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PROMOTING ACTION ON EQUITY ISSUES:

A KNOWLEDGE-TO-ACTION HANDBOOK

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GLOSSARY

Evidence-based medicine

describes the use of the best current evidence in making decisions about the care of an individual patient. Evidence-based medicine (EBM) is intended to integrate clinical expertise with the best available research evidence and patient values.

Evidence-informed decision-making

recognizes that many different forms of evidence, in addition to research, are needed to make decisions in the management and policy arenas.

Health inequities

are differences in health that are judged to be unfair or the result of some form of injustice (current or historical).

Implementation evaluation

refers to a focus of evaluation that is intended to determine whether an initiative was in fact implemented as intended. This is often an important step before attempting to measure the outcome or impact of an initiative.

Knowledge-to-action gap

— also referred to as the know-do gap—refers to the failure to implement what is known into practice (whether clinical, management, or policy).

Knowledge transfer

refers to the process of passing knowledge on to a specified audience.

Knowledge exchange

in contrast, describes the process by which parties (e.g. researchers and decision-makers) share expertise and knowledge for a specific purpose.

Knowledge translation (KT)

has been defined in many different ways and is often used interchangeably with knowledge transfer. In this handbook we have adopted the Canadian Institutes of Health (CIHR) definition:

> a dynamic and iterative process that includes synthesis, dissemination, exchange, and ethically sound application of knowledge to improve the health of Canadians, provide more effective health services and products, and strengthen the healthcare system. This process takes place within a complex system of interactions between researchers and knowledge users that may vary in intensity, complexity, and level of engagement, depending on the nature of the research and the findings, as well as the needs of the particular knowledge user.

A knowledge user

is an individual or group who is who is likely to be able to use the knowledge generated through research to make informed decisions about health policies, programs, and/or practices. The knowledge users for any research or KT project will vary on the situation, and can include practitioners, policy makers, managers and administrators, community-based organization, or patients.

Language and ethnicity indicators

are questions or categories that attempt to measure concepts related to a person's background in a quantitative way. Examples of such indicators include: mother tongue, language spoken at home, country of birth, Aboriginal status, immigration status, or ethnicity.

Organizational diversification

refers to organizational change that is undertaken with the intent of creating an organizational environment that supports, values, and benefits from the contribution of its members, whatever their background. It requires a change in how an organization operates (e.g. policy changes, human resource management practice), not simply provision of diversity training.

A stakeholder

is a person, group, or organization with an interest in a project, or who may be affected by a project.

Synthesis

refers to the contextualization and integration of research findings of individual research studies within the larger body of knowledge on the topic. There are many different forms of syntheses. Synthesis in this context emphasizes the inclusion of local, contextual data, and current knowledge user needs and interests, along with research evidence.

INTRODUCTION

INTRODUCTION

Why this handbook was written

In both North America and Europe, the increasing diversity of national populations is accompanied by growing attention to issues of equitable treatment and access. However, in spite of an increasing emphasis on evidence-based practice and evidence-informed decision-making, there have been few resources developed to support action to move the evidence on issues of concern to underserved and culturally diverse populations into planning and practice.

This handbook is intended to address this gap by providing practical guidance and support to those working to address health inequities and promote organizational cultural diversification. It will be of interest to health-service administrators and managers, quality and safety officers, managers of interpreter and other diversity programs, organizational change managers, and leaders within ethno-cultural communities.

The handbook is based on results of a multi-phase Knowledge to Action research project (funded by the Canadian Institutes of Health Research—CIHR). The objective of this research was to determine what strategies were effective in moving evidence of concern to culturally diverse groups into healthcare planning and decision-making. It evaluated strategies used to promote action on five different diversity issues within a large Canadian health region (the Winnipeg Regional Health Authority—the WRHA):

a. organizational action to provide trained health interpreter services;
b. introduction of language and ethnicity indicators into an electronic hospital information system;
c. adoption of an organizational diversity framework;
d. development of a co-ordinated response to the health needs of newly arrived immigrants and refugees; and
e. development of a community health assessment report to inform planning for immigrant and refugee communities.

The strategies found to be effective have previously been shared with other organizations in other jurisdictions. This broader experience has also been incorporated into the handbook.

Defining health equity and inequity

There are important differences between the concepts of health disparities, inequalities, and inequities. The term *health disparities* refers simply to differences between population groups defined by specific characteristics (we may note, for example, that women and men have different prevalence of certain conditions). *Health inequalities* is the generic term used to designate differences, variations, and disparities in the health achievements and risk factors of individuals and groups. This term may not imply moral judgement (e.g. differences in health outcomes that result from personal choice or biological endowment). *Health inequities* are differences in health that are judged to be unfair or the result of some form of injustice (current or historical)—it is inequities that are major focus of public health action.[1]

How the handbook is organized

This handbook is organized into four main sections.

- **Section 1: Knowledge Translation 101**
  A brief overview of what is currently known about the science of moving knowledge into action.
- **Section 2: Getting ready**
  Practical guidance for framing and focusing activities in ways that will increase the likelihood objectives will be achieved.
- **Section 3: Starting in the right place**
  Summarizes the six different phases for moving knowledge into action.
- **Section 4: Developing a comprehensive strategy**
  Concrete examples of strategies useful at all stages of the knowledge-to-action process.

Throughout these sections, key points are illustrated with examples from the development of WRHA (Winnipeg Regional Health Authority) initiatives, with an emphasis on the development of the Language Access interpreter service.

Finally, the Conclusion reviews some of the key messages. This is followed by a list of references and a series of worksheets to support planning.

The use of specific case examples

Throughout the handbook, key points are illustrated with concrete examples (most of which are taken from the experience of development of the WRHA Language Access service) to illustrate how the principles outlined in the handbook were applied to a specific equity issue.

When the Language Access initiative began in 2004, there was no point of organizational responsibility for services in the region. Some interpretation services were provided by Aboriginal Health Services, and French language services policies were in place. These services were supplemented by community-based services of varying quality and coverage (the majority of which did not ensure interpreters with appropriate training, or meet the standards identified in the literature). Collaborative action to bring the risks of language barriers and reliance on untrained interpreters (to both patients and to the health system) to the attention of decision-makers, and to promote development of an evidence-informed regional response, resulted in development, funding, and implementation of quality health interpreter service. Several other initiatives, designed to address equity issues (e.g. immigrant and refugee health service design; changes to health information data collection systems) built on the momentum achieved through this activity.

How to use the worksheets

There are seven worksheets designed to help you think through each stage of your planning. However, as will be discussed in the handbook, the planning process is likely to be iterative—and you will likely find yourself going back and forth between various stages (corresponding to sections of the handbook). For this reason, it may be useful to review all the worksheets before beginning.

SECTION 1:

KNOWLEDGE TO ACTION 101

Why so little action in response to equity and diversity issues?

A question that has long frustrated many advocates of health equity is this: *Why, when there is such compelling evidence on many issues related to health inequities and cultural diversity, has so little action been taken to address them?*

For example:

- Why, although there is emerging evidence on the limitations of many approaches to cultural training, do so many educational programs rely on messages that are known to contribute to stereotyping?
- Why are health organizations so slow to adapt to the diverse needs of an increasingly multicultural society?
- Why are trained interpreter services seen as a nice-to-have but not necessary service?

The problem in context: The knowledge-to-action gap

The gap between current evidence and practice is a major challenge facing healthcare systems in all countries: there is a significant gap between what we know and what we do in either healthcare practice or health system management.[7] Recognition of this knowledge-to-action gap has resulted in focused interest in developing what are often referred to as knowledge translation (KT) strategies.[8] Knowledge translation encompasses a broad range of strategies intended to promote evidence-informed action. Some of the strategies adopted include requirements for researchers to incorporate a KT plan in their funding proposals, dedicated funds for KT (or implementation science) research, making information available in an accessible and user-friendly format, development of clinical practice guidelines, and funder requirements that clinicians and managers justify funding requests by demonstrating use of evidence in planning and priority setting. In spite of these initiatives, KT efforts to date have had modest impact,[9] even in the field of evidence-based medicine where most of the attention has been directed. A number of barriers to evidence-informed action have been identified, including issues related to individual interest and capacity to use research and other forms of evidence; the nature of the knowledge to be transferred; organizational and contextual factors, and presence or absence of resources to facilitate evidence use.

An example:

The issue of language access provides a dramatic example of the gap between what we know (the evidence) and what services we provide. There is compelling international evidence of the risks of language barriers and use of services of untrained interpreters (to both the health of individuals, and to the health system itself). Several systematic and general reviews highlight the impacts of language barriers on participation in health promotion and prevention activities, delayed presentation for care, increased risks of misdiagnosis, poorer patient understanding of and adherence to prescribed treatment, lower patient satisfaction, lower quality of care, increased risk of experiencing adverse events, poorer management of chronic disease, and poorer health outcomes.[2-5] There are also risks to health providers and organizations, as language barriers commonly result in failure to: obtain informed consent; to appropriately assess and prescribe treatment (increasing risk of failing to meet care standards); and to protect client confidentiality. There is growing evidence on the often hidden costs of failing to appropriately address language barriers: increased use of high-intensity services and decreased use of primary care services, misdiagnosis and repeat visits, and longer lengths of stay and more intensive use of resources in some settings.[6]

In spite of this evidence, however, in many jurisdictions little action has been taken to address language barriers. Very often language access services are seen as nice to have but optional services. Why is this the case and what can be done about it?

Type of Barrier	Example
Individual characteristics	Lack of education or training; beliefs that research is irrelevant; resistance to change
Type of knowledge	'Soft science' (e.g. qualitative findings) are less likely to result in action than 'hard science'
Organizational factors	Lack of leadership; inadequate resources; failure to provide protected time to find and use evidence; crisis management culture; absence of processes or structures that facilitate research use
Contextual factors	Funder requirements that do not support, or allow time for, appropriate collaboration; evaluation
Resources	Access to library resources; no protected time for research

Most commonly cited barriers are lack of time and resources, and factors related to organizational culture and leadership (e.g. the crisis management culture of healthcare where what is urgent takes precedence over what is important; leadership that does not value evidence use; and failure to protect time for the activities needed to identify, assess, and integrate evidence into planning).

A particular challenge in addressing population health issues, including equity issues, is that cross-program and even inter-sectoral action is often needed. Because many of our health and social services operate in silos, there is a need to creatively build relationships across sectors (system integration). Another challenge is finding the evidence to inform planning—issues of health equity often require integration of findings from many different literatures.

While it is important to understand these barriers (as such understanding gives us insight into the complexity of promoting an evidence-informed approach), many are now suggesting that we must focus on solutions (or effective strategies for getting knowledge into action) rather than on simply identifying the barriers to using evidence. This would involve focusing on how we can work differently, both in conducting knowledge generating activities, and in moving evidence into practice.

