiarize inter-professional (IP) teams to these key concepts, and we included other workshop content, such as team appreciative inquiry and team innovation/project management to support the application of key concepts to leadership practice within the organization. Time was allotted for interactive exercises and team discussions. To promote post-workshop leadership development, team members were instructed to maintain individual, self-reflection journals (leader self-development); to practice team appreciative inquiry during regularly, scheduled team meetings (collaborative teamwork); and to rotate formal team leader responsibilities on a regular basis to promote leadership skills among all members (collaborative leadership within teams). In addition, executive leadership was asked to regularly meet with teams to discuss IP team progress with respect to their expectations for enhanced collaborative teamwork and leadership within the organization.

Some research has indicated that power distance differences in cultures can influence team preference for leadership styles [7]. In cultures, such as Asian cultures with high power distance between leadership and staff, leaders are expected to be directive—participative styles are not viewed positively. We addressed this concern with executive leadership, and they noted that one of their organization's explicit cultural expectations is more egalitarian teamwork and leadership among disciplines.

2. The Workshop

The purpose of the workshop was to prime leaders for a shift from "I" leader development that focuses on the individual leader to "we" or collaborative leadership development [8,9]. The following sections provide theoretical and empirical evidence for chosen workshop content and instructional processes.

2.1. Key Concepts

2.1.1. Emotional Intelligence

Increasing evidence supports the importance of emotionality and emotional intelligence abilities among leaders. There is evidence that emotionally intelligent leaders achieve superior outcomes in a variety of contexts (e.g., manufacturing, service, sports, technology, self-managed teams) [10–12]. Leadership is emotion-laden work, particularly in complex healthcare systems with multiple, daily stressors related to quality, safe care delivery and frequent life/death decisions.

The emotional intelligence (EI) work of Mayer, Salovey and others [13–15] has shown that there are four specific abilities (*i.e.*, perception, use, understanding, and management) that help people effectively deal with their own and others' emotions [12]. Individuals must have the ability to correctly perceive the emotions they are feeling and to accurately perceive others' emotions. The ability to use emotions is based on knowledge of how emotions influence cognitions and behaviors. The ability to understand emotions signifies that an individual can grasp the antecedents and consequences of emotions, and the ability to manage emotions involves regulation of one's own and others' emotions to attain specific goals. Affective Events Theory (AET) provides a useful framework for explaining how emotions, thoughts and behaviors are connected [11,16]. Emotions are triggered by affective events that result in cognitive appraisals and resultant behaviors. Emotions, therefore, are the drivers for feelings, thoughts, and actions. Individuals can be trained to recognize their own and others' emotions, to appraise the situation based on their knowledge and understanding of emotions, and critically consider how to best manage their emotions/others' emotions for best possible outcomes. A related concept is emotional contagion [17] whereby reciprocal transfer of emotions occurs between leaders and team members. Positive emotional work climates arise, for instance, when leaders express positive emotions to their team (e.g., enthusiasm, excitement), and team members reciprocate with similar positive emotions. Positive work climates are associated with greater productivity [18]. Conversely, punitive, autocratic leader behaviors can trigger team members' distress; negative leader-team exchanges feed off each other, creating a toxic work climate [19]. Regulation of the emotional work climate is a complex phenomenon that requires leader EI.

2.1.2. Authentic Leadership

If team members sense ingenuity or faked emotions among their leaders, they rate these leaders as less effective [11]. One leadership style associated with genuine, sincere emotionality is authentic leadership [20,21]. Authentic leaders "discover and construct a core sense of self" by knowing their own values, emotions and beliefs, and by recognizing how their positive and negative attributes influence their behaviors and others [22] (p. 1120). Our chosen definition of authentic leadership is: "a pattern of leader behavior that draws upon and promotes both positive psychological capacities and a positive ethical climate, to foster greater self-awareness, an internalized moral perspective, balanced processing of information, and relational transparency on the part of leaders working with followers, fostering positive self-development" [23] (p. 94). This definition of authentic leadership particularly resonates with our partner organization's executive leadership: They have been witnessing moral distress among their healthcare providers due to public cynicism and government pressures on the Taiwanese healthcare system. During our needs assessment, one executive leader commented, "We need to re-instill in our

leaders their true moral compass-their professional code of ethics—the reason why they became doctors and nurses." A solid foundation of moral, ethical values provides stability and consistency for leaders and their team members [20]. In one study with managers and their direct reports [24], authentic leadership behavior was associated with higher levels of worker engagement and organizational citizenship behaviors. Mediators were worker empowerment and identification with the leader. There is considerable research that documents significant associations between leader authenticity, worker engagement, and positive well-being [22]. Authenticity is the kind of leadership that can restore individuals' confidence in themselves and whose actions, in turn, can positively transform others into authentic leaders [25].

2.1.3. Self-Development

Leadership development should be based on progressive skills development where changes in information processing and construction of more sophisticated knowledge structures result in advancement from novice to expert leadership skills levels [8,9,26]. Leadership development depends on the intrinsic motivation to continuously learn and develop as a leader. Authentic leadership development requires "ongoing processes whereby leaders and followers gain self-awareness and establish open, transparent, trusting and genuine relationships, which in part may be shaped and impacted by planned interventions such as training" [21] (p. 322).

Leadership development begins with self-development and the construction of an identity as a leader [25]. The field of positive organizational psychology advocates for a "reflected best self" (RBS) approach that promotes positive attributes [27–29]. The journey of self-identity construction has been framed as clarifying one's own personal values and finding one's voice [30]. This transformation occurs in relation to others [31]. Positive self-reflections with feedback from others can be used to create an RBS that serves as a foundation for leadership development. As the RBS evolves over time, a positive *versus* negative perspective may act as a buffer against "jolts" in the environment that often derail leaders. Leaders with RBS approaches are also more likely to respond to jolts and critical incidents with constructive *versus* destructive responses [9,27,32].

