

APPENDIX 1

Research Forum Participants

Yvonne Ashford, Central Community Care Access Centre

Elizabeth Baker, VON Canada

Lois Beamish-Taylor, Closing the Gap Healthcare Group

Mary Beaudoin, McMaster Child Health Research Institute

Nicole Beben, Care To Know Centre, Saint Elizabeth Health Care

Hasmik Beglaman, The Change Foundation

Debra Bell, Ministry of Health and Long-Term Care

Katherine Berg, University of Toronto

Jerry Bilton, Pro Wellness Health Services

Kevin Brazil, McMaster University

Catherine Brookman, Ontario Community Support Association

Larry Chambers, University of Ottawa

Andrew Costa, University of Waterloo

Dawn Dalby, Wilfred Laurier University

Stacey Daub, Toronto Central Community Care Access Centre

Raisa Deber, University of Toronto

Janet Doering, Hamilton, Niagara, Haldimand and Brant Community Care Access Centre

Diane Doran, University of Toronto

Lisa Droppo, Ontario Association of Community Care Access Centres *

Diane Duff, York University

Leslie Eckel, Ontario Home Care Research Network *

Don Embuldeniya, Research Unit, Ministry of Health and Long-Term Care

Joanne Fluker, Erinoak

Andrea Foebel, University of Waterloo

Cathy Fooks, The Change Foundation

Dorothy Forbes, University of Western Ontario

Jane Fry Sutherland, Ontario Association of Community Care Access Centres *

Monica Gabriel, Ministry of Health and Long-Term Care

Tara Ann Glasgow, Erie St. Clair Community Care Access Centre

Evelyn Harris Williams, Ontario Association of Community Care Access Centres

Peggy Hewson, Ontario Association of Community Care Access Centres

John Hirdes, Ontario Home Care Research Network *

Nadia Hladin, Heart and Stroke Foundation

Michelle Kohli, University of Toronto

Sandi Kossey, Canadian Patient Safety Institute

Joanne Kviring, Sick Kids Foundation

Georgia Livadiotakis, Health Canada

Jacquelyn Lochhaas-Gerlach, Hamilton, Niagara, Haldimand and Brant
Local Health Integrated Network

Lori Lord, Spectrum Health Care

Dierdre Luesby, Seniors Health Research Transfer

Margaret MacAdam, Canadian Policy Research Network

Maureen Markle-Reid, McMaster University

Lynn Martin, Lakehead University

Elsa Marziali, University of Toronto

Paul Masotti, Queen's University

Cheryl Missiuna, McMaster University

Frances Morton, University of Toronto

Margaret Mottershead, Ontario Association of Community Care Access Centres

Barbara Newport, Champlain Community Care Access Centre

Alison Paprica, Ministry of Health and Long-Term Care

Cheryl Perera, VHA Home HealthCare

Jennie Pickard, Central East Community Care Access Centre

Jeff Poss, University of Waterloo

Susan Putney, Ontario Physiotherapy Association

Susan Rappolt, University of Toronto

Ian Ritchie, North West Community Care Access Centre

David Salib, Ryerson University

Evelyn Sarfeld, Ontario Association of Speech-Language Pathologists and Audiologists

Nancy Sears, South East Local Health Integrated Network

Arvind Sharma, Mississauga Halton Community Care Access Centre

Gordon Simmons, Ontario Association of Community Care Access Centres

Trevor Smith, Nipissing University

Karen Spalding, Ryerson University

Julia St. Jean, Hamilton, Niagara, Haldimand and Brant Community Care Access Centre

Stacey Stewart, University of Waterloo

Susan Thorning, Ontario Community Support Association *

Esther Turner, Ministry of Health and Long-Term Care

Donna Unwin, North Simcoe Muskoka Community Care Access Centre

Vida Vaitonis, Mississauga Halton Community Care Access Centre

Sue VanderBent, Ontario Home Care Association *

Kim Voelker, Waterloo-Wellington Community Care Access Centre

Frank Wagner, University of Toronto

Mark Walden, South East Community Care Access Centre

Georgina White, Ontario Association of Community Care Access Centres *

Nancy White, Canadian Institute for Health Information

Leslie Whittington-Carter, Dietitians of Canada

Tim Young, Tim Young and Associates *

* Denotes members of the Research Forum Planning Group

APPENDIX 2

GUIDELINES FOR GROUP DISCUSSIONS

Morning Session

Research Issues and Priorities

Purpose:

To identify the research issues and priorities of the home and community care sector by type of research (identify the research gaps, needs and priorities and categorize as to 1: critical 2: important 3: for future consideration):

1. Priority populations and rationale, e.g.
 - Frail elderly
 - Medically complex children

2. Clinical interventions and impact, e.g.
 - Disease- or condition-specific pathways such as diabetes
 - Clinical practices or protocols such as dressing wounds

3. Policy and system improvement and contribution, e.g.
 - CCAC service limits
 - Collaborative models (e.g., clinical or functional teams, vertical or horizontal integration initiatives)

4. Determinants of health and impact, e.g.
 - Population-based program interventions (e.g., frail elderly, family caregivers)
 - Linking with other sectors to address social determinants of health

5. Other

GUIDELINES FOR GROUP DISCUSSIONS

Afternoon Session 1

Development of Leadership and Research Capacity

Purpose:

To discuss how to develop leadership and enhance research capacity within the sector:

1. How can we incent more research-oriented leadership in home and community care?
 - Research-oriented home and community care leadership
 - Research-oriented clinical leadership
 - Research leadership that partners well for system, operational and clinical improvement

2. How can excellent research, practice and operations partnerships be enhanced and supported?
 - What are the fundamental characteristics of good research/policy/operations partnerships?
 - What can best be done at the provincial, regional and local levels
 - If good partnerships exist, how would anyone know about them or have the opportunity to emulate them?

4. How can the sector attract more researchers?
 - What does the home and community care sector offer researchers?
 - Do different types of research require different strategies?

5. How can the sector attract more research funding?
 - What does the home and community care sector offer research funders?
 - What strategies can be used to advocate for a larger share of research funding for home and community care?
 - What targets should be set?
 - What are appropriate roles for the Government of Ontario and LHINs and which should fund what?

GUIDELINES FOR GROUP DISCUSSIONS

Afternoon Session 2

Knowledge Transfer and Promotion of Evidence-Informed Practice

Purpose:

To define how best to support knowledge transfer and promote evidenced-informed practice both in general and in relation to specific client groups.

1. What infrastructure is needed to enable knowledge transfer and adoption of evidence-informed practices in Ontario's home and community care sector?
2. What communications strategies and practices are needed enable and sustain improved knowledge transfer
3. What drivers exist or can be put in place to create a culture of evidence in home and community care? E.g.
 - The role of accreditation
 - The role of accountability to funders for performance
4. What would support wider adoption of good practices?
 - Is this about communicating good news, or creating some good news to communicate or both?
 - What tools or infrastructure would help?

APPENDIX 3

Summary of Group Discussions on Research Issues and Priorities

Group 1

The members of this group were researchers and others with a specific interest in children's health issues. Their priority population was children with chronic illness, complex needs and life-long disabilities. Given the impact the child's illness has upon the family, a "family focus" for this population was emphasized.

The group stressed that research on children's health issues should move away from diagnostic boundaries to a non-categorical approach. Their research priorities were the key transitions across service systems, providing the best supports to families given current system barriers, and testing new funding approaches and models of care.

With respect to policy and system improvements, the group members pointed out that four government ministries provide services to this population. The group emphasized the importance of creativity when addressing the needs of children with chronic illnesses, given the differences between ministries regarding the definition of *child*, the geographical boundaries, service models, practices and eligibility criteria. The group also stressed the need to remove the policy and funding barriers which are driving current practice. For example, services which are tied to diagnostic admission criteria may impact on a child's priority for early intervention, even if the child has an obvious need but has not as yet been diagnosed.

