

LEVERAGING KNOWLEDGE: ***Tools & Strategies for Action***

Report of the 7th CHSRF
Annual Invitational Workshop
Montreal, Quebec
March 3, 2005



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

Our Purpose

Vision

Our vision is a strong Canadian healthcare system that is guided by solid, research-based management and policy decisions.

Mission

To support evidence-based decision-making in the organization, management and delivery of health services through funding research, building capacity and transferring knowledge.

Strategy

To establish and foster linkages between decision makers (managers and policymakers) and researchers in the governance of the foundation and in the design and implementation of programs to support research, develop researchers and transfer knowledge.

This document is available on the Canadian Health Services Research Foundation web site (www.chrsf.ca).

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Table of Contents

Main Messages	4
Executive Summary	5
Evidence-Based Government: No Quick Fix	7
<i>A Cultural Shift</i>	7
<i>Systematic Reviews and Research Literacy</i>	9
<i>Collaboration</i>	10
Past the Edge of the Old Place	11
The Communal Tool Box	13
<i>Harnessing Technology</i>	13
<i>Bundling Research for More Effective Decisions</i>	14
<i>Accessing Information</i>	14
<i>Nurturing Communities</i>	15
<i>Collaboration between Researchers and Decision Makers</i>	15
<i>Impact and Evaluation</i>	16
A Call to Change	17
References	19
Additional Information	19
Appendices	20
<i>Appendix A: Agenda</i>	20
<i>Appendix B: Participant Demographics</i>	22

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Main Messages

- Evidence-based government is possible. In fact, it is already well-established in some areas of policy.
- The reality of evidence-based government is that policy is far more than an exercise in implementing research – experience, tacit knowledge, judgment, and the expertise of bureaucrats and ministers combine with the components of politics to shape policy.
- Using only research evidence is not a quick fix for the complex challenges of decision-making. However, evidence-based organizations help to make well-informed decisions by putting the best-available research at the heart of policy.
- Habit is the greatest barrier to implementing evidence-based policy-making.
- Collaboration between the various players who use and create research evidence continues to be at the heart of fostering effective evidence-based organizations and processes.
- More research is not enough. We need to do a better job with the research that we have – packaging it in a format that can be implemented, ensuring the research is of top quality, bundling results from various projects, and so forth.
- Building evidence-based organizations requires a culture able to adhere to high standards for finding and using evidence, a culture committed to developing the skills and tools needed to integrate evidence into decision-making.
- Creating a culture that will embrace the many elements of evidence-based decision-making requires vision, risks, flexibility, diversity, inquiring minds, and commitment.
- Commitment from health system leaders and senior government officials is essential to ensure the success of evidence-based organizations.
- Impact and evaluation are fairly new in the world of evidence-based decision-making. Looking ahead, it is important to understand what strategies work or not, the contexts in which they apply, why they are effective, and how to measure impact.


Executive Summary

In an ideal world, making policy would be an exercise in addressing issues with sound knowledge and reasoned judgment – a conscientious application of thought and information to developing plans for the actions of government or organizations. But as we know, many other components – including politics, lobbying, and resources – have a huge impact on shaping policy. Knowledge based on research evidence is often well down the list of ingredients when making decisions and implementing policies. When it is present, it is often misused: manipulated to suit the situation, incomplete, dated, or of poor quality. Despite the odds, examples of evidence-based policies exist at organizational, local, provincial, and national levels.¹ The question that remains is how do we foster the creation of evidence-based organizations and policy more often? It requires a culture able to adhere to high standards for finding and using evidence and committed to developing the skills and tools needed to integrate evidence into decision-making.

The need to develop culture, skills, and tools led to the theme for the Canadian Health Services Research Foundation's 2005 annual workshop, *Leveraging Knowledge: Tools and Strategies for Action*. We took a new approach to the workshop this year. The concepts of knowledge transfer and exchange are becoming well-established in the health services community. So this year, over the course of the day-long meeting in Montreal, more than 170 health services researchers, managers, and policy makers from across Canada shared their commitment to integrating research into policy-making and explored ways to make that happen.

It requires a culture able to adhere to high standards for finding and using evidence and committed to developing the skills and tools needed to integrate evidence into decision-making.

