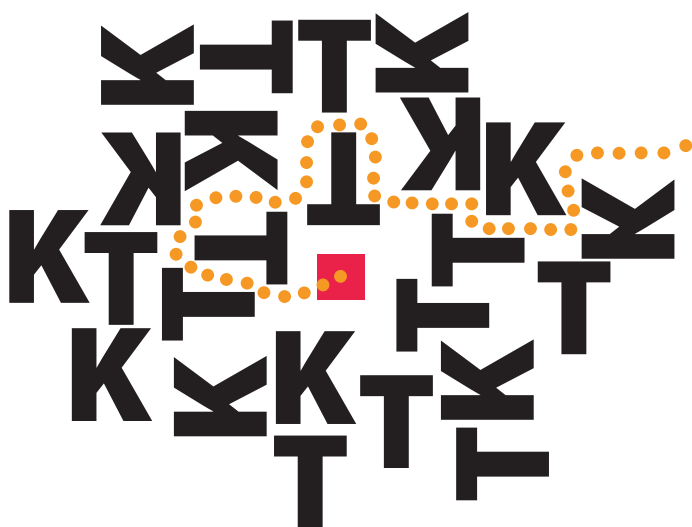


Lost in Knowledge Transfer?



Finding Our Way Together.

Research Transfer
Network of Alberta
RTNA '08
Conference Proceedings

September 28 - 30, 2008

Banff Rimrock Hotel
Banff, Alberta

 *rtna*
health research transfer
network of alberta



AHFMR
ALBERTA HERITAGE FOUNDATION
FOR MEDICAL RESEARCH

Table of Contents

Sponsoring Organizations	3
Acknowledgements	4
RTNA 2008	
Background and Overview	5
Knowledge Transfer Workshops	6
Orientation to Knowledge Translation (KT)	
Research Use – Assessing the Quality	
The Role of Facilitation in Knowledge Transfer (KT)	
Key Messages	7
Conference Sessions	
Knowledge Exchange When There are No Bells or Whistles	9
Opening Presentation by Elliott Churchill	
Finding Our Way... The Knowledge Transfer Organization	11
Sarah Bowen, David Johnson, Malcolm Maxwell and Anne Sales	
Finding Our Way... The Power of Narrative in Knowledge Transfer	17
John Parboosingh and Joe Tetlich	
Finding Our Way... e-Tools for Knowledge Transfer	21
Wayne MacPhail	
Concurrents: Finding Our Way... A Showcase of KT Projects and Knowledge Transfer Research in Alberta and Across Canada	23
<i>Various Presenters</i>	
A. e-Tools Being Used for Training, Best Practice Support, Continuous Learning	
B. Relationships and Networks – KT Within and Between Organizations	
C.1 Print Material, Presentations and Workshops	
C.2 Developing KT Skills	
Finding Our Way... People Tools for Knowledge Transfer	25
John Parboosingh and Rob Wedel	
Making a Difference	29
Closing Presentation by Bryan Kolb	
References of Interest	32
Websites of Interest	35
Social Software Tools	36

Sponsoring Organizations

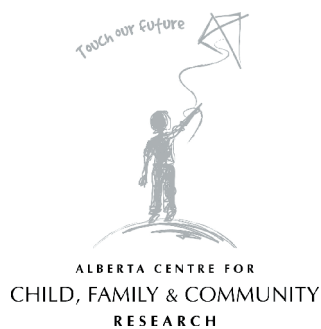
Diamond:



Gold:



Silver:



Acknowledgements

The RTNA wishes to thank the Conference Organizing Committee for their work in planning the conference and facilitating the concurrent sessions:

Tanya Ewashko
Dave Clements
Melina Dharma-Wardene
Mark Moland
Christine Thompson

Thanks also go to Buksa Associates for their very capable assistance with conference management, and Bob Robertson for his graphic design work.

Background and Overview

RTNA 2008 was the third conference since the official inauguration of the Research Transfer Network of Alberta (RTNA) in 2002. Each one of these conferences has moved the agenda forward in knowledge transfer (KT) and further strengthened the RTNA's efforts to encourage a culture of participation, networking, open dialogue and mentorship in support of an overall vision of a health system where research or knowledge transfer is understood, valued and optimized. What started as a relatively small group of participants at RTNA 2002 has grown into a delegation of 130 in 2008.

The agenda for this third conference was developed in response to an expressed need from both the RTNA membership and others working in health research and on the frontlines of healthcare to learn more about how to practice knowledge transfer. With its theme of Lost in Knowledge Transfer: Finding Our Way Together, RTNA 2008 took us past the theories and models of knowledge transfer to explore the practical tools and strategies that will help to incorporate knowledge transfer into our work and our organizations.

The conference provided participants with both structured and unstructured opportunities to learn, generate ideas, challenge notions and make connections. A diversity of outstanding speakers and delegates took the participants beyond the basics of research and knowledge transfer, and shared their firsthand experiences putting KT into action.

Program themes addressed:

- The learning organization;
- The power of narrative;
- E-tools and people tools;
- Building research use capacity; and
- The challenges of evaluation.

RTNA 2008 was preceded on Sunday afternoon, September 28th by three optional workshops and a welcome reception. Conference sessions officially commenced on Monday morning, September 29th and ended Tuesday afternoon, September 30th, 2008.

Knowledge Transfer Workshops

Conference participants were invited to choose from the following concurrent workshops provided on an optional basis in conjunction with the RTNA 2008 conference sessions:

1. Orientation to Knowledge Translation (KT)

Melanie Barwick, Health Systems Scientist, and Donna Lockett, Knowledge Translation Broker, from the Knowledge Brokering for Pediatric Healthcare Research Team at SickKids Hospital in Toronto facilitated this three-hour short course in knowledge translation. Participants came away from this workshop with a basic understanding of KT: what it is; how to develop a KT plan; how to improve dissemination; and how to make those all-important connections for knowledge exchange.

2. Research Use – Assessing the Quality

Brenda Petzold, Manager of Technology Reviews and Diffusion at Alberta Health and Wellness, used a case study to facilitate an overview of the Alberta Health Technologies Decision Process and to examine the importance of assessing the quality of research. This three-hour workshop exposed participants to a government perspective on use of evidence as well as planning and strategies for bridging the gap between knowledge, policy development and decision making.

3. The Role of Facilitation in Knowledge Transfer (KT)

Facilitation is recognized as an effective knowledge translation intervention but little or no attempt has been made to determine what knowledge and expertise constitutes an ability to facilitate KT. Alison Kitson, Supernumerary Fellow at Green College, University of Oxford, United Kingdom, led this two-hour workshop that had participants share their knowledge around facilitation. The workshop was in itself a knowledge translation activity as the results will feed into a national symposium and inform a methodology about facilitation as an effective KT intervention.

Key Messages

Since its official inauguration in 2002, the Research Transfer Network of Alberta has sponsored three conferences on knowledge transfer, each of which has advanced our overall knowledge on KT and helped to move the KT agenda forward.

The first RTNA conference in October 2002 addressed two primary themes: the role of research in making health policy decisions and effective ways to transfer research. Each session emphasized the fact that knowledge transfer is not an arcane science. It is about people and culture. Emotion, trust, and storytelling are all crucial to its success.

The second RTNA conference, Knowledge Transfer: Raising the Stakes for System Change, was held in October 2007. Sessions focused on the need for system change; tools and strategies for thinking creatively; and the realities of knowledge transfer related to ethics, politics and consumer involvement. Once again, knowledge transfer as a social activity was an overarching theme. Consultation, collaboration and empowerment were emphasized as key enablers, as well as leadership, flexibility and transparency.

RTNA 2008, *Lost in Knowledge Transfer: Finding Our Way Together*, took the participants a step further, beyond the basics of research and knowledge transfer into the challenges around evidence-informed decision making and the innovations, processes and practices that support and promote KT. As before, the overarching message of knowledge transfer as a social activity was key, and context and culture, relationships and relationship building were emphasized as critical considerations. Emotion and storytelling were again highlighted as important enablers.

RTNA 2008 opened with a keynote address by Elliott Churchill on Knowledge Exchange When There are No Bells or Whistles. In her presentation, Ms. Churchill commented on the importance of "listening to the grandmothers". This phrase clearly resonated with both the other presenters and the audience at this conference. It gathered more meaning as each session unfolded and was repeated often throughout the two days of *Lost in Knowledge Transfer: Finding Our Way Together*. Other key messages from RTNA 2008 are noted below, followed by an in-depth review of the full conference proceedings.