The group recognized the need to translate research evidence on clinical interventions into practice and to modify the current funding models. Also, a standardized database was considered essential for tracking children with chronic health conditions as they utilize the services of multiple ministries while transitioning through developmental stages to adulthood and across different service systems. Furthermore, the group pointed out that the Ministry of Health and Long Term Care policies for adults also apply to children despite the fact that children with complex care needs require more hours and different models of care. Early identification and intervention were considered critical with the preschool children in order to avoid social and health costs in the future.

Group 2

This group stressed the importance of easy access to data and long-term financial support to enable research in the sector. They pointed out that home care is part of a larger system and identified the integration and coordination of services as research priorities. They suggested the following specific areas for study: 1) access to services, models of care, care coordination, and urban health diversity; the homeless and under-housed; client choice to remain at risk; and ethical considerations; 2) human resources in health sector, client and caregiver safety, and retention of paid and unpaid caregivers; and 3) understanding and meeting the needs of clients (e.g., ethno-cultural diversity and client involvement in service planning).

The group identified as specific populations for research the non-frail elderly with intellectual disabilities or mental health issues who face challenges as they transition from one provider to another and from one set of entitlements and policies to another. The group acknowledged the challenges of long-term sustainable funding for research, access to data, attracting top student researchers, and balancing short-term research priorities with the academic curiosity. And, they noted, good research does not happen in a vacuum, but in collaboration with the field.

Group 3

This group emphasized the need to understand the determinants of the underlying culture driving our activities (i.e., public, policy makers, service recipients and providers). They felt it was important to balance short-term priorities with academic curiosity. Their priorities were to assess the impact of home care on caregivers (quantity and quality); identify the indicators of what is working or not; study the public and individual perceptions about the policy related to living at risk; evaluate the adoption and impact of research findings on practice; and study long-term care home utilization, in particular the variations in use across Ontario.

Other, less critical priorities were the management of co-morbidities; mismatch between available services and caregivers' wants; policies and practices (e.g., fee for service); and the application of the generalist vs. specialist approach to community care management and service delivery.

Group 4

This group emphasized the moving away from the biomedical model and focusing the research on healthy communities. Under this approach, social capital and teaching people about networking were to be considered. The group thought that there is a greater acceptance of what constitutes good evidence when mixed methods of qualitative and quantitative research are used. They suggested building upon existing evidence, improving knowledge sharing, and measuring the social benefits of service beyond the specific goal of intervention (e.g., a personal support worker's visit also addressing social isolation).

The group's priority populations were families of medically fragile children and mental health clients. Furthermore, the group saw the need for more innovative research to help home care clients to discover where help is available and how to build resources and networks, and to allow communities to determine their own priorities.

Group 5

This group identified the need for research to determine if care in the community setting makes a difference and what mix of services is most effective (e.g., to determine what populations do well with peritoneal dialysis and chemotherapy at home). The group pondered how home care might better support people with chronic cancer and cited the Cancer Care Ontario approach as a model for other chronic diseases. Populations served by home care, who may need long-term care and support, include clients who have received short term rehabilitation after hospitalization, persons with mental health problems, and persons in hospital requiring alternate level of care (ALC).

The group identified the need for research to prove the value of rehabilitation therapies and to determine under what circumstances dieticians/physiotherapists/other therapists should be utilized. Given the shortage of therapists, the group also highlighted the need to consider other care approaches for clients on waitlists.

Consistent with other groups, they identified systems issues that should be addressed, such as the reasons for re-admissions to hospitals, the need for better use of existing data, inter-professional education, and the human resource shortages in the health care sector.

Although the group did not indicate any critical priorities for research, they wanted to move forward on Telehomecare, E-health, and improved

communication between providers. Adverse events (e.g., hospital-acquired infections), patient and staff safety, and the quality of life of informal caregivers were identified for future consideration.

Group 6

This group recognized the repeat users of the acute care system, the “Frequent Flyers”, as a population requiring more study. Their first priority was to determine the causes for this repeat use (e.g., the gaps in services, the challenges, and the unintended consequences for this population). The second priority was the ALC population. Questions to be addressed included how to identify triggers and warning signs for early intervention, what differentiates the ALC needs, and how to predict them.

