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THE NEED TO KNOW PROJECT
2002-2004 EVALUATION REPORT

EXECUTIVE SUMMARY

This report summarizes the results of the evaluation of The Need to Know Project for the period April 2002-March 2004. This five-year project (2001-2006) was designed to address the critical need for research to support the decision-making of Manitoba’s rural and northern regional health authorities, and to further promote and develop models of collaborative research. The project, which involves the Manitoba Centre for Health Policy (MCHP), the ten Manitoba rural and northern regional health authorities (RHAs), and Manitoba Health, has three major goals:

1) to create new knowledge directly relevant to rural and northern regional health authorities, both in Manitoba and as a model for the wider community;
2) to develop useful models for health information infrastructure, as well as for training and interaction, that will increase and improve capacity for collaborative research interaction; and
3) to disseminate and apply health-related research so as to increase the effectiveness of health services, and ultimately the health of RHA populations.

The Need to Know Project is undertaking three types of activities required to support a collaborative research process: new knowledge creation and development; improving capacity to support collaboration; and developing processes to communicate, disseminate, and apply research results. Three research projects (or “deliverables”) are being developed through the project and provide a foundation for the collaborative research process.

As winter of 2003/04 marked the mid-point of the project, this report is intended to provide an opportunity for overall assessment of the project as it has developed to date, and guidance for any re-direction that may be required. It is also intended to provide a detailed record of the implementation of the project and factors that led to further development or project adaptation, and to document project findings regarding effective strategies for collaborative research.

Project Organization and Structure

There has been good continuity in team membership since project began; the only attrition has been due to team members leaving their employment with the RHA. A major change to The Need to Know Team has been the decision to provide the opportunity for each RHA to have two “official” representatives and increase the number of regularly attending Manitoba Health team members to seven. In addition, the Winnipeg Regional Health Authority (WRHA) was invited to send a representative in order to facilitate liaison and communication among all RHAs in the province. Another important development in the project has been the inclusion of the RHA team representatives in planning activities. The first planning meeting incorporating this expanded membership took place on December 10, 2003, with the second on March 30, 2004. To date, input has focused on planning for team meetings.
Due to the relocation of Dr. Charlyn Black, Dr. Patricia Martens is now the sole principal investigator of the project. Project staffing has remained stable, although there have been changes to how administrative support is organized.

Project Activities

The Need to Know team meetings (held for two days, three times a year in Winnipeg) continue as the focus of project objectives and activities. Six team meetings have been held since April 2002; June 2002; October 2002, Feb 2003, June 2003; October 2003, and February 2004. The October meetings were held in conjunction with the Rural and Northern Health Care Days, where the Team members acted as facilitators in RHA discussions of research reports. Orientation sessions were developed and offered for new team members; three of these have been conducted since June 2003.

The first deliverable (The Manitoba RHA Indicators Atlas: Population-Based Comparisons of Health and Health Care Use), commonly referred to as The RHA Atlas, was completed on schedule (June 2003) and has been used extensively in provincial Community Health Assessment activities. A process for selection of the remaining two deliverables was selected and implemented. The second deliverable (“The Mental Health Report”) is well underway, with an expected release date of fall 2004.

The web-site has developed significantly since the first year and now hosts a number of separate pages. In addition to general information on the project, current and past team meetings and project newsletters, the site also hosts a Bulletin board, reports produced by the project, background materials related to these reports (e.g. graphs and maps), and links to educational resources.

The project has already made a number of conference presentations (poster and oral) and it is beginning to generate publications. As of March 2004, a total of 18 conference abstracts had been accepted. A draft article, which includes The Need to Know Team as an author, has been submitted for publication.

Other project activities include presentations by project staff to Board meetings, AGMs and other events in the regions; regular contact with the RHA CEO network; one-on-one consultation between MCHP staff and RHA team members; ongoing training activities for academics; and development of a proposal for a fourth research report (evaluation of regional policy and program initiatives).

The success of some project activities has also resulted in development of additional activities beyond the parameters of The Need to Know project. The WRHA (Winnipeg

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1 The second deliverable “Patterns of Regional Mental Health Disorder Diagnoses and Service Use in Manitoba: A Population-Based Study” is commonly referred to as “The Mental Health Report”. The third deliverable is entitled: “Patterns of Sex Differences in Health Status, Health Care Use, and Outcomes of Care: a Population-Based Study for Manitoba’s Regional Health Authorities.”

2 An additional proposal to address the issue of organizational barriers to research use (From Evidence to Action) was submitted to CIHR in June 2004.
Regional Health Authority) requested a similar report to the RHA Atlas which would provide equivalent data on their districts, and a research day parallel to the Rural and Northern Health Care Day. The template for the Rural and Northern Health Care Day has been used for both the WRHA Research Days (2003, 2004), and for an equivalent Manitoba Health Day (2004).

**Project Evaluation**

The primary purpose of the project evaluation has been formative evaluation; i.e. to assist in development and ongoing improvement of the project. However, this utilization-focused evaluation has evolved to become a) a support for team building and trust-building within the project, b) a strategy for reinforcing and developing participation of all stakeholders, and c) an important tool in developing KT (Knowledge Translation) theory.

The definition of project “stakeholders” was expanded in this phase of the project evaluation to include the organizations represented by team members. The RHA CEOs, members of the project Advisory committee, and MCHP were included as stakeholders in the project evaluation. All stakeholders were invited to participate in identifying evaluation questions. The evaluation questions of greatest interest to these stakeholders related to organizational change. In addition, stakeholders felt that ongoing monitoring and evaluation of activities was valuable, and highlighted sustainability of project activities as an issue of increasing concern. There was significant interest in learning from the perspectives and activities of other RHAs and other stakeholders.

Methods employed in the evaluation included key informant interviews, workshop evaluations, a pre-test/post-test survey, observational methods, document review, unobtrusive measures (e.g. monitoring of the project website), and explicit feedback processes.

**Key Findings**

All methods indicate that overall satisfaction with the project remains extremely high. Attendance at team meetings has been excellent, there has been no avoidable turnover of representatives, and there were requests from the regions to include additional participants. Workshop evaluations remain consistently positive. The three “rounds” of interviews conducted with *The Need to Know* Team members (summer/fall 2001; fall 2002, and fall/winter 2003) indicate steadily increasing confidence, engagement and satisfaction of participants. Findings are consistent across both methods and stakeholder groups.

Two key themes emerge as the greatest accomplishments identified by team members. The first theme is development of relationships between team members (and stakeholder groups), the second relates to selection, development and completion of deliverables. Also identified as an important accomplishment is the increase in confidence of team members in their research-related role.
Relationships are reported to have improved in all areas: between the RHAs and MCHP, between RHAs and Manitoba Health, between Manitoba Health and MCHP, and among the RHAs themselves. Several team members reported contacting MCHP staff for information or guidance on research related issues within their regions.