One self-development approach is to create a unique narrative or a story about oneself to tell to others. Narratives recount how core values guide an individual through different times and events: Others' responses to the story assist individuals, such as leaders, to craft a story that is appealing to others' values and beliefs. Authentic leaders develop stories that are genuine and congruent with their core values. Stories often unfold around "trigger events" that are particularly relevant to the leader with respect to how they acted according to their core values. One way to promote authentic leader self-development is to encourage leaders to write a story based on positive trigger events in their lives [33–35].

2.1.4. Collaborative Teamwork

Teams are the basic functional unit of healthcare organizations and an ideal environment for *in-situ* leadership development [9,36,37]. Teams are the "strategy of choice within organizations confronted with complex and difficult tasks" [38] (p. 540). Collaborative teamwork within IP teams has been linked to better efficiency of service delivery and resource utilization [39,40]. Collaborative teamwork is enhanced through shared common goals, shared exchange of critical information, multiple interactions,

knowledge of each other's roles and responsibilities, symmetrical or shared power, and organizational support [41]. Organizational support in the form of educational forums and workshops is especially important since the individual disciplines are typically educated in siloed professional programs [40,42]. Effective leadership acts as a catalyst for building team trust and respect as a collective [40,43,44].

Effective team communications are associated with quality, safe care delivery and a shared sense of teamwork [44,45]. "Communication is the currency of collective leadership" [46] (p. 936). Communications are necessary to share critical information, delineate team parameters (e.g., who does what), and establish the team climate. The leader is needed to ensure that team members have a voice in team processes (e.g., decision-making); to set expectations around collaboration; and to facilitate frequent communications exchanges [46]. There are three forms of constructive leadership language that can be trained and practiced in dyads, teams or other social contexts. These forms include direction-giving language (e.g., clarifying goals, expectations); meaning-making language that communicates values; and empathetic language that imbues communications with positive affect. Authentic leaders use all three to enhance collaborative teamwork [46,47]. The leaders' influence over team communications may be more important for diverse teams such as IP teams, because team members prefer to talk with others who share a similar language and understanding (e.g., within disciplines *versus* across disciplines). To enable communications among diverse team members, a leader must establish common ground via shared goals and expectations [48].

There are specific communications strategies that are key markers of collaborative IP teamwork and they can be taught and reinforced through a variety of training modalities (e.g., case-based discussions, role play, simulations). Some communications tools that systematize exchange of critical information and raise team awareness of critical contextual cues are evidence-based checklists and SBAR-R (situation, background, assessment, recommendation, response) tools [45].

Collaborative teamwork also depends on an appreciation of one another's skills and abilities. Task assignment and negotiation among team members and the leader is expedited when legal scope and competencies are clear [49]. Lack of scope and role clarity has been associated with significant breakdowns in team communications [50]. As with other complex systems, healthcare providers work more effectively together when they can negotiate with one another about how to best meet patient needs. In a patient-centered culture, once patient needs have been determined, decisions need to be made about who is best suited (*i.e.*, most clinically competent) to carry out certain patient care interventions. These types of negotiations operate most smoothly when team members understand each other's roles and responsibilities and are comfortable with the patients and each other's practice.

A positive, collaborative work climate is more conducive to efficient, effective team negotiations. Negativity can shut down team discussion and negotiations. In one qualitative study with nurses, negative emotions of frustration and anger limited team negotiation [51]. These researchers found that within intra-professional nursing teams, clear communications, knowledge of each other's legal scope of practice (e.g., roles and accountabilities) and respect for each other's contributions to the team were paramount to quality, safe care delivery [51].

There are two broad categories of conflict that can occur within teams; emotional and task conflict. Emotional conflict is typically interpersonal and it often follows from negative emotions, such as anger and frustration with others. Task conflict occurs when team members have different perspectives on how to carry out a task. Both types of conflict can negatively influence team performance, depending on

leader-team approaches to the conflict. A leader's response to conflict can influence team affect [52,53]. In one study, "pragmatic leaders" emphasized super-ordinate team goals and interdependency. These focused on the team or collective, they guided discussion that minimized the presence of negative emotions, and they garnered team commitment to shared decisions [52]. Another study demonstrated the situational nature of team leadership styles with respect to the type of conflict: A leader should use a relational style to address relational conflict and a transactional or task-oriented style to address task conflict [54]. These findings emphasize the importance of EI: Leaders must be able to read team cues to know how to appropriately respond to conflict.

Complexity theory has been used to study relationships within teams [55,56] and organizations [57–60]. One ethnographic study of an IP transplantation team described different disciplines as "constellations of intersecting units" whose degree of "coupling" influenced their capacity to adapt and respond to team task demands [55]. Coupling refers to the contrast between autonomy (loose coupling) and interdependence or team responsiveness (tight coupling). Disciplines often exert their autonomy via their unique legal scopes and roles and accountabilities, while in teams, tighter coupling or interdependence is a requisite for building a shared mental model (*i.e.*, shared cognitive structures and knowledge) and team cohesion. A "back and forth" can ensue between autonomy and inter-dependence, and without leader guidance, conflict can arise between these two points on a coupling continuum. Effective leaders craft team tasks that effectively utilize members' expertise, while reinforcing more tightly coupled team activities with respect to information-sharing, communications, problem-solving and decision-making. From a complexity standpoint, collaborative teamwork represents a team's capacity to respond as a single constellation rather than as autonomous providers [55].

2.1.5. Collaborative Leadership in Teams and the Organization

In complex work environments, collectivistic forms of "we" leadership are considered more effective than single "I" leader approaches [9,61–63]. "We" leadership is a dynamic form of leadership where members of the team assume "leadership roles over time in informal and formal relationships" [63] (p. 382). Dynamic leadership is needed in healthcare environments, for instance, with changing environmental demands, multiple providers and patients. In collectivistic approaches, the traditional power distance of formal authority is minimized. A number of different collectivistic leadership models exist with varying degrees of empirical testing. For this project, we chose to focus on collaborative leadership, beginning within teams and eventually extending across teams within the organization.