Their final research priority related to supporting clients to self-manage chronic health conditions. The group discussed the differences between Telehomecare and telemonitoring and the role technology can play in self-managing chronic diseases. They concluded that research should be undertaken to determine the situations where these interventions work, to identify the success factors, and consider the role that depression plays in people self-managing their chronic disease.

When considering policy and system challenges, the group identified the need to obtain better qualitative information from clients regarding the integrated system (i.e., clients’ experience about moving across the system over time, and the differences between their expectations and needs and what the system can provide).

The group identified the following questions for consideration at the systems level:

- To what extent is self-management of chronic disease able to fill the gap in service? What are the risks and benefits of other approaches, such as maximizing volunteers in supporting these clients?
- How can we manage the ALC clients within the existing budgets, and what is the impact of this population on other services and parts of the system?
- Who are the aging population at home, and how can we find them sooner?
- What is the role of informal caregivers in chronic disease management, and how do we identify indicators for burnout?

The group posed the question “What should we base our priorities on?” and discussed the following issues: matching the home and community care priorities with those of the Ministry of Health and Long-Term Care;

researchable questions; the impact of research on the system; turn-around time for completion of research; and taking full advantage of emerging opportunities

Group 7

This group identified three priority populations for study: individuals with chronic co-morbidities; cognitively impaired and isolated seniors; and informal caregivers. The group stressed the need for a better “conversionality” of results into front-line practice, and for the multi-disciplinary team of front-line staff to be informed about and involved in research initiatives.

Some of their clinical priorities included the evaluation of current models of service provision by, for example, looking at

- o decisions made by case managers in developing service plans and determining to what extent case manager discretion influences the amount or level of care provided. Or, to what extent the funding, availability of services or resources and other considerations affect these decisions
- o incentives for quality care. What if agencies were paid for outcomes of care and not for visits? What is the value of outcome-based funding and allowing the funding to follow the client across the continuum of care?

At the systems level, the group agreed on the importance of a clearing house for home care research; information and best practice guidelines; and developing a home care classification system. A framework for ethical decision-making on who should receive home care was also deemed to be important.

Group 8

This group identified three priority populations for research:

- o palliative care and end of life care - evaluating the effectiveness of end-of-life programs across health care systems
- o mental health and addiction services for all age groups
- o understanding which clients are receiving community support services, what their needs are, and what they are receiving

At the clinical level, an evaluation of the effectiveness of early interventions for people with chronic, particularly multiple chronic, conditions was considered necessary.

At the policy level, the urgent issue was the human resource availability in this labour-intensive sector with significant labour problems. The group discussed the fragmentation and “siloization” of the health and social service delivery system and the need for cost-effectiveness studies on service limits and community services, such as meals on wheel and day programs. They commented that community care access centres and community support service agencies need to work together more effectively.

The group agreed that better population-based data is needed to support strategic decision-making; housing options for the poor and marginalized groups need to be improved; and the social determinants of health must be considered when managing transitions across the health care system.

Group 10

This group identified as the priority populations for research the psycho-geriatric population; medically complex children; teens with mental health issues; chronic disease groups; developmentally delayed (young or aging); and the population requiring alternate level of care (ALC). With respect to ALC, the group saw a need to define who the ALC clients are; what their service needs are; what the appropriate care is for them; and how to effectively meet the expectations of the system.

At the clinical level, the group members saw the need for a better understanding of how to manage key populations and support knowledge transfer. Also, good outcome research was considered necessary to determine the effectiveness of the provided care. The group’s specific priorities were strokes; consensus on standardized best practices for wound care; congestive heart failure; predictors of future function in activities of daily living and instrumental activities of daily living (ADLs and IADLs); and how resource allocation impacts the adoption of best practices.

The group’s research priorities on policy and system improvements for future consideration were the levels and delivery of school health services; transitions between institutions and the community, including coordination and linkages with primary care; evaluation of the impact of new initiatives, such as the ER (hospital emergency room) strategy; integration of systems and collaborative practice; intensity and skill mix of service; and case mix and resource allocation.

