Building the Knowledge Base

INSTITUTE
FOR WORK & HEALTH
INSTITUT DE RECHERCHE
SUR LE TRAVAIL ET
LA SANTÉ

CHEPA
Centre for Health Economics
and Policy Analysis

SickKids

camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

CHSRF FCRSS
Canadian Health Services Research **Foundation**
Fondation canadienne de la recherche sur les services de santé

**Report of the Ontario Regional
Knowledge Transfer and Exchange
Workshop**

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1.0 Messages from the workshop

In lieu of an executive summary, we have provided you with the key messages from the Ontario Regional Knowledge Transfer & Exchange Workshop: Building a Knowledge Base.

In extracting the overall messages from the workshop, we will rely on the wisdom of knowledge transfer researcher, Dr. John Lavis, who says that a message is: "A compelling idea that relates to the audience's decision-making and suggests who should 'act' and what should be different."

We have endeavored to apply this test in each of the statements that follow and suggest that the stakeholders/audiences for these messages are the workshop participants, i.e., "those who participate in the science and practice of knowledge transfer and exchange (KTE)."

The KTE field needs more evidence about effective knowledge transfer strategies.

One way to get more evidence is to link practitioners, those who develop and implement KTE strategies, with researchers, who have the expertise to study the practitioners in action. As KTE practitioners and experts in relationship building, we must not neglect the importance of developing and sustaining relationships between those who do KTE and those who study and research it.

Relationships built with stakeholders/audiences are fragile and need care and tending.

Engaging stakeholders/audiences in generating, translating and implementing research knowledge is an ideal way to increase their capacity to understand and use research knowledge. However, we must ensure that stakeholder/audience participants have a clear role and are not sought simply as subjects or data sources. One method is to create a "Project Charter" which spells out roles, expectations and targeted outcomes at the beginning of an initiative. We need to ensure that we do not take stakeholders/audiences for granted or assume we know them well enough that they no longer need to be consulted. KTE practitioners have a vital role in ensuring stakeholder/audience priorities are considered in setting research agendas.

Measuring impacts in KTE is essential but challenging.

Many KTE processes are non-linear with innumerable, uncontrolled variables making traditional research methods difficult to apply. One solution is to use the logic model, an existing and proven tool borrowed from program evaluation. Logic models structure the mapping of activities (what we do) to outputs (tangible evidence we have done something) and outcomes (did it make a difference).

Selecting realistic outcomes is essential.

The logic model helps to break outcomes into short-and long-term and assists planners to critically evaluate the feasibility of causal links between the defined activities and impacts.

Learn evaluation by doing it.

KTE practitioners should challenge themselves to undertake evaluation at the "project" level. This has the dual benefit of increasing KTE practitioner evaluation skills and knowledge while contributing to advancing our collective knowledge about "what works" in KTE.

We need to support the leadership group who volunteered at this meeting to take the first steps in creating a useful mechanism to link KTE practitioners in Ontario.

KTE practitioners need each other and want to work toward an ongoing mechanism of association. We can learn from each other and advance our individual practices by sharing information, ideas and experience. We can strengthen the field of KTE by creating shared definitions, models, frameworks and by contributing to and promoting the KTE research agenda. None of this will happen without leadership and support for that leadership.

Do not have unrealistic expectations about the impact of research messages on decision-making.

KTE practitioners should recognize that stakeholders/audiences (clinicians, policy-makers, program leaders) will ultimately be the translators of research knowledge into practical applications. In many cases the research knowledge will be used to inform but not necessarily prescribe the eventual decision made. Understanding this will help to target realistic outcomes.

KTE should facilitate culture shifts.

Culture shifts are seen when the audiences' appetite for, and capacity to use research grows and when researchers move towards a greater understanding of audiences' decision-making processes and real world priorities for new knowledge. KTE practitioners should not view this as a project but as an ongoing process.

Do not let technology replace human contact.

Technology is a great boon to KTE but it should not entirely replace face-to-face meetings. These encounters will always be necessary to build and sustain relationships between people.

Report of the Ontario Regional Knowledge Transfer and Exchange Workshop

2.0 Ontario regional KTE workshop report

Introduction

The Canadian Health Services Research Foundation (CHSRF), in its vision to support the development of knowledge transfer and exchange capacity, issued a call for proposals to bring together knowledge brokers regionally. This report provides a summary of the process undertaken to plan and deliver the Ontario Regional Knowledge Transfer & Exchange Workshop.

This workshop invited selected individuals from across Ontario who specialize in the science and practice of knowledge transfer and exchange. In addition, some of the decision-makers who partner with the knowledge brokers were invited to participate.

The specific objectives of the workshop were:
- To share practice experiences in knowledge brokering (KB) and knowledge transfer and exchange (KTE) through dialogue and by example
- To initiate a repository of practice and experiential learning that will include major strengths and challenges of knowledge brokering practice
- To assess how the field evaluates the impact of knowledge transfer and exchange and where improved methodology is required
- To initiate a regional community of practice for knowledge brokers

Planning the day

Invited participants were asked to submit a knowledge transfer story prior to the workshop. A template was used to collect this information (see Appendix for submitted stories.) These participant submissions were then circulated to all the invitees for them to rank order the summaries to identify which of the stories they wished to have presented and discussed on the day of the workshop. Participants whose stories were selected were invited to speak at the workshop. Four stories were selected.

In addition to sharing stories, the workshop also addressed the issue of evaluation with a panel presentation and discussion about the impact of KTE efforts including methodologies, successes and challenges in this area.

Finally the invited participants explored the interest and feasibility of developing and sustaining a regional Community of Practice for KTE in Ontario.

3.0 An account of the day

Just five years into serious growth of knowledge transfer and exchange in Canada, the message at a recent workshop was that we must find ways to connect more broadly. We have to connect with the community, with patients and with practitioners if decision-making is to be truly knowledge and evidence based. We also need to find ways to share the successes and challenges of those working in this emerging field.

It is one more challenge for Ontario's growing cadre of people working in knowledge transfer. Many of us are still looking for ways to make the first, crucial connection between the research and decision-makers. Now we are told that, important as it is to introduce research into the policy and practice processes, transfer and exchange don't end there. How to expand the scope of transfer and exchange - and how to measure their results, which is another growing concern - were on the agenda at the first meeting of Ontario knowledge transfer and exchange practitioners in Ontario.

One challenge: Matching researchers' ideas to decision-makers' needs

It is the great paradox of education that the more we learn, the more we realize what we do not know, a paradox that's as true in knowledge transfer as in any field. At first it seemed if we connected academics and the decision-makers running the health system, they would learn to use research. Then it became clear that researchers should work with input from the people they were trying to help if they were going to produce ideas that were useful and effective.

We are still working on opening those channels and making ideas flow through them but meanwhile it becomes even more obvious that research is only one factor when health-care decisions are made. We have to start looking for ways to expand knowledge transfer and exchange beyond researchers and decision-or policy-makers to include front-line health workers, community groups, patients, their families and the public at large.

It will not be easy.

The gradual growth in comprehending this bigger challenge can be seen in the work of Suzanne Ross and her colleagues from McMaster University. Ms. Ross was one of four morning speakers at the knowledge transfer and exchange workshop. Rather than a case study, her presentation was about a knowledge transfer research project that yielded unexpected results.

The original goal of the study was to help policy-makers and researchers to communicate better by using consistent language that meant the same to both of them. Ms. Ross and her colleagues had observed that researchers rarely described their work with the same words decision-makers used when they talked. The McMaster group developed a four-point categorization scheme for coding policy issues:

- Program content (which services should be provided?)
- Delivery arrangements (how should services be delivered?)
- Financial arrangements (how should revenues be raised, organizations funded, and providers paid?)
- Governance and jurisdiction (who makes the other decisions?)

A sample of policy-makers were asked to code decisions accordingly. The results showed researchers found policies don't fit neatly into categories. Instead, the policy-makers doing the coding put 90 per cent of issues into three out of four categories –because they saw issues as a combination of program, delivery, financial and governance concerns.

In short, the real world is too messy for typologies and carefully categorized ideas. "They are talking about making change. Not a particular 'what,' but many 'whats,'" Ms. Ross told the workshop. "They're thinking trade-offs, and other issues–and all implementation is coloured by strategy."

But the study group thought perhaps they could still work toward their original goal if they developed 15 or 20 subcategories, whose greater detail would permit them to match the language of researchers and decision-makers. This time, they had a hit: as long as the policies were for handling specific health conditions or technologies, they could match the language. However, as soon as complicated, multi-faceted issues, such as integrating care or human resources management were tested, the coding system failed.

Two important lessons came from their study, according to Ms. Ross. One was that the theory behind making changes cannot be separated from implementation; they are too closely knitted together, especially in the Canadian healthcare system. Who will plan,

who will deliver, who will pay and who will make decisions all shape what ultimately happens to ideas for health care.

The second important lesson was that researchers were focusing too much on getting existing research used by decision-makers. Instead, research must be put in context of all the considerations that go into making policy. That, however, requires that researchers recognize they are not experts in creating policy, and they need decision-makers to tell them what the implications of their work are and how it fits with all the other factors to be taken into account.

In other words, researchers need to learn to work with policy-makers to create research that meets their needs. Policy-makers need to know what's going on elsewhere, what is going on in the system now, they need to have research that has been translated into useful knowledge for policy and they do not want to see a lot of duplicated effort.

Above all, researchers need to appreciate that the use of evidence in decision-making is not an easy, straightforward process but rather, as speaker Karen Parent said later in the day, "messy and challenging."

Making the public part of public health knowledge

Suzanne Ross and her colleagues discovered how difficult it was to codify the information needs of policy-makers. Michelle Gold, Manager of Knowledge Transfer at the Hamilton District Health Council, on the other hand, realized very quickly that doing her job properly meant setting standards, educating participants and organizing systems to make the whole process of knowledge gathering and sharing more effective.