The conference began with a keynote address by Phil Davies, deputy director of the United Kingdom's Government Chief Social Researcher's Office. His job is to ensure policy is evidence-based. He defines evidence-based government as an approach to "help people make well-informed decisions about policies, programs, and projects by putting the best available evidence from research at the heart of policy development and implementation."²



An academic and researcher before joining government, Dr. Davies' goal is "to ground thought in robust evidence." Robust evidence is more than just up-to-date information. It must be systematically gathered, evaluated, and interpreted to the highest standards possible – and then the other aspects of policy-making come into play. "We must remember," he told the meeting in his keynote speech, "evidence-based government is no substitute for thinking-based government. If you don't think about your audience, then evidence-based government has no meaning."

"...this is a time for new skills, more openness to each other, and a return to valuing flexibility and encouraging creative questions."

– Sister Elizabeth Davis

Dr. Davies set the tone for the whole day by providing the foundation for participants to discuss ways to create, exchange, and transfer knowledge for healthcare policy- and decision-making. Throughout the day's panel presentations, group discussions, and workshops most participants acknowledged the challenge associated with making this a reality: troubled times in healthcare over the past decade have left a battered workforce led by risk-averse managers and a general confusion over where to go or what to try next. But as Sister Elizabeth Davis, chair of the foundation's board, said in her closing remarks, this is a time for new skills, more openness to each other, and a return to valuing flexibility and encouraging creative questions. "Vision," she said, "can never be held by one person. It has to be held by the community."

Evidence-Based Government: No Quick Fix

The United Kingdom's labour government identified the importance of evidence-based government in two papers. *Modernising Government*³ said government policy must be evidence-based, properly evaluated, and based on best practices, while *Professional Policy Making for the Twenty-First Century* said "policy making must be soundly based on evidence of what works."⁴ According to Dr. Phil Davies, deputy director of the U.K.'s Government Chief Social Researcher's Office, some departments have adopted the concept more readily than others, and there is a great deal to learn from both sides.

"...the rhetoric around evidence-based government does not translate into a quick fix. It's not even a slow fix. It is about an attitude that helps you fix things, helps you see things more clearly."


– Dr. Phil Davies

Clearly, evidence-based government is not a miracle solution for the complex challenges of creating policy. According to Dr. Davies the rhetoric around evidence-based government does not translate into "a quick fix. It's not even a slow fix. I don't think it is a fix of any kind. It is about an attitude that helps you fix things, helps you see things more clearly."

Above anything else, Dr. Davies is uncompromising about quality: the evidence used in policy-making must meet consistent, rigorous standards. "Where it doesn't, its shortcomings must be acknowledged – although simply falling back on the old plea 'more research is needed' is not the answer." According to Dr. Davies, cultural changes both within and outside of government must be made. Policy makers need to be trained in critical appraisal and research use. Researchers must leave behind the tradition of academic squabbling and work together with decision makers to deliver knowledge tailored to need. Above all, there must be top-level officials who have made a commitment to the concept of using evidence in policy.

A Cultural Shift

There are plenty of challenges in moving to evidence-based government. Policy makers are not trained to develop research questions, so working together with researchers to define the issue in an answerable form is crucial. Researchers must adapt and learn not to say "that's the wrong question." Policy research must challenge accepted wisdom; many policies have failed because no one ever questioned the underlying assumptions they were based on. Research that is to influence policy must question the biases and assumptions that influence current practices, moving beyond the acceptance that this is how things have always been done.



Habit is the greatest barrier to change and, therefore, to implementing new processes such as evidence-based policy- and decision-making. The attitude that “we’ve always done it this way” is difficult to overcome. That may be why, even when valid evidence is presented, it takes special incentives to get it implemented into policy – these can come in the form of rewards for implementing good evidence and/or some form of disincentive for not using it. The greatest incentive is support from the top. Evidence-based policy is successful when it is applied and encouraged by senior officials. Time after time, if health system leaders are seen to “take ownership” of research, its integration into policy-making is far more likely to succeed.

The reality with evidence-based government, Dr. Davies pointed out, is that policy is far more than an exercise in implementing research – experience, tacit knowledge, judgment, and the expertise of bureaucrats and ministers combine with the components of politics (lobbying, public opinion, the media, and values) to shape policy. “We as evidence-based practitioners ignore that at our peril,” he told participants. “Evidence-based means integrating experience, judgment, and everything else with the systematic use of research evidence.” The many factors that influence policy should not be ignored. Rather, they must be acknowledged and understood for evidence-based government to become a reality.