Key Messages from RTNA 2008

- Knowledge transfer is social and context is everything.
- Listen. Pay attention to the audience and the context in which knowledge is being used. Do not make assumptions. Understand audience priorities, values, levels of understanding and acceptance of concepts.
- Look at KT from the audience's point of view: What do you want to tell me? Why should I care? What do you want me to do?
- Research is interpreted within a particular context and KT is not so much about the techniques of research as it is about the value of mutual learning.

Key Messages (continued)

- The healthcare world is full of competing interests. KT must let go of an emphasis on rationality and start to take on these complex realities.
- Researchers come with answers but often do not understand the questions.
- Research needs to run alongside a problem not separate from it.
- Users of knowledge do not need to be involved in all phases of knowledge production but we do need their input to understand the problems, determine appropriate solutions and ensure uptake.
- Reflective time and space are needed to look at problems and identify solutions.
- It is not just about information sharing but power sharing as well. We are better at dealing with the content of research findings and less capable of looking at the processes by which decisions are made or priorities set.
- Change usually occurs around some traumatic event when people are destabilized. It is harder to change when things are comfortable. There are usually a million incremental changes, however, that support the big change.
- Technological innovation will support knowledge transfer at the individual level and the knowledge will move across many communities of interest, bringing about change within organizations.
- There is a strong appetite for doing things better. Involve frontline staff to generate a significant degree of control over the quality of care they are able to provide. Provide the knowledge and skills to increase capacity for staff to facilitate the application of research.
- A structured use of narrative (generative dialogue) can help to bridge perspectives, norms and values; build trust; and create new knowledge.
- Narrative is a conversation that influences you to do something different.
- Consider bandwidth (the multiple conversations going on within and between people).
- The future is here now. It is just unevenly distributed.
- e-Tools help us to move applications and data from our desktops to the Web to share with others, support collaboration and make the knowledge we want come to us. Trust your community to share and be honest. Believe in the common good. Notwithstanding, determine guidelines together on how your group will behave.
- If you are not solving a problem, people will not use the information.
- Working in teams can facilitate KT but there must be role identification and role clarity.
- Create sustainability of KT in a team through ongoing measurement.
- We are the tools. The biggest information repository in most organizations is in the heads of those who work there.
- KT requires repetition and materials that people understand and can take away.

Opening Remarks

RTNA 2008 kicked off on Monday morning, September 29th with a welcome from Conference Moderator Steven Lewis, a health policy and research consultant based in Saskatchewan and Adjunct Professor of Health Policy at the University of Calgary.

Jacques Mangan, Interim CEO of the Alberta Heritage Foundation for Medical Research (AHFMR), officially opened the proceedings and thanked the many conference sponsors for their support: Canadian Institutes of Health Research, Institute of Health Economics, Canadian Agencies for Drugs and Technologies in Health, Alberta Cancer Foundation, SEARCH Canada, and the Alberta Centre for Child, Family & Community Research.

Conference Sessions – Day One

Knowledge Exchange When There are No Bells or Whistles

Opening Presentation by Elliott Churchill

The keynote address, Knowledge Exchange When There Are No Bells or Whistles, provided an excellent start to the conference with a focus on the grassroots of knowledge transfer. As a consultant affiliated with the Centers for Disease Control and Prevention, Elliott Churchill has spent most of the last 20 years consulting in ministries of health and training public health staff across the globe in a variety of programs addressing such difficult issues as HIV/AIDS, hemorrhagic fever and chronic disease. Her primary areas of interest are public health communications strategies in the absence of sophisticated technology, and the creation of interactive communications networks that include public officials, the general public, public health staff and representatives of the mass media.

As Steven Lewis indicated in his introduction, we quickly learned that Elliott Churchill is, indeed, the personification of what can be accomplished through the successful facilitation of knowledge exchange without the benefit of technology and with audiences who have vastly different cultures, languages and lived experiences. Her presentation captured the essence of knowledge transfer; the particular and immense challenges of teaching in the global classroom; and the subsequent rewards at both a professional and a personal level.

Ms. Churchill evocatively described some of the challenges she has faced and the challenges her students continue to face on a daily basis living and working in conditions that often reflect extreme poverty. Her talk was a powerful reminder of how we take our western freedoms of movement and speech for granted and our assumptions around world-wide access to a world-wide web – assumptions that close the door to knowledge exchange for many international students and professionals. As Ms. Churchill suggests, our technocratic view of knowledge transfer misses the bigger picture – our information is not having its intended impact because of our lack of attention to the audience and the context in which it is being used.

Conference Sessions – Day One (continued)

The practical lessons that Elliott Churchill has gathered from her work in the developing world apply to work with local audiences as well. Her stories were international, but her messages were global.

Key Learnings

- When working internationally make it clear that you are not there with a political agenda. You are there to help and you will follow protocol.
- Remember that you are the foreigner. Familiarize yourself with cultural mores.
- Connect with the local community and try your best to fit in.
- Make a commitment to be a colleague for the long term. This is especially important with global colleagues as the concept of data rape is commonly associated with western scientists.
- Learn your students' first names and address them this way as often as possible. Respect their needs and remember their faces.
- Understand the priorities and values within the group. Introduce tools for conducting an analysis of your target audience to explore their values, fears, commitment, levels of understanding and acceptance of concepts.
- Listen closely. Your clients will tell you what they need.
- Watch gestures carefully. This will help you to determine whether the culture places more value on the individual or the group. In some cultures, the students can be extremely uncomfortable being singled out for recognition.
- Identify comfort zones related to eye contact.
- Icebreakers might not work. Students can remain solemn and unsmiling.
- Communicate clearly. Choose your words carefully and be sensitive to cultural issues. Telling it like it is might be offensive to other cultures.
- Establish storytelling as an acceptable method of knowledge exchange. They can be used as metaphors for describing situations that are difficult to present as fact.
- Integrate local culture into the classroom setting to help build community and strengthen rapport. Make note of the stories your students tell and build material from these stories into your work.
- Build capacity that can be taken advantage of such as writing, publishing and grant application skills.
- Use a short course approach in an adult learning environment.
- Use small, problem solving groups for work on assigned tasks and have each group report back. Provide positive feedback to the group and the reporters.
- Think about your collaborations and how to do them.
- Understand that the Internet not always a viable option.
- Translate your message into the language of the country you are operating in. Give the people what they need in order to understand it. Do not worry about 'dumbing' things down. No one has ever complained that something is too clear.
- Use terms that your audience is familiar with and comfortable with.
- Put the bottom line up first – the single overriding communications objective.
- Ask yourself three questions: What do I want to say to them? Why should they care? What do I want them to do?

Conference Sessions – Day One (continued)

- Limit the number of messages you give your audience.
- Every message in public health must be based in data but tie your health messages to hope.
- Connect with community leaders. Ask them to help you understand the situation. This is a useful empowerment tool – a community development opportunity.
- Try to look happy in strained situations. View surprises as potential benefits.
- Humour and flexibility are very important.

Where Elliott Churchill described knowledge transfer strategies in the absence of technology, the next session made use of sophisticated technology to actively involve the conference participants in a panel discussion on creating and sustaining knowledge transfer within organizations.

Finding Our Way... The Knowledge Transfer Organization

Sarah Bowen, David Johnson, Malcolm Maxwell and Anne Sales

In this session, four panelists, with the help of facilitator Steven Lewis, explored the importance of culture, processes, context, research use capacity and other factors that help or hinder knowledge transfer within organizations. To start off the discussion each panelist provided an opening statement and individual overview of their experience of KT within their various work environments.

David Johnson is Associate Medical Officer of Health at Capital Health and Clinical Professor in the Department of Internal Medicine at the University of Alberta. He was trained in internal and critical care medicine as well as anaesthesia, and has an MBA and Masters of Public Health.

In his opening statement, Dr Johnson described knowledge transfer as not new or different, but evolving. He outlined three key themes within KT that need to be incorporated into medical care: the basic science theme or the commercialization or 'marketalization' of medicine; the behavioural change theme; and the population or organizational theme tied into theories around the determinants of health.