Knowledge transfer in a community setting means incorporating community values as part of the evidence, Ms. Gold told the Toronto meeting. There were a lot of frustrated people at the Hamilton District Health Council when she started in 2001 who did not feel they were succeeding in doing that. District health councils were created to advise Ontario's Ministry of Health and Long-Term Care on local health issues, and over the years they have gathered a lot of statistics and generated a lot of information. They are unusual because they both use research and produce information. But there often seemed to be no link between the work they did and the action taken by the provincial government.
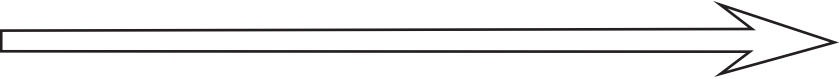
Ms. Gold set out to create a knowledge transfer strategy, to increase the use of evidence and best practices (in the council's research, and in work done with council information), as well as to increase the dissemination of knowledge. She started by working to expand the council's relationships–both with the community and with the ministry.

Working better with the community required a set of ethical planning guidelines to ensure more vulnerable groups in society (such as the elderly and the homeless) were properly and fairly included in the council's work. She tried to reach out to the community in a variety of ways, including:

- Creating project charters to define objectives and deliverables
- Doing a more thorough job of identifying stakeholders in issues
- Clearly identifying the roles of all involved
- Spending more money to ensure the public was properly engaged
- Guaranteeing follow up, with information back to participants within six months.

She also worked at getting the ministry to be more communicative, for instance by making it clear whether they were looking for information for research or for planning imminent changes in programs. As the ministry realized the Hamilton District Health Council was working differently, it became more cooperative about explaining its plans for the information it wanted. This in turn generated more relevant research, Ms. Gold said. She also tried to explain the political imperatives behind provincial government actions to a community that is not always aware of the mix of forces behind policy.

Ms. Gold's previous job as an academic at McMaster helped her build bridges to the academic community, strengthening the council's ability to do research as well as encouraging academics to use the council's community contacts. But here too, she set standards. As the idea of knowledge transfer spreads, pressure mounts on academics to work with the community. Ms. Gold found people were looking to the council to serve as a research partner; or to broker links between researchers and other community-based decision-makers. These requests were sometimes more for show than function. As this trend became apparent, she created a list of discussion questions to assist decision-makers in clarifying potential roles with researchers and developed a conceptual framework to convey the range of involvement decision-makers can negotiate with researchers. This framework is adopted from a model proposed by Ross et al. (2003).

Framework for District Health Council Involvement in Scholarly Research in a 'Decision-Maker' Role			
	Formal Support	**Participant**	**Partner**
Arrow implies that each level of involvement may include all previous functions and scope	⟶		
Scope of Participation	• provides support for research study • not informed or actively involved in research process	• responds to researcher initiated study with ideas, information or advice	• significant involvement in initiating and shaping purpose of research, process and outcomes
Typical Roles	• legitimizes research is relevant to outstanding issues and/or needs that require information	• facilitates access to data and/or other resources • involved in interpretation of results • involved in identifying key messages and target audiences	• focuses research questions, purpose and goals • formulates and implements knowledge transfer strategies

Although Ms. Gold believed when she started she would work herself out of a job by changing the culture of the place, she changed her mind. "Now I think there will always be a need for knowledge brokers. Not all researchers have the skills to broker and disseminate knowledge," she said. "One study is rarely enough to shape policy. It takes a blend of research and ideas that only someone who has been around and has a broad perspective can supply."

Gaining access to knowledge and understanding the role of personal contact

The CanChild Centre for Childhood Disability Research opened at McMaster University in 1989 and was practicing knowledge transfer and exchange before most people had even heard about it in theory. CanChild's Knowledge Transfer Coordinator, Rachel Teplicky, told workshop participants that the group's original target audience was service providers in Children's Treatment Centres in Ontario. Its goal was to engage them to "maximize the participation and life quality of children and youth with disabilities… through health services research, education and dissemination of knowledge."

Over the years, CanChild has broadened both the target audience for its research and the scope of people involved in its work to include the children themselves, their families and Ontario's Ministry of Children and Youth Services. As Ms. Teplicky spoke, it became clear that its 15-year history–almost unequalled experience in knowledge transfer–offers an important long-term perspective on what works and what doesn't.

CanChild began with extensive consultation with the people who worked in the treatment centres. Over the first ten years, they kept going back and asking which providers and administrators in the centres needed research. Significantly, they found a large discrepancy between what those people wanted and what researchers were interested in studying. "There was fear the partnership would break down," Ms. Teplicky said, but a program of small grants for research by clinicians in the centres opened up lines of communication between the centre's researchers and practitioners. The idea of linking the two groups, unusual in the '80s, became normal.

CanChild used a variety of approaches for knowledge transfer, including:
- Sending out brief summaries of research, rather than peer-reviewed papers
- Regular meetings with practitioners
- Regular contact with researchers who worked in the centres
- A research "roadshow," where CanChild staff would travel to the centres making presentations and leading workshops
- Many visits to conferences around the province.

The techniques worked; information flow was good, and research was responsive to providers' needs. But times are changing. CanChild's funding has been cut; researchers no longer work in the Children's Treatment Centres and the flow of information is drying up. Also, Ms Teplicky thinks researchers may start to assume they know what providers need and get less conscientious about asking. There is less money for local travel, too–although CanChild continues to be in demand at conferences around the world.

Technology has also profoundly affected the way CanChild works, and not always for the better. "One thing that supported our partnership is we didn't have electronic communication," Ms. Teplicky said. CanChild now has a website, and e-mail, which make it possible to reach a great many people, but they also mean much less face-to-face discussion. They are hoping to make the most of dwindling resources with an intranet, "an electronic community of practice." Recognizing that not only researchers have expertise, they are drawing on clients and their families for the kind of feedback and participation they once got from in-house researchers–a practical necessity, and one that reflects the trend to widen the scope of people involved in knowledge exchange.

In discussion after the presentation, Melanie Barwick of the Community Health Systems Resource Group at the Hospital for Sick Children cautioned that electronic communication is not a substitute for face-to-face encounters. Her experience with children's mental health practitioners, points to a huge desire for in-person support from a workforce that is still not comfortable or experienced with computer technology. "The challenge is that knowledge exchange places new demands on the researchers' time,"said Jane Gibson, Director of Knowledge Transfer & Exchange at the Institute for Work & Health. Many acknowledged that in-person knowledge exchange, while effective, is hugely time consuming. Her colleague, Rhoda Reardon, a Knowledge Transfer Associate at the Institute, agreed in a line that became an unofficial theme of the conference, "While attending conferences in the cities of Europe is glamorous, we also need researchers to bring their messages to the folks at home," Ms. Reardon said.

Ms. Teplicky concluded on an optimistic note. She hopes that academic values will change, and there will be more rewards in the future for researchers doing knowledge transfer so it won't only be a drain on their research time.

Building from the ground up

Rachel Teplicky provided a retrospective view of knowledge transfer and exchange. Caroline Lonsdale brought a case study of the launch of a knowledge transfer project. Ms. Lonsdale is a program consultant in the Ministry of Health and Long-Term Care and is working on the development of the Ontario Knowledge Exchange, a project to get knowledge to front-line workers in long-term care facilities.

Long-term care has not been a topic of much interest to health-services researchers, Ms. Lonsdale explained. Thus, there has not been much pressure to disseminate knowledge. But that is changing as more people live longer with complex illnesses, both in long-term care centres and in the community–and everyone involved, from clients and their families to front-line workers and administrators, needs better information. Research and advocacy group activities are increasing.

The various types of long-term and community care and the variety of people involved present a particular challenge: many workers and consumers have limited access to computers, so the web-based approach of many knowledge-transfer efforts won't necessarily work for them. As well, workers in long-term care often have less education than those in hospitals–but they are every bit as busy. All those factors dictate a need for convenient access (including by phone, fax and face-to-face) to information that is packaged so it can be understood easily and quickly.

The idea of the Ontario Knowledge Exchange is to blend research knowledge and professional expertise through a combination of geographical chapters and "communities of practice" based on common interests (such as Alzheimer's, stroke or diabetes). The chapters will have "learning agents"–likely nurse practitioners–on site and there will be a librarian available to provide information and support research. Professionals will be able to consult each other (although this part of the exchange will not be available to clients).