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Adding another element to the equation, Dr. Kevin Keough, president and chief executive officer of the Alberta Heritage Foundation for Medical Research and formerly chief scientist at Health Canada, reminded us that politics often trumps research. Ultimately, Dr. Keough said, while the use and acceptance of evidence in policy-making is increasing steadily, if you can’t sell an idea at the cabinet table, the evidence doesn’t matter. And you won’t sell your idea if you can’t communicate in a simple form; ministers don’t have time for even page-long briefing notes. To make the most out of research evidence and to reach policy makers, “give them something in a paragraph (to) get their attention; better still if you can give one sentence that can be a slogan, a mantra they can repeat. That’s the most important thing you can do for them.”

Beverley Clarke, CEO of Health and Community Services for St. John’s Region in Newfoundland, said evidence is moving into practice, although slowly. “You can see evidence coming through in terms of the focus now on patient safety and the focus on having indicators and benchmarks,” she said. Despite the apparent lack of support for research in the provincial government’s policy shop, measuring results and setting standards encourages evidence-based decision-making. “We need more people doing it and we need to create a culture where research really does make a difference in terms of the decisions we make,” Ms. Clarke said.

Systematic Reviews and Research Literacy

Dr. Davies outlined some of the tools and processes needed for decision makers to use evidence more effectively. He emphasized that all work must begin with systematic reviews of existing evidence, “a way of learning what we do and don’t know.” Evidence-based government doesn’t inherently mean doing more research; there is already too much hastily commissioned and executed research and too much duplication. Systematic reviews apply transparent and rigorous standards of selection and appraisal to the gathering of information. Single studies, which are probably the most common source of research evidence used by government, tend to be too context-specific, and the information they provide can be unrepresentative and difficult to adapt to varying contexts, populations, and conditions.

Furthermore, there is a definite need to train and build the skills of health system managers and policy makers. It is not enough to teach researchers to package their research in a user-friendly way. Policy makers also need to become more rigorous, fair, and thorough in their use of information. Dr. Davies counters that most professions, such as the law, medicine, and architecture, demand practitioners have an ability to manage evidence. “Only policy-making still thinks of itself as an amateur enterprise, dilettantes doing the best they can,” he said. Policy makers need to develop research literacy and learn how to appraise its quality. At the same time, researchers need to leave behind their competitive tendency to attack each other’s work and learn instead to share information and work co-operatively with policy makers and each other. The academic tradition of focusing more on the limitations of research than on its findings doesn’t help either – it’s a challenge for policy makers to find the message when it is too thickly hedged with warnings and caveats.

Despite its best attempts, the fact is that some research is woefully inadequate for policy-making, said Dr. Davies. Research studies are often badly designed, and reports in journals offer too little data, use data selectively in order to give a “sexy” twist that will capture interest, or present conclusions that aren’t supported by the data. To counter that, Dr. Davies said, we have to strive to do the best job possible with the different types of research available, from randomized controlled trials to pilot projects to opinion surveys and statistical modelling. Dr. Patricia Martens, acting director of the Manitoba Centre for Health Policy, added that there are often more ways to approach communicating research, such as using anecdotes to convey information.⁵ “Evidence often comes in the form of stories, not merely graphs,” Dr. Martens said. “We as researchers have to be creative enough to find all sorts of ways to look at and present data.”

Collaboration

Dr. Martens stressed the importance of collaboration and relationship-building and fostering evidence-based organizations. Researchers need to get government involved in actually creating research evidence. Sometimes the involvement is financially based: for example, the Manitoba Centre for Health Policy has a contract to produce six pieces of research a year for the province. “If they are paying, they will listen much more readily to the results,” she said. The centre gets about half its funding from the province, but under terms that guarantee academic freedom. Further, the questions and issues must be defined collaboratively right at the outset of research projects, aiming for consensus between researchers and decision makers. According to Dr. Martens, the interactions with users lead to less emphasis on randomized controlled trials; these may be the “gold standard” for research, but often it is quasi-experimental designs that are most useful in terms of guiding health districts.

It is a message we hear over and over again, and it is just starting to flourish in our organizations. There is a need and a desire to build collaborative partnerships between health system managers, policy makers, and researchers. These partnerships foster the creation of evidence that is responsive to the issues facing the health system. Above all, they encourage a culture of trust and therefore increase evidence-based decision-making in the organization, management, and delivery of health services.