Malcolm Maxwell has worked in leadership roles within regional health systems, hospitals and health ministries across four provinces, and is currently President and CEO of Grand River Hospital in Kitchener, Ontario.

Mr Maxwell described key strategies an organization can use to do a better job of KT:

- create an agenda related to what they want to achieve;
- set priorities and let people within the organization know these priorities;
- arm their employees with the skills and tools that will allow them to be successful in making change; and
- engage people on their own terms to use these tools to carry the agenda forward.

Conference Sessions – Day One (continued)

He suggested that the hardest part for healthcare is engaging people in seeing that the health system can be different and making a change. Mr Maxwell sees knowledge transfer as a large part of this effort. He also sees it as subject to the environment it works within.

Sarah Bowen is Director of a research and evaluation unit within the Winnipeg Regional Health Authority, and Assistant Professor in the Department of Community Health Sciences at the University of Manitoba. will soon be taking on the position of Academic Co-Director of the SEARCH Canada Program in Edmonton.

Dr Bowen described two radically different, even opposed paradigms at work in our conceptualization of knowledge transfer: the basic, political, evidence based world of medicine where research is done and the world of health services where all of the players have a contribution to make and together they identify priorities, figure out solutions and take part in it. In this second paradigm, the research is interpreted within a particular context and is not so much about the techniques of research as it is about the value of mutual learning. Dr Bowen expressed her desire to see us move more towards this second paradigm.

Anne Sales is Associate Professor in the Faculty of Nursing and Canada Research Chair in Interdisciplinary Healthcare Teams at the University of Alberta. She served as a research scientist in the Veterans Affairs (VA) Northwest Health Services Research and Development Center of Excellence at VA Puget Sound Health Care System in Seattle, Washington.

Dr Sales described how a healthcare organization's success is often more about the way people interact within the organization or the way in which the professional groups within the organization capture and reflect its culture, than about evidence or improving care through rationalization. She suggested that Veterans Affairs is losing ground because of the effects it is feeling as a political entity – its mission is not always clear and its survival is dependent on financial issues.

After this preliminary introduction of the four panelists, Steven Lewis posed a series of questions to both the panelists and the audience. An interactive polling process was used to gather real-time feedback from the audience and involve them directly in the discussions.

1. Do you think KT is moving forward?

Audience Feedback: 74% Yes 26% No

Panel Discussion:

- Sarah Bowen said the research shows that physicians will pay attention to evidence they have played a role in producing; however, directly involving physicians in the research process is very labour intensive. The KT paradigm she describes does not propose that users of knowledge be intimately involved in all phases of its production and/or the development of practice guidelines, but that we do need input from the people directly impacted at critical points in the process e.g. framing the research question.

Conference Sessions – Day One (continued)

- Anne Sales described how, as a political entity, the healthcare world is full of interests and this has implications for knowledge transfer. The challenge for KT is to let go of an emphasis on rationality and start to take on these complex realities.
- Malcolm Maxwell stressed the fact that we do now have a knowledge transfer industry. Each province has one or several organizations fostering the uptake and application of evidence and the development of skills around this activity. Organizations have seen the benefit and it has been translated into support services as a part of what they do. The next step is to make it more effective. KT can contribute to understanding how to foster what is good in complex systems and minimize the negative.
- David Johnson described how evidence based medicine has become a mantra in clinical medicine and how he feels this climate will foster behavioural change. He suggested that knowledge transfer is not an organizational phenomenon, but an individual skill set that is brought to organizations and, as such, something we will be able to take advantage of. Dr Johnson cautioned that assumptions get built in around evidence based on context and the knowledge may be interpreted in such a way that contravenes it. Because of this, the KT process needs to be more participatory. He also indicated that the wins will be slow around changing medical practice as it will take time to diffuse the knowledge into the culture and will require some turnover of individuals.
- In response to a comment by Steven Lewis that organizations create an ambivalent message by not being very vigorous around variations in practice, Anne Sales suggested that Canada has a greater degree of clinical autonomy or 'enshrined anarchy' than the United States. The success of the change process at Veterans Affairs was partly related to the fact that there was a very clear authority structure and the practitioners were required to sign contracts agreeing to achieve certain indices. Dr Sales described how the challenges are different between evidence based practice and evidence informed decision making. We are better at dealing with the content of research findings and less capable of looking at processes by which decisions are made or priorities are set. It is not just about information sharing but about power sharing as well.

2. Do you practice evidence informed decision making in your organization?

Audience Feedback: 68% Yes 32% No

Panel Discussion:

- Malcolm Maxwell highlighted the dissonance in our healthcare system where we promise to maximize population health at the same time as we promise to give individuals the greatest care. The evidence needs to inform the process but politicians, governing bodies and professional associations do have to make certain choices. You have to work within the values and priorities of the community as you hear and understand them, and choices will be different from community to community.

Conference Sessions – Day One (continued)

At this point in the discussion, Steven Lewis asked the panelists to comment on different approaches to engaging planners of healthcare delivery in the knowledge transfer process.

- Sarah Bowen described a strategy in Ontario to embed research and evaluation units directly into individual regional health authorities, and the following lessons she learned while developing one of these units:
 - A ground up process was needed that would not give people a lot of extra and useless work. You could not ask program staff to advance the evidence until the people at the top said they would pay attention to it.
 - Decision makers need to indicate what areas they will fund and what resources there are available.
 - Political priorities will often lead the way and you need to recognize this.
 - Reflective time is required to look at the problem and identify a solution.
 - Research needs to run alongside a problem, not separate from it.
 - A problem-focused approach is best.
 - Developing research in an area where a gap exists is often a question of communicating what is already known – a critical thinking exercise.
 - Everything is context sensitive.
- Anne Sales emphasized that individuals within organizations take the research and figure out how to make it work within their context. These decisions have to be made quickly as there is usually a sense of pressure to act and fix things. She emphasized as well the need for more time and space for reflection.
- David Johnson emphasized the importance of introducing upstream information so that organizations will take responsibility for upstream problems. Strategies are needed to take care of people who are ill as well as those who are not yet ill.
- Malcolm Maxwell stressed how organizational decision makers are accountable to a defined population and that, until decision makers get away from thinking that their sector is more important than any other, progress will be muddled and slow.

3. All things considered, should we expect knowledge transfer to move forward more quickly in Canada where we have a lot of clinical autonomy, etc.?

Audience Feedback: **47% Yes** **53% No**

Panel Discussion:

- The panelists started off this discussion by exploring what moving forward in knowledge transfer really meant. They suggested that progress in KT would mean:
 - Actually being able to imbed research into decision making and finding the mechanisms to do that;
 - Moving forward on improving the health of the population;
 - A stronger and more seamless connection between research and decision making; and
 - Established mechanisms and programs to improve receptor capacity.

Conference Sessions – Day One (continued)

- The conversation then moved into a more generalized discussion around KT terminology. Anne Sales suggested that the term 'knowledge transfer' was used as a code for, "I want a better healthcare delivery system with better outcomes", as the assumption is that research and new knowledge will improve things.
- Sarah Bowen suggested that 'knowledge transfer' is not a very helpful term because it obscures very different ideas and concepts. We will not be very successful if we only value research evidence. We need to also value patients, communities and clinical expertise. Processes need to be established that allow evidence to be synthesized and used more easily rather than having to fight its way in. More evaluation will help us to determine how well what we are doing is working in any given context.

In response to questions from both Steven Lewis and the audience, the panelists reflected on the process of change and what lessons could be learned from the magnitude and pace of change that occurred at Veterans Affairs, as well as changes that occur in private industry.