The modest achievements in closing the knowledge-to-action gap have led to an intensity of interest in determining what works in KT.[10] It is increasingly recognized that simple, linear conceptions of how knowledge is transferred are inadequate—dissemination of research is not enough. Many theories have been developed to explain the barriers to evidence use, and to propose effective knowledge-to-action activities. Research has identified interaction between researchers and users as a critical factor in research uptake.[11-12] This understanding has resulted in evolution of KT theory and a focus on promoting research partnerships between users and researchers. An important development has been the differentiation between *end of grant* (the conventional approach to KT, focusing on dissemination) and *integrated* KT.[8]

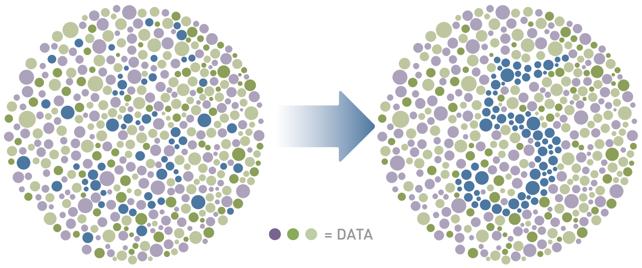
In integrated KT, researchers and knowledge users work collaboratively to determine the research questions, decide on the methodology, interpret the findings, and help disseminate the research results. This attention to integrated KT (also referred to as Mode 2 research, collaborative research, action-oriented research, or co-production of knowledge)[13] reflects the research on the importance of collaborative approaches, not only in promoting action on research findings, but also in helping ensure that research is relevant and responsive to important social problems.

In spite of these developments, there is continued scepticism about demands for decision-makers to use evidence, and some indication that this call is being resisted.[14] One reason for this is that the approaches and strategies used to support evidence-based medicine (strategies that are most familiar to decision-makers) are often insufficient, or even inappropriate, in promoting evidence use in organizational planning or policy development, or in addressing broad social problems such as health inequities—concerns of many decision-makers.

From evidence-based medicine to promoting evidence-informed action on health equity

In spite of a recognition of the need to promote evidence use in order to improve health, much of the attention has focused on development of interventions to promote evidence-based clinical care, rather than on management decision-making (e.g. health system re-design issues). Applying the principles of evidence-based medicine to evidence-informed program planning and policy is not appropriate.[15] We also know that management (program and policy) decision-making is fundamentally different than clinical decision-making—in cultural environment, type of decision, timelines for decision, and the types of evidence relevant and appropriate to apply to the decision.[16]

There has been even less research exploring what KT strategies are effective in promoting action on knowledge related to issues of health equity and cultural diversity, and there are special knowledge-to-action challenges in this area. We know that additional challenges are found in promoting evidence-informed action in areas that are considered soft science,[17] which is often the case in areas of population/public health. In addition, evidence related to underserved populations tends to be marginalized in health system planning.[18] Decision-makers often reflect those from the dominant society, and they may have little direct experience with issues of importance to underserved populations.



Knowledge is created when information is interpreted and understood, and we can discern patterns.

But what is evidence?

We often hear decision-makers call for more data. While we do need good data, data alone is not sufficient to inform planning—data are isolated facts. We need to identify the relationships between these bits of data before they are usable information. Knowledge is created when information is interpreted and understood, and we can discern patterns. This means that knowledge is created through critical and evaluative thinking, which makes sense of what are otherwise often isolated and disparate 'bits' of evidence. This is essential, not only in population health, but also in health-service provision. As one example, although many of the problems facing the health system are issues that cut across sectors of care, a 'bit' of data (e.g. hospital length of stay) may only highlight one area of concern. If only that 'bit' of data is attended to, the focus may be on trying to reduce hospital length of stay without exploring the reasons leading to it (e.g. adequacy of primary/preventive care; long term care alternatives)—issues outside of the realm of hospital care.

All too often, when people talk about using evidence, they are referring to one form of evidence—research. Well conducted, rigorous research is often the best form of evidence, and should be central to decision-making. However, this is not all the evidence that must be considered. Often there is little or no research to inform needed action on a given issue. At other times, research offers contradictory messages (or has been conducted in a completely different context than the one you are working in). Research must be assessed carefully to determine whether the results are applicable in a specific decision-making context.

Because there is rarely sufficient research to inform management decisions (and contextual evidence is often needed), other forms of evidence are also critical to planning—such as evaluation findings, local data (administrative, clinical, or population), community and client experience, professional expertise, resource availability, or local practice and priorities. These other forms of evidence should always be used alongside the research evidence. In each of the sections that follow we will explore what forms of evidence should be considered at each stage of the KT journey.

The importance of synthesis in context

It is not enough to simply gather evidence. It often happens that when people talk about using research to inform planning, they have actually found one or two articles that support their proposal. This is often referred to as decision-based evidence making—it is often possible to find some research that supports what you would like to do, but this is not evidence-informed planning.

It is essential first, that there is a systematic search for evidence. This can often be a challenge as such a search can be time consuming, and specific skills are needed. It is often useful to involve a librarian who can help set up a search for you. In the area of health equity and diversity, it is particularly important to also ensure that a broad range of evidence is considered (including unpublished literature—the grey literature), and a librarian will be a great resource. There may useful data available at the national (e.g. census, national health surveys), provincial (analysis of population or health administration data), regional or municipal level that will help inform your planning. Just as importantly, the experience of communities and clients needs to be systematically explored. Often community consultation activities (sometimes many of them) have been previously conducted— and results of these should be incorporated.

Then this evidence needs to be synthesized, analyzed and interpreted for applicability in your specific context. As discussed in the following section, this is one of the important reasons for working in partnership with stakeholders on the specific issue you hope to address.

The particular challenges of knowledge translation in a global health context

While context is critical for planning all knowledge translation activities, there are particular challenges in working in inter-cultural contexts—whether here in Canada, or in international settings. How we frame issues is often culturally determined—how we see the problem is very much the result of our own assumptions and background; and those from outside the cultural community may lack important knowledge. Too often, there is a reliance on transferring knowledge generated from the dominant culture (or in the international context, from developed countries) into other settings, without first assessing the relevance of this evidence for the specific context, or ensuring that local expertise and conditions are integrated into analysis of research data.[19] This highlights the need for collaborative and respectful partnerships to ensure that the intended benefits of these health initiatives are achieved.

This section will focus on what are perhaps the most important activities in preparing a knowledge-to-action plan: ensuring that the appropriate people are involved; clarifying the challenge you are hoping to address; and determing the audience for your current activity. While many readers will have already undertaken the steps outlined in this section, it may be useful to review past actions to make sure you are starting from a sound foundation. Careful planning is essential. These early steps may come together very quickly, or may take months of preparatory work.

SECTION 2:

GETTING READY

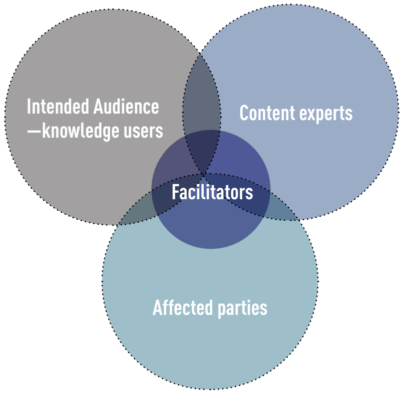
Plans are nothing; planning is everything. –Dwight D. Eisenhower

When schemes are laid in advance, it is surprising how often the circumstances will fit in with them. –William Osler

CAUTION:
While the following information is presented in a step-like fashion, these activities are often iterative. For example, the coalition of partners may change after the problem is clarified with the initial group.

Step 1: Build a coalition of partners

KT theory tells us that meaningful involvement of those who are intended users of research findings is critical to promoting evidence-informed action. This is also true of any initiative to promote evidence-informed action, including evaluation activities. Having all the necessary partners on board with your initiative is essential. Therefore, the first step should be to establish an appropriate collaborative working group to guide activities. It is highly likely that the collaborators will come from a broad range of backgrounds, as discussed below.



Who should be involved?

Who should be involved?

Think of including individuals from the following categories:

- ***Intended audiences*** (knowledge users); those who you hope will be moved to action (or those with direct access to those making the decision you want to inform). The concept of knowledge user is an important one, but also the source of much confusion. Not all stakeholders (or interested and affected parties) are the intended users of a particular research or knowledge translation activity. It is important in designing any KT initiative to be clear about who it is hoped will act on the knowledge generated. Think broadly—most issues of health equity require inter-sector collaboration, and are the responsibility of different agencies and government departments. Even within healthcare, most issues of health equity cut across sectors of care (e.g. public health, primary care, acute care, and emergency).
- ***Content experts***. Those with both practical and research knowledge of the issue of concern.
- ***Affected parties***. Those who care about, or are, or will be affected by the issue and its solution. These can be both community and organizational partners, people who bring the evidence of lived experience.
- ***Facilitators***. The group also needs individuals who can make links between stakeholders with often diverse perspectives and backgrounds, and facilitate the objectives of the initiative—to help move discussion into action.

While it is essential that all these members are included, they may not need to be involved at the same time or in the same way. Often it is more effective to have different engagement strategies reflecting the roles, preferences and needs of your collaborators.

If those who are the intended audiences or actors are not included in early planning, they will likely not be receptive to your messages. You also want to benefit from the insights and experiences of those affected by the issue—this gives your work both expertise and legitimacy. Those who are affected are likely to include both communities and established services for which your initiative may have implications. Content experts are needed both from a research and a local evidence perspective, from various program areas and organizations. It is also an enormous advantage to have someone with experience in moving knowledge into action—these individuals can come from a variety of different backgrounds.

What format should the working group take?

If at all possible, try to find an appropriate group (or groups) already in existence that can take on this role. People are always busy, and if there is already an existing group that can play a steering role, it may be easier to tag on a steering committee function to existing activities. This strategy may also facilitate spread of knowledge and skills to other activities.

It may not be feasible to have all those on a collaborative committee attend at the same time—particularly if you are including individuals in senior positions, or those who are very busy. In such cases, it will be necessary to develop a consultation strategy, as well as a carefully thought out communication plan, to ensure ongoing two-way communication as the initiative develops.

Going to where people are, and meeting around their activities, has a number of advantages:

- It increases the likelihood of participation;
- It minimizes the time required of participants (often very busy people);
- It allows the flexibility to use different formats and methods—each appropriate to the audience;
- Each group can spend more time on its area of concern/expertise;
- As project initiator, you will have the opportunity to learn more.

Another alternative is to form a specialized virtual advisory committee, where those with specialized skills can be consulted on an as-needed basis.

You may need to be prepared to undertake creative efforts to include those who cannot, for good reasons, participate in regular working group meetings.

Example from practice:

A regional Language Access sub-committee was selected as the Steering Committee for the implementation evaluation of the new Language Access Interpreter Service. The committee realized, however, that it was essential to have input from the vice-president of the portfolio funding the service, but that he would not have time to participate in planning meetings. After the evaluation plan was drafted, a short 15-minute meeting was scheduled with this executive to go over the evaluation questions. The purpose was not only to get his support, but also to ensure that all questions of concern to senior management were included.