All respondents reported a high level of satisfaction with the team workshops – the majority describing themselves as “very” or “extremely” satisfied. Workshop evaluations remain consistently positive and the majority of team members identified the meetings as central to project success. Working on the deliverables, and the “101” research skills sessions were the workshop components most highly evaluated. Participants also appreciated the opportunity to hear of new and ongoing research directly from the researchers involved. The “team suppers” were identified as an important component for team building. Current interests for future workshops focus on organizational capacity building and change. There is also interest in greater opportunities to interpret and apply data in concrete situations. The Rural and Northern Health Care Days are also highly evaluated both by the Team members and other regional participants, and there is strong support for the role of The Need to Know team members as facilitators and presenters. Participation in homework activities following team meetings is more variable, although most participants feel that these activities are important.

In general, respondents report relatively little use of either the MCHP or The Need to Know secure websites, although there is significant variability in this regard. A number of factors were identified as contributing to low use; team members felt, however, that there was limited action the project could take to increase use.

The “site visit” component of the project has not, to date, been well developed, although there is significant interest in further development from both RHA team members and RHA CEOs. Several different models for site visits have been proposed; many participants feel that site visits have the potential to play an important role in increasing organizational awareness and capacity related to use of research.

A number of Team members have taken the opportunity to attend related conferences. Benefits of conference attendance to The Need to Know project include heightened national exposure, opportunities for information sharing regarding effective knowledge translation strategies, and increased confidence of RHA team members.

The effects of the project were explored from various perspectives and at several different levels. Three levels of impact were identified related to RHAs: personal learning; how staff do their job; and how RHAs make decisions. Important impacts were reported at the level of personal learning in three categories: learning related to research concepts and findings; learning where and how to access information; and changing attitudes towards research and one’s relationship with research. There is also growing evidence that the project is affecting how team members “do their job”.

However, less impact is noted at the level of RHA decision-making, and, although support for the project is reported to have increased, most respondents were not content with the level of impact the project has had to date within their regions. There is also limited evidence of impact at the organizational level within MCHP and Manitoba Health, although academics directly involved with the project report change in both knowledge and attitudes.
towards collaborative research. It is reported by all partners that the project has had significant impact on the functioning of some provincial networks and committees.

The major challenges currently facing the project, as identified by team members, are those related to the need to impact change at the organizational level. RHA team members emphasize the need for strategies to increase research utilization within their RHAs, and to affect change in how decision-making is conducted. A number of barriers to this organizational change were identified: time constraints and work demands of staff; organizational priorities; the need to raise awareness and develop skill among RHA staff; commitment of regional leadership; and constraints placed on RHA decision-making. A number of suggestions were made as to how the project could assist in affecting change at this level. Other challenges identified by participants included: ensuring sustainability of project activities; strengthening provincial networking and communication; focusing greater attention on the roles of MCHP and Manitoba Health; and exploring opportunities for ongoing education for team members.

Contribution to KT Theory

One of the most exciting aspects of The Need to Know Evaluation has been the role it has played in development and refinement of knowledge translation (KT) theory. The Need to Know project has found that the most crucial KT principles are well understood by a lay audience and can be easily communicated. The development and circulation of an article entitled “Demystifying Knowledge Translation – what researchers can learn from the community” provided the opportunity for direct team input on KT insights emerging from the project. The evaluation confirms many of the proposed characteristics of effective KT identified in the literature. However, it also suggests that there are limitations in how these principles are commonly interpreted. Key elements in KT identified through the project relate to quality of relationships; recognizing the expertise of community partners; respecting time and resource limitations of community partners; developing trust; allocating sufficient time for development of relationships and activities; moving beyond a focus on individual capacity building; and addressing barriers within academia.

Key issues for replication include: ensuring that appropriate networking and interpersonal skills are available on the research team; incorporating strategies and resources for organizational change; and selecting representatives based both on their role and reporting relationship within their organizations, and their ability to form collaborative relationships with peers.

Conclusion and Recommendations

The Need to Know project has already achieved, or made good progress towards, all of its objectives, and in many cases exceeded the expectations of the partner groups. It has evolved to gain the enthusiastic support of all partners, and has generated research that is viewed as important and useful to the rural and northern health authorities. In spite of minor differences in perspective, there is impressive consensus on the part of stakeholder groups
regarding satisfaction with the project and its activities, project accomplishments, and key challenges now facing the project.

The project is now at the point where it is facing a major decision. While there is exceptionally high support for project activities to date, additional objectives identified by team members by the end of the first year of project operation have grown in importance. Many of the team feel that attention should now be directed towards the challenges of promoting greater use of research in planning within the regions.

Several recommendations are made. Some of these recommendations support continuing with approaches and activities identified as effective to date (e.g. format for team meetings; feedback processes). It is also recommended that the project develop and implement strategies for collaborative evaluation of alternatives for promoting and facilitating “organizational capacity building” within RHAs, and consider redirecting attention towards issues at this level. Additional recommendations relate to development of site visits, expanding the project evaluation, and addressing concerns around sustainability of project activities. Specific recommendations related to current activities are also included.

In addition, it is recommended that strategies for incorporating team members into project planning and development should be continued and expanded, and additional mechanisms for such participation (e.g. working groups) explored.
THE NEED TO KNOW PROJECT
2002-2004 EVALUATION REPORT

INTRODUCTION

PURPOSE OF REPORT

In February 2001, the Manitoba Centre for Health Policy (MCHP)\(^1\) received confirmation of funding for a major CIHR project designed to address the critical need for research to support the decision-making of rural/northern regional health authorities, and further promote and develop models of collaborative research. This five-year project, The Need to Know (NTK) Project, includes as partners the ten\(^2\) Manitoba rural and northern regional health authorities (RHAs), along with Manitoba Health.

This report summarizes the results of the evaluation of The Need to Know Project for the period of April 2002-March 2004. As winter of 2003/04 marked the mid-point of a five-year project, this report is intended to provide an opportunity for overall assessment of the project as it has developed to date, and to provide guidance for any re-direction that may be required. It is also intended to provide a detailed record of the implementation of the project and factors that led to further development or project adaptation, and to document project findings regarding effective strategies for collaborative research.

A separate report (The Need to Know Project Evaluation: 2001-2002 Report) summarizes the evaluation of the first year’s activities. This 2001-2002 report\(^3\) provides additional background on the original project proposal (Sections 1.2-1.3) and development of the project over the first few months (Section 1.4). It also outlines the conceptual model for the project, its goals and objectives, and the specific components of the project. As this report will make reference to activities and findings from the 2001-2002 Evaluation Report, readers are encouraged to refer to it.

This report has been prepared by Sarah Bowen, the Evaluation Coordinator for the project. When the project was approved, the Manitoba Centre for Health Policy contracted with her to conduct an “arms length” evaluation of the project, initially focused on formative evaluation. As described in the 2001-2002 report, while the evaluator is a member of the NTK team, she maintains a position of neutrality among the stakeholder groups. Charles Burchill, Senior Systems Analyst, collected and analyzed web site data referenced in the report, and Elaine Burland, Research Assistant, undertook the data analysis for the quantitative component of the pre- and post-test questionnaire.