"We hope that by all the people accessing this–researchers, residents, government–that we'll improve the quality of care," Ms. Lonsdale said. The importance of human connections will not be underestimated. One of the reasons for learning agents is to create and sustain that important face-to-face contact the workshop had already talked about. "The learning agent will be a person making face-to-face connections," Ms. Lonsdale said. "Communities of practice wither and die if you set them up and then leave them to themselves."
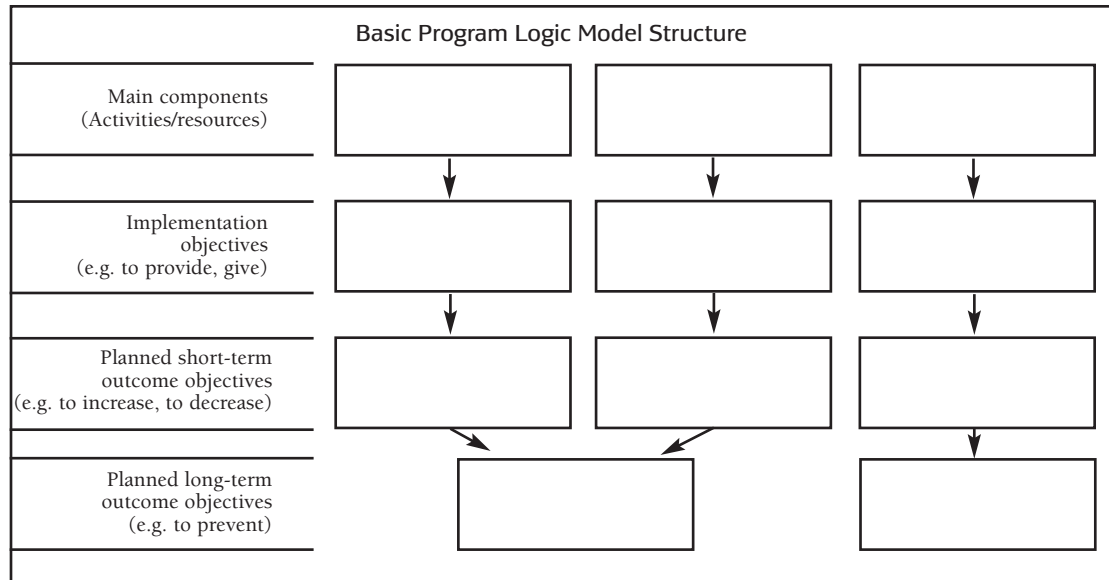
Gaining knowledge about transfer and exchange

Healthcare is complex. Healthcare is demanding. Healthcare is changing fast. And healthcare is under financial pressure. There isn't time to wait 10 or 15 years to do retrospective studies of what has worked in knowledge transfer and most of us have managers funding our work who want proof it does some good. So the afternoon session at the Ontario Regional Knowledge Transfer and Exchange Workshop focused on evaluation. How soon can one start evaluating? What's needed to do a good job of evaluating something? What is success?

Dale Butterill, Manager of Knowledge Transfer at the Centre for Addiction and Mental Health's Health Systems Research and Consulting Unit, chaired a panel on evaluation. It was opened by the University of Toronto's Rhonda Cockerill asking when it is fair to start evaluating a program. Some believe evaluation should be done from the beginning, others that programs must be allowed to find their feet first. Dr. Cockerill told participants evaluation is a framework to see if program goals are being met, and whenever it starts, these basic questions should be asked:
- What is the program trying to accomplish?
- What would success look like?

When programs are launched, people often fail to clarify the benefits they expect from them, or what they would see change if the program were working, in which cases, evaluation is not possible. Another flaw is that people's goals are often too broad–"improving health" may be the ultimate goal of a knowledge transfer effort, but it will be almost impossible to link cause and effect between improved communication of research and ideas and people getting healthier. Smaller, more realistic options, such as measuring adaptation of a report's recommendations, probably make a more reasonable goal for evaluation.

Brian Rush, Associate Director of the Health Systems Research and Consulting Unit, Centre for Addiction and Mental Health, offered the participants a logic model for evaluating programs.

Basic Program Logic Model Structure			
Main components (Activities/resources)			
Implementation objectives (e.g. to provide, give)			
Planned short-term outcome objectives (e.g. to increase, to decrease)			
Planned long-term outcome objectives (e.g. to prevent)			

To set up a logic model of a program, the squares are filled in with the inputs–such as money, staff and supplies–committed to the program, as well as constraints (perhaps laws or regulations) that will affect what is being undertaken. Then the activities are entered (in knowledge transfer, this could include setting up meetings, releasing research syntheses, or searching out information needed for policy and putting it in context for the decision-maker), followed by the planned short-and long-term objectives. These might include introducing the head of the policy branch of a ministry to the director of a research centre, or (long term) setting up an exchange program between government policy analysts and researchers. Once the inputs and goals are clear, assessing success on them should be possible.

Dr. Rush warned, however, that many aspects of evaluations vary depending on who does them. If the overall goals of a program are being assessed, the evaluation may not focus on knowledge transfer and its impact. "The discipline of the person you hire (to do the evaluation) will influence the measures selected and outcomes you find," he said. "An epidemiologist will look for and find different results than an organizational psychologist."

Another caveat is that logic models are very inward looking; they don't easily allow for external context. So they can show the connection between what you want to do and your intervention, but they will not reflect external factors that may have influenced the outcome.

Katherine Boydell told the workshop about an evaluation that the Canadian Coalition for Seniors' Mental Health did on the dissemination and uptake of inventories of resources for seniors' mental health issues. The attractive inventories listed books, websites, programs and videos on seniors' mental health and were directed mainly at front-line workers and caregivers. They reported needing more information–but did the coalition's inventory meet their needs? Distribution alone was no proof of use or value. They wanted to know whether people "acquire, assess, apply and adapt" the inventories to meet their needs.

Acquisition went well; most received the inventory through a mail out and no one reported barriers to getting it. Recipients responded well to it. Almost 100 per cent of front-line workers and caregivers considered it attractive and easy to follow, although one in five workers and one in three caregivers complained that information they wanted was missing. Application and adaptation were less satisfactory, however. Workers used it more; almost 80 per cent said they used it to find information, the largest share (89 per cent) to find websites, 54 per cent for books or magazines, 31 per cent for videos or CDs. But only half of caregivers in the survey said they used it. For them, too, websites and books were the most popular resources.

Karen Parent of Queen's University will undertake an evaluation of the Canadian Health Services Research Foundation's six Knowledge Brokering Demonstration Site Projects with colleague Malcolm Anderson. Their goal is to discover whether the work the foundation is sponsoring "increases the appropriate use of high-quality research evidence in decision making." They are also breaking new ground in methods of evaluating knowledge brokering. Their logic model consists of four components: structures, process, evidence and individuals.

There are different indicators to measure shorter or longer-term successes, Ms. Parent told the workshop participants. "In year one we hope to see increased resources for knowledge transfer–money, leadership support and protected time (for transfer activities)." "A successful broker," she added, "should have been able to get more people seeking research and more thinking critically about research. Do decision-makers accept research? Do they see its validity?"

In the long term, the questions will change. Is research evidence actually being applied? Is it changing policy or practice? "We really are looking for infiltration of research into the organization," she said. "We want to see signs of a cultural shift."

Successful implementation of evidence requires users to consider the clarity of the evidence, the quality of the context, and what actions are needed to bring about a successful change process, Ms. Parent said.

Proof of the effectiveness of knowledge brokering is important–first to get more research evidence used in health services delivery and policy development, then to win more support for knowledge transfer and knowledge brokering efforts themselves. Proof would encourage universities to allow time for knowledge transfer as a recognized part of an academic's work, and for organizations to recognize the value of knowledge brokering. It could also encourage the support in research grants that would permit transfer and exchange to be sustained over months or years.

Although it was heartening to hear in the morning sessions that so much is going on in knowledge transfer and exchange around the province, it was clear from the afternoon session that evaluation of transfer and exchange will never be easy. "Implementation of evidence is not linear," Ms. Parent warned. "It's messy and challenging."

Where are we going?

The workshop ended with a discussion of where to go next. Do Ontario's knowledge transfer practitioners want a formal organization? What is a community of practice and can we make it work? Would a chat room do, or do we just want to be friends?

Dr. Barwick from Sick Kids told the meeting that participants in a community of practice "create, expand and exchange knowledge to develop individual capabilities and a shared practice." The group, she said, is self-selected and held together by passion and commitment to the topic, although resources and facilitation are required for growth and sustainability.

Discussion at the meeting suggested people like the idea of a community of practice, but would like it based on something a little more solid than shared passion for a topic. Certainly, a desire to share knowledge, practical experience or advice and tales of success and failure were common themes, but there were also calls for some kind of framework or leadership. "List serves fail because no one facilitates them," said Caroline Lonsdale. Rhoda Reardon, who was leading the discussion, agreed. "People in this room are interested in forming a relationship that goes beyond today…but it won't happen unless somebody provides some leadership."

With a little persuasion, leadership was forthcoming: a group of volunteers agreed to meet to plan the meeting.

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4.0 Next steps

At the close of the workshop, several individuals expressed active interest in organizing another meeting, perhaps as an inaugural community of practice. One individual volunteered to facilitate this next meeting.

As with other knowledge sharing activities, we anticipate the biggest barrier to subsequent events to be time for participation. Workshop participants overwhelmingly wish to see future KTE/KB workshops in Ontario, however, focus and funding will need to be addressed in order that such workshops can be provided.

The Ontario workshop was developed on the basis of the CHSRF's desire to support regional knowledge brokering networks that could contribute to knowledge development and exchange on this important and evolving topic/role. We believe the Ontario workshop met its stated objectives (*please see Section 5.0 Evaluation on the next page*), and look to the CHSRF for guidance and support regarding future knowledge brokering and knowledge transfer workshops for Ontario. In the meantime, we will pursue the project's other deliverables and disseminate this report to multiple audience within Ontario and beyond.

# 5.0 Evaluation: Did the workshop meet objectives?

The Ontario Regional Knowledge Transfer & Exchange Workshop sought to bring together selected individuals from across Ontario specializing in the science and practice of knowledge brokering and knowledge transfer, in addition to the decision-makers with whom they partner. The purpose of the workshop was to advance understanding about the practice of knowledge transfer and exchange (KTE) and efforts to evaluate the impact of KTE activities.

Specific objectives for the regional KTE workshop were:
1. To share practice experiences in knowledge brokering (KB) and knowledge transfer and exchange (KTE) through dialogue and by example;
2. To initiate a compilation of practice and experiential learning related to KTE that will include strengths, challenges, and impact evaluation methodologies;
3. To uncover practices, successes and challenges in evaluating the impact of KTE efforts;
4. To explore the development of a Community of Practice for Ontario practitioners and scientists in KTE.

A participant evaluation was designed to assess the extent to which the workshop met its intended objectives. Responses were received from 23 participants, most of whom identified themselves as knowledge brokers or managers in knowledge transfer and exchange. The intended audience representation was achieved.