- Anne Sales described how most of the change at Veterans Affairs occurred at the ground level among the frontline practitioners. The VA was ready and able to respond when a push for better care came from the people who worked there and from the patients. As an organization, the VA was completely regionalized and its resources were devolved. It had been set up to do research; the people who went to work there expected to do research; and this drove cutting edge care. What they knew as best practice and what was being delivered were not aligned, however, and there was a strong sense of identification with the patients. It all produced an outcome that no one really expected but it was hard to keep that kind of momentum going within such a large, varied organization.
- David Johnson indicated how change is often based on some external event and can be quite dramatic. In a setting of imbalance people will be willing to change because they are destabilized and the old is not tenable. It is harder to change when things are comfortable.
- Malcolm Maxwell agreed that large scale organizational change usually does occur around some traumatic event but suggested that there are usually a million incremental changes involved that allow this to happen. A hierarchical, structured model will engage evidence in the decision process in one way. The best way forward, however, is when the organization allows staff to do something they want to do anyways; i.e., if the organization makes good information more easily accessible and it attends to the processes they work within. You need to be at the level of work teams and work groups as this is where the greatest commitment exists to make things happen.
- Anne Sales was not sure there was a lot the public system could learn from the private system as dealing with human beings receiving care is fundamentally different from producing a product and making a profit. There seems to be a general sense that in private healthcare the decision making is controlled internally, but most decisions are driven by what is good for the investor. The investors might be quite removed, but they do exist.

Conference Sessions – Day One (continued)

The panelists then discussed what they felt the best conditions were for change, and whether or not we have the system incentives and policies aligned to make the evidence environment better.

- Sarah Bowen indicated how there is more to knowledge transfer than just sharing knowledge. It involves creating informed political thinking. We do need to attend to the processes and the incentives, and help people understand and speak to this self-interest. Knowledge transfer is not just a formal research activity; it is a critical thinking process – a way to build capacity for thinking through problems. You can use the evidence you have to re-steer the focus of a problem and more effectively engage decision makers in solving it. In complex systems, the problem can be off to the side where you are not looking, or decisions can be made that create problems elsewhere. Remember to look sideways. You need to recognize that there are perverse incentives, then figure out how to outsmart them.
- Anne Sales emphasized the value of mapping the process and the problems.
- Malcolm Maxwell described the 'four squares' approach where, when embarking on significant change, you consider and 'square' professional autonomy, personal autonomy, quality and income. If you do not understand what is going on within these four areas, you are not prepared and good ideas fail because you have not considered the implications across these squares.

As a wrap-up to this question and the session as a whole, Steven Lewis asked the four panelists to reflect on whether or not they felt optimistic about a continued increase in and more effective application of knowledge transfer in healthcare.

- David Johnson reiterated his strong belief in technological innovation, and how knowledge transfer would come at an individual level, move across many communities of interest enabled by technology and bring about change within organizations.
- Sarah Bowen emphasized the strong appetite that exists for doing things better. We should explore how to meet that need and use it as our starting point, with more humility from the research end around what the problems are and how best to address them.
- Anne Sales described how there is an increased interest in participating in research to improve practice coming from across the full spectrum of professional groups involved in providing care. Researchers need to build on and sustain this interest and commit to working hands-on in a collaborative way. We also need to be sharing what we do so others can be doing it too.
- Malcolm Maxwell indicated that by involving frontline staff in these efforts you generate the feeling of a significant degree of control over the quality of care they are able to provide to their patients. Further, providing the knowledge and skills to add the capacity to disseminate information at this level within organizations is even more effective. Through this and technology you can facilitate the uptake and application of research along faster timelines.

Unfortunately there was not enough time left in the session for the panelists to address the last three questions, but the following feedback from the audience was captured.

Conference Sessions – Day One (continued)

4. Does the knowledge transfer movement overstate the role scientific evidence should play in decision making?

Audience Feedback: 48% Yes 52% No

5. Do you think your organization needs to change its approach to knowledge transfer to be successful?

Audience Feedback: 88% Yes 12% No

6. Has this session made you more optimistic about the future of KT?

Audience Feedback: 55% Yes 45% No

The next panel session of the day addressed the power of narrative as a tool for effecting knowledge transfer.

Finding Our Way... The Power of Narrative in Knowledge Transfer **John Parboosingh and Joe Tetlich**

At its first conference in 2002 when the Research Transfer Network of Alberta was officially inaugurated, a number of speakers touched on the importance of narrative and its usefulness as a tool for knowledge transfer. Putting the research into context humanizes it and makes it more meaningful to the audience, which is particularly useful if your audience is a decision maker. At RTNA 2008, this theme was once again a very strong and recurrent one. It was particularly poignant in this session where two speakers representing two very different worlds presented equally vivid examples of the power of narrative.

The first presenter was John Parboosingh, Professor Emeritus in Medical Education and Obstetrics and Gynecology at the University of Calgary. Dr Parboosingh has a strong background in both clinical and scholarly studies and is very interested in organizational theory; specifically, how multidisciplinary teams achieve change. He has particular expertise in the area of Communities of Practice (CoPs), and how team member interactivity, motivation and the natural flow of information impact team cohesion and quality of care. In his presentation, Dr Parboosingh described how medicine today is practiced within complex adaptive systems involving complex problem solving, tacit learning, judgment, uncertainty, conflict of interest and collaborative problem solving. In this complex environment, new approaches are needed to effect change.

Conference Sessions – Day One (continued)

John Parboosingh described an increase in and more structured use of narratives as a tool to bridge perspectives, norms and values; build trust; create new knowledge; build professional identity and job satisfaction; and evaluate learning applied to practice. He reviewed the two key concepts that drive the power of narrative to effect change: the concept of 'generative conversation', a conversation that influences you to do something different; and the concept of 'bandwidth', the multiple conversations or supporting factors going on within and between the people involved that can be used to predict intention and behaviour.

Key Learnings

- Narrative is a construct created in a suitable format to describe a sequence of events. Story refers to the sequence of events described in a narrative. The narrative is more the collective; the story more individual.
- Evidence is used to determine team direction. Stories change people's values and behaviours. Use both evidence and stories.
- To influence performance and change culture, facilitate peer interaction. Use stories to mentor each other and reconstruct practice. Meet each morning and have someone tell a story. Tell a story as well about the consequences of change, such as how your institution can now run much smoother or your patients have more access.
- Our actions tend to follow very robust, ingrained patterns. If you do not create a shift in a person's pattern of behaviour by changing their values, they will go right back to how they did things before.
- Narratives can be presented in a variety of ways; for example, through drama, music and stories. You can write a story down then share it with the person beside you and have them add on to it. This process helps to promote the internalization that needs to take place if you want to influence values.
- Stories create knowledge and knowledge only gets value when it is managed. You need a method to store and share your knowledge such as digital storytelling, voicethread, storyshare, or a person within your organization who is responsible for capturing stories.
- There are three levels of conversation in the workplace related to the nature and flow of information: the practice level, the team level and communities of practice. The practice level relies entirely on accuracy. In a team we start to defend a position and become directive. When we leave the team and talk to each other, storytelling comes in and it is the improvisation and judgment here that is important to tacit work and thinking about how to do things better. Through communities of practice you can legitimize this and allow it to happen.
- Communities of practice allow for generative dialogue or dialogue that influences you to do something different.
- Address the bandwidth of the conversation or the multiple conversations going on within a conversation to change behaviour. This will give you the supporting evidence you need relative to the factors that predict change. Examples of the bandwidth include such things as: How is this going to influence my practice? You are the expert. I do not know if I have the learning capacity to make that change.

Conference Sessions – Day One (continued)

- Relationships can control the bandwidth of a conversation. A bandwidth is much less complex and easier to manage if people already know one another. Build a foundation of relationships. Create a culture that does not just see new guidelines as a new project but invests in relationships as well.
- Have a discussion within your group on a regular basis to assess and reassess progress. Ask questions such as: What keeps you coming back to the table? What do you expect from this group? There are quality measurement tools you can use for this that the group develops itself using specific principles.
- Atmosphere is important. A group in a boardroom with fancy chairs will move quickly from narrative to abstract. When you put them in lounge chairs around a coffee table, they will tell stories.
- The boss cannot facilitate the group.
- There is a scientific basis for narrative skills and it can be taught. Columbia University offers a Masters course in narrative called “The Program in Narrative Medicine”. See <http://www.narrativemedicine.org/> for more information.

The next presenter in this panel session was Joe Tetlich, Chair of the Porcupine Caribou Management Board and Community Justice Worker for the Vuntut Gwitchin First Nations in the Yukon Territories. At an early age Mr Tetlich was separated from his parents and his community and spent 12 years in a residential school. After this experience he lived a traditional subsistence way of life in order to re-connect with his family and his aboriginal roots. Although Mr Tetlich's presentation highlighted a very different use of narrative, there were many strong parallels between the knowledge transfer process in his world and the world of healthcare.