Team leadership, in particular, has been extensively studied, and there are numerous links between this form of leadership and team effectiveness and performance [63,64]. To initiate a shift to collaborative leadership, the formal or focal team leader typically serves as a coach for team members to develop their leadership skills [65]. To facilitate the transition from "I" to "we" leadership, the focal team leader constructs team learning experiences that promote collaboration with respect to information sharing [63]. There is evidence that over time, teams create a shared mental model that enhances team communications and performance. Frequent face-to-face interactions with knowledge exchange and team problem-solving promote the development of shared mental models [63]. In one study that examined leadership within teams, leader empowerment behaviors (e.g., coaching, providing feedback, sharing responsibility) accounted for almost 31% of team learning. Overlapping knowledge and shared

values and beliefs permit more rapid and smoother coordination of behaviors and provide access to a greater pool of information for problem-solving, task completion and innovation [66].

Collaborative leadership requires "true participation in leadership and decision-making at all levels and in multiple decision processes" [67] (p. 155). Whether in formal or informal leadership roles, each team member must contribute to the team process. The shift away from traditional hierarchical approaches to collaborative leadership can be facilitated by action learning (*i.e.*, hands-on learning). In a team learning environment, for instance, the focal leader steps back from making unilateral decisions and encourages the team to brainstorm solutions. To build collaborative leadership capacity, the focal leader often rotates formal leadership responsibilities to other team members to help them test out new leadership skills in a safe environment [9,68]. A collaborative leadership definition that complements EI and authentic leadership is: "Leadership emphasizing collaboration exists when one or more people within an organization engage one another in such a way that leaders and followers raise one another's levels of motivation and morality and nurture interdependence among multiple parties" [69] (p. 556). The hallmark of collaborative leadership within an organization or across systems is frequent interactions and information exchanges among multiple stakeholders. Communication gaps or failures indicate breakdown in collaboration. To succeed, collaborative leadership must be viewed by executive leadership as the central approach to leadership/management *versus* the traditional top-down approach [69,70].

The shift from "I" to "we" leadership can be difficult for individuals who require individual recognition and credit for the work they do [71]. Depending on the leader, collaboration can spiral up or down in team and organizational contexts [46,71]. A focal leader must be prepared to "allow collaborative leadership to occur from any person" involved in a project, task or innovation [71] (p. 1025). Positive psychology approaches, such as AI, complement collaborative leadership. Being open and transparent creates vulnerabilities, and leaders who respond positively to others' attempts to collaborate are reinforcing a work climate or culture that promotes ongoing collaboration.

Some research indicates that sharing or distributing leadership among team members does not necessarily improve team performance. Instead, leadership must be truly collaborative: This is a mindset rather than a mere assignment of leadership duties. Members of the team or organization must acknowledge the importance of leadership and see each other as true leaders working in collaboration [72]. Collaborative leadership, therefore, invokes a kind of philosophy that needs to be instilled and reinforced through interactions and communications between leaders and team members. One testable model that needs more empirical support is the IMOI model where I is Input, M is Mediational Influence, O is outcomes and I is input, suggesting the cyclical nature of building collaborative leadership capacity or social capital [8,9,73]. Input refers to individual team member contributions to leadership capacity. Teamwork and team learning mediate the relationship between individual team member inputs and outputs. Through this cyclical process, collaborative leadership grows as team members become more interdependent and share more leadership responsibility for team and organizational processes and outcomes.

2.2. Supportive Content

2.2.1. Appreciative Inquiry

Authentic leadership development can be promoted via appreciative inquiry [34,74,75]. Appreciative inquiry (AI) can be used to enhance self-awareness and other-awareness of positive attributes. The purpose of AI is to uncover an individual's existing strengths through a relational, reflective process that can have a ripple effect among participants and create a positive, critical mass within an organization [76].

2.2.2. Organizational Innovation: Managing Continuous Change

Organizational success depends on the capacity to continuously change and innovate, and organizational innovation requires collaboration within and across IP teams to identify, test and assess potential solutions to complex problems [77]. Research has shown that EI may be positively associated with key project management competencies, such as collaborative teamwork and conflict management [10,78,79]. Project management is often finite in nature, requiring leaders and team members to establish quick trust and commitment to each other and the project goals. The previous leadership styles and competencies (discussed above) lend themselves to open, transparent relationship-building [80,81]. One way to build support for innovation is to match project goals to organizational strategy. Leaders can foster an innovative work climate by sharing their project vision in clearly stated, attainable terms [80].

For this segment of the workshop, diffusion theory as described by Berwick [82], was used to explain the process of innovation and the key roles and responsibilities for leaders and team members (e.g., innovators, early adopters). In addition, a basic project management tool kit was provided to participants with evidence-based best practices [83].

2.3. The Process

2.3.1. Adult Learning and Leadership Development

Leadership skills develop from a "cognitive bootstrapping process" that depends on exposure to new knowledge [26]. New knowledge is organized into higher level cognitive systems that influence and are influenced by an emerging leader identity. New knowledge acquisition and the unfolding leader identity happen in social, relational contexts [26]. Experience in social contexts helps to mold and refine how leaders develop over time. One leadership development model [26] is a novice to expert continuum; as leaders move along this developmental continuum, they are able to more flexibly draw from internal cognitive resources (e.g., mental representations of different contexts). This model characterizes leadership skill development as a change in a leader's capacity to effectively access and use stored information. Adult learning indicates that as skills become practiced, organized and stored in long-term memory, short-term working memory becomes freed-up so that leaders can focus more on self-regulation (*i.e.*, how they respond to affective cues). As stated by Lord and Hall, "The ability to make this shift from self to others is facilitated by lessened demands of routine tasks on working memory" [26] (p. 596). As leaders develop their self-identity in relation to others (e.g., comparing their responses to others), they become primed to turn their focus towards others' needs and concerns. An

experienced leader, therefore, has a wealth of knowledge stores to access quickly; allowing time to reflect and craft a response that is emotionally, cognitively balanced and reasoned.