The use of narrative accounts of participants' experiences on the job was rather innovative, and we were interested to know whether participants viewed this approach as a desirable and useful way of sharing knowledge about current practices in knowledge brokering and knowledge transfer. Note that values are percentages.

Workshop Attendees by Role/Title
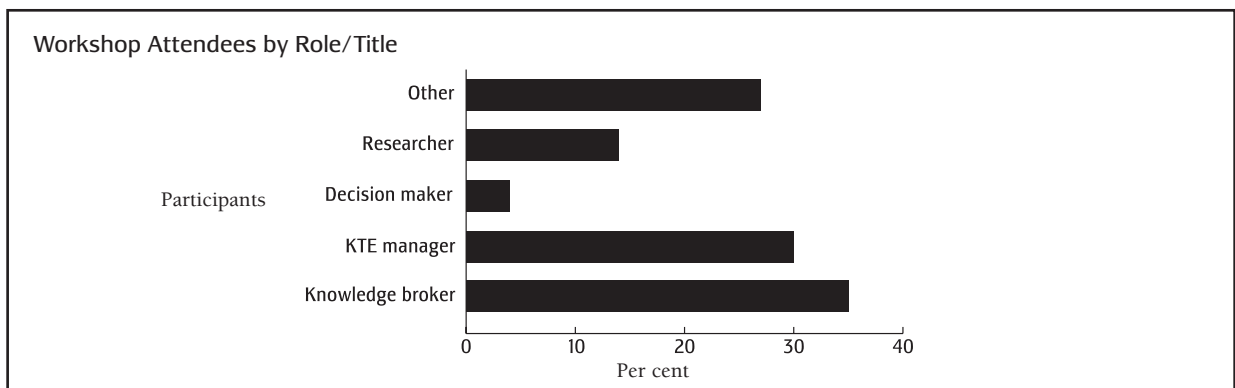
Response to Stories (in per cent)	Disagree Strongly	Disagree	Agree	Agree Strongly
I learned something new…	–	4.3%	56.5%	39.1%
I will take what I learned back to my work setting and share with colleagues…	–	4.3%	60.9%	34.8%
I liked this "Story" format for exchanging KT activities and lessons learned…	–	8.7%	34.8%	56.5%

The purpose of the afternoon evaluation panel was to address the question of evaluating the impact of knowledge transfer and exchange. Participant responses indicate that the format was effective for sharing knowledge on KTE evaluation, less so for evaluation of knowledge brokering.

Response to the Panel (in per cent)	Disagree Strongly	Disagree	Agree	Agree Strongly
I learned something new about evaluating the impact of knowledge brokering…	–	14.3%	61.9%	23.8%
I learned something new about evaluating the impact of knowledge transfer…	5%	10%	80%	5%
I will take what I learned back to my work setting and share with colleagues…	–	20%	55%	25%
I liked the panel format for exchanging evaluation knowledge…	–	4.8%	47.6%	47.6%

The workshop participants clearly appreciated the format for knowledge exchange and all reported interest in continuing the workshops for this group in Ontario. There is also majority interest in developing a network or community of practice environment for knowledge sharing and development of KTE and knowledge brokering practices and evaluation. Lastly, there is perceived value in a compendium of KT strategies and associate evaluative methodologies. However, given the recent direction for the development of a similar compendium from CIHR, it is unclear whether an Ontario-centric compendium would be useful to the field.

Response to the Workshop (in per cent)

	Disagree Strongly	Disagree	Agree	Agree Strongly
The workshop provided a good networking opportunity…	–	8.7%	34.8%	56.5%
I would be interested in attending a similar workshop for the Ontario region in the future…	–	–	36.4%	63.6%
I am interested in actively participating in the development of an Ontario KT/KB Community of Practice…	4.5%	4.5%	54.5%	36.4%
I am interested in actively participating in the development of an Ontario KT/KB Network (e.g., Contact information)…	4.5%	–	54.5%	40.9%
I would like to see a dynamic, web-based compilation of KT practice examples that would include examples of KT strategies, related challenges, and impact evaluation methodologies…	–	13.6%	36.4%	50%

Appendix: The KTE submitted stories

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Building concurrent disorder capacity at CAMH- pilot

The Concurrent Disorders Capacity-Building (CDCB) team was formed in response to the CAMH strategic priority of facilitating the capacity to offer integrated addiction and mental health treatment in all program areas at the Centre for Addiction and Mental Health (CAMH). In order to accomplish this goal, the CDCB team will coordinate the provision of CD training, knowledge transfer and exchange, clinical consultation and ongoing support.

One of the challenges in building capacity in such a large organization, with its diversity of programs and specialist areas, is to provide relevant and tailored education, training and support. We also recognize the importance of inter-departmental communication; collaboration and referral at CAMH, in order to provide the most seamless and integrated client care possible. Therefore, the CDCB team is focused both on assisting programs in their development of integrated CD capacity, and on fostering linkages between programs wherever possible.

Target audience:

CAMH Clinical Programs

Goals:

To facilitate the development of internal program capacity in offering fully integrated addictions and mental health care.

Methods:
- Programs set goals in Functional Program exercise: review and renew
- Each program identifies project leaders for their CD priority plans
- CDCB team works as resource to each program through all phases of this process

In order to accomplish these objectives, we are proposing a comprehensive CDCB curriculum that will cut across programs, and engage front-line staff and managers in an ongoing process of continuing professional education, development of new and/or enhanced client services, clinical consultation, and troubleshooting. We anticipate that the benefits of a curriculum that engages multiple programs and departments will extend beyond building capacity in CD treatment; we also envision a process of inter-departmental networking, support, and problem-solving.

The core curriculum is intended to go beyond traditional continuing professional education (CPE) initiatives, which emphasize clinical training workshops and follow-up consultation. Building on past research and practice in the areas of capacity-building (NSW Health Department, 2001; Iowa Practice Improvement Collaborative, 2003; CD Training Strategy Work Group, 2004), dissemination and knowledge transfer and exchange (Rogers, 1995; Martin et al., 1998; Cunningham et al., 1998; Herie and

Cunningham, 1998; Cunningham et al., 2000; Herie & Martin, 2000), this model can be regarded as multi-stage approach, broad in scope, that addresses:

- Readiness to adopt innovations (at both front-line and organizational levels)
- Practitioners' behaviour post-training
- Sustainability of new program initiatives, and
- Inter-departmental communication and collaboration.

The development and delivery of the core curriculum in CDCB will, itself, be a model for the approach by partnering with other CAMH departments in its development and application. Collaborating departments include:

- Staff Development
- Product development
- Clinical Programs
- Research

The core curriculum will be multi-faceted, ongoing and informed by research.

We recognize that the diverse programs at CAMH will vary with respect to their readiness to adopt CD integrated services, existing knowledge of CD, resources, client/patient demand for services, and overlap with other programs and departments. Therefore, the curriculum will be designed in such a way that each program can adapt and tailor CDCB offerings to fit with their own needs. Curriculum components include:

- A CD readiness and planning "tool kit," providing assessment instruments and templates for departmental and program planning in CDCB
- A CD clinical training series, in the form of face-to-face and online learning sessions
- CD clinical consultation/liaison service
- Clinical demonstration groups
- Online and classroom-based brief seminars and Rounds
- CD Journal Club
- Online CD journal
- Standardized training materials, including facilitators' guides
- Supplementary products, including books, videos and clinical tools, published by CAMH press, and
- Formative and summative evaluation data.

The configuration of these components, according to the needs and preferences of programs and staff, will be reflected in each program's CDCB planning document.

Evaluation:

A detailed and comprehensive evaluation component will be built into the capacity-building process. This will allow us to continue to refine the knowledge dissemination and exchange model we are developing, so that it can serve as a framework to guide our efforts with community partners in Ontario and beyond.

Lessons learned:

This project has just started.

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A unique knowledge brokering role

Target audience:

District Health Councils (DHCs) throughout the province of Ontario have a legislative mandate to plan for the delivery of health care in their communities and advise the Ontario Minister of Health on local health system requirements. This generates a rather unique situation in the knowledge transfer field, as health services research is of relevance to our organization as both a user of information; and in our role as local health planning researchers and advisors to the decision-makers that we serve.

Purpose:

As Manager of Knowledge Transfer at the Hamilton District Health Council, I provide leadership in implementing knowledge transfer and exchange. I am the only person in the provincial DHC system delegated specifically to the field. This position arose out of the foresight of my Executive Director, who was involved as a decision-making partner in one of the Canadian Health Services Research Foundation's (CHSRF) communication infrastructure studies.

Knowledge transfer and exchange role:

As a knowledge broker, it is essential to maintain personal contact and a presence with decision-makers. I sit on a variety of external planning committees and health services networks and participate regularly in local, provincial and national consultations. Within our organization, we have developed a formal approach to environmental scanning in order to identify emerging issues and trends that impact the health system or concern our community. This information is intended to inform our work. I am involved in clarifying information needs of decision-makers, who are often unable to express their requests in terms of research questions. We have created succinct, plain language reports from our larger technical reports to better communicate to target audiences' key messages from our findings. DHCs engage & facilitate the involvement of stakeholders to ensure our research is relevant and incorporates a community perspective. We have developed Ethical Guidelines to ensure our planning partners receive the support they require from us. Conversely, we recently developed a protocol for reviewing requests made to our organization to endorse and/or participate in academic research, which identifies a continuum of roles we might take, as well as define how we as decision-makers, wish to be treated in the partnering relationship. My time is also allocated to enhancing research capacity of our board and staff. I maintain an academic appointment as assistant professor (part-time) in the Department of Clinical Epidemiology and Biostatistics at McMaster University. A primary role involves teaching graduate students about the knowledge

transfer role from an in-the-field perspective. This academic time is supported by my employer.