Past the Edge of the Old Place

Summarizing the morning's messages from the panel and discussion groups, Sister Elizabeth Davis, chair of the Canadian Health Services Research Foundation's board of trustees, said that while a culture of trust and collaboration is what we need, it is not so easy to find. The new ways of thinking needed to make knowledge transfer and exchange a reality are at odds with the profound risk-aversion of health system managers and policy makers. In Ottawa, a minority government and the Gomery inquiry, with its focus on the lack of accountability, supervision, and responsibility in spending public funds, have made public servants hyper-cautious. That attitude can only add to the concerns of health administrators and providers at every level, who face limits on what they can do in the face of constant upheaval in healthcare.


From the participants' responses to discussion questions, it became clear that "we have a crisis mentality," Sister Elizabeth said. "One province or another is always retooling its structures... We have all learned to be risk-averse to save our jobs. We are being told to avoid risk at the moment we need to take risks."

There has never been a more important time to base policies on evidence. The emphasis on accountability means administrators need evidence to guide and support their decisions, but researchers need to understand that administrators cannot wait for them to find the *right* answer. Sister Elizabeth said administrators have to be satisfied with a "promising practice" – an idea of what the best they can do would be.

The culture needs to change too: to be more inclusive, to recognize the ability to build communities as an important skill. "Who truly are the decision makers?" Sister Elizabeth asked. "We are talking as though only deputies and ministers are decision makers. But [decision makers are everywhere]: around the dinner table, in rural areas, and in urban centres."

There has never been a more important time to base policies on evidence. The emphasis on accountability means administrators need evidence to guide and support their decisions, but researchers need to understand that administrators cannot wait for them to find the right answer.

Resonating from participant comments, Sister Elizabeth echoed a strong desire for the culture to change to open up to evidence – with the power it can offer and the challenges using it involves. "This is a new place. This is not the edge of the old place. We are not pushing the envelope.

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We are in a totally new envelope,” said Sister Elizabeth. Her presentation emphasized that although we as health system stakeholders are ready to jump in, we are restricted by conflicting fear. Fear of the unknown, fear of repeating the same mistakes, fear of taking action, fear of doing nothing at all.

Sister Elizabeth added that people are ready to take action with the incredible resources at hand. For example, the selection of posters at the workshop displayed the many “promising practices” in evidence-based decision-making employed by decision makers and the eagerness of researchers to facilitate knowledge transfer as a part of their research programs. Sister Elizabeth urged participants to tap into the promising practices that exist around us, to share each other’s stories, to support innovative efforts, and to continue developing our communal tool box.

The Communal Tool Box

Sharing tools is a fine Canadian tradition, whether it's your neighbour's hammer or your colleague's expertise. Much of the workshop was given to discussions of tools and strategies people are using to leverage knowledge. During smaller sessions, participants explored and discussed different tools and strategies to foster a culture of evidence-based decision-making ranging in topics from building effective networks to bundling research to accessing information.

Harnessing Technology

One of the greatest challenges of evidence-based decision-making is the sheer bulk of evidence available. It can overwhelm decision makers, making it difficult to manage evidence, let alone use it. A single source of *trusted* evidence is crucial, said Dr. Robert Hayward, director of the Centre for Health Evidence.

"In reality, more information may worsen the plight of busy decision makers. They experience information hunger in the midst of plenty. The content of health knowledge is so volatile and expansive that (health system managers and policy makers) increasingly must manage, not contain information... For (us) to make more informed choices, (we) need to *know what to do*, because best information supporting best practices is readily available at the point of decision-making; *do what is known*, with aids to problem recognition, question formulation, resource selection, information acquisition, and use; and *understand what is done*, because information use is monitored and managed."⁶

The centre promotes evidence-based healthcare through Internet-based desktop resources for health professionals. The emphasis at the University of Alberta-based centre is on having a trusted source of information with ease of access, simple sign on, simple interfaces, task-oriented searches, and a help desk that guides users to the information they need.

To make the most out of "information overload," a health information system must complement, not conflict with, the predominant culture of information exchange in healthcare. The information tools must make it easier to find and use information and decrease the informational burden while easing communications with colleagues and participation in learning and decision-making communities. Although different researchers and decision makers have a wide range of information needs, the health information system must be able to be customized to the user's unique needs. Embracing this information technology will result in better sharing, managing, tracking, and modifying of health services research information, thereby promoting evidence-based decision-making.