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\(^1\) The Manitoba Centre for Health Policy is often referred to as “The Centre”, by team members, and therefore in several quotes used in this report.

\(^2\) When the project was initiated there were 11 RHAs involved in the project, however, in 2002 two RHAs (Marquette and South Westman) were amalgamated to form the Regional Health Authority of Assiniboine.

HOW THIS REPORT IS ORGANIZED

This report is organized into four main sections. Section 1 summarizes project activities over the two-year period. Section 2 focuses on evaluation of these activities over this time period. Section 3 discusses the role of the project evaluation in development of knowledge translation theory, and describes some of the key findings related to effective knowledge translation arising from the project. Section 4 summarizes the evaluator’s conclusions and recommendations for further development.

A word about format and terminology
Direct quotes are noted in italics. Where possible, participants’ own words are used in description of issues (e.g. lists of challenges facing the project). Removal of identifying information has resulted in minor changes to some quotes.

In order to avoid both the awkward use of “he or she” and the grammatically questionable use of “they”, and as the vast majority of team members are female, the female pronouns (she, her) will be used in all cases.
SECTION 1: PROJECT ACTIVITIES

Following an overview of changes in project organization and structure from April 2002-March 2004, this section describes project activities for the same period. Most of the project activities to date have been organized around the “team meetings”, held three times a year in Winnipeg; each of the project components is also discussed separately. Evaluation of project activities is covered in Section 2.

PROJECT ORGANIZATION AND STRUCTURE

TEAM MEMBERSHIP

There has been little turnover of membership since the project began; the only attrition has been due to team members leaving their employment at the RHA. This loss has been limited to northern health authorities, where staff turnover is not uncommon. One strategy employed by the project to mitigate anticipated turnover in these regions was to include the MOH (Medical Officer of Health) responsible for two northern regions as an additional team member, with the intent of providing continuity should loss of regional staff designated to The Need to Know project occur. However, in December 2003 (at a time when there was no representation on the team from one of these two RHAs) the MOH in this role moved to a position outside the province. Although two new members have since been assigned by the RHA, the result was, for the first time, a break in continuity for one region. In total, five people who served for some time on the NTK team were no longer members by March 2004: four of these were from the same health authority.

One of the major changes made to team structure was, beginning in the spring of 2003, a decision to provide the opportunity for each RHA to send up to two “official” representatives. Although, since the beginning of the project, each RHA had the option of sending an additional “unofficial” representative (and some of the RHAs had taken advantage of this), there were difficulties experienced with this approach. (The rationale for, and evaluation of, the decision to expand membership are discussed in section 2.4.3.4). It was the decision of the project’s Advisory Committee that, with the exception of travel costs for the northern health authorities and costs incurred during The Need to Know meetings, other costs related to participation of the additional member would be borne by the sponsoring RHA. As of February 2004, all but two of the RHAs had chosen to send two official representatives.

Similar accommodations were made for Manitoba Health representatives; where originally three other staff (in addition to three “official” members) had been regularly attending meetings. There are now seven Manitoba Health staff (from three units) who are considered team members. Description of the role and responsibilities of team members has been revised to reflect these changes (Appendix A).

Another change in team membership was the decision to invite a representative of the Winnipeg Regional Health Authority (WRHA) to participate on the team in order to
facilitate liaison and communication between all RHAs in the province. This WRHA participant, selected by the WRHA CEO, has been part of the team since the June 2003 meeting.

PROJECT DIRECTORSHIP

Early in the project, one of the original Co-principal Investigators (Dr. Charlyn Black) relocated to a position with the University of British Columbia. While she continued in her role on The Need to Know Advisory Committee via teleconference call, in August 2003 she withdrew from her position as co-principal investigator (although she now fills the position of external academic representative on the Advisory Committee). Dr. Patricia Martens is therefore the sole Principal Investigator. The project continues to incorporate a number of researchers from MCHP as co-investigators.

PROJECT STAFFING

Project staffing has also remained stable. There have been some changes to how administrative support is organized, with financial/travel arrangements remaining with the original Planning Coordinator, and logistical arrangements for meetings and communication being assigned to a new staff person as of December 2002. The additional team members, as well as increased attendance at Rural and Northern Health Care Days, have resulted in need for additional administrative support. At the same time, development of WRHA and Manitoba Health days (described in later sections) has also resulted in an increased need for general administrative support within MCHP.

A list of all team members, co-investigators, and project staff and their positions can be found in Appendix B.

PROJECT ADVISORY COMMITTEE

The Advisory Committee has continued to meet three times a year at the same time as The Need to Know meetings (June 14, 2002; October 8, 2002; February 5, 2003; June 10, 2003; October 7, 2003; February 3, 2004). Attendance at Advisory committee meetings has been less regular than at team meetings. There have been minor changes to the makeup of the committee since 2001-2002. A “Manitoba Health representative” selected by all Manitoba Health team members has been added. This position is equivalent to the “North” and “South” representatives selected by RHA team members at the beginning of the project, and is in addition to the appointed organizational designate representing the health department. Dr Charlyn Black now holds the position of external academic advisor. Figure 1 below outlines the revised committee structure.
PROJECT PLANNING

An important development in the project has been the inclusion of the RHA team representatives in planning activities. The first planning meeting incorporating this expanded membership took place on December 10, 2003, with the second on March 30, 2004. To date, input has focused on planning for team meetings.

PROJECT ACTIVITIES

TEAM MEETINGS

As was the case in the first year of the project, The Need to Know team meetings (held for two days, three times a year in Winnipeg) continue as the focus of project activities. Six team meetings have been held since April 2002: June 2002; October 2002, Feb 2003, June 2003; October 2003, and February 2004.

Appendix C contains copies of the agendas for each of these workshops. A summary of each workshop is found below. Descriptions of the first three team meetings (June 2001, October 2001, and January 2002) can be found in the 2001-2002 Evaluation Report.

A Word about Rural and Northern Health Care Days

The fall Need to Know team meetings are held in conjunction with the annual MCHP Rural and Northern Health Care Day. These research days have been held on an annual basis since 1994, and by 1999 had already evolved into a forum for interaction between MCHP researchers and RHA personnel. These meetings provided the base from which the project developed. Attendance at this meeting has grown from 30-40 participants in the 1990’s to 120 (not including MCHP staff) in 2003. Participants include RHA Board members, senior management (including regional CEOs and V.P.s), Medical Officers of Health, planners and program managers, as well as some direct care staff.
Team Meeting #4: June 3-4, 2002

Objectives of this workshop were to:

- Review graphs for the RHA 2002 deliverable (The Manitoba RHA Atlas') and provide insights into related documents
- Distribute the first Evaluation Report document
- Discuss specific dissemination strategies within and between RHAs, Manitoba Health and the MCHP
- Understand benchmarking and how this relates to RHA planning
- Discuss topic areas for the second research project
- Understand the Canadian Community Health Survey, and how data can be accessed and used by RHA planners.