Implications for health system action:

Make sure you include on your working group, not only affected community members, but also representatives of community-based organizations already providing service in related areas. This needs to be done with thought to timing and representation (as discussed in the section *Selecting individuals* below). You will benefit from their experience and support in moving forward. Community-based groups have often taken initiative in the absence of action by the larger healthcare system. If they are not included, and their expertise and contribution not recognized, they may feel used, or be critical of your initiative. They need to be included. At the same time, not all of these community services represent the needs or perspectives of communities themselves.

Implications for community-based action:

Make sure you include organizational expertise on your committee—a working group made up only of people from the outside the organization (and who are pressuring to make changes) is unlikely to be that effective. You need the insights and expertise of those from within the system, and the direct links to decision-makers.

Example from practice:

The first action taken by the Winnipeg Regional Health Authority (WRHA) to promote action on the issue of language access was to form a Language Access Committee. This committee reported directly to an organizational vice-president, ensuring direct connection to the senior executive decision-making body. It included managers and front-line staff who recognized the problems caused by language barriers and who were committed to addressing them, a researcher with expertise in this area, and representatives of existing health interpreter and language services (from deaf, immigrant, Aboriginal, and francophone communities). In this way it included both those who understood the issues, and those who need to be on board with any recommendations going forward. The committee worked hard to create a climate where different perspectives and areas of expertise (research, clinical care, management, community interpreting) were respected and valued.

Selecting individuals

Once you have identified the stakeholder groups you need to include, it is necessary to choose specific individuals who can best represent the perspectives of these groups. This is often not that easy.

The challenge of community representatives:

A common challenge will be found in selecting community representatives. How does one select an individual who 'represents' the community? Is this even possible? Rather than representation of entire communities, think of strategies to include diverse community perspectives in your planning, while at the same time bringing on board the knowledge and skill you need. A common mistake is to select one community representative rather than developing strategies for ensuring community engagement.

There are even times when it might be better NOT to include direct community representatives. One example might be where community perspectives have already been clearly identified, and the major challenge is to bring about consensus on next steps from those within the health system. In other situations, an organization that has weak links to the community may want to undertake some pre-planning, and some behind-the-scenes learning, before going out and recruiting individuals to work with them. It is recommended by some authors that it is better to begin with an informal network until the organization has the opportunity to learn more about the community and who would be a useful and credible partner.[20] Too many organizations have had to backtrack in their planning (or have been led down the wrong road) through selecting one or more token representatives, who may be relied on in areas outside their expertise, and even may not be respected or trusted by those you are hoping that they represent.

CAUTION: It is important to treat this process as an opportunity to build an ongoing collaborative relationship, not simply to get the champion or the community representative to do something for you.

Finding organizational champions:

The importance of a champion at the highest levels cannot be overstated. But what is a champion? And what have been some of the limitations of focusing on champions to move evidence into action?

First it is important to think about the necessary characteristics of a champion. In our experience a champion must:

- have credibility with the audience you want to reach. In the case of our Language Access example, this meant that the champion needed to have credibility with—and access to—senior management;
- be knowledgeable about the issue (this does not mean that they would need to be an expert, but wise enough to know what they do and do not know);
- be able to advocate for, and support, a collaborative and effective process, and,
- believe the issue is important enough to champion.

However, it is often not as simple as finding a champion: there may not be a readily identified individual who is both knowledgeable and committed and, at the same time, based at an appropriate level in the organization to help you move your project forward. Sometimes it will be necessary to create champions. This requires identifying individuals in key positions that you feel would be sympathetic to the issue, and finding opportunities to meet with them. Sometimes this can be done directly, at other times it may be necessary to find an intermediary, or even undertake a snowball sampling approach until you identify the appropriate person.

Example from practice:

A special committee was created to explore options and guide integration of ethnicity and language indicators into organizational health information systems. However, it was realized that there were a number of organizational and community concerns about ethical/legal implications, the feasibility of collecting this data, and whether there would be support from front-line staff. To move this initiative forward the original steering committee created three other groups. Individuals with responsibility for organizational ethics, legal counsel, and privacy agreed to act on a resource committee and supported the project on an as-needed basis. The advice from these experts helped address initial concerns. In addition, two working groups consisting of IT expertise and managers and staff of departments responsible for implementing the change were also created, in order to ensure that opinion leaders in these critical areas were also engaged with the initiative.

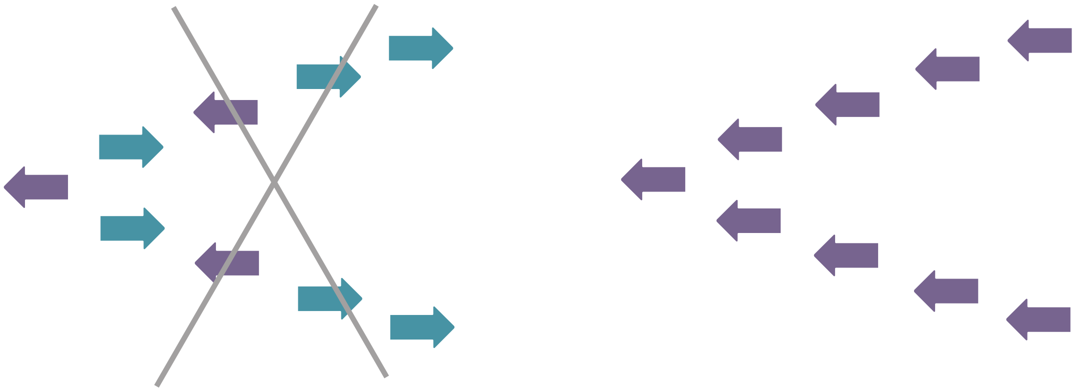
There are also some potential risks of relying on champions. It is important to remember that a champion of your cause may not be credible or have easy access to all decision-makers. Often support is needed from many different quarters. So, it is important to develop a plan to involve individuals from all affected parts of the community and/or organization.

In addition, champions can leave, or move on to other interests. So, while a champion is often a major component of a knowledge-to-action strategy, once a decision for action is taken, there is a need to turn attention to institutionalizing this support within organizational processes and structures.

Step 2: Determine the current challenge

Another critical activity is to determine exactly what knowledge-to-action challenge you are trying to address. To get you started on this task, this section identifies six phases of a knowledge-to-action plan. Coming to agreement on the specific challenge you are facing will also help build common purpose among partners, and provide a focus to your activities.

Be careful not to rush to a solution until you well understand what the issue is. In healthcare, it is common that when a problem is identified there is a sense of urgency to do something. This can result in failure to truly establish the nature of the problem, and a subsequent misalignment between the issue and the proposed solution. It takes time to explore an issue and ensure all are engaged. In addition, it is likely that the issue will be understood differently by different stakeholders. The key perspective, and one that must not be neglected, is the perspective of those who are living with the inequity in question.



Common purpose is essential for success

From understanding the challenge to determining the KT phase

So, it is important to collaboratively (and carefully) determine where you are in the policy trajectory, in order to undertake the next step: determining the phase of a knowledge to action plan that is most appropriate for action. Six phases of a knowledge to action plan were identified through our work:

- **Clarifying the problem.** It's important to be clear on exactly how the issue is defined.
- **Getting an issue on the agenda.** Sometimes the issue is clear to those in the know, but is not recognized at higher levels in the organization.
- **Informing a response.** In other situations there is recognition of the issue, but guidance is needed in determining what to do about it.
- **Informing implementation.** Sometimes it is believed that if a decision is made, the problem is fixed. However, often the change is not implemented as intended—with the result that the desired effects are not achieved. We also need evidence to inform implementation.
- **Changing practice.** Even after a decision is made about a change or intervention, there is often a gap between the intended response and what actually happens at the front line.
- **Maintaining support.** It is especially important when promoting evidence use on equity and diversity issues to plan for ongoing reinforcement of key messages. Key decision-makers change, and there will be competition for scarce resources.

In Section 3, we will explore in greater detail strategies for each of these stages.

Phase 1	Understanding and framing the issue
Phase 2	Getting the issue on the agenda
Phase 3	Informing the response
Phase 4	Informing implementation
Phase 5	Changing practice
Phase 6	Maintaining support

Example from practice:

In the Language Access example previously described, the problem was clearly defined. The region was relying on untrained and ad hoc interpreters, with resulting risks to patients and the organization. However, this issue was not even on the agenda of decision-makers—no reference to the issue could be found in senior management minutes, nor was there a clear organizational responsibility centre (except for Aboriginal or French-speaking patients). Therefore, the initial challenge was to get organizational acknowledgement that there was a problem and that it should be addressed.

Step 3: Clarify your intended audience

Although you will, by this stage, have given some thought to your intended audience, the entire steering committee should have a focused discussion to address the question: Who do we need to act on the issue at this stage?

Example from practice:

In the previous example, once it was determined that the initial challenge was get the issue of language access on the agenda, the intended audience was clear. All initial efforts were, therefore, focused on senior executives.

Interested and affected parties versus intended knowledge users:

There is an important difference between stakeholders (or those interested in and affected by an issue) and those who it is expected or hoped will act on the knowledge provided (knowledge users). It is necessary to plan for incorporating these two groups in different ways.

Those most affected by an issue (e.g. patients, underserved communities) must be included in meaningful ways in generating knowledge to inform action: their insights and preferences must guide the process at all stages.

Knowledge users, on the other hand, are those you hope and expect to act on the knowledge you are providing—these may not be the people who most care about the issue or benefit from the changes. It is essential that these stakeholders—who are required to buy in to the issue and to use and act on the knowledge you want to share—be integrally involved from the beginning of the activity, as the knowledge-to-action activities are designed for them. If for some reason, you do not have ready access to the intended knowledge users, it is critical to have a credible champion who will be able to act as the link with them in an ongoing manner right from the beginning. It is useful to undertake this planning when you begin your activity.

Table 1 provides an example of the process of differentiating between interested and affected parties and knowledge users in planning health interpreter services, and illustrates how it guided planning for the Language Access Committee.

W1 **WORKSHEET 1:** INTERESTED AND AFFECTED PARTIES VERSUS INTENDED KNOWLEDGE USERS

Table 1: Comparison of interested and affected parties and intended knowledge users: The WRHA Language Access Initiative

Question	Who should be involved?	Strategies
Who is affected by this issue? Who cares about the result? (affected parties)	• Language minority communities • Patients lacking English language fluency • Current providers of language services • Front-line staff	• Include results of previous community-based research • Conduct community consultations • Gather specific local cases to illustrate research
Who is in a position to act on the knowledge generated? (knowledge users)	• Organizational senior management • Site and program leaders from different sectors • Providers of language access services • Provincial immigration services	• Include on steering committee • Ensure official reporting line from steering committee to senior management • Develop targeted communication strategy

It is also important to note that the intended knowledge users will be different at different stages of your activity as illustrated by comparing the identified knowledge users for two different equity initiatives (Table 2).