Response:

The Hamilton DHC has generated an increasingly high profile in the field of knowledge transfer among provincial DHCs. Last year I was an invited speaker at the annual conference of District Health Councils. This resulted in an invitation to discuss our approach with the Ministry of Health and Long-Term. As a result of that meeting, the Ministry's template for requesting information from DHCs was improved to better communicate the intended use of requests for research and information. This enables DHCs to produce more relevant information for the Ministry. At the four year juncture point, knowledge transfer is better integrated into our organizational culture, language and ways of working. We have varied products and clearly articulated strategies and protocols for increasing the utilization of our health planning information and advice.

Lessons learned:

The leadership of the CHSRF has been invaluable in providing the initial high profile needed to propel the evolving knowledge transfer field to the forefront. As knowledge transfer becomes an integral component in the training of researchers, I envision greater incorporation of the knowledge transfer function by researchers and enhanced ability to produce relevant, audience-specific information. However, there will continue to be the need for continuous entrée into the decision-maker community by persons skilled in brokering relationships to ensure that research engages decision-makers in appropriate steps along the way. In addition, more attention needs to be directed towards operationalizing the mechanics of evidence-based decision-making. Decision-makers still lack rudimentary understanding how to use and weigh evidence and consequently cannot champion this approach with colleagues. In my opinion, this limits the opportunity for research to inform deliberated decisions, when they occur. If this need is addressed, there may likely be an even greater need for individuals who can broker information at timely junctures that transcends the work and availability of individual researchers.

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Inter-organizational networking for knowledge transfer

Target audience:

The target audience of The Greater Toronto Area Network of Hospital Programs for Dementia Care was management and clinical operators of such specialized and diverse programs in acute, rehabilitation, continuing care, and tertiary care hospitals.

Purpose:

Previously, there had been no mechanism for benchmarking, sharing best practices, or addressing common concerns in the dementia care sector. Six such programs in the GTA convened the Network in 2000 as a forum in which dementia care providers can share tacit knowledge and promote encoding their expertise into formal knowledge.

Transfer methods:

Network meetings hosted by participating hospitals showcased respective specialty program features. Thematic presentations on restraint use, fall prevention, ethical challenges etc. provided opportunities for struggles and learning to be shared. Operational policies are compared to facilitate refinement. The Network has inventoried differential resources offered by different hospital-types to guide future program development. More importantly, an informal peer consultation network has been established through member programs can readily access each other for support and test ideas for resolving challenging clinical and organizational crises.

Lessons learned:

Formal knowledge may abound in professional journals and accessible through conferences and seminars. But the sharing of tacit knowledge so vital to day-to-day service adjustment and resolution of immediate, complex operational and clinical issues requires trust between enquirer and consultant as well as an interactive context. The diversity and richness of knowledge accessible through a multi-organizational network is far superior to that restricted to one's own contextual organization.

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Report of the Ontario Regional Knowledge Transfer and Exchange Workshop – Appendix

"Gloss and finery" versus "show and tell": Understanding the complexities of effective poster presentations.

Category:

Researching and evaluating knowledge transfer to better understand what is effective.

Purpose:

My goal was to understand the role of poster presentations in the communication and exchange of knowledge. Although they are widely used for research and education purposes, poster presentations are almost taken for granted. But how do they facilitate the sharing and exchange? What types of information and knowledge are actually shared? What is the experience like for those preparing and presenting posters? How do they acquire the skills to do so? Does the experience of presenting posters enable individuals to take on more active roles in knowledge transfer and exchange in their organizations?

I explored these questions in qualitative case studies in two contexts: poster presentations by members of quality improvement collaborative teams in a health care organization and Research Day poster presentations by graduate students in a university department. I used a variety of methods, including interviews of participants before and after their presentations, observation of the presentation events, a survey of audience members at the quality improvement presentations, review of the posters, and review of the resources about posters that are available on the Web and in the literature.

Lessons learned:

Effective poster presentations combine three aspects: appealing visuals to capture attention; well organized, meaningful content; and engaging interaction with poster viewers. This mode of communication and exchange depends on visual and verbal rhetoric, and visual literacy.

Preparing and presenting effective posters requires multiple skills, including, for example, the ability to:

- Condense complex information down to a few "key messages"
- Represent the messages with strong visual elements and minimal text
- "Read audiences" to gauge their needs, level of interest and understanding

Basic 'tips and techniques' available on the Web and in most of the literature do not portray the complexities of this genre adequately. There are ways to coach (novice) presenters to help them acquire and improve those skills, but it seems that this need is often overlooked.

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Coordinated approach to implementation of preoperative testing: Clinical practice guidelines in Ontario hospitals.

Our story:

A story of using various transfer methods and mechanisms to bring research knowledge to those who can apply it in day-to-day decision-making.

Target audiences:

All health professionals involved in the ordering of preoperative testing (individual surgeons, anaesthesiologists, family physicians, nurses), Hospital Chiefs of Medical Staff, Chiefs of Surgery and administrators, and local opinion leaders.

Background:

Data suggest substantial inappropriate or over-utilization of routine preoperative testing for low and intermediate risk surgery in Ontario, specifically electrocardiograms and chest radiographies.

Goal:

The Guidelines Advisory Committee (GAC) undertook a guideline-based initiative to promote utilization of these tests consistent with best available evidence-based recommendations, and to reduce inappropriate use of preoperative testing.

Transfer methods:

Strategy consisted of multi-pronged interventions, including a Hospital Feedback Study, development of relevant clinical policies and practice tools (such as a preoperative testing grid), training of local Opinion Leaders, and Continuing Medical Education. It relied on GAC's unique partnerships through the Ontario Guideline Collaborative, representing the licensing authority for the province, the five medical schools' continuing education divisions, the provincial hospital association and others. Through the Feedback Study, hospitals received individual preoperative testing utilization profiles, guideline summaries, practice tools, and two follow-up reminders.

Evaluation:

Preliminary evaluation through a hospital survey conducted with Chiefs of Staff or designates indicates that the multi-faceted implementation strategy employed has influenced change in hospital policy for, and utilization of, routine preoperative testing.

Lessons learned:

Factors that can contribute to the success of knowledge transfer include: strategic selection of project partners (for this project, members of the Ontario Guideline Collaborative) and strong collaboration with them; integration of interventions in a multi-level, multi-pronged fashion; and adaptability and ability to employ alternate strategies to increase the impact of planned activities.

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Translating the field of Knowledge Transfer: Talking about KT in the breast cancer community

Target groups:

Women with breast cancer and breast cancer information workers (community group leaders, cancer information service workers, breast cancer nurses and social workers)

Purpose:

In 2003, the Centre for Research in Women's Health did an extensive literature review to understand the meaning of knowledge transfer for the breast cancer community. We combed through white and gray literature and carefully sorted through the myriad knowledge transfer terms we found. By the end of the review, we could talk about key ideas in KT theory and could differentiate between terms like knowledge translation, knowledge transfer, knowledge exchange, knowledge mobilization, and knowledge utilization. The final stage of this project involved sharing the literature with stakeholders from the breast cancer community to see whether the ideas we had uncovered were valid and meaningful in reference to their experiences providing and seeking breast cancer information.

Exchange methods:

We assembled focus groups of breast cancer survivors and breast cancer information workers to find out what ideas from the knowledge transfer literature meant to them. During these focus groups, we asked people to share their experiences seeking and sharing breast cancer information, and we also asked them what they thought about key concepts from the literature.

Lessons learned:

During these focus groups, we learned the degree to which the language that has developed in the KT field lacks relevance for people outside of the field. While we did our best to define any KT terms we used, focus group members saw the terms as needlessly dense and felt alienated from KT vocabulary. During the literature review stage of this project, it had seemed so important to understand and differentiate between the terms used by different groups (often to mean different things), but these terms only hindered our attempts to communicate with people on the front-lines of the very area we were trying to understand. We learned that the field of knowledge transfer itself requires translating to have meaning outside of its own research and practice circles. As KT

researchers and practitioners, we can be protective of the terms we have thought so long and hard about. However, in order to understand the KT that is going on in practice, we must be willing to discard our precise vocabulary and use language that has meaning within the communities we are engaging with.

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KTE story

It was a dark and stormy night…

Ok, I admit I'm bending the rules a bit. The guidelines say we are to relate our experiences actually doing KTE, not researching it or theorizing about it. This story is research-based but if we consider KTE activities including building relationships with audiences, and listening to them, then I think you could say we were doing KTE as much as researching it and theorizing about it. Already the plot thickens…

The story starts with a good idea (or so it seemed at the time). Let's help health services policy-makers describe their "policies" (i.e. what they want to inform) using consistent language that is meaningful to them so that then we can use this same language to describe health services research. Voila! Then policy-makers will know what research will inform their policies because the research will be described in a way that matches how they think about their policies. We'll get right on that.

Yo. I'll spare you the details here, but what we learned is that a policy is not a policy is not a policy. Our language efforts tried to get policy-makers to describe the "what" they wanted to inform. But they weren't trying to inform solitary "whats" that could be matched to individual research topics. They were trying to inform context-specific policy processes–many "whats" and the trade-offs between them.

Yo. Yo. This has huge implications for how we think about informing the policy process. Existing research needs to be interpreted and translated according to the decision-making process it can inform, and we likely have to promote new areas of broad policy-relevant research.

Did they kiss? Safely? Will they live happily ever after?

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Ontario knowledge exchange: Making knowledge more accessible to the community care and long term care sectors

Target audience:

Consumers, direct care providers, volunteers, managers/administrators and board members will be eligible to become members of a geographic local chapter of OKE or interest specific communities of practice (e.g. Alzheimer's).