This workshop combined two different components; the regular team workshop on Day 1 (which was similar in organization and style to previous team meetings); and participation by the group in a separate workshop, planned by Manitoba Health, on CCHS (Canadian Community Health Survey) data on Day 2.

On Day 1, the workshop began with an introduction by the Project Director, Pat Martens. This introduction utilized the theme of the “first birthday” celebration of the project, and noted the developmental progress of the team. This was followed by a brief evaluation report and an introduction to the “utilization-focused” approach proposed for the evaluation. The draft 2001-2002 report was circulated: team members were encouraged to review it and give feedback before the report was publicly released. Deadlines for feedback – either to the North/South representatives or directly to the evaluator – were identified.

The next activity provided the opportunity for team members to critique drafts of the “RHA Atlas”, the first research project of the team. Staff provided detailed information on the kinds of questions and practical problems faced in producing data and graphs. This discussion included details on the safeguards built into the process of analysis, but there was also frank acknowledgement of the possibility of error and a description of the potential sources of such error. The roles of project staff in developing the deliverables were also clarified. One graph was reviewed in detail to provide an understanding of how to interpret the drafts. The process for accessing the internal web site was reviewed. (A section on Website instructions was also included in the workshop binders). The team was also reminded of the confidentiality requirements surrounding sharing of preliminary data. The Bulletin Board created for use of team members was introduced at this time.

A major activity was the presentation by team members of the dissemination plans used in their regions or organizations. This was introduced by a group activity “the whisper game”, which was used to demonstrate that multimedia and concise messages were important in dissemination. Most of the regions or organizations then made a brief presentation. A

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1 The full name of this report is *The Manitoba RHA Indicators Atlas: Population-Based Comparisons of Health and Health Care Use*.

2 The full name of this report is “The Manitoba RHA Indicators Atlas: Population-Based Comparisons of Health and Health Care Use”, but is commonly referred to by the team as “The Atlas”, or “The RHA Indicators Atlas”. The report can be found at [http://www.umanitoba.ca/centres/mchp](http://www.umanitoba.ca/centres/mchp) and go to “Research Reports”.
number of RHAs indicated that their organizations were just starting to get dissemination plans in place; many of the presentations focused on current organizational structure rather than outlining a dissemination strategy.

Before breaking for lunch, team members who had attended conferences (the Regionalization in Health Care conference in Vancouver, February 2002, and the CAHR consultation in Ottawa) gave brief reports. An announcement was also made regarding upcoming conferences.

Lunch was held on site, with time allotted for the North/South groups to meet privately. Afternoon activities included a presentation by on “Benchmarking” by Dr. John Millar of CIHI. This was followed by a presentation by one of the RHA team members (Sue Crockett) on the “scorecard” used in NorMan region.

The final activity introduced the task of selecting the topic for the second project “deliverable” (research report). After a short discussion and an overview of suggestions already collected through the evaluation and by MCHP staff, team members worked in small groups to brainstorm around research priorities. Their suggestions were then presented back to the group. Mental Health, Prevention, Seniors Health, Intervention Effectiveness, Environmental Issues, Primary Health Care, Public Health Data, and Implementation of Best Practice guidelines were identified as priority topics. There was some time spent in discussion of these options. RHA team members were asked to consult with their CEOs on priorities for the deliverables, and to inform the Project Director of the results of the discussion by September 15, 2002. The team was informed that the final discussion would occur at the October team workshop.

The regular team dinner meeting was held at the Royal Crown Restaurant. The ‘Birthday Party” theme was continued. The MCHP directors attended, along with several of the MCHP programmers.

Day 2 (June 4) consisted of a workshop on Canadian Community Health Survey (CCHS) data organized by Manitoba Health, and included many other participants. Presented by staff from Statistics Canada, the workshop provided an overview of data and methods related to the CCHS. Separate evaluations were compiled for the two days.

**Team Meeting #5: October 7-8, 2002.**

Objectives of this team workshop were to

- Discuss interpreting and using specific data provided by Manitoba Health to the RHAs
- Discuss topic areas for the second research project
- Learn about encouraging a pleasant work environment
- Preview and critique the RHA 2002 deliverable data
- Become familiar with the two MCHP reports highlighted at the Rural and Northern Healthcare day
- Brainstorm about organizational capacity-building.
As in the previous year, only one day of the full workshop was strictly for The Need to Know Team – the second day, which team members were expected to attend, was the Rural and Northern Health Care Day.

Day 1 began with an introduction, which included an update on the first deliverable “The RHA Atlas”. This was followed by an overview of Manitoba Health data presented by one of the Manitoba Health team members (Deb Malezdrewich) and two other staff of the department (Wendy Doight and Rachel McPherson).

After coffee break, the discussion returned to the question of selection of the topic for the second deliverable. The proposed process was that designated speakers would address the potential of each topic on the short list; this would be followed by small group discussion and a “straw vote”, to determine how close the group was to consensus. Invited guests with expertise in specific areas spoke to the topics of Mental Health, Diabetes, Gender Issues, Public Health Data Sources, Health System Indicators and Primary Care Quality of Care Indicators. Potential and limitations of these topics were outlined, and speakers also identified related research that was planned or already underway. Dr. Patricia Martens provided information on the appropriateness of the topics for analysis using administrative data. Following further discussion, there was voting by “ballot” (each of the RHAs had one vote, and Manitoba Health and the MCHP had one vote each). The topic of Mental Health received eight of the votes; a decision was made to take the topic of Mental Health forward for approval.

Over lunch the video “FISH”, focusing on creating a positive work environment, was shown for those interested.

The first topic for the afternoon was discussion of the first deliverable, “The RHA Atlas”. Key statistical concepts were explained (e.g. significance, suppression). Staff led the team through specific graphs, asking for questions and feedback. A number of topics in the report were covered: the topics of immunization, AMI, stroke, pharmaceutical use, illness burden, and Personal Care Home use, received the most discussion. Differences in graphs by location of service and location of patient’s residence were highlighted.

After coffee break, a session was offered to help team members prepare for their role as facilitators for the Rural and Northern Health Day the following day. This focused on an overview of the “First Nations Report” and the report “Why is the health status of some Manitobans not improving” (the focus of table meetings for the day). This was followed by a brief overview of “capacity building” at the organizational level. All RHA team members who wished to participate were asked to complete the “Post-test survey”, either on site or later that day. The afternoon concluded with confirmation that the team would proceed with “Mental Health” as the topic of the second deliverable.

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3 Manitoba Health, who funds the development of the deliverable, was required to give final approval to the topic selected by the team.
4 The full name of this report, commonly referred to as “The First Nations Report”, is “The Health and Health Care Use of Registered First Nations People Living in Manitoba: A Population-Based Study”. It is available at http://www.umanitoba.ca/centres/mchp/reports.htm
5 Why is the Health Status of Some Manitobans Not Improving? The Widening Gap in the Health Status of Manitobans, is available at http://www.umanitoba.ca/centres/mchp/reports.htm
The regular team supper meeting was held at Tiffani’s restaurant.