Table 2: Examples of Knowledge Users

Knowledge-to-action Stage	**Knowledge Users — Language Access Initiative**	**Knowledge Users — Language and Ethnicity Indicators initiative**
Getting the issue on the agenda	Senior management	Senior management, board
Informing the response	Senior management, providers of related services	Senior management, privacy office, legal counsel, Ministry of Health
Informing implementation	Institutional and program management	Management of pilot site, registration and IT directors
Changing practice	Managers, front-line staff, others	Registration managers and front-line registration staff

An iterative activity:

This activity of clarifying the audience may bring to light gaps on the steering group—as links to the intended audience are critical.

The previous section highlighted the importance of positioning your activities appropriately for the specific challenges you face at each point in the policy/planning trajectory. This section will expand on each of these six phases, providing practical ideas for assessing your situation and developing a response. This work is usually most appropriately conducted in collaboration with your working group.

It is important to note, however, that this is unlikely to be a simple linear process. For example, you may determine that you are already at one phase, but with further exploration, discover that earlier phases should be revisited. Similarly, in a multi-component initiative, specific activities may be at different stages of the KT process.

SECTION 3:

SET—STARTING IN THE RIGHT PLACE

You need to know where you are before you can figure out where you are going.
It doesn't matter how fast you climb the ladder if it is leaning against the wrong wall.

Phase 1: Understanding and framing the issue

Once a problem or issue has been identified in collaboration with stakeholders, the first step is to clearly understand and frame the issue. This framing will influence the level of action (e.g. system redesign, enhanced training, or community development).This step is important in overcoming the all-too-common pattern, particularly within the health system, of a few people identifying a problem and then quickly leaping to action. The result, all too often, is poorly informed action. Acting too fast, and implementing an action that is not informed by evidence, can prevent progress—first because it may not work, and secondly because a partial response may give a message to those who do not fully understand the problem that the issue has been addressed.

Framing an issue incorrectly and not seeing the whole picture can result in poorly informed action.

Example from practice:

In one hospital, recognizing an increasing number of immigrants from different countries who had difficulty communicating in English resulted in quick management action. An overhead call system was implemented where anyone who happened to be in the hospital and who spoke the required language was asked to volunteer to interpret for the patient. It was also believed that these volunteers could explain cultural practices to medical staff. Unfortunately, this speedy and concerned response resulted in action that in no way meets accepted practice. Further exploration would have both identified the risks of using untrained, ad hoc interpreters (which can be greater than the risks of no interpreter at all); as well as the cultural diversity within any language group.

Not only was the opportunity to plan an evidence-informed response missed, but this quick-fix removed any sense of urgency to address the issue, even though patients were not receiving acceptable service.

Step 1: Determine what is known about the issue

The first task is to identify the evidence that will help you understand the nature and scope of the problem. Table 3 outlines types of evidence you may want to consider, with examples of evidence used in the early stages of the WRHA Language Access initiative. As this example illustrates, your search for evidence will often lead you to draw on many seemingly disconnected bodies of evidence.

Table 3: Example of specific forms of evidence used

Type Of Evidence	Examples Of Evidence Used In Phase 1 & 2: Language Access Initiative
Research	Research on the risks of language barriers, as well as what was known about using ad hoc interpreter services Local research assessing cultural responsiveness of hospital services
Demographic projections	Demographic projections of total and sub-populations; provincial government plans for immigration
Local evaluation findings	None identified
Analysis of administrative or population data	Provincial landings data, census data
Consultation with local communities	Results of several local community consultations conducted over the years, showing consistent perspectives on the issue, provided data to inform planning
Patient experience	Specific examples of communication breakdown, and resulting impacts, provided by committee members and communities
Professional experience and expertise	Reports from front-line staff of their challenges serving patients and clients lacking English language fluency
Ethical, legal, or professional guidelines	Provincial and organizational privacy legislation, consent policy, professional codes of practice
Organizational mission, values, objectives	Mission and value statements related to diversity and quality of care
Decision-makers perspectives and level of understanding	Gathered through consultation with Language Access Committee members

Who should determine what relevant evidence should be included?

How the problem is defined will be affected in important ways by who is involved in framing the issue. It is essential that the experiences of those experiencing the inequity are part of framing the problem at this stage.

Use the evidence to frame the problem:

Be clear in your framing about implications of where the problem lies. For example, it has been observed that much of the cultural awareness literature defines the challenge of providing care to diverse populations as a problem based in the deficiencies of a particular subpopulation. In other words, the problem is defined as '*they don't speak English*', '*they have different cultural practices*'. This framing will often lead to solutions that focus on the individual patient (encourage them to speak English, educate them on how we do things in Canada). In contrast, if the problem is defined as a failure to provide equitable care to all patients, and the risks to ensuring quality of care and patient safety, the focus of intervention is more likely to be on structural or systemic change or program redesign. Work in framing the problem may also highlight important gaps in the evidence gathered to date.

Example from practice:

As one organization was considering how best to meet the reproductive health needs of immigrant/refugee women, a number of sister agencies were urging development of an immigrant health clinic. Consultation with women needing these services found that they were framing the problem differently. They didn't want an immigrant clinic. Rather, what they identified was a failure of the healthcare system to address the barriers to their participation in the range of health promotion, prevention, and primary-care services available to other Canadians. They wanted to have access to the broader range of health services (across the continuum) and not be limited to a specific service targeted at immigrants.

Step 2: Determine barriers to use of evidence

At this initial stage it is also important to begin to identify barriers, and potential barriers, to evidence being integrated into planning, as well as any facilitators to appropriate knowledge use. This knowledge will also help frame and inform your evidence search and synthesis of the evidence.

- Document the different perspectives of those who can help facilitate or hinder your planning. Identify areas of potential disagreement.
- Identify the level of knowledge of intended knowledge users on the issue: how do they define the issue, and how important do they feel it is? What potential misconceptions might they hold?
- Gage support for getting action on the particular issue. Actively engage those who are supportive.
- Undertake a simple assessment exercise: meet with champions and other trusted advisors and ask directly what barriers, or resistance, might likely be encountered.

CAUTION:
While the following information is presented in a step-like fashion, these activities are often iterative. For example, the coalition of partners may change after the problem is clarified with the initial group.

Example from practice:

In the process of attempting to respond to immigrant and refugee health needs, it became apparent that one important barrier to action was the lack of knowledge of decision-makers on newcomer health issues. As a result, the next focused community health assessment report provided not only data on immigrant health, but also a conceptual framework for thinking about and categorizing priority populations, priority health issues, and principles for designing a service response.

W2 **WORKSHEET 2:** FRAMING THE PROBLEM

Phase 2: Getting an issue on the agenda

If the problem is appropriately framed and there is a good understanding of the evidence about the problem, you may be at the stage of needing to get an issue on the agenda. This is a common starting point in addressing health inequity and diversity issues.

There are three reasons why it will likely be premature to suggest solutions to the equity issue you have identified:

- Until decision-makers are committed to doing something, details on potential solutions may inadvertently provide reasons NOT to act (e.g. worrying about how much something will cost before they have decided that action is necessary).
- The process of using evidence to inform a response is very different than using evidence to get an issue recognized. You will want to have sufficient time to plan for the next stage.
- Often, as will be discussed in the next section, decision-makers need to be exposed to new information, many times and in incremental steps.

The focus of your communication with decision-makers at this stage, then, is to position the issue in order that you will be asked to undertake further work on the next stage—informing the response.

IMPORTANT CAUTION:
Focus at this stage on getting the issue on the decision-making agenda. The intent is to get support for the idea that there is a problem we should address, NOT to suggest a solution or details of a service response.

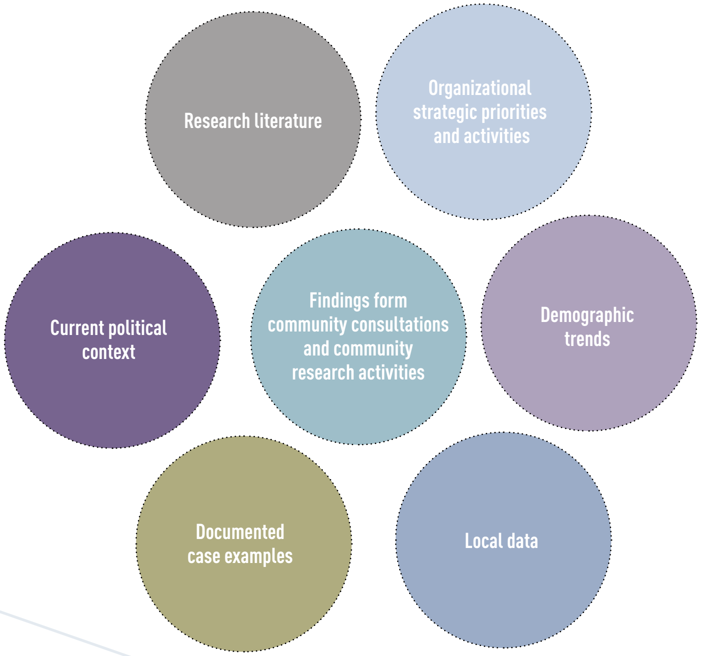
At this stage, the evidence to be used is that which will illustrate the nature and severity of the problem and its impacts: your goal is simply to get the issue on the agenda of the decision-making body and motivate the knowledge users to act on that knowledge. This means that the issue has to be viewed as both important and relevant to decision-makers. To accomplish this, there needs to be an understanding of the decision-makers priorities, conceptual frameworks, and world views. It is not simply a matter of telling decision-makers what they should know, or why it is important. Work is needed to determine:

- Priority issues that currently have the attention of decision-makers, and how your issue relates to these concerns;
- Forms of evidence decision-makers find most credible and convincing;
- Concepts and vocabulary that resonate most strongly with decision-makers;
- Individuals who can best play the roles of credible messengers in conveying knowledge on this issue.

Before beginning it is important to determine whether, within the organization(s) of interest, there are individuals or unites with responsibility for the issue you hope to address.

Example:

Some organizational initiatives have found support from privacy officers (Language Access), and risk management/patient safety personnel (health equity initiatives).



Getting an issue on the agenda: useful sources of evidence

What evidence should be considered?

At this point in the KT journey the following sources of evidence are likely to be useful:

- Research literature on prevalence and impacts of the equity issue;
- Local data related to this issue;
- Demographic trends and projections related to the issue;
- Results of local community consultation and research activities;
- Documented case examples;
- Organizational strategic priorities and activities; and
- Current political context.

Be aware that decision-makers may be sceptical of research and challenge its applicability in their context. This is why it is critical to have local evidence (e.g. population data on measures of poverty), as well as research data. Quite legitimately, local decision-makers want to know how general trends apply to areas within their mandate. At the same time, one or two incidents will often be dismissed as anecdotal. But several stories, used to illustrate findings from the larger literature, can be used to put a human (and local) face on national trends and local data.

W3 **WORKSHEET 3:** GETTING AN ISSUE ON THE AGENDA

Phase 3: Informing the response

You may find that the issue of concern is already on the agenda. The real challenge may be in determining how best to respond to the issue—how to design a response.

What evidence should be considered?