Purpose or goals:

Better system and organizational support for using knowledge and best practices are essential to continually improve healthcare practice in the community. Individuals in the community and long term care sector have increasingly complex care requirements. Community and LTC organizations have seldom had the critical mass, time, resources or infrastructure for research and knowledge transfer.

Organizations involved in delivering community and long-term care services across the province have collaborated to form the Ontario Knowledge Exchange for Community and Long-Term Care, (OKE). The OKE will connect the dots of local and disease-specific learning initiatives already underway across the province, and provide a single point of contact to facilitate research and knowledge transfer.

Transfer method(s):

Access to relevant information in a practical and useable format (e.g. on the job, rooted in the reality of the front line practitioner) will be coupled with training in the skills to find and use it in a timely manner, as well as facilitated peer and expert consultation.

Members will be able to access OKE via Internet, fax, telephone and in person. Learning agents will be assigned to chapters and communities of practice to promote OKE, and assist learners to find and apply new knowledge and make the connection back to other chapters and communities. A librarian will support literature and resource searches, posting the results of popular topics in a format that is easily absorbed. Experts will also provide QuiKEs (summaries) in their fields that can be shared with consumers and front line health care providers.

Based on their login ID, individual learners would "see" their local chapter and the communities of practice in which they have an interest, related resources and opportunities for engagement to improve practice in community and long-term care sector activities. The peer consultation area of the website will be accessible only to health care professionals as a forum for exchanging innovative practices.

Evaluation:

Pilot phase has not yet been started, but does incorporate an evaluation component.

Lessons learned:

This OKE has been several years in the making, with several other initiatives in Ontario leading the way either on a regional or Community of Practice basis. Much interaction with the research/academic community has been required, as well as careful consideration given to the needs of learners in the sector.

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Building partnerships and enhancing knowledge transfer and exchange through a health system-linked research unit: Lessons learned over 15 years

Goals of our research unit:

The overall goal of CanChild is to maximize the participation and life quality of children and youth with disabilities and their families through health services research, education, and dissemination of knowledge.

Target audience:

When CanChild began in 1989, our primary target audience was service providers in Children's Treatment Centres in Ontario. Over time, our focus has broadened to include key decision-makers, such as the Ministry of Children and Youth Services (MCYS), and children with disabilities and their families.

Transfer methods:

Engaging our partners through research:
- By involving service providers, students, and families in research studies we have been able to provide training and education, and foster interest and enthusiasm for the results. In turn, our partners provide input that facilitates interpretation of findings and implications for practice.
- We have provided service providers an opportunity to "get their feet wet" in research by funding them to do their own studies, reviews of the literature review, or prepare proposals.
- We work collaboratively with the MCYS on projects specifically requested by them.

Translation, education and exchange:
- Written materials: journal articles, project reports, Keeping Currents, newsletters
- Computer supports: website, Intranet, self-directed CD ROM teaching tools
- Face to face networking: workshops, focus groups, presentations, teleconferences, responding to requests for information, identifying and nurturing champions

Evaluation:
- Documenting impact: clinical issues surveys; Buxton & Hanney's Payback model
- Tracking visits to our website, requests for information & visits
- Systematic evaluation of knowledge transfer techniques: written materials, knowledge brokers

Challenges:

- Current year to year funding makes long term planning and evaluation of KT strategies difficult
- Competing pressures on our partners to provide service at the expense of research and time to learn how to implement the research results in their own context
- Need for validated measures of research uptake

Successes:

CanChild is seen as a model of research partnerships around the world. Our long-term funding (initial funding was for 2 five year terms) has allowed for a more systematic program of research and transfer activities. It has also given us the opportunity to build long-term relationships that have fostered mutual support and trust with our partners. Working with our partners, we have learned how to be brief and targeted in our transfer materials. We have been able to provide increased opportunities and training for students and international colleagues. And we are still here after 15 years…

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The Link between Sustained Engagement and Knowledge Translation in Tobacco Control

This summary reflects our attempts as researchers to better understand the process involved in translating research into practice such that we can help promote evidence-based practice. We share the story of a provincial tobacco control coalition and its journey towards knowledge translation and exchange via their efforts to evaluate their tobacco control strategy. The Communities of Practice concept (Wenger, 1998) frames our description of their experiences with a focus on how *mutual engagement* between coalition members facilitated their knowledge use, translation and exchange efforts.

Target audience and goals:

The target audience of this provincial tobacco control coalition was the community and province at large. Situated within a small Canadian province, the coalition evolved from a recognized need to coordinate efforts across several sectors (NGOs, government, Hospitality and Tourism, Department of Education, business owners, researchers, etc) to develop and implement effective tobacco control legislation. The coalition therefore had two targets–to get a broad range of representatives from a number of sectors (target 1) committed to reducing tobacco use across their province (target 2). To do this properly, the coalition focused on implementing and evaluating all aspects of their provincial comprehensive tobacco control strategy.

Transfer method(s):

A core group of members involved in the 'start-up' of the coalition took an inclusive approach to garnering interest from others to join. This same approach was used when attempting to educate the public about tobacco use and garner support for legislation. Inclusiveness and ongoing engagement facilitated the development of unlikely partnerships as well as relationships (social and work) among coalition members and the public, making it easier to access, transfer and exchange information and knowledge.

To streamline their efforts, coalition members organized around specific areas of interest and expertise in tobacco control (e.g., cessation, prevention, protection committees). One committee was in charge of evaluating all efforts put forth by the coalition and translated evaluation results to the coalition in language that was easily understood and inherent within their "community of practice."

Committee members met monthly and the coalition gathered annual for their general meeting to debrief each committee's progress. Face-face contact of all members served to share their experiences, brainstorm and re-establish ties that further supported positive relationships. It also served as an effective means to keep members accountable such that

ongoing knowledge use, transfer and exchange activities were occurring within and external to the coalition throughout the year.

Lessons learned:

The experience of this coalition has been positive overall. Formation of the coalition was a struggle since a few core members had to gain support from a community whose culture did not yet support tobacco free concepts. They worked hard to engage diverse members of the community (business owners, schools, government officials). Political reps would not concede on implementing tobacco reduction legislation because the community was not favourable to this notion. Through ongoing, sustained engagement that allowed all to 'lay their concerns on the table', the coalition was successful in recruiting a comprehensive membership base and changing the province's culture around smoking, evidenced by the implementation of the desired legislation.

Difficulties have surfaced in maintaining constant membership. Membership has dwindled and seems to inflate when the coalition is focusing on an area of interest to the agencies involved. This continues to be an area of concern and has prompted contact with all members via telephone–indicated to be an effective means of reestablishing commitment. NGOs subsuming their identity under the coalition's name have also been a basis of contention. Through ongoing discussion members collectively negotiated how to give credit to individual bodies that were involved in tobacco control programs under the coalition's name. Degree of role specificity among coalition members has presented interesting barriers to knowledge transfer and exchange efforts. Coalition members often sit on more than one committee within the coalition as well as serving on committees external to the coalition (non-tobacco specific). Demands on members' time and having multiple foci limit the coalition's knowledge transfer and exchange activities. Conversely, being too specific in a role has presented problems. Depending on one evaluation expert, for example, has limited the amount of knowledge transfer and exchange and the expert's current leave from the coalition has halted evaluation efforts at this time.

The key feature of this "community of practice" was the presence of highly developed *mutual relationships* (Wenger, 1998), which facilitates open lines of communication and an environment where coalition decisions are collectively negotiated. The relatively small population size of the province and the coalition's emphasis on engaging many sectors has resulted in social capital, facilitating access to resources and expertise within the province and through these links, connected with and exchanging information with those beyond the province.

Reference:

Wenger, Etienne (1998) *Communities of Practice: Learning, Meaning and Identity*. New York: Cambridge University Press

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Youth and drugs and mental health: A resource for professionals

This resource is an updated version of the original Addiction Research Foundation's Youth & Drugs. It was researched, developed, & produced by CAMH in 2004. The resource is divided into three main sections:

Part One includes chapters on the following: an overview of youth substance use and mental health; relevant knowledge, skills and approaches in working with youth; identifying, assessing and planning treatment; treatment and support; and a chapter on pharmacotherapy.

Part Two has appendices that include information on risk factors and protective factors; a comparative overview of substance use and mental health services for youth in Ontario; a Do You Know section with information on common substances; a summary of screening and assessment tools information.

Part Three consists of *First Contact: A Brief Treatment for Young Substance Users with Mental Health Problems*, a treatment manual for service providers who are interested in an integrated intervention for youth with substance use and concurrent mental health problems. It incorporates motivational interviewing, and cognitive, behavioural and harm reduction approaches.

Before beginning work on the resource, the end users were consulted on what material needed to be included, the length, the format and price. They were also consulted regarding their preferred mode of training. The *First Contact* was field tested in five community agencies in Ontario followed by clinical trials at two hospitals and a community agency. The resource had an external advisory committee consisting of both addictions and children mental health representatives. 10 external expert reviewers from key provincial stakeholders' organizations reviewed the final draft of the material.

Target audience:

Any service provider or clinician who works with young people with substance use issues who may also have mental health issues

Purpose or goals:

To provide an up to date easy to read resource with the current best practices regarding working with this population. The objective of the first component of the dissemination rollout is to use this resource as an opportunity to bring together youth service providers (addiction, mental health and allied) who are interested in working together to develop and implement integrated treatment (screening, assessment, brief intervention) for Concurrent Disorder youth in their community.