As leaders develop over time, there is a shift from individual focus to a collective focus. A new leader is inner-focused or absorbed with new information and an emerging self-identity. Based on their successes and their social feedback, leaders shed leader identities that do not work for them, and they refine their leader self-identity to fit with their values and others' positive feedback. Progression along the leadership development continuum is marked by increased interest and concern for others and the collective good.

New leaders often lack the problem-solving capacity to respond quickly to team or organizational issues or to social feedback. Controlled experiments have shown that new learners should be explicitly shown what to do and how to do it when dealing with novel situations [84]. Cognitive load theory suggests that in highly complex settings, such as healthcare settings, free exploration without guided instruction and feedback can lead to frustration—particularly in new learners who often lack appropriate mental schema for storing and integrating new information with prior knowledge. Novices often need training interventions that focus them on surface skills, such as effective behavioral styles that they can assimilate quickly [26,85]. Training programs that focus on basic leadership skills can be successfully offered in brief sessions, such as a few days [26]. Leaders advance to intermediate and expert skills levels by practicing and honing their skills in varied contexts. As knowledge is constructed at deeper cognitive levels and as leaders develop relational comfort with others, leaders acquire more sophisticated appreciation of themselves and others within their teams, the organization, and the community. The shift from the "I" leader to "we" leadership becomes evident in leader actions that emphasize the relational and collective nature of team and collaborative leadership. A table (See Table 1), adapted from Lord and Hall [26] (p. 605) illustrates the leadership development continuum.

Table 1. The novice to expert leadership development continuum.

Skill Domain	Novice	Intermediate	Expert
Task	Generic problem-solving and decision-making	Domain-specific skills	Task and self-regulation
Emotions	Expressive	Empathy: Domain-specific emotional regulation	Advanced emotional regulation
Social	Awareness of basic social influence tactics	Self-monitoring skills	Authentic, principle-based
Identity	Self-identity	Relational identity-shift to collective identity	Values-based identity

Adult learning research suggests that didactic instruction and active/action learning are complementary [84,86]. Adult learning strategies typically include didactic instruction where an instructor reviews basic concepts and principles, followed by different modes of active learning to promote deeper-level thinking, such as analysis, synthesis and evaluation. Pre-work and post-work are used to facilitate learning, and instructional scaffolding is employed to gradually decrease learner dependence on external supports, while increasing the realism and interactivity of learning experiences [87,88]. One leadership development program will be described to illustrate a variety of evidence-based adult education approaches.

The Emotion Management and Orientation Training Exercises (EMOTE) program of the U.S. military [86] develops leaders who can influence others to efficiently and effectively meet team objectives. The four targeted leader behaviors are: (a) using one's own display of emotions to influence team members' behavior; (b) using communications to influence team members' behavior; (c) recognizing team members' emotional and personal situations that influence team performance; and (d) implementing and assessing/evaluating strategies that effectively and efficiently guide team dynamics. This program uses instructional scaffolding to grow leader confidence and competence: Instructional scaffolding results in better transfer of leader skills to real-life contexts [88]. In addition to didactic instruction, the program employs active learning exercises, such as role-play scenarios and interactive discussions among peers and faculty; and there are carefully structured pre-and post-workshop activities to enhance workshop learning. Pre-work includes selected readings with guided questions, and post-work, to enhance continued learning, involves follow-up conversations with a mentor or coach, self-reflective journaling and structured assessment processes (e.g., 360 degree feedback). Teams are also expected to work on projects that require collaborative teamwork [86].

Project work is often used as a way to promote a collaborative learning environment [89]. Collaborative teamwork is facilitated through the process of working on a shared problem or task and assigning responsibilities based on skills. "Mutually shared cognition" is established through a social process of regular interactions and/or communications that require negotiation to achieve agreement—often facilitated by a leader. These types of negotiations typically involve "constructive conflict" as members share different perspectives and new information that must be re-worked into a mutual agreement of the problem or task [89]. Conflict is constructive if it positively influences the team's development of a mutually shared cognition or agreement. These interactions have a cognitive component and a relational one, because they provide opportunities for team members to learn more about each other, such as each other's strengths and preferences. Finally, the project process enhances the capability of the team to keep learning and working together. Project work, therefore, can enhance team learning, team performance and team viability, but an authentic EI leader is often needed to moderate team communications and facilitate constructive conflict [89,90].

In a leadership development program for novice nurse leaders, a 4-day workshop with lecture (didactic instruction) and interactive exercises (active learning) was coupled with a year-long innovation project of relevance to participants' respective organizations [91]. Workshop content highlighted empowerment theories and leader empowering behaviors. After the workshop novice leaders met regularly with senior administrators for coaching and networking opportunities. Pre-and post-workshop evaluations with validated survey tools were conducted on program participants and comparable nurse leaders who did not attend the program. The study found significant positive increases in participant leaders' perceived use of trainable empowerment strategies.