In Mr Tetlich's world, storytelling represents the primary means of providing information to and sharing success with one another. It is an important vehicle for maintaining good health at an individual and community level. As Mr Tetlich explained, not only is storytelling a way for community members to share laughter together, it is also an important safety tool. It is an effective way to pass on knowledge derived from both accumulated wisdom and firsthand experience – knowledge that is essential to ensuring survival in a very harsh environment. Mr Tetlich also emphasized how, in the aboriginal culture, knowledge is a source of pride because it has the power to educate. When you convey information through stories you speak from your heart and this, in combination with your firsthand knowledge from real life experience, is a powerful way to get your message across and educate others. He used the example of how he had successfully ‘lobbied’ the American government to protect the caribou calving grounds in Alaska as a way to illustrate this process and also to demonstrate how educating is much more effective than lobbying.

Joe Tetlich also talked about the research that was being done within aboriginal communities around land claims and climate change. He stressed how important it was for researchers to take the time to establish a relationship with the community and develop an understanding of their culture in order to gain access to information and assistance. Researchers need to come in prepared and open to participating in the community if they wish to learn from it. Mr Tetlich emphasized how this establishment of trust and respect is a two-way street. It is as important to the community as it is to the researcher.

Conference Sessions – Day One (continued)

Key Learnings

- Being seated together at the same level where you can make eye contact is important in meetings or gatherings for creating a connection between one another.
- To understand the information you are receiving it is important that you get to know the individuals behind the stories – to really understand them and their culture.
- To change people's minds it is important to tell real life experiences. If you have experienced it, you can express it. It is a matter of both experience and story.
- The impact of the message can be enhanced through the use of pictures.
- A story has to be told truthfully to maintain its integrity and effectiveness over time.
- Sharing stories is a people tool that leads to productivity, quality and safety. It is tacit knowledge information sharing in a social way. It should be tolerated and incorporated into the workplace from the top down and seen as an acceptable part of a learning culture.
- Learning to do things in practice is a social phenomenon. Use strategic approaches towards using information in a social way. Bring people who are retiring in as mentors to groups of students and use orientation programs that immediately place newcomers into groups.
- Use traditional knowledge in combination with technical knowledge to influence policy. Local experts have a lot of good information and past knowledge that can benefit scientists.

At the end of this session, John Parboosingh provided some further thoughts on where and how to start the knowledge transfer process in an organization.

- The first stage is to try and use some principles from research to determine whether you might be going in the right direction.
- Shrink-wrap this into something operational with consideration for the cultural context.
- When you have the model, look at ways of improving it through an evaluation process.
- When you get to a stage of improvement that is acceptable and feasible, do a formal evaluation.
- The speculation-based-on-research phase is very important, but if you subject the first innovation to an official randomized control you would not get any further.

This panel session on the power of narrative was followed by a plenary presentation on e-tools and the newest social media tools that can be used to help support knowledge management and knowledge exchange.

Conference Sessions – Day One (continued)

Finding Our Way... e-Tools for Knowledge Transfer

Wayne MacPhail

Wayne MacPhail is President of w8nc inc., an emerging technology communications company with clients in media, healthcare, and the non-profit and university sectors. He is also the founder of the rabble podcast network and is currently working with rabble.ca to launch rabbletv. In his keynote address, Social Media Unboxed: Making Sense of the Conversation, the Cloud and the Common Good, Mr MacPhail focussed our attention on the Web as a social medium and described its power as a catalyst for conversation and community. He introduced us to a number of the latest social media e-tools such as Twitter, Second Life, Rabble TV, podcasting, webcasting, wikis and Web 2.0, and outlined how these tools provide us with a collective and collaborative system that we can use to facilitate easier and more efficient management and exchange of knowledge and information.

Mr MacPhail walked us through the origins and concepts behind a number of rapidly emerging processes such as folksanomic tagging, social bookmarking, and RSS feeds, all of which represent an on-line but natural extension of our social environment and the choices we make on a daily basis to define our world. He showed us how these e-tools allow us to move applications and data from our desktops to the Web for shared content collaboration, and how they serve to enhance community, conversation and a blurring of the lines between author and audience. In conjunction with this, he outlined strategies for embedding codes, talked about creating a common good and facilitating crystallization or engagement. He provided a practical demonstration on finding your favourite sources no matter where you are and having these sources come to you – all useful, timesaving tools for researchers, decision makers and policy makers.

Key Learnings

- The Web has the capacity to bring together diverse points of view and provide us with a wider perspective on the world.
- Folksanomic tagging is a social bookmarking system of tagging that allows labelling online content so that you and others can find it easily.
- Taxonomy is a top down tagging system where codified keywords are used to define terms related to papers, books and documents.
- Save information on the Internet using Delicious (del.icio.us), a social bookmarking web service, to create a source of items that can be shared.
- Syndicate your bookmarks by setting up an RSS feed then the information can come to you.
- Use tools such as ning.com or projectforum.com to create websites for sharing and editing information. You can make use of these e-tools for podcasts or Internet radio, video tutorials, etc.
- Make your websites more engaging by using WordPress, TypePad or Twitter.
- Do not use tools that require high bandwidths as they will cut off access to a large proportion of the rural population.

Conference Sessions – Day One (continued)

- Do not encourage the use of PDFs. You want documents to be living things.
- You want more than just traffic on your website. You want engagement.
- Your message is more powerful if you go to where the people are rather than have them come to you.
- Create a common good collaboratively and believe in it. If you trust your community to share and be honest, you will have a wonderful common good. If you do not believe in it, it will fail.
- Determine guidelines on how the group will behave. Open the development of these guidelines up to the group so that everyone has a stake in them.
- Create effective boards peopled with enthusiastic members.
- You need moderators who are good at understanding human dynamics as well as volunteer moderators.
- It must be a user centric design to ensure that people get something out of it. Listen to your clientele to understand what their issues are. If you are not solving a problem, no one will use it.
- Make things online easier than offline.
- At the beginning, provide reminders to go to the site. After a time this will not be necessary.
- Provide access to everyone in the organization from the CEO down.
- If your organization does not understand that this is good, you are working in the wrong place.
- Give up the concept that you are the author – the centre. This is a decentralized sense of storytelling. Everyone has a story to tell.
- Focus on concepts not applications.
- Live and think in the future. If you think in the past you will not see opportunities.
- Be bold. Take chances.

Networking Reception

Day One of RTNA 2008 ended with a Networking Reception where the conference participants were provided with a further opportunity to exchange ideas, experiences and insights on knowledge transfer. Conference presenters presided over a number of specific topic tables and other tables were made available to the participants for impromptu discussions.

Conference Sessions – Day Two

Day Two of RTNA 2008 opened with a series of concurrent sessions that showcased a variety of provincial and national knowledge transfer projects and programs. A full listing of the concurrent sessions and presenters is provided below. Session abstracts are available in the conference program.

Concurrents: Finding Our Way... A Showcase of KT Projects and Knowledge Transfer Research in Alberta and Across Canada

A. e-Tools Being Used for Training, Best Practice Support, Continuous Learning

- **Mapping Our Way to the Future of Knowledge Transfer: Development of a Wiki in an Evidence-Based Practice Physical Therapy Course**

Anita Hamilton, Pat Edney and Susan Armijo-Olivo, University of Alberta

- **The Evaluation of Practice-Based Evidence in Nutrition (PEN) – A Knowledge Translation Service for the Dietetic Profession**

Jayne Thirsk, Dietitians of Canada

- **Designing Communities of Practice to Support Knowledge Transfer in Primary Care Networks**

Dorian Frère, d frère Consulting

B. Relationships and Networks – KT Within and Between Organizations

- **Jurisdictional Context Specific Knowledge Utilization: A Successful CADTH Journey**

Donna Champagne, Canadian Agency for Drugs and Technologies in Health

- **Putting Principles into Practice: The Development of an Evidence-Informed Organizational Milieu in a Northern Health Authority**

James Chan, Tanis Hampe, Deb Collette, Jeanette Foreman and Jane Handina Kanchense, Northern Health, British Columbia

- **Communities of Practice – “Getting Off on the Right Foot!”**

Christine Thompson and Ron Schlegelmilch, SEARCH Canada

- **Knowledge Translation in Action: Sharing the Experience**

Hope Beanlands, National Collaborating Centre for Determinants of Health
Kathie Clark, National Collaborating Centre for Methods and Tools