Very often, within the health system, a lot of attention is directed to gathering evidence to promote awareness of the extent of a problem, but very little evidence is used to inform the actual response to the problem. For example, well documented arguments may be made about the prevalence and health impacts of Type 2 diabetes in a population, leading to a decision that something must be done. All too often, however, the same quality of evidence is not used to design the response to the problem of addressing diabetes (in fact there may simply be a rush to do *something*). An intervention is identified (sometimes based on evaluation of a similar program somewhere else, but sometimes in response to one person's idea of what might work), but there is not careful analysis of evidence to determine what intervention might be most effective. In some cases the proposed solution may inadvertently create a problem elsewhere in the system. This is why it is important to have representation across all sectors that may be affected.

Evidence use is just as critical at this stage, but forms of evidence used might be somewhat different:

- Research literature (best or emerging practice) on interventions related to the issue in question;
- Evaluations of similar programs or services;
- Experience of local initiatives and those in other jurisdictions;
- Standards of practice, codes of ethics;
- Local demographic data and projections;
- Existing services and community initiatives;
- Community preferences;
- Community and decision-maker values; and
- Financial realities.

CAUTION:
Determining community preferences is not a simple activity. Depending on the issue, community may be defined in terms of geography, specific demographic characteristics, or shared interests or concerns. Ensuring appropriate community input can be challenging and takes time.

Interpret evidence in context:

As you review the research (or information on other initiatives) remember that the specific context you are working in is critical to your planning. Evidence that must be combined with research evidence includes the demographics, values, services already in place, organizational readiness for change, and practical issues related to design, funding, and implementation of the intervention. A common mistake is to simply promote adoption of an initiative that has been successful in another setting. Success in one context does not mean success in another. For example, planning a newcomer health service in a large urban centre that receives tens or even hundreds of thousands of immigrants every year will not be appropriate for a small town in a largely rural area.

Be prepared for challenges

Even more than in the previous stage, building support for a specific response is likely to be politically challenging. While all may agree there is a problem, there is less likely to be agreement on how to address the problem. (We may be able to demonstrate the prevalence of child poverty in our city, and get agreement that this is not a desirable state of affairs, but are less likely to get agreement on what to do about it). Remember that any decision is likely to result in benefit for some participants, and less benefit—or even loss—for others.

Create a culture of evidence use:

This is why building a culture of evidence use within your steering committee (or whatever structure you are using to support your coalition) is so important. The goal is to avoid conflict around potential solutions based on personal preference or loyalty to existing practice by keeping a focus on the evidence. This evidence does, of course, include local experience. One strategy that is often helpful is to develop, as a group, a set of principles that will guide your work. These principles should, wherever possible, reflect the evidence, but also include values of how (for example) the initiative will work with affected communities. See *page 73* for Principles developed to guide the work of the WRHA Immigrant/Refugee Working Group.

Example from practice:

The initial meetings of a working group to address newcomer health issues faced a number of challenges. This was the first time that there had been a co-ordinated attempt to plan for immigrant/refugee health at a regional level, and as a result different organizations had developed speciality services in various areas—and were concerned that they could lose funding for these as the result of a co-ordinated plan. Some participants were advocates for one refugee health issue only, and were promoting a single issue response.

The solution identified was to develop a concept paper that included definitions, research, and contextual evidence, and integrated these into principles for responding that summarized and synthesized the literature, community experiences and preferences, and identified principles for service development. Over the course of a number of meetings, revisions were made to the concept paper, which was subsequently approved as a the core document to guide committee planning.

Keeping a focus on the evidence can help build consensus around proposed action.

Identify the specific dimensions around which decisions must be made:

Another useful strategy is to divide up the design challenge into dimensions—look at the evidence related to each dimension separately, and at the end of this collaborative process, roll up the consensus decisions into one proposal.

Example from practice:

The Language Access Committee had representation from French Language Services, Aboriginal Health Services, sign language providers, and immigrant services. All had very different traditions, preferences, and standards for health interpreting. At the stage of developing a model of language access services that would be supported by all stakeholders, the group identified six dimensions on what decisions about the model of service delivery should be made:

1. accountability of services;
2. interpreter role;
3. how the interpreter was to be employed (e.g. employee versus independent contractor);
4. location of interpreter services (internal reporting lines);
5. area of coverage of interpreter services; and
6. scope of interpreter services.

After a review of the evidence for each dimension it was possible to reach consensus on each of these dimensions. As a result, the final model proposed went forward with the support of all parties. This model was the first co-ordinated language access service in the country.

Be prepared to make the business case:

Costs of interventions are another important source of evidence—concerns about what your proposed response will cost can risk closing down discussion at this stage. Be aware also that if what you are proposing is accepted by decision-makers, you are likely to be asked to put a cost figure on what you are proposing. It is more effective, however, to situate the proposed budget into a larger context, e.g. what do we know about the costs of NOT responding to the issue?

Example from practice:

The WRHA Language Access Committee was aware that decision-makers would be concerned about the total cost of implementing trained health interpreter services. Two strategies were developed to respond to this concern. First, a national scan was able to determine the costs of services in other health regions. As it turned out, these costs were only a fraction of what senior management was expecting. Secondly, a visual illustration of the hidden costs of language barriers was created based on evidence from the research literature. This strategy was used to illustrate the current (but hidden) costs of failing to provide trained interpreter services.

Your work to date may also suggest how changes (sometimes minor) to other services could support your proposal, and you might want to include such suggestions for redesign in your proposal. Redirecting current resources (if there is evidence to support the change, and those affected are in agreement) is often viewed more favourably than a request that is viewed as a new program.

Be aware of timelines:

Because there are likely budget implications, be aware of when in the funding cycle is the best time to submit a request. Where possible, break down your proposal into phases to make the total cost more attractive to funders.

W4 **WORKSHEET 4:** INFORMING THE RESPONSE

Phase 4: Informing implementation

We often assume that if a decision is made, then our work is done. This is rarely the case. However, the challenge of implementing a good decision is an often neglected area. Unless the initiative is small and fully funded (and unless you have organizational and staff readiness) the implementation of a strategy is likely to be multi-phased.

What evidence should be considered?

The forms of evidence you will probably find most useful at this stage will include:

- Research literature. Depending on the equity issue, this could include evidence not only on priority health areas and priority populations, but also the implementation science, organizational change, and priority setting literature.
- Knowledge of organizational culture, structure, processes, leadership, and readiness for change.
- Local assessment of information needs, and of barriers to change.
- Results of monitoring and implementation evaluation activities.

Example from practice:

When the Language Access Program was approved, there were no trained health interpreters, and the plan was to provide service to the entire Winnipeg health region—acute care, community services, and long-term care. In order to develop an implementation plan, it was necessary to look at the evidence to determine a) what languages should be prioritized and b) what health services and areas presented the most risk to patients when a language barrier was present. This was determined from landings data and projections, data on English language proficiency in newcomer communities, identification of refugee-producing countries, community and provider consultation, and analysis of the academic literature. Other factors considered were the interest and knowledge of specific programs, as it was easier to launch the new service in areas where there was already good support. Another activity undertaken to support implementation was an extensive assessment of organizational knowledge of the issue, perspectives on the proposed service, and potential barriers to implementation.

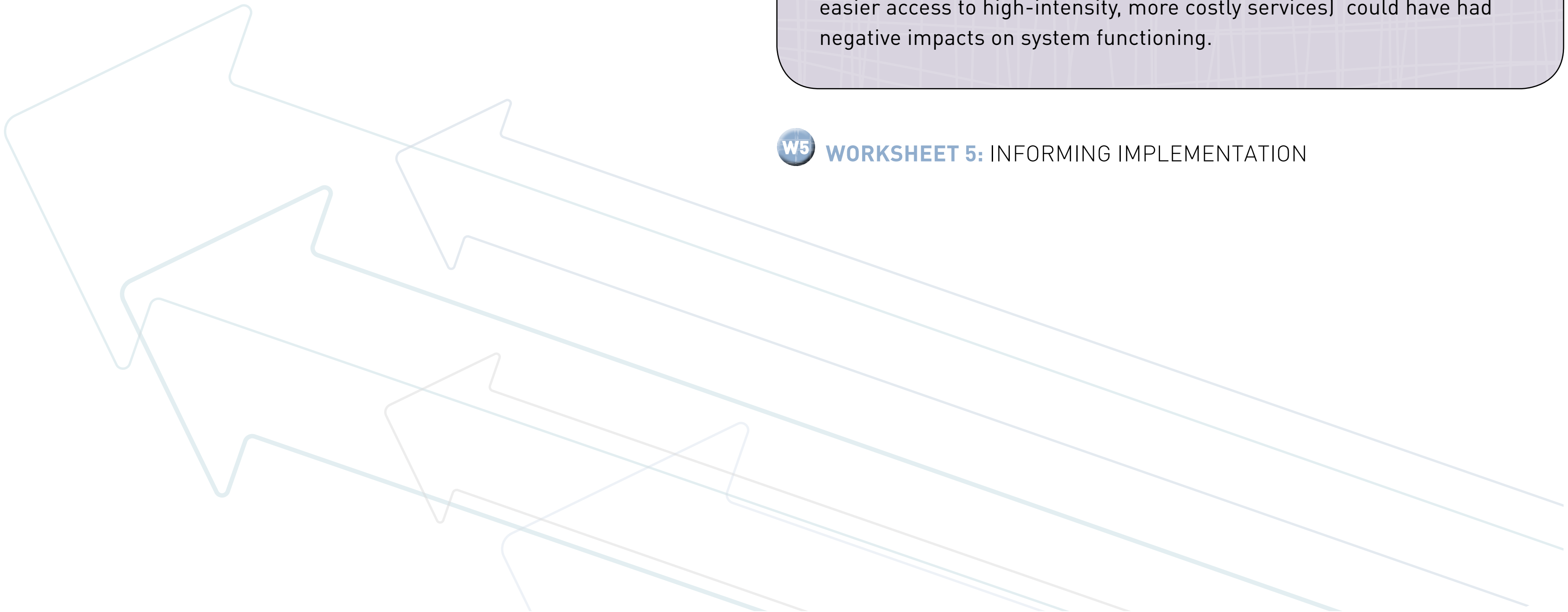
Integrate implementation evaluation with your KT strategy:

A critically important strategy at this stage is to monitor and evaluate the implementation of the initiative. Some evaluation approaches (e.g. utilization-focused evaluation, developmental evaluation) actively support knowledge-to-action activities and can serve as important mechanisms for not only learning about how well implementation is proceeding (and what local adaptations are needed), but also can continue to build consensus around evidence, generate new knowledge, and serve as a strategy for ongoing capacity building in the area.[21, 22]

Example from practice:

The evaluation designed to support the implementation of the Language Access interpreter service found that, because pediatric services at a children's hospital had been prioritized, hospital-based clinics were seeing increased workload—families were choosing to access the clinics instead of community-based physicians, even for routine matters. This led to a decision that the interpreters would be able to follow the patient wherever they went in the community, and quickly avoided a situation where service introduction (by providing easier access to high-intensity, more costly services) could have had negative impacts on system functioning.