Transfer methods:

Provincial workshops (eight in total) in communities where CAMH regional staff, in consultation with key partners, have identified service providers and allied partners who have an interest in providing integrated treatment. The workshop is held over two days with agencies sending a manager and a clinician as well as representatives from allied partners in the system i.e. education, youth justice, child welfare, government representatives. The workshop activities have separate and joined activities for the managers and clinicians with managers and allied partners attending the first day. CAMH will provide follow up support (training, protocol development, funding proposals etc)

The resource will be available in French and English through CAMH marketing at an affordable $40.00 (over 300 page resource) and an E-course is in development

Evaluation:

At three and six months, follow up contact will be made with the participants to evaluate whether the resource and workshop have had an impact on the clinical practice of the participant and/or their agency. At the workshops, CAMH will solicit targeted feedback on the resource itself, the training, and suggestions for future activities

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Accomplishing what cannot be accomplished alone: When health and safety partners are part of the research

Target audience:

The target audience was identified as potential users of research on effective interventions to reduce musculoskeletal disorders in the workplace. The audience was made up of occupational health and safety system stakeholders, including consultants within different sector health and safety associations, the Ministry of Labour, the Workplace Safety & Insurance Board, ergonomists and kinesiologists.

Purpose:

To include potential users of the research as advisors as well as partners within the research process. The goal was to ensure the relevance and usefulness of the research project, and help researchers gain access to community members, workplaces, and hard-to-reach decision-makers. We wished to achieve practitioner buy-in and involvement. We wanted to increase awareness and knowledge of the research findings, and increase the probability of the use of the evidence-based research in their decision-making.

Methods:

Over the last 13 months, there have been:
1) regular meetings with the organizational representatives that make up the Advisory Committee where representatives from four organizations and the scientist group have been present. Also, 21 meetings organized with researchers and different members of these organizations.
2) Twelve meetings with researchers and HSA consultants/ergonomists who will be the interveners in the workplaces.
3) Nineteen meetings with or presentations to organizations within the larger environment
4) Bulletins sent out to a mailing list of manufacturing and service sector organizations.
5) Newsletter articles written.

Evaluation:

The evaluation framework used two major criteria. The establishing a strong partner-researcher relationship was noted with evidence of establishing goodwill, reciprocity, and long-term alliances. The transformation of the research design and process through collaboration was noted when there was evidence of conceptual, structural, and strategic

changes to the research. Conceptions behind the research and implementation plans changed substantially during the development period in large part due to the input, ideas, challenges, and opportunities presented by the different partner organizations. The rate at which ideas have changed or been dropped, revised and adopted, has sometimes be problematic for both researchers and partners who sometimes have felt frustrated with the uncertainties. Health and safety system partners have often wanted the researchers to be more practical and for the research to reflect more of their workplace experience. Such feedback on what was feasible and what should be done have led to both clarification and strengthening of the research program.

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Beyond the Label: An educational kit to promote awareness and understanding of the impact of stigma on people living with concurrent mental health and substance use problems

Beyond the Label is a resource manual that has been designed to:
- Assist service providers in ensuring that their services are accessible and supportive to individuals with concurrent mental health and substance use problems by examining stigma and the barrier it presents
- Provide mental health and addiction workers with concrete tools to use in their agencies and in the community to raise awareness about the stigma associated with concurrent disorders.

Beyond the Label has been developed from research in the fields of stigma and concurrent disorders and through the knowledge obtained from people living with concurrent disorders, their families, and the professionals working closely with them. This is not an information resource on concurrent disorders. This educational kit focuses on the stigma associated with concurrent mental health and substance use problems. It includes activities that can be used in workshops from five minutes to three hours. Through this learning process, participants will build on their ability to understand stigma and its impact

Target audience:

The target audience is those who provide addiction and mental health services and have a critical role to play in addressing stigma. It is also intended to be used with volunteers and board members of agencies.

Transfer methods:

A series of interviews with consumers, CAMH staff and people in key positions of influence across Ontario identified stigma as a barrier to service. The literature and major Canadian and American groups were identifying stigma in mental health as an issue to address. A project team developed the resource and a pilot was held with 11 communities and over 100 participants to evaluate the training. The results indicated that the participants intended to change their practice as a result of participation in the session. This evaluation effort was not only part of the review before completion of the manual but also part of the transfer method.

Beyond the Label will be distributed to agencies across the province, and available in a print format, disc format and Portable Document Format on the CAMH website. A number of presentations have already been given about *Beyond the Label* to a broad audience of providers across Ontario. CAMH project consultants will be conducting a number of workshops in cooperation with another facilitator in each region and leaving the manual with the agency. Internal transfer methods are in the planning phase.

Evaluation:

The Capacity survey to be conducted this spring and in three years will ask about attitudes and attitude change about stigma.

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Best practices in community education in mental health and addiction with ethnoracial/ethnocultural communities

This project builds on recent research reports and needs assessments conducted in partnership with culturally diverse communities and health promotion/population health initiatives undertaken by CAMH. The Phase One focused on low-risk alcohol use, and employed the Low-Risk Drinking Guidelines (LRDG) as the vehicle to test the best practices approach. The project is a direct response to needs identified by different ethnocultural communities for a culturally and linguistically appropriate health education initiative addressing mental health and substance use problems including alcohol use. A model for best practices in community education and knowledge exchange in mental health and addiction with ethnocultural/ethnoracial communities, the final outcome of the project, will provide comprehensive, effective and culturally sensitive approaches to meet the health promotion needs of diverse communities.

Project aim:

This provincial project aims to research, identify and develop a best practices model for community education and knowledge exchange in mental health and addiction with ethno-cultural communities to ensure that programs effectively address the needs of these communities.

Target audience:

Mental health and addiction systems, agencies serving persons from diverse ethnoracial/cultural communities, members of ethno-racial/cultural communities. The project aims to increase access to the best approaches in addiction and mental health community education and knowledge transfer for CAMH staff, service providers and allied professionals. A model for best practices in community education and knowledge exchange in mental health and addiction with ethnocultural/ethnoracial communities, the final outcome of the project, will provide comprehensive, effective and culturally sensitive approaches to meet the health promotion needs of diverse communities.

Transfer methods:

The project is a partnership between CAMH and community-based organizations that provide services to the following groups: Polish, Portuguese, Punjabi, Russian, Serbian, Somali and Tamil. Over the period February–July 2004, 18 focus groups were conducted with key informants and community members from the seven participating communities

that differ substantially in their cultural characteristics and religions. The main purpose of the focus group discussions was to identify alcohol consumption patterns, cultural practices and culturally appropriate and effective health promotion strategies to address substance use and mental health issues within participating ethnocultural/ethnoracial communities. The focus groups findings will guide the next phase of the project to culturally adapt the LRDG or develop alcohol related messages that incorporate the audience's cultural beliefs and values, and translate them in the native language of the communities. The translated materials will be pilot tested with both primary and secondary audiences, produced and disseminated.

Evaluation:

Process evaluation has just been conducted. Outcome evaluation will be conducted in the fall of 2005.

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Ask the people: Building a collaborative network to advance the arthritis care research agenda

The use of non-pharmacological treatment is common among people with arthritis; however, patients and clinicians are facing some challenges concerning their use. First, the evidence on the majority of non-drug treatments is either weak or inconclusive. Second, there is a lack of knowledge on the elements associated with models of team care and non-pharmacological care. Finally, disparities in knowledge translation have hindered the adoption of evidenced-based interventions and the growth of research in the field. These challenges can only be successfully addressed through a collaborative effort of patients, decision-makers, clinicians and researchers.

The Third Care Conference on Team Care and Non-Pharmacological Management of Arthritis The overarching aim of the Care Conference (CARE III) is to improve team care and non-drug, non-surgical interventions for people with arthritis. On May 12 - 14, 2005, 75 invited delegates (patients, policy-makers, clinicians and researchers) from North America and Europe will gather in Toronto to discuss important issues on team care and non-pharmacological intervention research. The purpose of this international consensus meeting is to develop a meaningful research agenda and to establish a knowledge exchange network among researchers, clinicians, funders, administrators from disease specific organizations, and patients.

Knowledge exchange strategies

The Care III planning committee has developed the following framework to engage stakeholders and the arthritis community-at-large in the development of the research agenda and knowledge exchange strategies: (See table on next page)

Participants	Researchers	Clinicians	Funders	Administrators	Patients
KE Activities					
1. Involve representatives in the planning committee	●	●	●	●	●
2. Invite representatives to participate at the CARE III consensus meeting	●	●	●	●	●
3. Involve participants in the design of the conference contents using online "Team Rooms"	Care III invitees are obligated to participate in one of the three virtual working teams facilitated by 3-4 planning committee members.				
4. Online patient survey (Canada, USA, UK, Sweden, The Netherlands) on issues relevant to arthritis care and research priorities. The results will inform discussions at Care III	Design & interpret findings	Design & interpret findings	Design & interpret findings	Design & interpret findings	Design, complete survey & interpret findings
5. Create linkages with upcoming research and policy conferences in arthritis and collaborate on KT strategies	Care III Co-chairs work collaboratively with planning committees of Bone and Joint Decade Meeting and Standards of Care Conference (Oct 2005)				
6. Engage the arthritis community-at-large in discussing, developing and disseminating the research priorities, and to facilitate the implementation	• Editorials about care research and Care III published in relevant academic journals • Workshop proposals submitted to Canadian and international conferences to disseminate outcomes of Care III • Partnerships with disease specific organizations and the industry to develop a public relation strategy.				

Evaluation

The evaluation framework of Care III is currently being developed. We foresee some of the major outcomes will be the creation of funding themes related to the proposed research priorities by major funding agencies and an increase in proposal submissions on arthritis team care and non-pharmacological intervention research.

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Communications as a support activity for successful knowledge transfer

At the Institute for Work & Health, the Communications Department and its activities are an integral part of the overall knowledge transfer strategy. The Communications group supports KT initiatives through the use of corporate communications vehicles (primarily the web site and newsletter), media relations, and the development of specific materials that support the activities of Knowledge Transfer Associates in their exchange of information with target audiences. The KT activities are built on five guiding principles including the principle of audience-specific messages. This principle is inherent in all communications activities.