Regarding the determinants of health, there was strong support for more longitudinal research to better identify and predict those at higher risk and target them with appropriate interventions. Research on how to support and

enhance the well-being, function and autonomy of informal caregivers was also viewed as important.

APPENDIX 4

Summary of Group Discussions on Development of Leadership and Research Capacity

Group 1

The group discussed the need to reward home-care leadership to be more research-oriented. Researchers are not rewarded for collaborating but for obtaining grants at the federal level and for publishing in peer-reviewed journals. To rectify this situation, the group suggested such incentives as recognizing and rewarding researchers who develop partnerships and collaborate with the sector, and rewarding them for taking on students.

In addition, support was considered essential to sustain what has been demonstrated to be effective. The group suggested that the funding model be based on case costing and outcomes, and that an arm's-length foundation for home and community care research be established that would

- receive start-up funding from the Ministry of Health and Long-Term Care
- raise funds
- provide support for research and students
- obtain input from the government and the Local Health Integrated Networks (LHINs) when developing strategic priorities

They also proposed that government look at alternatives to competition for contracts and include research credit into what constitutes a preferred provider.

To link and inform the sector about current research, the group suggested maintaining an inventory of home care research and establishing long-term funding for an email service to answer questions in order to build expertise. To attract more researchers to the sector, sustainable funding and employment are necessary. Also, students must be provided with learning incentives and support for research.

Group 2

This group pointed out that leadership may vary based on the research question. The group saw leaders as the champions who represent the collective voice and come from all levels of the system. Researchers act as resources and mentors.

They agreed that to be successful in research, sustainability is critical. Resources need to be shared across organizations and partnerships rewarded. Other, related fields should be involved (e.g., economics and pharmacology), and both organizations and academics need to have a good understanding of the incentives that drive each others' practice. Furthermore, health care organizations need to be able to uptake and use research findings.

To attract more researchers to the field, the group saw it necessary to develop a broad range of research questions, and the researchers must understand the implications and applicability of the research to their own work. The group noted that more people should be involved from related fields. Graduate students should be recruited, and there should be more meetings like today to bring together like-minded people and those committed to research. In addition, sustainable funding is required, and clinical data needs to be linked to academic researchers. Real opportunities to operationalize the research findings are a must.

To draw more funding to home and community care research, the public needs to be more informed in order to influence political priorities. A greater effort is necessary to promote research results and the impact of research through events (e.g., the Research Forum, Ministry of Health and Long-Term Care Innovations Expo) and other methods of knowledge dissemination and exchange. The group also suggested that researchers become involved in the development of provincial strategies for funding home care research. Researchers need to understand the political drivers and deliver information rapidly without compromising ethics or work. The group agreed that good leadership will draw scholars.

Group 3

This group suggested that to attract more research-oriented leadership in home and community care, the research findings must be worthy of being transferred to practice. They noted that research should not be driven by home-care ideology and stressed that the role of the researcher is not to prove that home care works, but to find out what works and what does not.

The group recognized the legitimate fear of being found to be doing something ineffective, such as the treatment of pressure ulcers.

The group indicated that access to data should be granted at the systems level to remove any conflict of interest when the institution releasing the data for research purposes is seeking specific funding. They also noted that knowledge transfer should not be the sole responsibility of individual researchers. Top-down training and funding are required to build research skills into organizational culture and to develop the skill base of individual practitioners to recognize the value of evidence-based practice.

The group identified the need for a conceptual framework for research for the health and community care system. They believe that the LHINs are in a good position to enhance and support partnerships and facilitate research across the continuum of care. Currently, client transitions and research related to transitions need improvement. The system tends to support individual researchers rather than collectives. This requires too much of each researcher who must serve as the grant writer, project manager, information gatherer and data analyst. The group suggested the establishment of research networks or centers of excellence to support collective endeavours.

To raise the profile of home and community care with new researchers, the focus of research should be on episodic care (i.e., from diagnosis to end of the episode) and across the whole continuum of care. Potential researchers need to be educated that home care is part of the continuum of care. Therefore, by concentrating solely on the home-care sector, the point is missed. Also, the dilemma is circuitous: how do you get good people to do research when you do not have examples of good research to point to.