WORKSHEET 5: INFORMING IMPLEMENTATION



Phase 5: Changing practice

While it can be a long process (and difficult struggle) to get to this point, there is more work to be done. Making decisions, changing policy, issuing directives, and providing resources does not necessarily mean that what actually happens on the front line will change at all. The same collaborative process that is needed to inform decision-making and program planning is also needed to change practice. If you find you are at this stage, it is critical to undertake the same strategies with program managers and staff as those recommended for engaging with decision-makers.

What evidence should be considered?

The evidence you will likely find useful at this point includes:

- Organizational change literature;
- Local evidence on effective and failed strategies to promote organizational change;
- Local assessment of information needs, and of barriers to change;
- Results of monitoring and implementation evaluation activities; and
- Professional codes of practice.

A common mistake is to view practice change as simply a question of sharing information on the need for the change, and the new expectations. However, what we have learned from quality improvement initiatives within healthcare, and a broad variety of knowledge transfer and knowledge translation initiatives, is that it is not enough to is simply communicate information.

First, it is necessary to gain the support of those whose behaviour you hope to affect. Different kinds of evidence, and different kinds of motivators, will be needed at the front line, compared to the decision-making level. You will also have to address specific information needs. If these are knowledge users who have been involved from the beginning (the phase of clarifying and framing the issue), you will have already made a good start.

Second, the barriers to, and motivators of, behaviour change need to be understood. In the Language Access example, while senior decision-makers were motivated by risk management concerns, many of the clinical staff were motivated by their professional and personal commitment to provide quality care to the patient.

Third, there needs to be attention to process design—your intent is to make the new, desired practice easier and more rewarding than the old practice.

Example from practice:

In the previous example, the implementation evaluation identified that one of the greatest challenges to providers using the new Interpreter Service was wait times (being put on hold by the intake/dispatch service). These wait times were cited as the major reason for low initial usage. This example illustrates that the key barrier was not lack of knowledge or provider willingness to change practice, but rather the absence of appropriate processes to support staff who were trying to adopt evidence-informed practice.

W6 **WORKSHEET 6:** CHANGING PRACTICE

Phase 6: Maintaining support

Even if you are successful in using knowledge to promote evidence-informed action (and your proposed response is implemented in an evidence-informed way), continued attention is required to ensure that the integrity of the initiative is maintained, and that it continues to be integrated into—and to inform—larger organizational planning. Vigilance is needed to ensure that support for the initiative is not eroded, and the equity issue does not fall off the agenda.

Keeping the issue on the agenda

Unlike some health issues—particularly those that are high profile, and have immediate exposure (wait lists, emergency department overcrowding)—strategies to address health equity can easily fall off the agenda, even if they initially find strong support. There are likely to be continual competing demands for support and a risk that the urgent (e.g. ER crisis) will overpower the important (the well-being of vulnerable communities). Here are some strategies you may find useful:

- **Make the organization proud.** If you have been successful in building an evidence-informed, effective response in your setting, think of ways of publicizing it. It helps to be recognized from outside your own community or organization. And share good stories. A letter or email from a provider or client commenting on a positive impact of your initiative should be passed on through appropriate processes to decision-makers.

- **Keep communicating—keep educating**. Because issues of health equity and diversity tend to be low awareness issues about which decision-makers tend to be less informed, additional efforts are needed to:
  - **Educate new decision-makers**. There is much turnover, and the decision made, or policy or program supported, by one senior manager may not be a priority for her successor.
  - **Reinforce key messages**. Don't assume that because you obtained support at one time that it is there forever. Look for opportunities to provide updates and share positive feedback.
  - **Anticipate potential challenges**. Keep alert for events (the opening of a new program, a change in government policy) that may cause decision-makers to reconsider their commitment.
  - **Negotiate opportunities for regular reports and updates**.

- **Position around emerging incidents**. Keep your eye on organizational challenges or near misses, and be prepared to illustrate how your initiative is helping or could help.

- **Measure your progress**. It is important to evaluate your efforts. One of the best ways to maintain ongoing support for your initiative is to evaluate it. This will allow you to monitor progress, identify any problems early, and continue to improve how the initiative is designed and operated. Remember to prioritize evaluation.
  - Include costs of evaluation in your budget planning;
  - Develop an evaluation plan ***before*** you start;
  - Ensure evaluation expertise on the team ;
  - Don't forget that good quality improvement practice can also support monitoring and ongoing development of many initiatives; and
  - Look for outside support (government department, research funds) to supplement your evaluation.

The importance of continual learning and development

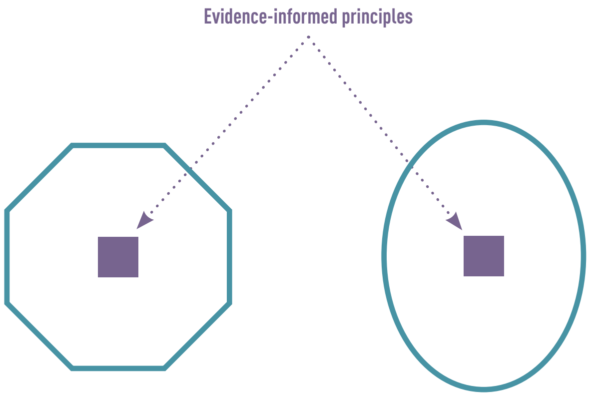
Support, however, will depend to a large extent on continued excellence and innovation. A common error made by many innovative programs is to think that once a program or service has been implemented, they are done. An initiative that is considered leading edge when it is launched can quickly fade in relevance and quality. Resources are needed to ensure that there are mechanisms in place not only to monitor program quality, but also to respond to changing trends, and to identify and act on emerging evidence.

Unfortunately, few initiatives ensure the necessary resources (in expertise or budget) to support appropriate implementation, evaluation, and ongoing program development. As a result, many of these initiatives remain as projects, vulnerable to the personal support of key decision-makers.

The issue of scaling up: transferability versus replicability

There is currently a great deal of interest in scaling up, or replicating successful initiatives. If there is good response to your initiative, you may find that there is eagerness to look for other opportunities to try the same thing, either in another location or on a broader scale. This is another reason why evaluation is so important: an initiative that is successful in one setting, or for one issue, may not be successful (or even appropriate) in another.

It is important when evaluating equity initiatives to identify principles or characteristics, associated with success (e.g. understand why something is working), not just whether positive changes can be measured. This will allow you to identify transferable principles that can be applied to other initiatives, rather than simply attempting to replicate a model you have found successful in one setting. As suggested earlier, the evidence of success (or failure) of a specific initiative needs to be understood within the context it was developed. A similar issue in a different context may require a very different approach, and what looks like a similar issue may have different roots, or be interpreted very differently by local stakeholders.



Identify transferable principles that can be applied to other initiatives, rather than simply attempting to replicate a model you have found successful in one setting

Even more importantly, there is a need to build the collaborative relationships proposed in this handbook in the new environment. The knowledge users in the new environment will have concerns that must be addressed, as well as insights that can contribute to an effective response.

While knowledge of a successful initiative may give a head start in addressing problems in other jurisdictions, it is important to consider at what phase these settings find themselves, and undertake the needed developmental work in collaboration with local partners.

WORKSHEET 7: MAINTAINING SUPPORT

Summary

This section has outlined general guidelines for proceeding through each stage of a knowledge-to-action plan. The next section will summarize the results of an evaluation of specific strategies to support this phased process, and specific suggestions for activities that you may find useful at different phases of your work.

SECTION 4:

GO—DEVELOPING COMPREHENSIVE STRATEGIES

The previous sections have suggested a framework for planning an evidence-informed knowledge-to-action strategy, based on identifying the phase of the knowledge-to-action process. The worksheets have provided a structure for thinking through your planning at each phase. The real work comes in developing a comprehensive strategy customized for a specific equity issue in your specific context.

Plans are only good intentions unless they immediately degenerate into hard work. *–Peter Drucker*

A summary of strategies

This section suggests some strategies that you might find helpful in developing your plan. They are based on a comprehensive and collaborative evaluation of strategies[23] used to promote action on the five different diversity issues identified in the introduction to this handbook:

- organizational action to provide trained health interpreter services;
- introduction of language and ethnicity indictors into an electronic hospital information system;
- adoption of an organizational diversity framework;
- development of a co-ordinated response to the health needs of newly arrived immigrants and refugees; and
- development of a community health assessment report to inform planning for immigrant and refugee communities.

Example from practice:

In all these examples, some form of steering committee or working group that incorporated key knowledge users and other stakeholders was formed. Researchers participated in all aspects of planning, implementation, and evaluation. Some of the reflective space was created from within existing committee meetings. For example, through development and review of concept papers and reports, the working groups built not only knowledge about the specific issue, but also skills in applying evidence to addressing it. Researcher participation also provided the resources to research and write the background documents, conduct community consultations, etc.

An approach rather than techniques

It is important to note, however, that these strategies were not used as isolated techniques. Consultation with program collaborators in identifying effective strategies suggests that these strategies were effective because they were embedded in an overall approach, rather than used as a collection of specific strategies. Critical factors inherent to this approach appear to be:

a. The relationship among researchers (or providers of evidence) and managers and staff. This included accessible and timely support (what participants called 'research running alongside' program operations). In this model, the researcher(s) is an integral part of the program team.

b. Provision of space and time for reflection and consideration of evidence.

c. Structures and processes that promoted early and genuine participation of all those affected, at every applicable level. Various types and levels of participation were recognized —from grassroots people to participation of senior or specialized staff—(referred to by one participant as a '*KT strategy in itself*'). This strategy included individuals who brought passion as well as those who understood organizational processes. A related theme was a commitment to addressing concerns of affected staff and decision-makers.

d. Creative and collaborative strategic thinking—including integration with organizational activities, responding proactively to potential opportunities, seizing the moment, and building on and linking with other projects. This also included working within organizational structures, processes, culture, and politics.

Results of evaluation of strategies to develop a successful KTA plan

Identified Strategy	Practical Examples
Creating structures (e.g. steering committees) to engage planners, managers, and staff with direct practice experience.	Formation of Regional Language Access Committee, Regional Language and Ethnicity Indicators Committee, Community Health Assessment Committee, and Immigrant/Refugee Working Group. Members of each of these committees were co-participants in research and KT activities.
Recognizing importance of, and allocating time for, development of strategies for promoting action on the evidence.	Contracting with researcher early in development of Language Access initiative. Regular reporting of ongoing research and evaluation activities at committee meetings.
Starting with, and remaining focused on, the evidence related to the issue.	Allocating resources to develop a recommended context-specific health interpreter service based on available evidence. Developing concept paper for Immigrant/Refugee Working Group.
Ongoing researcher participation to inform activities/strategies.	Participation of researcher as a committee member.
Positioning the issue around emerging incidents and organizational pressures.	Linking need for interpreters with Personal Health Information Act concerns.
Building on success of related projects/initiatives.	Success of Language Access initiative provided support and credibility to initiatives to integrate language and ethnicity indicators into health information systems as well as planning for co-ordinated immigrant/refugee services.
Identifying all the key areas for decision-making around a specific issue and then addressing each one separately.	Identifying separate elements of the proposed Language Access model, and discussing each separately at a committee meeting. Developing a framework that helped decision-makers consider the different kinds of health issues affecting immigrants and refugees (those related to newcomer status, world area of origin, refugee experience, and language and cultural differences with host country).
Combining local community and/or client experience with research evidence.	Reports commissioned by the Language Access Committee integrated local community experience (including specific case examples). The Language and Ethnicity Indicators initiative began with community consultations on knowledge and attitudes related to use of ethnicity and language indicators.