Conference Sessions – Day Two (continued)

C.1 Print Material, Presentations and Workshops

- **Local Information for Local Planning: Active Dissemination for the Alberta Diabetes Surveillance System (ADSS)**
Stephanie Vermeulen, Institute of Health Economics
- **Family Physicians' Evaluation of a Revised Geriatric Interim Discharge Summary**
Marjan Abbasi and Sheny Khera, University of Alberta
Robert Flook, Caritas Health Group
- **What's In Your Toolbox? Studying Community-Based Research Workshops as a Capacity-Building Tool for Mobilizing Knowledge**
Elizabeth Huebert and Sherry Ann Chapman
Community-University Partnership for the Study of Children & Families
- **Knowledge Mobilization: Theory and Evaluation**
Kelly Shaw and Sherry Ann Chapman
Community-University Partnership for the Study of Children & Families
Monica Jack, Alberta Centre for Child, Family & Community Research

C.2 Developing KT Skills

- **The Pain and Dementia Toolkit: Teaching Family Members to Observe and Report Pain Behaviours**
Cary A. Brown, University of Alberta
- **KT Best Practices for Primary Care Researchers with Policy/Decision Makers**
Phyllis Marie Jensen, University of Alberta
Cheryl Levitt, Tina Karwalajtys and May Cohen, McMaster University
- **Evaluation of Work Disability Prevention: KT Initiative for Physical Therapists**
Audrey Lowe, College of Physical Therapists of Alberta

These concurrent sessions were followed by the third and final panel session of the RTNA 2008 Conference.

Conference Sessions – Day Two (continued)

Finding Our Way... People Tools for Knowledge Transfer

John Parboosingh and Rob Wedel

In this session, two of the most common people tools for knowledge transfer – communities of practice and interdisciplinary teams – were highlighted, together with the processes that help or hinder their success. Panelists John Parboosingh and Rob Wedel led the session.

The first panelist to present was Rob Wedel, Family Physician and Physician Lead of the Chinook Primary Care Network, a rural network that exemplifies a successful model of moving primary care towards interdisciplinary outcomes oriented practice. Dr Wedel is also Medical Director of the Chinook Regional Palliative Care Program, Assistant Clinical Professor at the University of Calgary.

a) “Professional Identity Under Reconstruction” Family Practice Teams in Evolution: An Alberta Experience

In this presentation, Rob Wedel talked about knowledge transfer within an interdisciplinary team. He outlined the evolution of the Chinook Primary Care Network into a community of providers in rural Alberta who are passionate about improving the care they provide, and learning and evolving together on a daily basis.

The Network originated with the Taber Integrated Primary Care Project, a SEARCH II project that had three goals or pillars of integration in mind:

- wrestle back some local decision making from the Chinook Health Region;
- see if paying doctors differently would make a difference;
- integrate technology into practice through the use of an electronic health record.

A number of key learnings along the way, however, led to the realization that what was really needed to shift practice was a different approach to patient care – a movement away from a medical management approach into case management and self-management. Dr Wedel identified how, as the project progressed, so too did the thinking around teams – around role identification and integration. And, as the Network evolved and settled into a team-based approach to care, the physicians realized a number of key benefits including ease of information sharing and communication and most importantly, better patient care.

Key Learnings

- Role identity is the key to teamwork, followed closely by role clarity.
- The people doing the work must change the work.
- Create sustainability through ongoing measurement.
- Look at both the big and small picture – what you do individually and beyond. Measure these things over the course of a year. Goal clarity, role ambiguity and conflict will change over the process of time.
- Plan what kind of team you need based on your patient profile, then look at what guidelines and protocols should be put in place to care for your practice.

Conference Sessions – Day Two (continued)

- Embed these protocols into everything you do. This will assist the team and reduce variations in practice. It builds pathways into care and everyone will know what the goals are and what they are responsible for.
- Develop guidelines around patients who are not at goal.
- When you focus on doing the right things you start to see the reliability of how you provide care. There is no falling through the cracks.
- Have weekly team meetings. There will be lots to discuss.
- Identify if and where the team needs more training. Allow staff to identify their own needs as well.

The next panelist to present, John Parboosingh, was already familiar to conference participants having co-led the session on the power of narrative in knowledge transfer.

b) People Tools for Knowledge Transfer

In this session, Dr Parboosingh discussed the role of Communities of Practice (CoPs) as an effective infrastructure for knowledge transfer. He described CoPs as groups of people who share a concern or a passion for something they do and collectively learn how to do it better through regular interaction. Dr Parboosingh highlighted the importance of the bandwidth of generative dialogue for effecting change in a knowledge transfer event. He also re-emphasized the use of storytelling as an effective tool for clarifying reality by pulling evidence into a conversation.

Key Learnings

- Knowledge transfer is used to facilitate change around embedded patterns of behaviour.
- Learning that leads to change is a construct between two or more people.
- Communities of Practice create generative dialogue that facilitates the internationalization of the message.
- We make sense of things through the quality of our interactions. This is where the tool is and this is what we need to operationalize.
- We need to make sense of information. Clarify current practice first by pulling in the different perspectives around the table. Look at how it fits your values and explore the barriers.
- Group intent and support is necessary and if it is interdisciplinary it is that much stronger. The more perspectives around the table, the more effective the bandwidth.
- Once you put the best practice in the middle of the conversation, the conversation ends. Good facilitation is knowing when to introduce best practice.
- You can control the bandwidth if the group knows each other beforehand. If you invest in relationships within the department, knowledge transfer is much easier.
- We are the tools. The biggest information repository in most organizations is the heads of those who work there and the web of conversations that bind them.

Conference Sessions – Day Two (continued)

c) CoP Reflective Exercise

Conference participants were asked to reflect on a team or any group in which they were currently involved and consider the following:

- i. How do you share practice habits within your group – the practical wisdom things that you do?
- ii. Do you want to protect your information or trade it? What is the culture in your organization? Do you depend on each other to keep up to date?
- iii. Do you feel that your contribution to the group is valued?
- iv. Are trainees and other care providers valued members of your group?

Participant feedback during this reflective exercise highlighted a number of key messages.

i. Sharing Practice and Work Habits

- It is easier to achieve high quality practice within a small group.
- Sharing practice is related to the degree to which people in the group are comfortable enough to disagree. It requires an environment of trust.
- When you are sharing practice you are not trying to achieve a melting pot. You need different perspectives around the table. Leave your baggage at the door, but bring your history and experiences with you.

ii. Sharing Information

- There are often ownership or approval issues around whether or not you can or should share information between health regions.
- The culture of the institution can create barriers to sharing information. It is more comfortable when the organization indicates support.
- Organizations should appoint a high level group to oversee investing in relationships.

iii. Valuing Individual Contributions

- Communities of Practice celebrate success without talking about it and prefer progress rather than evaluation.
- A generative organizational culture invests in conversational relationships.
- You should be rewarded for your contribution to group activity.
- If the organizational culture you are in does not respect this concept, you should not be in it.

iv. Valuing Trainees and Other Practitioners

- Use the concept of investing in relationships for orientation and exit programs. This facilitates a smooth transition into and out of an organization through the immensely valuable exchange of information.

Conference Sessions – Day Two (continued)

Other Comments and Key Messages

- Emotion is important and stories bring emotion to the table.
- Consider bringing other people to the table who might be helpful.
- You need to get comfortable enough to talk to each other about your roles. Achieving this comfort level can be hard, but you need to address it. Once you get through that it will build strength in your team.
- We live in a very individualistic society and to be dependent on one another can be perceived as a sign of weakness. In a generative culture, however, this can be turned into a strength.
- Address the soft competencies such as collaboration, communication, etc. The innovation is in how to institute this within the culture of an institution from the top down. This kind of activity needs to be talked about at the leadership level.

The CoP reflective exercise ended with a general conversation around how to initiate and sustain Communities of Practice.