Day 2 (Rural and Northern Healthcare Day) included a large number of participants from all regions of the province; attendance of approximately 100 (including The Need to Know RHA and Manitoba Health team members, but not including MCHP staff) was noted at the discussion tables. The morning began with an introduction by Dr. Patricia Martens, who introduced The Need to Know team. Summaries of the two MCHP reports\(^6\) were provided by authors of the reports. The presentation on “The First Nations” report included definitions and explanations of basic epidemiological and statistical concepts. After a few minutes spent in discussion and questions, the group broke into discussion tables by RHA, with an additional table for Manitoba Health participants. For the first time, The Need to Know RHA team members acted as co-facilitators with MCHP staff for this discussion.

Lunch was provided on site. After lunch, Steven Lewis, the invited guest speaker, presented on the topic of *How do you know if you are an evidence-based decision maker?* This presentation was followed by a panel discussion on the same topic (panel members included an RHA board member, the Director of MCHP, and an RHA CEO), followed by general discussion and questions.

After coffee break, participants were given the choice of presentations on two upcoming MCHP reports (*Estimating PCH Bed Requirements*, and *Health and Health Care Use of Manitoba Seniors*\(^7\)), or a workshop on *Computer orientation, – Navigating the MCHP website*. Most participants stayed for the presentations, with only five participants attending the computer workshop.

During her closing remarks, Dr. Martens alerted the CEOs to the fact that The Need to Know team members would be looking at decision-making within the RHAs.

**Team Meeting #6: February 4-5, 2003.**

Objectives of this workshop were to:

- Discuss theoretical and practical aspects of knowledge translation and research utilization within organizations
- Discuss and refine questions related to the Mental Health research project
- Discuss the RHA deliverable content and knowledge transfer plans
- Share observations and recommendations about conferences attended and MCHP site visits
- Discuss and refine the terms of reference (for team members)
- Learn basic statistical concepts related to health services research
- Learn computer skills related to NTK team needs.

On Day 1, an extended introduction was provided by Pat Martens in recognition of the number of new members (four) and guests attending. She outlined the progress made by the

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\(^6\) *The Health and Health Care Use of Registered First Nations People Living in Manitoba, and Why is the Health Status of Some Manitobans Not Improving?*

\(^7\) *These* reports are available on the MCHP website [http://www.umanitoba.ca/centres/mchp/reports.htm](http://www.umanitoba.ca/centres/mchp/reports.htm)
team to date. Feedback on the experience of facilitation at the Rural and Northern Health Care day was also solicited.

This was followed by a two-part session on Knowledge Translation: the first part focused on clarifying terminology and developing consensus on how terms would be used by the team, the second summarized how these concepts are modeled through the NTK project. This led to a structured discussion (“Barriers and Strategies”) on one of the homework assignments. Team members identified barriers to research use within their RHAs, and discussed how the project could help address barriers and what additional supports were needed. The draft 2002 evaluation reports for the RHA and Manitoba Health teams were distributed, and feedback requested.

Following the break, one of the RHA team members (Jody Allan, Assiniboine RHA), provided a workshop on Research Utilization. One of the goals of the discussion was to develop a revised model of research utilization applicable to The Need to Know project.

The first topic following lunch was discussion of the Mental Health deliverable. Members of the Working Group for the deliverable also attended. Dr. Martens updated the group on activities that had taken place since the last team meeting (e.g. the process of obtaining approval for this deliverable and the need for ethical approval). Christine Ogaranko, Manitoba Health, gave an overview of Mental Health Data available through the Mental Health Management Information System.

An extended afternoon coffee break allowed for North and South team meetings. Following the break, there was continued discussion of the Mental Health deliverable, and the research questions to be included.

The regular supper meeting was held at Bailey’s restaurant. Activities included “Earthquake” – an activity designed to demonstrate that group input into decisions tends to result in better decisions than would be obtained by relying on any one individual.

Day 2 began with review of the first deliverable, “The RHA Atlas”. Each of the sections in the draft report was reviewed, with time allotted for questions and discussion. Use of the report was then illustrated with four “stories” that could be told by the data (cardiac catheterization, hysterectomy, ambulatory visits and PMR/total mortality). The team was then given the task, in small groups, of finding a “story” in the data for their region.

After break there was an opportunity to share updates from conferences attended. Pat Martens also gave a summary of the visits and presentations she had made to the regions. The potential of site visits, and possible formats for them, were briefly discussed.

Copies of an updated terms of reference for the team members was distributed (Appendix A), highlighting the change which allowed for up to two official team members per RHA. A summary of notes from the previous day’s of discussion of “Barriers and Strategies”

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8 The second deliverable “Patterns of Regional Mental Health Disorder Diagnoses and Service Use in Manitoba: A Population-Based Study” is commonly referred to as “The Mental Health Report”.
9 The list of Working Group members can be found in Appendix F.
(organizational change) was distributed. Small groups of five then brainstormed and categorized the issues arising based on easy/high impact, difficult/high impact, easy/low impact, difficult/low impact.

After lunch (held on site), the team was broken up into two groups for concurrent skill-building sessions (Statistics 101 and Computer 101). The computer session included accessing the secure project web site, PubMed searches and using a Bulletin Board. After the coffee break the same sessions were again offered.

The closing remarks included an overview of the homework assignment, following which the team made a presentation to Pat Martens, and gave a performance of a song composed by the team – *Hey Team!* (to the tune of *Hey Jude*).

**Team Meeting #7: June 9-10, 2003**

Objectives of this workshop were to:

- Discuss the process for making a decision on the next deliverable topic
- Discuss plans for the upcoming 10th Rural and Northern Healthcare Day
- Acquaint team members with the Western Regional Training Centre
- Discuss findings and recommendations of the evaluation report
- Learn about ethical considerations as they relate to research in regions
- Discuss research use in RHAs and to redefine the model of research utilization
- Work collaboratively on the Mental Health Deliverable
- Learn how to use the medical library
- Learn how to design a survey for health research.

This workshop, which marked the “Second Birthday” of the team, began with an extended introduction summarizing many of the issues arising in project development. The introduction included a discussion of which reports should be highlighted for the October 2003 Rural and Northern Healthcare day.

The director of the Western Regional Training Centre (WRTC) made a presentation on that centre, and presented the opportunity of WRTC students having placements in the RHAs. The skills building session for this meeting, Ethics 101, was presented by the previous chair of the Faculty of Medicine Research Ethics Board.

Following coffee break, one of the RHA team members (Bev Cumming, Brandon) led a discussion of the homework assignment, where each RHA was requested to put together a dissemination plan for their region. Following presentations by team members, key points were summarized into “Guiding principles: Best Practices of Information Dissemination”.