Target audiences:

The Institute has several key audiences-clinicians (including physicians, physiotherapists, occupational therapists, occupational health nurses); workplace parties (employers, employees, organized labour); policy-makers (Workplace Safety & Insurance Board, Ministries of Health and Labour)

Purpose and goals:
- To support and further disseminate the audience-specific knowledge transfer messages that are developed by the knowledge transfer associates and the researchers
- To provide synthesis and plain language expertise in the development of support materials

Transfer methods:
- Both the web site and the newsletter have audience specific sections
- Media relations activities aim to reach target audiences through the selection of key media who reach those audiences
- Corporate contact database has been set up to allow identification of audience type and interest so new material can be targeted
- Conferences–IWH targets important conferences of key audiences and develops targeted materials for those events
- Syntheses–A highly skilled writer produces "lay" material in a variety of forms (newsletter, features, executive summaries and overviews etc.)

Evaluation:

Communications undergoes a full evaluation (multifaceted) every two years. Benchmarking exercise for the web site slated for end of 2004, early 2005. The last evaluation two years ago, suggested the web site was the main communication tool used by target audiences. A major overhaul of the Institute's website followed the evaluation.

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Ethics education for health care professionals: Distance education offered by the Provincial Health Ethics Network of Alberta

Note: Since I have just recently started in my position with the Ontario Women's Health Council, and since a large component of my position will be to work with the organization in developing knowledge transfer strategies, I am going to share a story here from a previous organization I had the privilege to be a part of.

Target audience:

Health care professionals working at the "front lines", e.g. nurses, physicians, social workers, health care administrators, members of ethics committees.

Background/goal:

Many health care professionals in Alberta, including those sitting on hospital or regional ethics committees, have limited or no formal education in health care ethics. Furthermore, courses in health care ethics offered by universities or institutions in urban centres are generally not accessible for practicing rural professionals. The Provincial Health Ethics Network (of Alberta) developed a distance education course with the goal of bridging theory and practice. The course aims to bring the tools of academic health care ethics to health care professionals working on the "front lines", in a format which would be accessible to busy, practicing professionals.

Transfer methods:

The learning activities of the 15 week course include:
1) Videotaped Lectures on various topics delivered by prominent bioethicists from across North America,
2) Weekly teleconferences, where a small group of participants have the opportunity to engage in a discussion session with an expert in the field of bioethics,
3) Class web-board/listserv where participants can engage with each other in facilitated discussion, and
4) Course readings and assignments.

Evaluation:

Course participants were asked to complete written course evaluations at the mid-point of the course and at the completion of the course. A group discussion was also held at the final "in-person session" to elicit participant's views of the strengths and weaknesses of the course. Course evaluations focused on
1) The effectiveness of the format and delivery mechanisms, and
2) How participants rated their change in ethics-related skills after having completed the course. One year after the course concluded, participants were asked to complete a follow-up evaluation describing how they rated their ethics-related skills immediately after completing the course, compared to one year later and exploring any barriers/challenges they discovered in trying to put their learning to practice.

Lessons learned:

- **Level of support required for busy professionals.** It was extremely helpful for us to recognize and appreciate the busy schedules of professionals, most of whom were working full time and undertaking this learning opportunity in their personal time. We sought to find ways of making the course as user-friendly and as supported as possible. This included trying to identify the learning needs of each participant and communicating regularly to ensure participants were "on track".

- **Value of knowledge exchange.** In the first few offerings of the course we were delighted, and somewhat surprised, to find how willing and enthusiastic our renowned speakers from all over North America were to engage in an evening teleconference with a small group of health professionals from Alberta. What we came to learn was that our speakers found these sessions to be valuable learning tools for themselves as they heard first hand about the ethical issues, challenges and needs the practitioners were facing.

- **Now what?** We learned from our one-year follow-up evaluations, and from communicating with graduates of the course, that there is a need for increased follow-up support as practitioners tried to implement their new skills. Some faced barriers within their organization's ethics committees or in navigating change of practices with other colleagues; others sought guidance as they aimed to develop an ethics committee or resource group within their institution, while others wanted to know how they could continue developing their skills.

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One knowledge broker's journey: Where am I and how and when did I get here?

Background:

Currently employed as a Knowledge Broker with a RCT research project, a "new" knowledge broker reflects about her new role and wonders, "When did I become a knowledge broker? Was it once I assumed this position and was officially granted the title? Did I not function in this role before without title, perhaps without recognition?"

Target audience:

Knowledge Brokers–official and otherwise

Purpose:

To explore, through a story and subsequent dialogue, the activity called knowledge brokering and the many ways, settings and people involved

Transfer methods:

In various roles and in various settings this knowledge broker has worked with researchers, audiences, built relationships and partnerships, developed communities, and participated in research and evaluation of knowledge transfer strategies.

Evaluation:

None

Lessons learned:

What is Knowledge Brokering?

It is not something simply done by those called "Knowledge Brokers." Whether or not you are doing this activity called knowledge brokering depends, not on title, but by the actions one takes, how one performs them, and with what results.

How to do it:
- Get to know people
- Start where they are "at"
- Keep current
- Create a network
- Never say no or I can't
- Learn from others and yourself
- Food always helps

Who can do it?

In this case, knowledge brokering was performed by a student, a front line public health nurse, a public health supervisor, a policy analyst within the federal government, a director with a national non-governmental organization, and now a knowledge broker.

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Research goes to the cinema: Rural research knowledge translation and documentary film

A 52 minute documentary based on the research study *The Rural Perspective on Continuity of Care: Pathways to Care for Children with Emotional and Behavioural Disorders*, Boydell, K.M., Pong, R., Volpe, T., Tilleczek, K., Wilson, E. and Lemieux, S. Ottawa, ON: Canadian Health Services Research Foundation, May 2004.

Background:

The rural health research project was a collaborative study by the Centre for Rural and Northern Health Research at Laurentian University and the Hospital for Sick Children in Toronto. It examines and documents the barriers and pathways in relation to children's mental health services in Ontario. In addition to community consultations, in-depth interviews were conducted by the researchers with 30 parents of children with mental health issues and 30 service providers.

Purpose/goals:

Research dissemination is becoming an integral part of the health research process. The research team decided to produce a documentary film based on this study as a means to communicate an important message to a wider audience in a more forceful manner. The target audience of the documentary is diverse, including mental health professionals, young people and their families, and policy and decision-makers. The documentary was intended to explicate the realities of the rural mental health "system" from the point of view of family members.

Lessons learned:

This presentation will outline the decisions made and the process undertaken in transforming this research into a documentary film. Included in the discussion are issues related to getting research participants to agree to be involved in the film project, ethics, disparate methodologies of social science and film, turning written material into visual narrative, reflexivity, editing, and working with an interdisciplinary research team and film crew.

The use of documentary film as a means of knowledge translation will be discussed. The juxtaposition between the documentary genre and social science research will be examined. Film is designed to serve scientific discourse– a complex construct–whereby cinematographic techniques are more or less purposely used to communicate a scientifically informed view on the subject matter. Film is a particularly rich and culturally embedded medium which relies on much more than purely visual channels of information.

Evaluation:

Funding is currently being sought to evaluate the community discussion groups and the effectiveness of the film as a knowledge translation strategy.

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Canadian Identities Database (CID): An interdisciplinary reference database of Canadian research on identity

Background:

A great deal of research has been done in Canada that focuses specifically on issues of identity. Unfortunately this material is difficult to access since it tends to fall under various overly general rubrics, including cultural identity, social identity, ethnic identity, racial identity, group identity, as well as self-concept. Used as keywords, these terms are often simply convenient 'catch-alls' that are primarily descriptive in nature. Moreover, variations in word usage also exist across the different disciplines. As a result only one in five items retrieved via existing search terms commonly used in various on-line search engines and library catalogues actually deals with identity per se.

Purpose/goals:

The Canadian Identities Database (CID) is an interdisciplinary electronic reference database of Canadian research on identity developed to facilitate stakeholder access to this highly specialized research literature. The CID database is based on a thorough literature search of the English-language Canadian research literature on identity and focuses on the major socio-cultural identities deemed relevant in the Canadian context, including aboriginal, ethnic, national, linguistic, regional, racial and religious identifications.

Database contents. The CID contains over 3000 retrieved or specially prepared reference abstracts for journal articles, books, reports, theses, videos, governmental documents, unpublished manuscripts, recent graduate work and research project reports from a wide array of disciplines and fields of study. The latter includes anthropology, education, geography, history, psychology, sociology, political science, as well as ethnic, native and women studies. These carefully selected research references were retrieved via extensive on-line literature searches and include both published and unpublished 'grey' materials. The database's timeframe is limited only by the various search engines services themselves includes very recent materials.

In addition to a complete reference abstract, each research reference item also contains detailed analytic coding regarding identity. This detailed analytic coding scheme has been specially developed for the CID and is based on a "content analysis" of all of the materials retrieved via the extensive literature search. It contains the following five main fields: Types of Identity; Specific Identities; Identity Processes; Group Dynamics; Role of the State. Detailed coding within each of these five fields provides maximum search flexibility as well as the rapid retrieval of references dealing with even the most specialized identity topics.

Target audience/evaluation:

The database's targeted audience includes researchers, scholars, policy-makers, program developers, media representatives, educators, students and the general public. Canadian Heritage has used the CID since 2000 to inform Ministerial briefings, plan research-funding priorities, and assist in the development of programmatic initiatives.

Transfer methods:

The CID is readily accessible via a desktop icon on staff computers at the Department of Canadian Heritage (Multiculturalism Program) in Ottawa. Plans are underway to translate database abstracts into French and to make the database accessible to the general public via government website access.

The Canadian Identities Database has been designated a University of Toronto invention (Rummens 2002).

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