2.3.2. Our Workshop Process

Our leadership development project was modeled after the two successful leadership programs described above [86,91]. We focused on the clinical level of leadership; clinically-based healthcare professionals who provide direct care to patients as IP teams. Due to the busy schedules of healthcare professionals, we developed a 1-day workshop accompanied by evidence-based strategies to use

post-workshop for ongoing leadership development. Fifty individuals from five teams attended the workshop. Each team was comprised of representatives from diverse disciplines, and the mix of disciplines varied by team. The representative healthcare disciplines were: medicine, nursing, pharmacy, psychology/psychotherapy, nutrition, and social services). Executive leadership asked for volunteer teams to participate in the workshop, and to commit to ongoing collaborative leadership development within their teams. Each team consisted of a formal team leader and nine team members from the different disciplines. One team, for instance, included three nurses, three physicians, a social worker, a dietitian, a pharmacist, and a psychotherapist. Each team sat together at their own table. As pre-work, teams were asked to meet beforehand, and to identify potential projects of interest for them to do over a period of three to six months. The workshop was conducted in English, although during active learning sessions, team members spoke in Taiwanese. Executive leadership was present during the workshop, and one of these leaders opened the workshop with an explanation of its purpose and importance to the leadership strategy of the organization. The faculty partners presented workshop material and facilitated active learning exercises. At the end of the day, the faculty partners and executive leadership urged individual participants to journal daily using self-reflective questions. Teams were asked to do the following: (a) meet at least once a week as a team to reflect on positive team events and successes (*i.e.*, team AI or appreciation); (b) regularly rotate focal team leader responsibilities; and (c) carry out a simple project or "quick win" to trigger innovation within the organization. Table 2 includes an overview of the workshop agenda content and exercises.

Table 2. Workshop agenda and exercises.

Content	Exercises

• Leadership development
• Emotional Intelligence
• Authentic Leadership
  • Core values
  • Reflected Best Self
	• Individual core values reflection
	• Team discussion: Core values of the organizational Vision/Mission statement
	• Team discussion: "What are our core team values?" "How are they aligned with the organization's values?"
	*Post-workshop***:** Self-reflective journaling
	"How are my core values aligned with team and organizational values?"
	Daily journaling—Document one encounter daily. "Were my words and actions a true reflection of my best self?"

• Appreciative Inquiry (AI)	• Team AI exercise: As a team, think of a time when you had great outcomes. (a) "What were the contributing factors?" (b) "How can you highlight and enhance these contributing factors?" *Post-workshop*: Set aside time for weekly team AI.

Table 2. *Cont.*

• Collaborative Teamwork • Team Processes • Team roles and responsibilities • Communications • Conflict	• Critical team tasks discussion: Among your team identify three team tasks/processes where you are dependent on each other. Critique team assignments, communications. Use AI to identify when assignments, communications went well. "How can we systematize what we do to enhance team assignments, communications?" • Team sharing of different conflict management approaches. Discussion: "What are some constructive ways to resolve team conflict?" *Post-workshop*: As above (AI exercise), when discussing team performance, use AI to appreciate assignments and communications that went well.
• Innovation • Project Management • Team networking	• Team Project Discussion: Map out the first steps of a project action plan. • Group sharing and discussion

3. Evaluation

When we discussed project evaluation methods with executive leadership, we proposed the idea of 360 degree feedback [92]. We were prepared to develop a competency framework to more objectively track leadership development among individuals and teams. We also suggested explicit criteria to guide assessments, such as specific behaviors and performance outcomes. These are evaluation strategies described in the literature [1,2,8,93]. The executive leaders chose, however, to wait at least a year to let things unfold on their own. Rather than prematurely setting developmental expectations, the leadership wanted to take a more inductive, qualitative approach to the first year of change. This approach to evaluation is in keeping with their values-based philosophy. As stated by Osula and Ng [4] (p. 92) in this time of complex, unpredictable environments, linear leadership and expectations may no longer work. "Rather, leaders and leadership has been likened to collaborative associations and ongoing construction of organizational reality where interdependence, trust and unscripted initiative drive the group, each performing within a conscious awareness of the role the other must assume and how to best facilitate that process in a manner that focuses on the good of the next person, and the group as a whole." We agreed to a mixed methods evaluation approach (*i.e.*, survey, focus groups and interviews) to formatively assess leadership development progress. We also agreed to re-visit "next steps" with executive leadership at the one year anniversary of the IP workshop. The Kirkpatrick four-level training evaluation model guided our leadership development project evaluation [94]. The model is a pyramid of four evaluation levels that increase in rigor. Table 3 displays the four levels and the strategies we used for each level. We obtained institutional review board ethics approval to conduct a formal evaluation of the project, and we received executive leadership and workshop participant consent to publicly share our findings.

Table 3. Program evaluation strategies based on the four-level Kirkpatrick model.

Level	Evaluation Strategies
1. Participant Reactions	Participant satisfaction survey
2. Participant learning: knowledge, skills, abilities acquisition	Pre-workshop and 6-month post-workshop survey (Collaborative Practice Assessment Tool
3. Actual behavior changes	Focus groups with participant teams at 6 months
4. Impact on the Organization	Executive leader interviews at 1 year (July 2014)

3.1. Level 1: Participant Satisfaction Survey

At Level 1 we administered a self-designed satisfaction survey to all workshop participants (N = 50). This tool has eight items in total: Four questions cover satisfaction with specific workshop content (*i.e.*, leadership styles, effective team dynamics, communications and conflict, and innovation and project management); One question asks about satisfaction with the instructional processes; One question relates to satisfaction with the venue; and there is a final overall satisfaction question. Open-ended spaces were provided for further feedback. The average score on a scale from 1 (Not at all) to 5 (Very satisfied) was 4.76. Fill-in comments indicated that participants especially appreciated opportunities to do the dyadic and team action learning exercises. "The workshop provided an environment for team-building." "The workshop allowed me to appreciate different opinions from other disciplines." "I recommend that our hospital holds regular activities, such as this workshop, to facilitate inter-professional communication and teamwork."