Initiating and Sustaining a Community of Practice

- A knowledge base creates the foundation for the group.
- Ensure the CoP has relevance so that the individuals involved come to the table on a regular basis despite their busy schedules. Ask yourselves what you want to talk about within your Community of Practice. Everybody needs to be in sync about this.
- A CoP is not a committee meeting that you can miss and catch up on. Each person is an active part of the exercise.
- Leadership is important. A good leader nurtures the conversation, stimulating it without taking it over.
- A CoP involves a core group with both an active group and a peripheral group around it. This is important as you will never get anything done if everyone is in the core group.
- Peripheral participation is legitimate and valuable. The core group may come to a decision then have someone come in from the periphery with a different and important perspective that might not have been thought of.
- Foster talk about practice by asking individuals to provide success stories. For example, make your handover rounds a learning experience by asking individuals to be prepared to share a success story from their shift addressing why they felt it was so successful and what about it made them feel good.
- CoPs do not use evaluation and success language. They use language around why it felt good.
- When you hear a success story you are being provided with an opportunity to understand people's values. Use a CoP journal to document these stories.
- Knowledge Transfer in Action workshops can be used to gather interdisciplinary groups together around a particular issue or need.

Conference Sessions – Day Two (continued)

These panel presentations clearly demonstrated the fact that excellence is truly possible. It is replication spread that seems to be the challenge. The session ended with one final, thought provoking question from the audience: “If we think we are doing good things, where is the tipping point for it becoming more widespread? Why aren’t we all doing this?” Steven Lewis took this question one step further and asked John Parboosingh and Rob Wedel to consider what they would do if they had the power to accelerate improvement and the application of all they have learned.

Key Learnings

- Culture usually eats process for breakfast. We can talk process but that does not get us there as quickly as what we start to feel and do in our work.
- We need to start investing in the people we already have within our organizations instead of hiring ‘messiahs’ from outside.
- Fiscal responsibility is currently defining the style of leadership. We need to change the focus and get at clinical excellence.
- The jewel is in measurement.
- Feed data into your conversations as quickly as you can. Patient satisfaction or feedback data is a good place to start and provides a good balance to Cochrane.
- Do not throw resources at the people you know will not change.
- You can still accomplish a lot despite all of the difficulties. Leadership helps but you do not necessarily have to wait for the people at the top. You can do things at a local level that will have a major impact on care. Start where you can; control what you can; and go for it.

The last session of Day Two and of the conference was Bryan Kolb’s presentation, Making a Difference – closing the gap between research and decision making in order to improve the health of individuals, populations and the healthcare system itself.

Making a Difference

Closing Presentation by Bryan Kolb

Bryan Kolb is a professor in the Department of Neuroscience at the University of Lethbridge, Fellow of the Royal Society of Canada and Killam Fellow of the Canada Council. His recent work is focused on the development of the prefrontal cortex; more specifically, how neurons of the cerebral cortex change in response to various developmental factors and how these changes relate to behaviour.

Bryan Kolb’s presentation effectively and provocatively answered one very key question, “Why care?” Current estimates suggest that half of the population will experience problems with their central nervous systems in their lifetimes. By understanding the nature of how the brain works we will be able to understand what treatments work. However, according to the Stroke Foundation, the translation time for scientific knowledge is 40 years.

Conference Sessions – Day Two (continued)

Dr Kolb did offer us a glimmer of hope, however, gained from his work with the Experience-Based Brain Development Program, a program developed by the Canadian Institute for Advanced Research. The program is a vehicle for transferring information on brain organization and function and the nature of addiction in an effort to influence the public and, through them, public policy. He described a number of strategies they were using and the various organizations they were accessing to get these important messages across. Specific target audiences include family judges, law enforcement officials, drug commissions, and early childhood education professionals among many others. By providing them with the information and knowledge they need to better understand the brain and changes in the brain in response to developmental factors that influence behaviour.

Dr Kolb highlighted many frustrations together with some bright lights of knowledge transfer that he has experienced from his point of view as a basic scientist or, as he described it, knowledge transfer from an alternate universe.

Frustrations

- Practicing knowledge transfer from academia is difficult. Academic researchers only get credit for presentations if they are given to colleagues or for publications in peer reviewed journals.
- Hunch and habit versus science. This is a two-sided lack of respect. There is a real lack of respect for basic research, and basic researchers do not understand the issues related to patient care. They come with answers but do not understand the questions.
- Physicians do not want to participate in research as they do not have the time and they do not get paid to do it.
- The knowledge does not get transferred to healthcare workers. There is poor access to policy makers and the professional organizations are apathetic.
- Most materials are not easily accessible and/or not accessible at an appropriate level.
- Media distortion - we hear about all these treatments yet nothing ever happens.
- There is a general failure to accept the brain hypothesis.

Bright Lights

- There is a growing interest in knowledge transfer and increased support from agencies such as the AHFMR and the Canadian Institute for Advanced Research.
- Fraser Mustard and his work as an advocate for the importance of early brain development on health, behaviour, learning and quality of life.
- There is huge public interest in knowledge transfer.
- The Internet has stimulated an interest in knowledge transfer – both good and bad.
- There are lots of public television programs being offered on the brain. People are primed to learn and start talking about brain function.
- The fact that we are here at a conference on knowledge transfer.

In addition to the frustrations and bright lights noted above, there were many other key learnings related to knowledge transfer in Dr Kolb's presentation.

Conference Sessions – Day Two (continued)

Key Learnings

- It is critical that you understand the purpose of knowledge transfer - why you are telling someone something.
- It can require repeated presentations for people to begin to see how they can use the information. It sinks in over time.
- Create materials that people can take away and understand.
- Knowledge transfer is social and context is important. To illustrate this point, Dr Kolb used the example of how he put clinical interns, post docs and students together in the same course and exposed them to both animal testing and hospital wards.
- Lectures give answers to people who do not understand the questions. Our job is not to give the answers but to give the questions. When you ask how the brain works and answer that question, you can look at a brain that dysfunctions and understand the treatments and why they should work.
- Start with the people who have the most at stake. You want to work from the ground up so that the policy makers hear about it this way.
- You are your brain. Everything you experience – prenatally, maybe even preconceptually, and for the first several years of life – will alter the way your brain develops quite profoundly and will have a huge impact down the road on your learning and your social interactions.
- Not to worry though – you can repair your brain after birth!

Conference Debrief, Wrap-Up and Close

The conference closed with a short wrap-up and thank you from Conference Moderator Steven Lewis and Conference Planning Committee Chair Donna Angus, Manager of Research Transfer Initiatives at AHFMR.

Where is the wisdom we have lost in knowledge?

**Where is the knowledge we have lost
in information?**

– T. S. Eliot, Choruses from *The Rock*, 1934 *(as quoted in Elliott Churchill's Keynote Address)*

References of Interest

The following references were noted by individual presenters during conference sessions at RTNA 2008. This is by no means a comprehensive listing, but it does provide some background readings that you might find useful. A listing of websites of interest follows.

Allee, V. (2003) *The future of knowledge increasing prosperity through value networks*. Butterworth Heinemann. New York, NY.

Allee, V. (2002). *Knowledge networks and communities of practice*. OD Practitioner, 32(4).

Batalden, P.B., Mohr, J.J., Nelson, E.C., Plume, S.K., Baker, G.R., Wasson, J.H., et al. (1997) *Continually improving the health and value of health care for a population of patients: The panel management process*. Quality Management in Health Care, 5(3), pp. 41-51.

Boulos, M.N.K. & Wheelert, S. (2007) *The emerging Web 2.0 social software: An enabling suite of sociable technologies in health and health care education*. *Health Information and Libraries Journal*, 24, pp. 2-23. Retrieved online 16 November 2008 at http://www.webdialogues.net/cs/cdc-new_media-library/download/dlib/1062/Emerging%20Web%202.0%20social%20software%20in%20health%20and%20healthcare%20education.pdf?x-r=pcfile_d.

Bray, B. & Boufford, B. (2006) *Beyond 'Eye Candy': Wikis for Collaborative Student Presentation Web Sites*. Paper presented at the IMPACT 2006. Retrieved online 16 November 2008 at <http://www.ualberta.ca/~bbray/Microsoft%20PowerPoint%20-%20WebCT%202006%20Beyond%20Eye%20Candy-04.pdf>.

Cohen, D. & Prusak, L. (1998) *In good company: How social capital makes organizations work*. Harvard Business School Press, Boston, MA.

Coiera, E. (2004) *Four rules for the reinvention of healthcare*. *British Medical Journal*, 328, pp. 1197-99. Retrieved online 16 November 2008 at <http://www.bmj.com/cgi/reprint/328/7449/1197>.