Results of evaluation of strategies to develop a successful KTA plan continued...

Identified Strategy	Practical Examples
Aligning with organizational strategic priorities or ongoing activities.	Positioning risks of untrained interpreters as a risk management/patient safety issue, and responding to privacy concerns
Aligning with provincial or federal policy direction or trends.	Highlighting immigration and workforce trends.
Working with strategically placed champions.	Direct report to organizational V.P.; regular meetings and consultations with this individual.
Identifying and using evidence to address concerns of decision-makers and staff.	Input from registration staff in designing language questions for data collection project. Use of risk framework and evidence-informed business case logic model in Language Access reports.
Presentation of proposed response as a solution to an existing problem.	Trained health interpreters proposed as strategy to address identified issues related to the Personal Health Information Act, and patient safety concerns.
Phased and sequential presentation of evidence over time.	Presenting information related to language barriers and interpreter services around phases of the initiative: a) need for organizational recognition of the issue, b) agreement on the best model for WRHA, c) approval of funding, d) promoting staff adoption of service.
Mechanism (e.g. formal reporting, policy) for accountability within organizational structure.	Formal and regular reporting (e.g. Language Access) through vice-president to senior management.
Providing forums (e.g. committee discussions) that provide reflective space to consider evidence.	Integration of research/evaluation evidence with ongoing operational meetings.
Developing and disseminating evidence-informed reports, backgrounders, concept papers.	Development of two Language Access reports, concept papers on organizational diversity and Immigrant/Refugee health issues; briefing note on Language and Ethnicity Indicators.

Suggestions for developing and maintaining a comprehensive strategy

Keep focused on the evidence:

One way of supporting collaborative action is to continue, in all discussions, to keep the evidence the focus of discussion (rather than what has been done in the past, or what an individual's personal interests and preferences are). This approach can also help maintain high standards. One way to facilitate this is to ensure that there is objective research expertise on the team.

As indicated in the previous section, it is also important to keep in mind that different kinds of evidence will be needed at various stages of an initiative. Don't overload decision-makers with all the evidence at the same time, particularly if the topic is likely to be new to them. Introduce the evidence in phases: focus the evidence to the decision that needs to be made at any time.

Think systemically:

There is still a common understanding of knowledge translation as simple transfer of knowledge. But in order to introduce and sustain interventions to promote health equity and cultural diversity, it will be necessary to promote organizational and system change—simply communicating knowledge is not an effective knowledge translation strategy. Because interaction and knowledge exchange is so important, it is critical to build in forums for discussion and reflection.

Example from practice:

Implementation of the region-wide WRHA health interpreter program was accompanied by informational material for staff, but also policy development. This policy:

- supports the organization in meeting legal requirements for informed consent and privacy/confidentiality;
- helps ensure patient safety and quality of care for patients through the provision of WRHA Interpreter Services;
- helps ensure that patients are able to discuss and understand their health condition(s), treatment(s), care option(s), and expected outcomes through the provision of WRHA Interpreter Services;
- provides direction and guidance to healthcare providers in appropriate use of Interpreter Services.

It is important to identify, and to build support for, the needed organizational change to support the change you hope to see. This change may involve change in processes and procedures, and may require policy support. Your challenge is to address not only information barriers, but also logistical ones in order to create an environment where doing the right thing is the easy thing to do. This is not to say that educational events are not useful, but they are unlikely to be sufficient to support the action you hope to see.

It is also important to ensure regular and ongoing two-way communication not only with key individuals, but also at the level of relevant organizations or departments within organizations.

Think strategically:

While the initiative you are promoting will be of most importance to you, it will be competing with a number of other important issues for attention. It is, therefore, essential to think strategically how about to position and present your issue. This can often be very challenging: we all work in our own areas, and keeping current with other initiatives and trends can be difficult. There are also challenges in maintaining a balance between leveraging opportunities to promote action, and potentially losing program integrity or focus by aligning with, or collaborating with, those with different agendas.

Position your issue within a wider policy trajectory. Don't let your issue stand alone. Link your activities with an already accepted trend or priority. Be aware of changes in the community, media coverage, policy changes, or areas of organizational interest or sensitivity.

Align with ongoing activities. Don't compete—jump on board. Explore how the issue you are addressing fits with issues already accepted as organizational or strategic priorities.

Example from practice:

At the time that the Language Access Committee was developing its KT plan, patient safety was a major organizational priority. The Language Access Initiative, therefore, aligned itself with this recognized organizational priority, presenting—with the evidence from the research—language access as a patient safety issue.

Position action as a response to an existing problem. If at all possible, try to avoid having others position your initiative as yet another service or program competing for funding. Look at strategies to position as a solution to already identified issues. In the example above, trained health interpreters were promoted as a solution to already identified problems—concerns about patient safety, community relations, and risks of failing to comply with privacy legislation.

Position around emerging events and pressures. One reason to stay closely integrated with the organization you are hoping to motivate to change, is that you will have more opportunity to learn of issues or problems that may give support to your work. One high-profile incident can provide an opportunity to promote action on the issue you hare attempting to address.

Build and nurture your coalition. One of the rewards of an integrated approach to KT is the potential this approach brings to build consensus, trust, and collaborative working relationships around shared issues of concern. So it is important that no matter how busy you get, to prioritize the nurturing and support of the coalition. As has been discussed throughout this handbook, the varied insights, experiences, and skills of a range of knowledge users are essential in developing, implementing, and evaluating your KT plan.

Communicate effectively:

While we have been emphasizing the importance of integrated KT throughout this handbook, effective communication—and dissemination of knowledge—is clearly important, and requires both careful planning and skill. Over the course of each of the initiatives referenced in the handbook, many different forms of communication were used over a period of several years. For example, the Language Access Initiative resulted in the following written materials in addition to dozens of in person presentations.

Documents/Activities	**Phase**
Report: *Language Barriers within the WRHA: Issues and Implications* (2004)	Getting the issue on the agenda
Report: *Development of a Coordinated Response to Addressing Language Barriers within the WRHA* (2005)	Informing a response
Initial implementation plan Communication plan Report: *Interpreting Knowledge into Action Phase 1 Findings Report* (2007) Report: *Implementation Evaluation Report for WRHA Language Access Interpreter Services* (2009)	Informing implementation
Language Access Resource Kit	Changing provider practice
Language Access Activities • Regular region-wide updates with key messages on Language Access interpreter services • Presentations to stakeholder/user groups • Ongoing registry of new Language Access clients (organizational users)	Maintaining support

The following are some of the communication strategies we have found helpful:

Speak to the world view of decision-makers. Those advocating for action on issues of health equity and diversity have often used the language of human rights, multicultural health, or cultural sensitivity. These concepts are not necessarily how health system decision-makers frame issues. For this reason it is a priority for your collaborative group to stay current on issues of concern to decision-makers in order to align your strategies with these priorities.

Example from practice:

The Language Access Initiative framed the available evidence within the conceptual frameworks used by decision-makers. Risk management and patient safety were key issues of concern to the organization at that time. Consequently, evidence related to language barriers and use of untrained interpreters was integrated into the regional risk management framework (illustrating strong evidence that 43 of the high level risks identified by the organization were directly impacted by language barriers).

Find a format that works. Keep it short. It is often joked that decision-makers don't have time to read past the paper clip. This highlights the importance of distilling down information into short, concise messages. One format that often works well is the CHSRF 1-3-25 format.[24] This is based on one page of key points, a three-page executive summary, and a 25-page report (though these numbers can vary). Remember that key points are not meant to be a précis of the whole report. Rather, they are best viewed as take-away messages that you hope will impact, and remain in the memory of, the reader.

Other useful formats are Briefing Notes (in the format used by the organization), and background/concept papers. Concept papers can promote not only increased awareness of an issue, but help frame the issue for further discussion.

Back it up. One of the reasons that the 1-3-25 format is often effective is that it also includes the evidence to back up the summary points made. Avoid oversimplifying complex situations, or arguing for a position for which you have little evidence.

Leave a paper trail. We often feel that we don't have time to take detailed minutes or document our activities. This work is essential. Meetings of the collaborative should be documented in detail, not simply as Action minutes, but providing the rationale (and arguments pro and con) leading to any decision. This can save significant time, especially where key individuals may miss a meeting, or new members join. Clearly documented developmental minutes can help you save time by avoiding reopening decisions around a consensus that has already formed.

Integrate local and research evidence

Academic Literature	Local Case Example
Language barriers affect the health and well-being of other family members. Relatives or friends may be forced to miss work (and often lose pay) to provide interpreter services. They often report stress related to the responsibilities of interpretation when they know their English language ability is limited (AMSSA, 2000). Mistranslation may result in tension between family members. Winnipeg school administrators report ongoing problems with children missing school to provide interpretation for their parents (Bowen, 2004).	Winnipeg: A woman went into labour at 30 weeks resulting in the stillbirth of twins. The circumstances of the birth were traumatic as one of the twins started to emerge while the mother was at home using the toilet. The family had been in Canada less than a year, and the woman spoke no English. An 18 year old relative was used for most interpretation. However, at the time of discharge, the social worker attempted to use the woman's 8 year old son as an interpreter, until it became apparent that not only was he not capable of interpreting, but that he was also in distress, and needed support and comfort.

Integrate local and research evidence. As stated earlier, decision-makers want to know the relevance of an issue for their constituency. If there is no research, one or two incidents may be dismissed as anecdotes. But if there are no local stories, the research may be viewed as irrelevant. Look for ways of integrating the two, as was done in this decision-maker report (above).

Tell a story; tell the best story. As illustrated by the example above, a story can be very powerful. Make sure that the story conveys the message you want to give.