3.2. Level 2: Collaborative Practice Assessment Tool

For Level 2, we did a literature review of publicly accessible assessment tools for collaborative teamwork or collaborative practice: We wanted a valid, reliable assessment tool to evaluate pre- and post-workshop team performance, and to avoid proprietary issues, we looked in the public domain for a tool that we could cross-culturally validate for Taiwanese healthcare providers. The partners selected the Collaborative Practice Assessment Tool (CPAT) [95] and obtained permission from the authors to adapt their tool for use in Taiwan. The tool is based on the construct, collaborative practice, which is defined as an inter-professional process focused on communication and decision making among different health care providers. The psychometric properties of CPAT were examined in two pilot studies. In the first pilot study, CPAT was administered among a sample of health care professionals in a palliative care team, a geriatric assessment team, and two family practice teams in Ontario, Canada [95]. Individual respondents were asked to indicate the extent of their agreement or disagreement from the perspective of the specific patient care team that they worked with most often. Internal consistency and internal structure validity of the tool were examined. Cronbach's alphas were found to be in the range of 0.70–0.90 for seven of the eight subscales. The results of the exploratory factor analysis were used to further refine the instrument's questions and structures. In the second Canadian pilot study [95], 111 health care professionals and personnel from six participating health care units of different clinical practice settings completed the CPAT, and their responses were used to confirm the internal structure validity of the CPAT. Confirmatory factor analysis results demonstrated that the 56-item measure consists of eight subscales: (1) Mission, Meaningful Purpose, and Goals; (2) General relationships (3) Team Leadership;

(4) General Role Responsibilities and Autonomy; (5) Communication and Information Exchange; (6) Community Linkages and Coordination of Care; (7) Decision Making and conflict Management; and (8) Patient Involvement.

We created a conceptually equivalent Taiwanese version of the CPAT. We used a well-established, three-step translation procedure [96]. In the forward translation phase, CPAT was first translated to Taiwanese by a translator who was fluent in both English and Taiwanese with the latter as her native language. In the process of translation, emphasis was given to conceptual rather than word for word translation to ensure the language was culturally acceptable to the broadest audience of the tool. A bilingual subject matter panel of experts (e.g., clinical administrators, academics) examined the Taiwanese version for clarity and cultural appropriateness. In the back translation phase, items identified as problematic in the previous phase were translated back to English by a different translator whose native language was English. Similar to the first phase, the focus of the back-translation was on conceptual and cultural equivalence. All 56 items were culturally adapted and included in the Taiwanese version of CPAT.

We conducted a pilot with the workshop population shortly after the completion of the back translation phase. The CPAT was administered to the 50 IP team members before the workshop and 6 months after workshop attendance. With the exception of the Decision Making and Conflict Management subscale (0.38), the remaining subscales as well as the total scale demonstrated satisfactory Cronbach's alphas ranging from 0.72–0.95. The factor structure of the Taiwanese version of the tool was not examined in this phase of the study, mainly due to the small sample size. Our plan is to administer the CPAT to all organizational team members in 2014–2015.

3.3. Level 3: Focus Groups

For Level 3, we conducted focus groups with the five workshop teams approximately 6 months after the workshop to determine their perspectives on teamwork/leadership developmental processes related to workshop instruction. Questions were given to participants in advance of a webinar between participants and the faculty partners. Team members were asked to write out their reflections to each question. The three major questions were: (1) How did the workshop help you as a team? (2) How did the workshop help you be a leader in your team? (3) What recommendations do you have for future leadership development within your organization? During the focus group, each team member was asked to share their reflections; then comments from others were invited at the end of each round of reflections. Content analysis was used to identify the common key themes within and across the teams.

With respect to the first question, all the teams agreed that the most beneficial workshop content pertained to appreciative inquiry and collaborative teamwork, particularly the application of appreciative inquiry for valuing different team members' contributions to teamwork, and building on team strengths. After the workshop, two of the five teams were meeting weekly to practice team appreciative inquiry. There was less consensus in themes across teams for the second question. Focus group participants from all the teams agreed with the concept of collaborative leadership and its benefits to team performance (e.g., sharing leadership responsibilities across team members). Only one team, however, was rotating leadership among its members; instead, the original team leaders for four of the five teams were still overseeing team functions. For the third question, all the teams agreed that ongoing organizational

support would help sustain leadership development within their teams; all the teams valued the workshop experience and wanted continued opportunities to meet as teams to learn together. They also acknowledged the importance of leadership development for other teams within the organization. Another common theme across teams was the value of conducting simple projects within their practice areas. The teams identified project work as a way to further leadership development within the organization—by sharing project responsibilities and working collaboratively towards short-term goals (e.g., "quick wins"). After the workshop, three of the five teams were working collaboratively on their projects.

One team in particular, carried through with all our recommended post-workshop team activities. Executive leadership also recognized the notable progress of this team. We have provided this team's key themes and exemplar quotes per question to illustrate positive shifts towards more collaborative teamwork and leadership. This team is comprised of a formal team leader who is a physician, two other physicians, a nurse, a nurse practitioner, a dietitian, a psychologist and a social worker. Each team member has clinical expertise and has been with this team for approximately two years. The physician is the only member who has had a formal authority role in this team. For the following quotes, P = participant and Exec = executive leader.

3.3.1. Exemplar Focus Group Responses to Question #1.

Question 1: How did the workshop help you as a team? The key themes were appreciative inquiry, authentic leadership strategies (e.g., self-reflection, sharing core values and beliefs with each other), and collaborative teamwork strategies (e.g., shared problem-solving and decision-making, communications, shared goals, conflict management). Interestingly, another theme that emerged was patient-centered care: Members identified patient-centered care as the core value that has helped them build a collaborative team. The majority of conversation focused on examples of improved, collaborative teamwork.

Appreciative Inquiry: Team members saw applications for AI among themselves (to build a better team), but more importantly, they saw applications for AI with respect to patient-centered care delivery.

> "After the workshop we began to focus on our team strengths. We also recognized the importance of focusing on the strengths of our patients and families—rather than their problems and deficits." (P1) "This new approach opened us up to more possibilities and new ways of thinking about ourselves and our patients." (P2)

Authentic leadership: The aspect of authentic leadership that resonated with all team members was its focus on core values—knowing those values and consistently practicing according to those values. They felt that sharing their core values helped them better understand, trust and respect each other.

> "This was the first time to take the time to learn more about the values and beliefs of other team members. It was good to recognize different values and to share these with each other." (P1) "Closer relationships and trust have been developed by sharing values opening—we now have a different appreciation of each other." (P4) "This leadership mindset and self-regulation is first and important—if you stick to this approach, your values show through naturally—and this is inspirational to all of us." (P5)

Collaborative teamwork: Team members recounted several strategies for enhancing teamwork, such as better communications, more support for each other, and shared goals.