After lunch, there was in-depth discussion of the Mental Health deliverable, which included members of the Mental Health Working Group. Chapter 5 of the report, which explored suicide, was the focus of discussion. There was an overview of graphs produced to date, followed by discussion and questions. A presentation was made on “predictors of suicide” by one of the MCHP staff.
Updates were given by team members who had attended recent conferences. An “art show” opening was held to showcase paintings – created by a fine arts student – representing each of the RHAs. Pictures of team members were taken beside their RHA “portrait” later in the workshop.

The regular team supper meeting was held at Café Carlo.

Day 2 began with an evaluation update. This report focused on key findings from the key informant interviews with RHA CEOs, and similarities and differences in perspectives of stakeholder groups. It also highlighted the insights related to knowledge translation theory arising from the project. A draft of an article (Demystifying Knowledge Translation: Learning from the Community) was circulated to the team, with a request for feedback and the suggestion that if the article represented the perspectives of the team, the team itself should be listed as an author. The evaluator then summarized recommendations areas arising from the evaluation that she had provided to the Project Director; more detail on these recommendations was provided in handout form.

There was extended morning coffee break to allow for North/South/Manitoba Health meetings.

Following the break, two concurrent skills-building sessions were held: Library Searches 101, led by staff of the Neil John MacLean Library; and Survey Research 101, presented by Dr. Patricia Martens. The same sessions were again offered after lunch.

Following the afternoon coffee break, the team returned for the closing and an overview of homework assignments.

**Team Meeting #8: October 6-7, 2003.**

Objectives of this team meeting were to:

- Discuss the process for making a decision on the next deliverable topic
- Learn facilitator skills for the next Rural and Northern Healthcare Day
- Learn how to create a map
- Learn how to create a poster
- Work collaboratively on the Mental Health deliverable.

This meeting marked the third occasion where The Need to Know team meeting was combined with the annual Rural and Northern Health Care Day.

On Day 1, the introduction included a review of the project timeline, an update on project staffing, and a quiz related to the project conceptual model. The issue of article authorship was revisited with consensus that the team should be listed as an author. Team members were asked to review and give feedback on the CHSRF assessment tool: “Is research working for you?”

The first major agenda item was debriefing on the first deliverable (“The RHA Atlas”), and discussion around timing of its release. The discussion then moved to the process to be used in deciding the topic of the third deliverable.
A half hour session was provided to allow for North/South/Manitoba Health meetings; this was followed by a coffee break. Following the break, there was extended discussion of the Mental Health report. An overview of the draft report as developed to date was provided, with time for discussion and questions.

Feedback from the North/South/Manitoba Health groups on the topic of the process for selection of the topic of the third deliverable resulted in support for the process of internal consultation within the RHAs, with the final decision to be made by The Need to Know team members.

After lunch, workshops on poster-making and map-making were facilitated by project staff. Following the coffee break, the MCHP staff who were to assist in facilitation of the Rural and Northern Health Care day joined the team. Each RHA was paired with a staff person; this team then decided on the approach to be used for each region, and key stories to be used in discussion of the “RHA Atlas”.

The team was reminded of the importance of consulting with their CEO to identify priority topics for the third deliverable, and a Bulletin Board discussion on the topics for the third deliverable proposed.

The regular team supper meeting was held at Vivere Ristorante.

Day 2 marked the Tenth Annual Rural and Northern Health Care Day. Attendance at the meeting (not including MCHP staff) was estimated at 120.

The day began with a presentation by the three elected team representatives (North regions, South regions and Manitoba Health) on The Need to Know project. Lorraine Decomb-Dewar (Manitoba Health) gave an overview of the project; Sue Crockett (North regions) explained the team and team activities, and Bev Cumming (South regions) outlined the benefits of the project to all partners.

Following an overview of “The RHA Atlas”, which included practical “fun” demonstrations of the concepts of incidence and prevalence, participants formed discussion tables by RHA, with an additional table for Manitoba Health. There were a total of 14 tables, as three RHAs were divided into two tables because of the large numbers of representatives attending.

After lunch (provided on site), Ray Bollman (Statistics Canada) gave a presentation on Rural Canada: From Strength to Strength. After break, participants were given a choice of two activities: a preview of upcoming deliverables, or a session on map-making. All but 14 chose to stay for the preview of deliverables (Diagnostic Imaging and Care at the End of Life)\(^\text{10}\), and Diagnostic Imaging in Manitoba.

**Team Meeting #9: February 3-4, 2004.**

Objectives of this workshop were to:

- Work collaboratively on the Mental Health deliverable

\(^{10}\) These reports are also available at [http://www.umanitoba.ca/centres/mchp/reports.htm](http://www.umanitoba.ca/centres/mchp/reports.htm)
• Discuss the next deliverable topic
• Learn basic quantitative research methods/program evaluation concepts and skills related to health services research
• Discuss findings and recommendations of the evaluation report
• Learn about the Quality of Care Indicators report as it relates to physician practices
• Review poster-making skills learned at October 2003 workshop and create a poster related to pertinent findings from the RHA Indicators Atlas.

Following introductory remarks, the morning focused on discussion of the Mental Health deliverable. It began with a presentation on data related to suicide and suicide behaviour, followed by an overview of the chapters developed to date. Members of the Mental Health Working Group attended and participated in the discussion. After the coffee break, discussion on the deliverable continued in four groups (North, South of TransCanada, Lakes region, and Winnipeg/Brandon). Insights found in the data by these small groups were then presented to the whole team.

The final half hour was directed towards discussion of the process for selection of the third deliverable. Each RHA, Manitoba Health, and MCHP was asked to vote on a list of potential topics. This list (which included suggestions from team members and MCHP staff, as well as input from discussions with Manitoba Health) had been previously distributed. Each of the 12 groups could vote for up to three priorities. Five of a total of 21 potential topics were selected for the short list for further discussion (women’s health and health care use patterns; chronic diseases; rural hospital performance indicators; outcomes in primary care; needs based and population health funding formulae). Further discussion resulted in clarification that, rather than focusing on women’s health, the primary interest was in gender-based analysis of health and health care use patterns.

A skills building session on Quantitative Research and Evaluation Methods, consisting of an overview and small group work, took place after lunch. Following the afternoon break, the question of the topic of the third deliverable was revisited. After a short discussion, each of the partners (the 10 RHAs, Manitoba Health, and MCHP) gave one vote for their first priority. The “Gender Report” (analysis of male/female differences by topic) received 10 of the 12 votes and a decision was made to take the suggestion forward for approval.

The regular team supper meeting was held at Hu’s Asian Bistro. Three faculty members of the department of Community Health Sciences attended the supper and made short presentations on their research interests and activities.

Day 2 began with an update on the project evaluation. The group decided that it was no longer necessary to circulate separate reports to each stakeholder group before the final report was developed. North, South, and Manitoba Health meetings followed. After coffee break, the rest of the morning was spent in poster making. Each of the RHAs was asked to develop a poster — using computer skills developed through the project — on a topic related

11 The full name of this report is Patterns of Sex Differences in Health Status, Health Care Use, and Outcomes of Care: A Population-Based Study for Manitoba’s Regional Health Authorities.
to research and their RHA. Staff provided a review and one-on-one coaching/problem solving. This activity was continued in the afternoon until the coffee break. Following the break, participants were given an overview of a MCHP report on Quality of Care indicators. After discussion of this presentation, there was brief summary of the poster-making activity, and homework activities for the coming months were outlined.