Bundling Research for More Effective Decisions


In a session on what policy makers want from research synthesis and what researchers can offer them, Dr. Davies stressed the importance of systematic review – defining specific criteria of ideal types of research. Together with Dr. Jeremy Grimshaw of the University of Ottawa, Dr. Davies emphasized that only transparent standards can yield the quality of information good policy demands, with consistent rules for issues such as how far back the search will go, which databases it will use, and how grey literature will be treated, and with the quality of work clearly identified.

Dr. Grimshaw said that a systematic review requires a clearly defined question but doesn't limit sources of evidence. It "is a generic methodology. You can use it for any source of information so long as you're explicit and say this is what we did." It is also important in the face of time pressure: policy makers often need information faster than researchers are comfortable producing it; if a review is systematic, its shortcomings will at least be understood, if not compensated for. "However quick and clear, or quick and dirty, your review is, it should still be systematic." Defining the "right" questions to ask can often be the key to finding the right information in a timely way.

Accessing Information

Whether research is bundled or not, information must be accessible to be used. According to Vivien Ludwin, past director of the Bracken Health Sciences Library at Queen's University, this involves changing the way libraries are used and, more significantly, a change in the way libraries work. "A librarian can no longer sit in her office, waiting for people to come and see her," she told participants in her session on information access. People need specialist librarians in their area who can anticipate their needs. Essentially, librarians can be knowledge brokers, actively forging linkages between decision makers and researchers to offer a trusted source of knowledge.

In the world of what she calls "blue sky information access," librarians do just that. Users can link to the library around the clock and from any location. They have access to a full range of information, from online books and journals to practice guidelines, databases, and synthesized information. It's one-stop shopping, guided by a librarian who knows how to search for and screen the information you need. Duplication of research services (such as libraries in teaching hospitals and at medical schools) is eliminated, evidence is more readily used in decision-making, and libraries across the province or the country can be linked together. Information is



tailored to the individual and can be delivered in the form of bulletins or alerts. This is a system that can easily be put in place with very few resources. It requires collaboration between organizations and among decision makers in diverse regions. Yet, with a little bit of vision, commitment, and time, it is a recipe for success.

Nurturing Communities


Communities of practice, according to Etienne Wenger, a globally recognized leader in development and implementation of communities of practice, “are groups of people who share a concern or a passion for something they do and who interact regularly to learn how to do it better.” Communities of practice have three crucial characteristics: a shared domain of interest and shared competence; a community, which engages in joint activities and discussions and helps each other; and a practice – common interests are not enough. Members of the community must be working in the field and share experiences, tools, and resources for recurring problems.

Communities of practice are traditionally self-sustaining and driven by passion. Today, many organizations are developing them as a learning tool. It can be difficult to capture the informal drive that creates a community of practice in a more formal organization, but it can be done. As long as knowledge is power and contributes to the hierarchy, it is very difficult to overcome this type of structure. If barriers such as trust, values, and traditions are openly addressed and links are encouraged by supportive practice, communication tools, and incentives, communities of practice can offer innovative governance models and decision-making procedures.

The values of collaboration and mutual respect drive this type of network. The passion of members to improve processes fosters a culture that naturally supports and encourages evidence-based decision-making.

Collaboration between Researchers and Decision Makers

Knowledge transfer plays a critical role in evidence-based decision-making. According to Richard Lavoie, Lise-Ann Davignon, and Reiner Banken of Quebec’s Agence d’évaluation des technologies et des modes d’intervention en santé (AETMIS), knowledge transfer and exchange must be continuous between researchers and those involved in healthcare policy-making, including the public, health-technology users, and other stakeholders. AETMIS reached this conclusion when it undertook a review process with a view to optimizing its knowledge transfer activities to policy makers in the healthcare system. From this process emerged the concept of knowledge transfer based on continuous interaction with those involved in healthcare policy-

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making, which resulted in a decision to integrate knowledge transfer throughout the research and assessment process. To enhance this process, AETMIS developed two committees: the members' council, made up of researchers from several disciplines and decision makers from many levels in the health system, which makes decisions about the scientific content of dossiers; and an orientation committee, made up of all levels of decision makers, to provide links among groups necessary for knowledge transfer.