"We have team meetings with staff where we discuss the patients. At first the staff thought they had heard everything before, but we emphasize discussion about the patients—not just telling. They rate this experience very highly. It was just our team, but now the other teams from other units have heard about us, and they have started to do meetings and rounds the same way. It is a great success." (P1) "Staff are starting to speak up, and they feel much better and much more confident about what they know and what they can do…We used to focus on patients' physical needs, but now they are thinking more holistically about psycho-social care and what patients need to be included." (P4)

"We learned that an important aspect of the team is helping each other out. Before, we focused on our own disciplinary area and what we had to do. Now we have over-arching goals of what the patient and family need, and we work together as a team." (P7)

"It used to be that you expected a team member to do something, and if it wasn't done, you would see that as a problem or deficit. Now it is an opportunity to work with that team member and better support them to get their work done. We need to help each other out—that is what we learned from the workshop—collaborative teamwork." (P3)

"We meet regularly-we have two formal, designated team meetings a week to talk with each other. And we meet more often and consult more with each other informally—we make a point of it." (P10)

"I feel more comfortable expressing myself and not running into conflict with others. It is OK to be different and to be respectful of others' differences. We work together towards the best solution for the patient." (P9)

Patient-centered care: Team members acknowledged a real shift in how they see their patients and families. They view patients more holistically, and they are starting to include the patients' perspectives in their team deliberations.

"Rather than just talking about physical data, we also share our self-reflections. Looking at the patient holistically invites us to share more about them. We look at the inner life of the patients-we take time to understand them through their own eyes." (P4)

"We have some strong personalities, but when we work towards a common, patient-centered goal, the conflict goes down. We have also learned to use an ethicist to find neutral territory for the team—to ensure the best, ethical approach for the patient and family." (P1)

3.3.2. Exemplar Focus Group Responses to Question #2.

Question 2. How did the workshop help you be a leader in your team? The key concepts from these reflections and discussion were egalitarianism (equal respect for each other) and rotated leadership responsibilities.

Egalitarianism: The team members indicated that true, collaborative leadership depends on having equal trust and respect for each other.

> "Collaborative leadership means we are all leaders. That means we are non-judgmental of each other—we respect what each other has to say." (P8) The formal leader: "It is very important for me to let go and to trust my team members to do it themselves. Some gentle pushing and some gentle letting go. I allow others to take charge." (P1)

Rotated leadership: In this team, the formal leader rotated team leader responsibilities as a way to encourage everyone to assume more leadership roles. As team members grew comfortable with rotated leadership, team members began to volunteer for formal roles, such as chairing team meetings.

> "We used to have one person lead our team meetings each week, and now we rotate each week with a different team member. I was happily surprised at how each person has been able to show off their abilities as a team leader. I saw things in others I had not seen before." (P4)

> "I have a hard time expressing my feelings. I asked to chair a team meeting when I saw how they were going. I found that it was very helpful for me to open up and express myself. The openness has led to trust among the team." (P9)

3.3.3. Exemplar Focus Group Responses to Question #3.

Question 3. What recommendations do you have for future leadership development within your organization? The key concepts were ongoing organizational support and simple projects with "quick wins".

Ongoing organizational support: The formal leader described how they have received funds to have a formal team retreat to celebrate their successes and to do more team-building.

> "We've found that sharing experiences with each other is very valued and important, and we have a retreat scheduled with a professional psychologist to help facilitate team-building. We need more of these opportunities to explore our values together and to get to know each other more." (P1)

Simple projects: Team members described how team leadership can be promoted by teams taking on simple projects within their organization. Rather than big, formal projects, collaborative leadership can emerge through small, organic innovations. Their example also demonstrates how team networking, sharing ideas with each other, can have a ripple effect (e.g., emotional contagion).

> "We found out about one service that had a cart for patients and families with music, books, entertainment. It was very successful with volunteers organizing it. So we found a way to do this on our unit using volunteers from high school and college-we have 12 volunteers now. So this idea came up in one of our team discussions, and we figured out how to make it a reality with volunteers. We all assumed some leadership responsibility. You start small—maybe it gets bigger." (P3)

3.4. Level 4: Executive Leader Interviews

Through progressive evaluation levels of the Kirkpatrick model, more time, energy and resources are required to see real change, particularly at an organizational level [3,94]. Level 4, the most comprehensive level, links leadership development with organizational performance [3]. Some common measurable organizational performance indicators include improved patient satisfaction survey scores, and better staff recruitment and retention. A qualitative evaluation approach often involves interviews with internal and external stakeholders to determine whether they have seen changes within the organization post-intervention. At 6 months, we interviewed executive leaders, and we asked them to reflect on change in teams and subsequent changes to organizational culture as a result of the workshop and the leadership development program. Their discussion with us acknowledged the hard work of sustaining leadership development. They noted that not every team was as successful as the exemplar team. Given the culture of the organization, however, executive leadership believes that a shift towards collaboration is underway.

> "For one team, the leader did not buy into shared leadership. Consequently, other team members have not changed their behaviors. They want to do so, but it takes a strong leader to help shift the culture to cooperation. The leader needs to role model how to value each professional role. Without that leadership support, it won't happen as planned." (Exec. 2)

> "Rather than pointing out negatives, we will emphasize the positives and hope that we can learn from each other. Considering how we are trained to practice in isolation, we are encouraged by the results so far." (Exec. 3)

4. Discussion

This paper provides a descriptive account of an IP collaborative leadership development project that was conceived through an academic–practice partnership with full support from the organization's executive leadership. Executive leadership helped us link leadership development goals to organizational strategy; they participated in a needs assessment to identify core workshop content; they were visible throughout the process of vetting the workshop and program with other levels of leadership; and they met regularly with participant teams post-workshop to provide encouragement and to monitor collaborative leadership progress. Most importantly, they recognized the need for a culture change within their organization—a shift from a traditional siloed, hierarchical approach to a more egalitarian, collaborative team approach. They also endorsed values-based, relational strategies for achieving a culture shift. According to Orchard *et al.* [2] (p. 1) "…there is a need to create a new culture in health systems that supports trust, a willingness to share in patient care decision-making, and meaningful inclusion of patients/and or their family members in discussions about their care." We have formative evidence that hoped-for changes are underway within some of the participant IP teams.