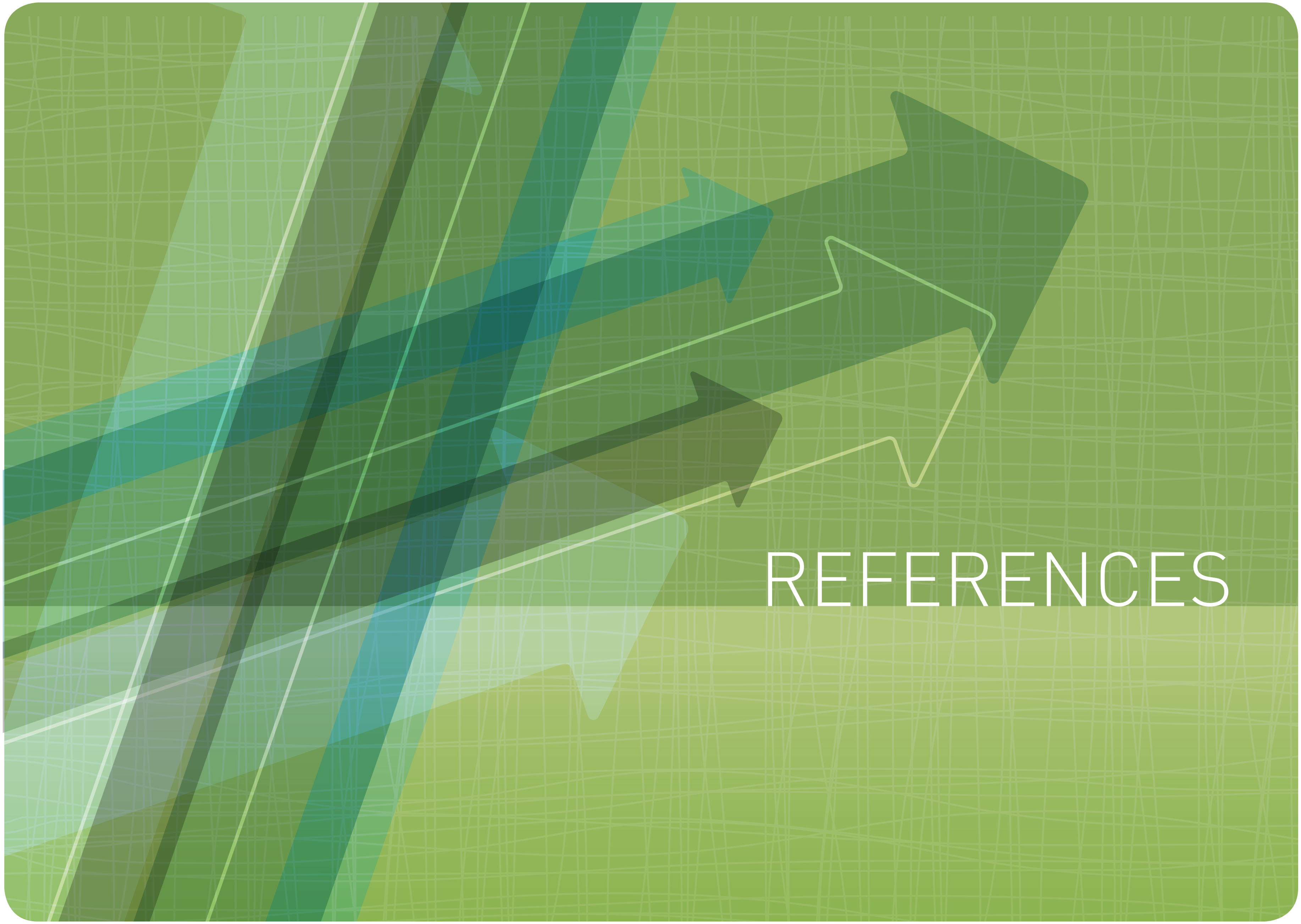
Send a trusted messenger. Try to make sure that your message is presented by someone credible to the reader or listener. This is not always the person who has prepared the report. Make sure that the person presenting is well briefed, and where possible, offer to also attend as a resource person in case there are questions. It is often effective, where you can negotiate it, to send a small team representing the entire coalition you have developed. A visual demonstration of the collaborative nature of your activity will often carry weight. If more than one person will speak, carefully plan the roles and think about who will bring credibility to the specific question under discussion.

CONCLUSION

This handbook is intended to support evidence-informed action on issues of health equity and cultural diversity—issues for which we often have strong evidence, but on which we have seen limited action. These knowledge-to-action challenges are very often substantively different than the challenges addressed in much of the knowledge translation literature, which is dominated by discussion of clinical practice change and evidence from only the research literature.

The purpose of this handbook is to help you to identify and frame a problem, identify what phase of the knowledge-to-action challenge you need to address, and develop a strategy that will promote action in your context.

We hope that the examples we have shared will assist in development and implementation of knowledge-to-action strategies that will promote equity for all Canadians.



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The following worksheets contain editable text fields. This option will *only* be accessible if you have Adobe Acrobat Professional. A Microsoft Word version has also been provided for your convenience.

WORKSHEETS

WORKSHEET 1: INTERESTED AND AFFECTED PARTIES VERSUS KNOWLEDGE USERS

What is the problem you have identified?

	Who should we involve?	How should we involve them? (e.g., as recipients of communication/information; as members of a steering committee, as research participants)?
Stakeholders (interested and affected parties) a) Who is affected by this issue? b) Who cares about the result? (e.g. patients, community organizations)		
Knowledge users (note that some interested and affected parties may also be knowledge users) a) Who is in a position to act on the knowledge generated? b) Who must be supportive if knowledge is to be moved into action? (e.g. decision-makers, those who have access to decision-makers)		

WORKSHEET 2: FRAMING THE PROBLEM

Beginning the process: What is the equity problem? How would you define it?

What evidence have we used to frame this problem?

Peer-reviewed research related to the issue you are addressing?

Demographic data and projections?

Local evaluation findings?

Analysis of administrative or population data?

What evidence have we used to frame this problem (Continued)?

Patient experience?

Professional experience and expertise?

Ethical, legal, or professional guidelines?

Organizational mission, values, objective?

Analysis of decision-makers' perspectives and level of understanding?

What other evidence do we need to consider (e.g. political)?

What trends is the evidence indicating? Is the situation likely to be time limited? Stay the same? Improve or get worse? How do we know?

What is the level of consensus on what exactly the problem is? On how to address it?

Rethinking the issue: What is the equity problem? How would you define it?

WORKSHEET 3:
GETTING AN ISSUE ON THE PLANNING/POLICY AGENDA

Who are the knowledge-users you are hope to engage? Can you name them?

What is their knowledge of this issue? How do you know?

Do knowledge-users have any misconceptions that need to be addressed?

What evidence would this particular group of knowledge-users find credible (e.g. prefer quantitative data? Want local examples?)

Who would be a credible communicator(s) to this group(s)?

How does your issue align with stated organizational or organizational funder-strategic priorities?

Are there others in the organization or larger community with responsibility for this issue? What is the best way to engage them in addressing the issue?

What are the concerns that decision-makers might have about acting on the issue (e.g. costs, mandate)? How can you find out?

What current societal trends, media issues, etc. does this issue align with?

How can acting on this issue be in the best interests of the organization (e.g. community relations, side benefits to staff or patients)?

WORKSHEET 4: INFORMING THE RESPONSE

What evidence do you have that this is the best response in your particular situation?

What evidence do you have that the proposed response is feasible in your context?

What local evidence must be integrated with research evidence to design a response appropriate for this specific context?

Who are the individuals who must buy in to the response you are proposing?

What groups or individuals may have a vested interest in the solution? How are they involved in the initiative?

If not involved, how can you best involve them?

What is their level of knowledge, and/or preconceptions about this issue?

What potential competing agendas are surrounding this issue? What are they?

Are there individuals and groups who will resist the proposed solution? Why?

What strategies can help build consensus on the issue?

Is your proposal a change to how things are done now (redesign or redevelopment) or a new initiative?

What are key timelines or deadlines that you need to be aware of (e.g. budget decisions)?

What are all the different sub decisions (dimensions) that should be considered in designing a response?

WORKSHEET 5: INFORMING IMPLEMENTATION

What evidence have you obtained from

a) the implementation science/organizational change literature?

b) your assessment of the local context that will guide the implementation?

Do you have the resources to implement the entire initiative at one time?

If not, what evidence do you have about:

Priority populations/clients?

Priority geographic areas?

Priority health conditions?

Priority health services?

Have you undertaken an assessment of potential barriers and facilitators to implementation?

If not, how could this be done?

If yes, where is there greatest support?

If yes, where do you anticipate challenges?

What information and/or education is needed by those responsible for implementation?

How will you evaluate implementation?

Do you have implementation evaluation expertise on your team? If not, where will you find it?

How do the knowledge-users understand evaluation? What questions do they want answered?

WORKSHEET 6: CHANGING PRACTICE

What is the specific practice(s) you want to change?

Who are the individuals who will be asked to change their practice?

Whose support is needed if practice is to change?

Can you identify opinion leaders for these groups?

Have they been involved to date? In what ways?

If not, how can they be included? What additional evidence might they have to inform the change you hope to see?

What are the barriers (organizational structure, processes, resources etc.) that might prevent practice change?

Who has the authority to address these barriers?

What strategies may help make it easier to do the new, rather than the old, practice?

Is there adequate policy in place to support the change? If not, what changes are needed?

WORKSHEET 7: MAINTAINING SUPPORT

Have you accomplished the tasks of the previous knowledge-to-action phases? What previous steps might you need to review?

What processes or mechanisms are already keeping this issue on the agenda?

Who are the key individuals who can help sustain momentum on this issue?

What structures and processes do you need to develop to sustain the change you have accomplished?

What potential threats to maintaining support for the initiative, and the standards of the initiative, can be identified?

What strategies can be developed to protect the integrity of the initiative?

What strategies need to be put in place to ensure that there are regular reviews of emerging evidence related to this initiative?

What strategies need to be put in place to ensure ongoing monitoring and evaluation of service/program quality?

What groups/individuals have responsibility to remain focused on monitoring this issue?

Do you have a timeframe for regular review?

PRINCIPLES

These principles were developed to guide the work of the WRHA Immigrant/Refugee Working Group. Participants came with many concerns and diverse interests and perspectives. It was essential to develop a shared set of principles that all could support before the practical work of planning began.

- The healthcare system must take responsibility for quality healthcare provision for all citizens, including immigrants and refugees.
- Extensive consultation that has already taken place with immigrant and refugee communities provides initial guidance for the committee's work.
- Appropriate community engagement is needed on a continuing basis to ensure that immigrant/refugee communities are partners in design and evaluation of services.
- Program collaboration between all community health services (e.g. WRHA direct operations, WRHA-funded community health services, primary care, mental, population, and public health) is essential in planning and providing timely and appropriate health services.
- Identifying populations at greatest need will be considered in planning effective response strategies.
- Planning processes must reflect research and community-based evidence of broad health needs and responses, including:
    - orientation to the Canadian health system;
    - newcomer assessment services;
    - facilitated access to primary care;
    - culturally and linguistically appropriate health promotion and prevention strategies;
    - specialized and accessible mental health and counseling services;
    - reproductive health and sexuality related services; and
    - development of and support to specific, specialized medical services in key areas (e.g. tropical disease, HIV and TB, and mental health services for trauma/torture survivors).
- Creating and supporting culturally responsive organizations, reflecting best practice in organizational diversification, is an essential component of effective services for immigrants and refugees.
- Models of service response will reflect the two WRHA concept papers: *Healthcare for Immigrants and Refugees: An Overview of Issues and Responses* (2006) and *A Proposed Diversity Framework for Promoting Cultural Proficiency within the WRHA* (2007).