The group acknowledged that support for research can be provided internally as is done at the Baycrest Centre for Geriatric Care, but it is expensive. They wondered if the model would work centrally and whether the Ministry of Health and Long-Term Care were willing to provide resources to research and answer the questions about what works and what does not work. They noted that there are other ministry-funded models, such as the Institute for Clinical Evaluative Sciences (ICES), which play this role to some extent by sharing data and supporting research. It may require a web-like network with a central hub and spokes. It would be desirable if researchers could spend less time writing grant proposals and more doing research.

The group pondered how to draw more funding to home and community care research. They noted that the current lack of money for new research does not mean that there could not be in the future. They pointed out that a few

years ago, there was no money for aging at home or money targeted for wait times.

Another issue emphasized by the group was that currently, research showing how to alter costs takes funding priority over outcome research. They encouraged the adoption of few highly effective practices in home care.

Group 5

This group saw the need for researchers to develop partnerships with other researchers and policy makers in order to support the development of more research-oriented leadership in home and community care. By enhancing partnerships, the researchers would be able to better match the partners' needs with research questions. The group stressed that funding, training in networking, and facilitation of communications with stakeholders were incentives to build research-capacity within the sector.

The group proposed improving partnerships via known contacts, networking and enhanced connections with Ontario Home Care Research Network to understand where the interests lie, align these interests, and collaborate. They also noted that researchers need to connect with provider associations, health professional associations and others with research needs, such as the Canadian Gerontology Association.

The group came up with several ideas. They thought that resources on a website (e.g., key funders, contacts and examples of previously funded projects) would be useful; "speed research networking" events similar to today's forum would also enhance and support partnerships; and the establishment of a foundation for home and community care research and research alliances with stakeholders would support research capacity.

Furthermore, to attract more researchers to the sector, doctoral students need scholarships and funding opportunities as it is important to nurture researchers early in their careers and to provide small-scale grants to support student-engaged research.

The group also stressed the need to generate national research initiatives in order to attract more funding and identified that a warehouse of information on funding opportunities and a Center for Home Care Research, as was suggested in the Caplan Report on Home Care, would be helpful.

They noted that to attract more dollars, it is necessary to prove the benefit and added value of research. Also, multiple-sector alliances must collectively lobby the various levels of government and advocate for funding.

APPENDIX 5

Summary of Group Discussions on Knowledge Transfer and Promotion of Evidence-Informed Practice

Group 4

This group stressed the need for bi-directional (academics and providers) capacity building and adequate and sustainable funding to enable knowledge transfer and the adoption of evidence-informed practice. They identified the following enablers: workshops to build research capacity; common tools to assist and assess research; and a centralized body for regular reporting to stakeholders on research progress and outcomes. The group agreed that there will be “buy in” at the front-line level when staff sees the benefit of research to clients.

Attracting lead researchers to the field, developing programs for researchers to mentor organizations, and establishing collaborative working relationships between front-line staff and academics were identified as effective strategies to support knowledge transfer. The group emphasized the role of leadership in building a culture that embraces evidence-informed practice. They also stressed the need to build research initiatives into strategic plans and develop policies to encourage and support funding and research. They concluded that some thought should be given to establishing a foundation at the provincial level that would fund research in the home and community care sector.

Group 6

This group discussed the need for infrastructure to enable knowledge transfer and adoption of evidence-informed practice. They identified that improving linkages between academics and providers, obtaining funding, promoting face-to-face exchanges with researchers, and establishing networks and communities of practice like the Seniors Health Research Transfer Network (SHRTN), would help to achieve this outcome.

Communication strategies and practices put forward by the group to improve knowledge transfer were to involve knowledge brokers in the process when research is being planned or undertaken; modify the reporting to address the user’s need (e.g., “What’s in it for me?”); provide them with access to information specialists and leaders for answers to questions; and ensure

knowledge is freely transferred and research results are translated for key audiences.