**ORIENTATION SESSIONS FOR NEW MEMBERS**

Addition of new members (either through staff changes at the RHA, or through the addition of a second “official” member) resulted in the decision to create a special Orientation Session for new members. Three of these were offered between June 2003 and March 2004: June 8, 2003, September 10, 2003, and January 2004. A total of eight team members participated in these orientations: some were new to the project; others had some previous involvement with the project as “unofficial members”. In addition, on March 15, 2004, an informal orientation was held for a new representative from Manitoba Health, along with two other Manitoba Health staff who required an overview of the project.

The first orientation was held over Sunday brunch, extending into Sunday afternoon (June 2003); the following two sessions were held over supper and into the evening of a weekday. The orientations took from 3-4 hours, and were scheduled around times when some or all of the team members would be Winnipeg.

Based on participant and staff feedback, the format of the orientation was changed significantly for the September 2003 orientation. Rather than a presentation format where project staff provided background on the project and an update of activities, the orientation agenda adopted an adult education approach. Materials were sent to the participants ahead of time, along with questions that encouraged them to review materials in consultation with the other team member in their region. Review of answers to a “quiz”, introducing the orientation session, provided the framework for questions and discussions around key themes. It was intended to promote discussion and allow the orientation to focus on issues of greatest concern to participants.

**DELIVERABLE DEVELOPMENT**

As the section on team workshops suggests, development of the project research reports (or “deliverables”), has been a major focus of the project, and an important agenda item at each team meeting. The first deliverable (“The RHA Atlas”) was scheduled for release in order to assist the RHAs in their Community Health Assessment process. This project was completed on schedule (June 2003) and with positive support from the team. Each RHA was requested to develop a dissemination plan for their region, and provided with a PowerPoint presentation to support presentations they might do in their region. The Atlas was the focus of the regional discussions at the Rural and Northern Health Care Day in October 2003. There was some limited media coverage of the release (see Appendix D).

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12 This report, *Using Administrative Data to Develop Indicators of Quality in Family Practice*, is also available on the MCHP website.
The team achieved agreement both on the process for selecting the deliverable topics, and on the selection of the remaining two deliverable topics. The topic of the second deliverable (Patterns of Regional Mental Health Disorder Diagnoses and Service Use in Manitoba: A Population-Based Study; commonly referred to as “the Mental Health Report) was decided at the October 2002 meeting; the topic of the third (and final) deliverable (Patterns of Sex Differences in Health Status, Health Care Use, and Outcome of Care: a Population-Based Study for Manitoba’s Regional Health Authorities) was selected at the February 2004 workshop. Both have received approval from Manitoba Health. In preparation for selection of the third deliverable, greater emphasis was placed on the importance of consultation by The Need to Know team members within their RHAs regarding priority topics for the deliverables, and the CEOs were informed by the Project Director that this decision-making was underway.

As of March 2004, development of “The Mental Health Report” is also on schedule, with an anticipated completion date of fall 2004.

TRAINING OF ACADEMICS

Training of academics is a clearly identified objective of the project. The most directly related activity is the incorporation of graduate students (four in 2002-2004) into the project. These students have had a number of roles (e.g., intensive work with the data used in the reports, logistical support to team activities, and participation in team workshops). Opportunities for students include both direct participation in aspects of collaborative research and knowledge translation activities, and attendance and presenting at national conferences. A list of these students and their positions is included in Appendix B.

Linkages with the Western Regional Training Centre (a UBC/University of Manitoba graduate training program for health services research), resulted in the Director and the Evaluation Coordinator contributing sessions on The Need To Know Team and on Knowledge Translation theory to the February 2004 workshop. (An RHA team member was also invited to present on the Community Health Assessment process used in her region). WRTC students have also attended MCHP Rural and Northern Health Care Days, and one WRTC student has been placed in a rural health authority for her practicum.

Another area of project impact relates to the learning and networking opportunities provided to MCHP researchers. The project has continued to have active involvement from MCHP staff. Various researchers have been asked to make presentations on their areas of expertise (see Appendix E) and have responded to individual requests for information and guidance. Participation is not limited to researchers – programmers and other administrative staff have shared their expertise in computer workshops and working groups, and have been invited to participate in team suppers. The first deliverable (“The RHA Atlas”) included MCHP researchers as resource persons. As the second deliverable is more specialized in topic, six researchers are involved. The expert working groups created to support the work of specific deliverables also provide a wider number of individuals (academics and researchers from other centres, practitioners and policy makers) with exposure to collaborative research approaches. The list of working group members for the deliverables can be found in Appendix F.
CONFERENCE ATTENDANCE

One component of the project is provision of funding to attend relevant conferences (Appendix G). This is not limited to staff on the project – each RHA is funded for up to two conferences in the five-year period. There have also been additional events such as CIHR-sponsored meetings where additional funding is provided for team members to attend. (Selection of participants for the latter events was made by having all those interested in attending indicate their interest in representing the team – the Project Director then conducted a draw from the names submitted). In addition, the project decided to consider costs of attendance for additional conferences in cases where a team member had an abstract accepted for either a paper or poster presentation related to The Need to Know team. There is an expectation that those attending these conferences provide a brief report to the team at the team meeting following their return.

PUBLICATIONS AND PRESENTATIONS

The project has already made a number of conference presentations (poster and oral) and it is beginning to generate publications. Members of The Need to Know staff team and the project evaluator have made poster/paper/workshop presentations at national conferences, participated in national consultations and provincial workshops, and made presentations to academics and graduate students. To date, one presentation has been made by an RHA member of the team. As of March 2004, a total of 18 conference abstracts had been accepted.

A list of presentations and publications resulting from the project can be found in Appendix H. A unique aspect of some of these presentations, posters, and articles is the inclusion of The Need to Know team as an author. It was felt that as the insights on knowledge translation emerging from the project were as much the work of the team members as the researchers (and as they were collaborators on The Need to Know research projects), the team itself should be listed as an author/presenter on many of the abstracts and articles submitted.

HOMEWORK ACTIVITIES

“Homework” activities (activities resulting from team workshops which are to be completed by team members between meetings) have been a regular part of the project. Many of these activities have focused on the development of the deliverables (consultation around selection of topics, reviewing drafts of deliverables in development, designing a dissemination strategy, or other related activities). Other “assignments” have been related to the evaluation process (e.g. reviewing draft evaluation reports or the draft article), while a few were intended to reinforce skills learned during the workshops themselves (e.g. poster making). A list of all homework assignments can be found in Appendix I.
SITE VISITS

The Principal Investigator has responded to a number of requests to present to RHA boards, AGMs and other regional events. These are summarized in Appendix H. While initial discussions have taken place with the team regarding further development of site visits, to date this component remains relatively undeveloped. Issues related to development of site visits are discussed further in section 2.5.3.