AETMIS reports are evidence-based, but the evidence is not strictly research-based: other sources such as political and social issues are considered as well. Because there is so much interaction and discussion throughout the process, the stakeholders know a good portion of the conclusions before they're published, which likely means the results are better understood and therefore more easily implemented. This case example exposed the value of integrating research and decision-making processes from the inception of the question to the implementation of the policy.

Impact and Evaluation

Though many of the afternoon sessions focused on specific strategies and tools to support evidence-based decision-making, the visioning room, with facilitator Peter Levesque, allowed participants with a wide range of experience, roles, and backgrounds to brainstorm on strategies for effective evaluation of knowledge transfer and exchange processes. As more and more people make a commitment to knowledge transfer, challenges emerge. Even trying to define knowledge transfer and exchange and its use is a difficult task because of the differing roles it can play for researchers and decision makers. While the researchers who attended the workshop had much experience in knowledge exchange activities, it was acknowledged that there is a need for a more robust evaluation strategy. For example, those working with First Nations to do research must find a way to acknowledge and evaluate First Nations knowledge without standard university credentials or common evaluation methods. Also, even at the most fundamental level, researchers and decision makers often have differing opinions on what constitutes knowledge exchange activities and evaluation.

Despite these barriers, knowledge transfer and exchange is increasingly seen as a means to improve the health system. But processes and strategies for making knowledge transfer and exchange effective will likely always vary across regions, organizations, and individuals.

A Call to Change

If one overarching message is to be taken away from the workshop's presenters, moderators, researchers, and decision makers, it is that there is an urgent need for a change to the status quo. Closing the workshop, Sister Elizabeth Davis challenged us to develop a culture embracing evidence-based decision-making by having vision, taking risks, becoming more flexible, welcoming diversity, asking questions, and above all making a steadfast commitment.

We must hope that moments of incredible change are also moments of incredible opportunity. We must "see with new eyes, hear with new ears, dare with new thinking, and act with new passion if we are to help create a truly strong and responsive health system in Canada."


Sister Elizabeth began by reviewing how the health system got where it is, because, just as when one rows a dory, she explained, you can't get anywhere without looking at where you came from.

We must hope that moments of incredible change are also moments of incredible opportunity. We must "see with new eyes, hear with new ears, dare with new thinking, and act with new passion if we are to help create a truly strong and responsive health system in Canada."

Her assessment was grim. The aging population raises unrealistic expectations. Canadians will be satisfied with the healthcare system, Sister Elizabeth said, "when it can keep everybody alive forever and keep everybody healthy in that time." Organizations that once existed to treat illness now are faced with a population that believes health to be not simple absence of sickness but a state of physical, social, emotional, and spiritual well-being. The system has responded by characterizing patients as clients and stating goals, values, and missions.

The health system has regionalized, leapt into measuring effectiveness and accountability, made moves toward public consultation and better use of evidence, and tried to form partnerships with every conceivable stakeholder. Every time things look like they are settling down, governments restructure again.

What we need then, Sister Elizabeth said, is a rainbow, intangible but a connection that "brings together water and light in a way that doesn't change." But we can't capture it. So what connects us? Vision, "the something significant we have left to do," values, and relationships.

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“The key to success in any human organization is relationships,” said Sister Elizabeth. In the organizations we work in, there are multiple cultures. It takes strong leadership to knit them together to make evidence-based governing and decision-making the norm. Although knowledge exchange is paramount, linking researchers and decision makers while leaving out citizens is a situation that must change.

Like the broken rocks used to create the symbolic inukshuk, sometimes we must break rules and make mistakes to accomplish greatness. As agents of change to promote responsible evidence-based decision-making, we must:

- be visionary;
- be prophets and disturbers of the peace;
- dare to take risks – decision makers must learn to encourage diversity;
- value flexibility and allow creative questions;
- learn to trust people from other communities – researchers should learn to work with decision makers more;
- move to new ways – it’s not just pushing the envelope, we have to leave behind what’s inappropriate; and
- give more value to networks and re-inspire our spirits.