The group indicated that leadership is required to create an organizational culture of evidence. They suggested the position of a chief knowledge officer in organizations as well as internal policies and procedures related to the sharing of data.

They noted that organizations can support wider adoption of practices by providing easy access to librarians, establishing communities of practice, and providing free online access to journals. The group felt that the LHINs have a role to play in supporting adoption of good practices. They viewed accreditation as one vehicle to create a culture of evidence and suggested that evidence-based funding models be adopted to improve performance.

Group 7

This group stressed that the home and community care sector needs to be recognized in strategies supporting knowledge transfer and promoting evidence-informed practice. In their opinion, the Ontario Health Care Technology Committee, which reviews and evaluates technology, is a possible model for supporting innovation and system change.

Web-based meetings were seen as one of the best ways to enable knowledge transfer and adoption of evidence-informed practice in Ontario's home and community care sector. Access to client-level data and shared electronic health records were also seen as structural enablers.

Communication strategies and practices that the group felt would better enable and sustain knowledge transfer included knowledge exchange workshops and twice-yearly meetings to talk about best practices, review data and showcase high performers, like those held by Kaiser Permanente International in Finland.

The group noted that an economic case needs to be made to obtain government funding for events of this kind. The Canadian Health Service Research Foundation (CHSRF) fact sheets could be a mechanism for supporting the adoption of good practices.

Group 8

This group listed the structural supports to enable knowledge transfer and adoption of evidence-informed practice in Ontario as follows: access to information; knowledge brokerage; adequate funding; and a culture that

supports change, education and evaluation. The group members stressed the importance of establishing relationships for sharing information and the need for knowledge brokers with the skills to evaluate the quality of data, to translate evidence into usable information, and to link researchers to stakeholders.

Regular face-to-face interaction between researchers and stakeholders, webinars (interactive web-based seminars), teleconferences, and building on existing mechanisms (e.g., newsletters and meetings), were seen as effective communication strategies to promote knowledge transfer.

Some of the drivers to help to create a culture of evidence included identifying and supporting organizational champions, particularly those who have not traditionally had a voice at the table; sharing success stories; a commitment to quality indicators; and the accreditation process. Building linkages between academic institutions, LHINs and stakeholders to generate interest and opportunity was seen as a priority. The group felt that wider adoption of best practices would occur in a system that rewards the sharing of information.

Group 10

This group considered the infrastructure required to support knowledge transfer and the adoption of evidence-informed practice. They emphasized the importance of accessing high-quality, evidence-based resources through university libraries, knowledge-transfer organizations, (e.g., Seniors Health Research Transfer Network [SHRTN]), and interactive technologies. They stressed the need for home and community care funding to support knowledge generation, synthesis and transfer (GST) for front-line staff, and a clearing house or similar service to review, compile and translate research.

Group members suggested that organizations should consider the full scope of research and evaluation, including the “gray” literature, and noted that guidelines and tools should be in place to evaluate this material. The RAI-HC training manual was identified as a model for supporting evidence-based knowledge transfer, as was the Edmonton Symptom Assessment Scale (ESAS) used by patients to communicate the severity of their symptoms to the health care team. The group emphasized that tools need to recognize clinical judgment and clients should be engaged in evidence-based practice.

To enable and sustain improved knowledge transfer, the group identified the necessity of active involvement across the system through communities of practice and professional practice leaders. Furthermore, they saw the creation of a culture of evidence at the organizational level as requiring a

multi-faceted approach and formal and informal champions. Leadership support and attention to system barriers as well as engagement of front-line staff was considered essential. Evidence-based practice was to be “hard-wired” into the system through policies, procedures, agreements, accreditation requirements, contractual obligations and guidelines and care pathways.

The group identified the Cancer Care Ontario focus, passion and commitment to using evidence as a model for supporting system-wide adoption of practices. The “Flo” Collaborative was mentioned as another model of innovation and system change. The group noted that adoption of good practices could also be encouraged through the creation of appropriate incentives, such as the wait-time strategy); use of the balanced scorecard; and Ministry of Health and Long-Term Care support for sustainability.