Davenport, T.H. & Prusak, L. (1998) *Working knowledge: How organizations manage what they know*. Harvard Business School Press. Boston, MA.

Day, K. (2008) Editorial: *Coming of age for healthcare knowledge management*. *Health Care and Informatics Review Online*. Retrieved online 16 November 2008 at <http://hcro.enigma.co.nz/website/index.cfm?fuseaction=archiveissue&issueid=67>.

Endsley, S, Kirkegaard, M. & Linares, A. (2005) *Working together communities of practice in family medicine*. *Family Practice Management*. Retrieved online 16 November 2008 at <http://www.aafp.org/fpm/20050100/28work.html>.

References of Interest (continued)

Estabrooks, C.A. (2007) *Prologue: A program of research in knowledge translation*. Supplement to Nursing Research, 56(4), pp. S4-S6.

Ferris, S. (2006) *Communities of practice to facilitate successful implementation of a knowledge management project in a complex adaptive system*. Health Care and Information Review Online. Retrieved online 16 November 2008 at <http://hcro.enigma.co.nz/website/index.cfm?fuseaction=articledisplay&FeatureID=041206>.

Fontaine, M. (2001) *Keeping communities of practice afloat*. Knowledge Management Review, 4(4).

Gallo, C. (2007) *How Ritz-Carlton Maintains its Mystique*. Business Week Viewpoint. Retrieved online 16 November 2008 at http://www.businessweek.com/smallbiz/content/feb2007/sb20070213_171606.htm?campaign_id=rss_daily.

Godin, G., Bélanger-Gravel, A., Eccles, M. & Grimshaw, J. (2008) *Healthcare professionals' intentions and behaviours: A systematic review of studies based on social cognitive theories*. Implementation Science, 3(36). Retrieved online 16 November 2008 at <http://www.implementationscience.com/content/pdf/1748-5908-3-36.pdf>.

Graham, I.D., Logan, J., Harrison, M.B., Straus, S.E., Tetroe, J., Caswell, W. & Robinson, N. (2006) *Lost in knowledge translation: Time for a map?* The Journal of Continuing Education in the Health Professions, 26, pp. 13-24.

Heiss, W.D. & Teasel, R.W. (2006) *Brain Recovery and Rehabilitation*. Stroke 37, pp. 314-16. Retrieved online 16 November 2008 at <http://stroke.ahajournals.org/cgi/content/full/37/2/314>.

Hsu, J. (2008) *The Secrets of Storytelling: Why We Love a Good Yarn*. Scientific American Mind & Brain. Retrieved online 16 November 2008 at <http://www.sciam.com/article.cfm?id=the-secrets-of-storytelling>.

Kift, S. (2003) *From bolting on to embedding: How do we progress the seamlessness of online and in-class learning environments to enhance student learning outcomes?* Paper presented at the OLT 2003 Excellence: making the connections. Retrieved online 16 November 2008 at <https://olt.qut.edu.au/olt2003/Proceedings/OLT%20Conf%20Proceedings.pdf#page=161>

Kolb, B. & Wishaw, I.Q. (2008) *Fundamentals of Human Neuropsychology* (Sixth Edition). Palgrave Macmillan.

Kolb, B. & Wishaw, I.Q. (2005) *Introduction to Brain and Behavior* (Second Edition). Palgrave Macmillan.

Langford, P. (2001) *Communities of practice – The practitioner's viewpoint*. Knowledge Management Review, 4(3).

References of Interest (continued)

- Parchman M., Pugh, J., Culler, S., Noel, P., Arar, N., Romero, R. & Palmer, R.** (2008) *A group randomized trial of a complexity-based organizational intervention to improve risk factors for diabetes complications in primary care settings: study protocol.* Implementation Science, 3. Retrieved online 16 November 2008 at <http://www.implementationscience.com/content/3/1/15>.
- Potts, H.W.W.** (2006) *Is E-health progressing faster than E-health researchers?* Journal of Medical Internet Research, 8(3), e24. Retrieved online 16 November 2008 at <http://www.jmir.org/2006/3/e24/>.
- Rycroft-Malone, J.** (2007) *Theory and knowledge translation: Setting some coordinates.* Supplement to Nursing Research, 56(4), pp. S78-S85.
- Samarawickrema, G.** (2007) *Wikis in Higher Ed.* Report. Deakin University, Melbourne, Australia. Retrieved online 16 November 2008 at <http://www.deakin.edu.au/itl/documents/wiki-report-fin.pdf>.
- Scott, C. & Hofmeyer, A.** (2007) *Networks and social capital: A relational approach to primary healthcare reform.* Health Research Policy and Systems, 5. Retrieved online 16 November 2008 at <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2048492>.
- St. Onge, H. & Wallace, D.** (2003) *Leveraging communities of practice for strategic advantage.* Butterworth Heinemann. New York, NY.
- Teasell, R.W. & Kalra, L.** (2005) *What's New in Stroke Rehabilitation: Back to Basics.* Stroke 36, pp. 215-17. Retrieved online 16 November 2008 at <http://stroke.ahajournals.org/cgi/reprint/36/2/215.pdf>.
- Wagner, E.H.** (1998) *Chronic disease management: What will it take to improve care for chronic illness?* Effective Clinical Practice, 1(1), pp. 2-4. Retrieved online 16 November 2008 at http://www.acponline.org/clinical_information/journals_publications/ecp/augsep98/cdm.htm.
- Wedel, R., Grant Kalischuk, R. & Patterson, E.** (2007) *Turning Vision into Reality: Successful Integration of Primary Healthcare in Taber, Canada.* Healthcare Policy, 3(1). Retrieved online 16 November 2008 at <http://www.longwoods.com/view.php?aid=19175&cat=499>.
- Wenger, E.** (2004) *Knowledge management as a doughnut: Shaping your knowledge strategy through communities of practice.* Ivey Business Journal. Retrieved online 16 November 2008 at http://www.iveybusinessjournal.com/view_article.asp?intArticle_ID=465.
- Wenger, E.** (n.d.) *Communities of practice: A brief introduction.* Retrieved online 16 November 2008 at <http://www.ewenger.com/theory/>.
- Wenger, E, McDermott, R. & Snyder, W.M.** (2002) *Cultivating communities of practice: A guide to management knowledge.* Harvard Business School Press. Cambridge, MA.

Websites of Interest

Championship Teams – Sarah Fraser & Associates Ltd.

(information on goal clarity)

<http://sarahfraser.com/index.php>

Chinook Primary Care Network

<http://www.chinookprimarycarenetwork.ab.ca>

College of Family Physicians of Canada (CFPC)

Primary Care Toolkit for Family Physicians

<http://toolkit.cfpc.ca>

Cpsquare

The Community of Practice on Communities of Practice

<http://cpsquare.org/>

Institute of Healthcare Improvement

<http://www.ihl.org.>

Taber Health Project

<http://www.uleth.ca/man/taberresearch/>

Wagner – Chronic Care Model

<http://www.ihl.org/IHI/Topics/ChronicConditions/AllConditions/Changes/>

Wenger – Communities of Practice

<http://www.ewenger.com/theory/>

Social Software Tools

Blogs

<http://www.blogger.com/home>

<http://blogsearch.google.com>

<http://bloglines.com/>

<http://technorati.com>

<http://wordpress.org/>

Collaborative Writing

<http://docs.google.com/>

Online Desktop

<http://www.google.com/ig>

Photosharing

<http://www.flickr.com/>

<http://picasa.google.com>

Podcasts

<http://www.how-to-podcast-tutorial.com>

<http://www.podscope.com/>

RSS (Really Simple Syndication)

<http://www.youtube.com/watch?v=OkIgLsSxGsU>

Social Bookmarking, Collaborative Tagging, Tag Clouds

<http://del-icio.us/>

<http://www.citeulike.org/>

Social Networking

<http://twitter.com/>

<http://www.facebook.com/>

<http://www.myspace.com/>

Videosharing

<http://www.youtube.com/>

Virtual World

<http://secondlife.com/>

Web 2.0 applications

<http://www.seomoz.org/web2.0>

Wiki

<http://pbwiki.com/academic.wiki>

<http://www.mediawiki.org/wiki/MediaWiki>