The focus group findings from one team demonstrate collaborative teamwork actions, shared responsibility for patients' care, shared responsibility for leadership, shared knowledge and expertise, shared planning and decision making, and a commitment to regular meetings and frequent communications. An indication of collaborative teamwork is the capacity to manage conflict or to constructively resolve conflict [97,98]. In this team, there was a sense of mutual trust and respect for

each other. The team also demonstrated the importance of having an authentic senior leader to model the way: An effective focal leader was the role model for collaborative leadership within the team [30,99]. Rotated assignments and "gentle pushes" permitted others to practice leadership roles in a safe, supportive team environment.

There is some research evidence that formal team leaders with authentic leadership styles positively influence team performance and effectiveness. As authentic leaders interact with their team members and positively model authenticity, more authentic team relationships develop over time, resulting in enhanced team outcomes, such as improved team productivity and citizenship behaviors [100,101]. The style of the formal team leader, therefore, may be an important criterion for successful transition from "I" to "we" leadership. Authentic leadership may be a foundational style that needs to be promoted with respect to individual leader development. Our findings from the exemplar team endorse the importance of having an authentic formal team leader: This team, in particular, made remarkable progress in adopting collaborative teamwork and leadership. The other teams, where the formal team leaders maintained control over team functions, offered less evidence of collaborative leadership. More research is needed to understand how formal and informal leadership within teams influences collaborative team processes.

An interesting point of discussion is the evaluation process. Our initial plan was to include quantitative measurement of individual, team and organizational performance indicators at a minimum of three points in time. We also chose the CPAT to assist with pre- and post-workshop assessments, and we cross-culturally validated and piloted the tool with the IP workshop teams. To legitimize project outcomes, we felt it was important to include quantitative measures. We discovered, however, that initial evidence of developmental team/leadership processes was best gleaned via individual interviews and team focus groups.

As we are learning more about collaborative teamwork and collaborative leadership in healthcare contexts: how to overcome siloed approaches to healthcare disciplines' education, training and socialization. Relational, values-based leadership development may require closer examination of the intrapersonal and interpersonal processes at play [8]. Qualitative developmental evaluation approaches (e.g., ongoing focus groups and interviews with key stakeholders) may help us better understand the mechanisms underlying complex healthcare systems culture shifts at the team level [102]. Another consideration is cultural in nature. We had considered 360 degree feedback for participant IP teams—aiming our questions at the team *versus* individual performance level [92]. Performance feedback can fail in organizations that are not primed to use it constructively [8]. When we originally discussed the possibility of this evaluation approach to executive leadership, the question of culture was raised. There were concerns with initiating a new evaluation process during a time of organizational vulnerability (e.g., promoting "I" to "we" leadership). There were also concerns with team acceptance of a feedback process that might be construed as critical *versus* constructive. Given the "newness" of this organization's culture shifts, we believe that developmental evaluation approaches best complement the values-based philosophy of its executive leadership [103,104].

Our one-year anniversary goal is to work with executive leadership to create action items that support ongoing collaborative leadership development at the clinical, direct care level. We are continuing to work with the original five teams to identify the types of supports they need to sustain collaborative teamwork and leadership. One change that is already underway is the implementation of regular,

organization-wide IP rounds to showcase the successes of teams who exemplify the collaborative strategies discussed in this paper. Our work to date has been conducted with the original five teams, and our 2014–2015 plan is to expand this project to the remaining IP teams within the organization. We believe that our work with IP teams is congruent with the recommendations for IP health education as stipulated in the Lancet Commission report, "Health professionals for a new century: transforming education to strengthen health systems in an interdependent world." Inter-professional healthcare delivery is associated with high-quality, comprehensive health service, and healthcare education in university settings is beginning to mandate IP team training [105]. We believe that our approach to leadership development, where the focus is on IP teams, complements a much-needed transformation of how healthcare professionals learn to practice together. This project is the first step towards our long-term goal to create a sustainable leadership development program for all healthcare leadership levels within the organization. As one workshop participant noted, "*You start small—maybe it gets bigger*".

5. Conclusions

There are numerous leadership competencies covered in leadership development programs. We chose to focus on emotions and values. We believe that emotional management (e.g., EI, emotional contagion) and appreciation of core values (e.g., authenticity, RBS) are leadership qualities that can be developed in relation to others—stimulating a ripple effect that will hopefully make its way throughout the partner organization. Although leader self-development is a stepping stone to ongoing leadership development, our focus was primarily on collaborative teamwork and collaborative leadership within teams. We found that at the team and executive levels, authentic, EI leaders were critical for building a foundation of purpose and core values for collaborative teamwork and leadership. Executive leadership has been especially integral to leadership development sustainability and its link to the organization's strategy. The work of leadership development has only begun within this organization, although there are some promising qualitative findings of developmental progress within IP teams. Hard work remains with respect to building a collaborative team/leadership network across the organization that will shift culture. We believe that when there is a critical mass of successes, the appropriate time may exist to promote quantitative evaluation strategies. For now, we need to use qualitative developmental evaluation approaches to truly appreciate those processes underlying collaborative teamwork/leadership development.

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Author Contributions

All the authors were involved in the conceptualization, design, writing and approval of the final manuscript. These authors represent an ongoing academic-practice partnership engaged in health care leadership development.

Conflict of Interest

The authors declare no conflict of interest.

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