References

1. The foundation's 2004 annual workshop explored the various interpretations of "evidence," and the foundation recently completed a paper titled "Conceptualizing and Combining Evidence for Health System Guidance." While there are many different forms of evidence, the foundation aims to move research-based evidence into policy. See Canadian Health Services Research Foundation. 2005. "Conceptualizing and Combining Evidence for Health System Guidance." www.chsrf.ca.
2. Davies P. 2004. "Is Evidence-based Government Possible?" Jerry Lee Lecture, Campbell Collaboration Colloquium.
3. U.K. Cabinet Office. 1999. Modernising Government. London.
4. U.K. Cabinet Office. 1999. Professional Policy Making for the Twenty-First Century. London.
5. Canadian Health Services Research Foundation. 2003. "Once upon a time... The use and abuse of storytelling and anecdote in the health sector." A report on the 2003 CHSRF Annual Invitational Workshop.
www.chsrf.ca/knowledge_transfer/pdf/2003_workshop_report_e.pdf.
6. Hayward R. 2003. The Desk Reference of Evidence-Based Practice. Oxford University Press.

Additional Information

Speaker bios and poster abstracts from the 2005 annual workshop are available on the foundation's web site at www.chsrf.ca.

Appendices

APPENDIX A: Agenda

REGISTRATION & BREAKFAST ~ 8:00 – 8:30

OPENING REMARKS ~ 8:30 – 9:00

Irving Gold, Director

Knowledge Transfer & Exchange, CHSRF

EVIDENCE-BASED ORGANIZATIONS IN HEALTH SERVICES

Keynote Presentation ~ 9:00 – 9:45

Evidence-Based Government: How do we make it happen?

Phil Davies, Deputy Director

Government Chief Social Researcher's Office

Prime Minister's Strategy Unit, U.K. Cabinet

Panel Response ~ 9:45 – 10:30

Lessons from Canada: Perspectives from health system managers, policy makers, and researchers

Patricia Martens, Acting Director, Manitoba Centre for Health Policy

Beverly Clarke, CEO, Health & Community Services – St. John's Region

Kevin Keough, President & CEO, Alberta Heritage Foundation for Medical Research

NETWORKING BREAK & POSTER PRESENTATIONS ~ 10:30 – 11:00

MOVING THEORY INTO PRACTICE – Small group exercise ~ 11:00 – 12:10

Health system managers, policy makers, and researchers will gather in groups of 10-15 to discuss lessons learned from the morning panel, how the lessons can be applied to their own organizations, and the relative roles of those involved in the process of knowledge transfer and exchange.

NETWORKING LUNCH ~ 12:10 – 13:30

Summary of Key Messages ~ 13:40 – 14:00

Sister Elizabeth Davis, Chair, CHSRF Board of Trustees

TOOLS & STRATEGIES FOR ACTION CONCURRENT SESSIONS ~ 14:00 – 15:30

The following skill building sessions will be unilingual (with one session in French as noted). Each session will focus on tools and strategies which can be applied in your organization:

Building Effective Networks & Communities of Practice

Facilitator: Etienne Wenger, globally recognized leader in development and implementation of communities of practice

Embedded Evidence

Facilitator: Robert Hayward, Director, Centre for Health Evidence

Effective Synthesis: Relative Roles of Researchers & Decision Makers

Facilitator: Phil Davies, Deputy Director, Government Chief Social Researcher's Office

Accessing Information: The New Librarian

Facilitator: Vivien Ludwin, r. Chief Health Science Librarian, Bracken Library, Queen's University

An Interactive Approach to Knowledge Transfer for Decision-Making (French)

Facilitator: Richard Lavoie, Communications Specialist, Agence d'évaluation des technologies et des modes d'intervention en santé (AETMIS)

and a new concept...

The Visioning Room – Exploring strategies for effective evaluation of knowledge transfer and exchange processes

Facilitator: Peter Levesque, Knowledge Exchange Specialist, Centre of Excellence for Child & Youth Mental Health.

NETWORKING BREAK & POSTER PRESENTATIONS ~ 15:30 – 16:00

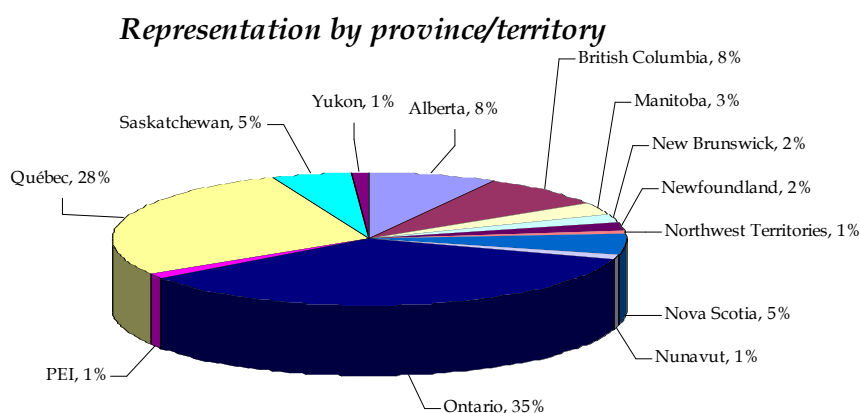
CLOSING REMARKS ~ 16:00 – 17:30

Sister Elizabeth Davis, Chair, CHSRF Board of Trustees

This session will build on activities throughout the day; it will offer a summary of concrete lessons and take-home messages. It aims to inspire each participant to take home at least one skill/strategy that can be applied in your own setting.

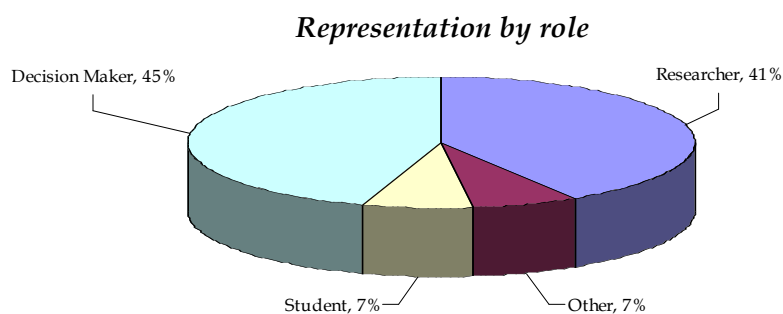
APPENDIX B: Participant Demographics

This year the annual workshop attracted more than 170 attendees (147 registered participants, 15 speakers/facilitators, and staff) and generated a healthy waiting list. For the first time in the history of this event, there was representation from every province and territory in Canada (see graph 1.1). The workshop also drew the attention of both researchers and decision makers in equal numbers (see graph 1.2). There were five last minute cancellations due to illness/conflicts, and five participants did not attend the workshop, offering no explanation.



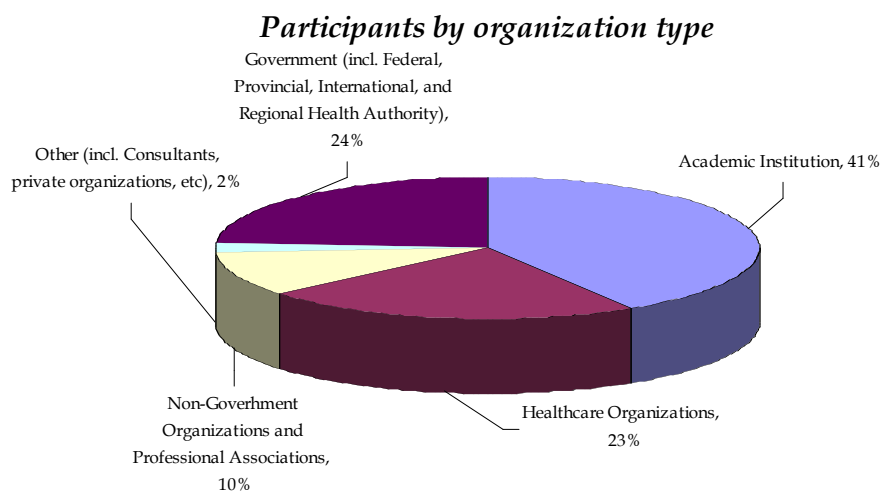
Graph 1.1: Representation by province/territory

Most participants at the annual workshop come from Ontario and Quebec (63%). However, for the first time in the history of this event, there was representation from every province and territory in Canada.



Graph 1.2: Representation by role

The number of decision makers was proportionate to the number of researchers.



Graph 1.3: Representation by organization

An analysis of the organizations represented at the 2005 annual workshop showed relatively equal representation between academic institutions (including universities and research centres) and organizations that represent health service decision makers (including regional, provincial, and federal government bodies and healthcare facilities).