WEB SITE AND WEB-BASED APPLICATIONS

The 2001-2002 Report summarizes the computer support provided to participating RHAs. The project-supplied computers are used for the training sessions, and are available to the RHA team members between meetings. Drafts of reports in development are available online, as are the detailed tables supporting the reports.

The web site has developed significantly since the first year and now hosts a number of separate pages. In addition to general information on the project, current and past team meetings and project newsletters, the site also hosts a Bulletin board, reports produced by the project, background materials related to these reports (e.g. graphs and maps), and links to educational resources.

As indicated in the section summarizing team workshops, meetings regularly include computer skills sessions (e.g. accessing the secure site, map making, poster making, literature searches, and using a Bulletin Board). Homework assignments have included the tasks of using the Bulletin Board and completing posters.

THE NEED TO KNOW NEWSLETTER

Six issues of The Need to Know newsletter have been published: March and August 2002, January, June, and October 2003, and Winter 2004 (Appendix J). These newsletters are also posted on The Need to Know web site.

MEETINGS WITH THE RHA CEOS

The Project Director continued to have regular communication with the RHA CEOs and made regular short presentations at RHAM (Regional Health Authorities of Manitoba) meetings – the Project Evaluator also attended two meetings. These presentations provided updates on project activities, asked for suggestions for including CEOs in the project evaluation, provided feedback on the telephone survey with the CEOs, alerted them to the “assignments” given to their representatives on The Need to Know team, and requested support for additional research activities (e.g. letters of support for additional funding proposals).
RELATED ACTIVITIES

The response to some project activities has also resulted in additional MCHP activities. Interest by the Winnipeg Regional Health Authority (WRHA) in having equivalent data to that included in the RHA Atlas resulted in the WRHA contracting with MCHP to develop a similar report for the Winnipeg region and its districts. The success of the Rural and Northern Health Care Days resulted in the provision of a similar day for the WRHA in both 2003 and 2004. The first WRHA day, which attracted 62 participants, was held in April 2003, with another scheduled for April 2004. The first Manitoba Health/MCHP Day was held on March 10, 2004, on the request of the Deputy Minister of Health. It was intended to facilitate discussion, dissemination and use of research within Manitoba Health. This event, which attracted 76 participants, was based on template developed for the Rural and Northern Health Days.

FOLLOW-UP ACTIVITIES/SUSTAINABILITY

The project has also initiated action to address the concerns raised by team members and the Advisory Committee regarding long term sustainability of project activities. Addition of a second team member – for which the RHA is responsible for paying some of the costs – is setting a precedent of RHA support for some level of continuance. The MCHP has also submitted a proposal ("What works"? Evaluating Manitoba's rural and northern health programs and policies at the population level) to CIHR13. This research proposes to examine eleven different regional health program or policy interventions, looking at population-level effectiveness over time, both within and between regions. If approved, it will provide funding that both allows continuation of project activities, and addresses some of the issues raised by participants regarding the need for greater organizational involvement of the RHAs in project activities.

SUMMARY

This chapter summarized the activities of The Need to Know Project over the two-year period from April 2002–March 2004. The following chapter will describe evaluation activities, summarize findings, and provide an analysis of key issues arising from this evaluation.

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13 An additional proposal to address the issue of organizational barriers to research use (From Evidence to Action) was submitted to CIHR in June 2004.
SECTION 2: PROJECT EVALUATION

EVALUATION DESIGN

PURPOSE OF THE EVALUATION

As indicated in the 2001-2002 Evaluation Report, the primary purpose of the project evaluation has been formative evaluation; i.e. to assist in development and ongoing improvement of the project. However, from this original role of helping the principal investigators to monitor and improve the project, the evaluation has evolved to become a) a support for team building and trust-building, b) a strategy for reinforcing and further developing participation of all stakeholders, and c) an important tool in developing KT (knowledge translation) theory. Like The Need to Know project, the evaluation is based on the principles of partnership, collaboration, and transparency. It was designed to reflect “best practice” in knowledge translation, and has been used as a tool for supporting participation of all stakeholders in both project and theory development.

This section first describes the approach and specific methods used in the evaluation. This is followed by a discussion of key findings (sections 2.4-2.7) as they relate to project development. Findings specific to Knowledge Translation theory, and insights from the team regarding principles of effective knowledge translation are addressed in Section 3.

EVALUATION FOCUS AND QUESTIONS

The collaborative approach to evaluation employed in this phase of the evaluation can perhaps best be described as “utilization-focused” (Patton, 1997), where the focus is on ensuring stakeholder input into the evaluation, and an emphasis on how answers to evaluation questions will actually be used.

As the evaluation component was not included in the original proposal, it was developed over the initial months of the project. It was assumed that the evaluation would, at the end of the project, assist in assessing the extent to which the project had met its stated objectives (goals-based evaluation), and would be based on the conceptual framework guiding the project. As indicated in the 2001-2002 Evaluation report, the goals of The Need to Know project were to:

1) create new knowledge directly relevant to rural and northern regional health authorities, both in Manitoba and as a model for the wider community;
2) develop useful models for health information infrastructure, as well as for training and interaction, that will increase and improve capacity for collaborative research interaction; and
3) disseminate and apply health-related research so as to increase the effectiveness of health services, and ultimately the health of RHA populations.
The three major types of activities required to support a collaborative research process (new knowledge creation and development; capacity building to support interaction and processes to communicate, disseminate and apply the research results) are expressed in the revised conceptual model. (The rationale for some of the changes to the original conceptual model is described in Section 10 of the 2002 Evaluation Report).

While the evaluation is designed to evaluate project success in meeting these goals and activities, it is not limited to this evaluation focus. As the evaluation emphasis in the first year was on formative evaluation, issues related to program implementation (implementation focus) and to expectations and experience of team participants (goal-free evaluation), were also incorporated. Emphasis on qualitative methods, and incorporation of perspectives of all stakeholder groups also provided the opportunity to identify unanticipated impacts of the project (impact focus).

Defining “Stakeholder Groups”
The definition of “stakeholders” was expanded in this phase of the project evaluation. Where initially stakeholders had been defined as The Need to Know participants from the three partner groups, in 2002 this definition was expanded to include the organizations represented by these partners. The first step was to include the RHA CEOs and the members of the project Advisory committee as stakeholders in the project evaluation. The Manitoba Centre for Health Policy (MCHP) was also defined as a stakeholder group.

Evaluation Questions Identified by Stakeholders
One strategy employed to increase participation in the evaluation was incorporation into the 2002 key informant interviews (with Team members, MCHP staff, Advisory Committee members, and RHA CEOs) the questions “What questions do you think should be included in the evaluation? What information are you hoping will come out of it?” and “What would be the best way to get at this information?” These questions were also revisited in the 2003 interviews.

Some respondents felt that what was being done now in terms of project evaluation was adequate (“Can’t think of anything other than what you’ve already been doing,” “think we’re getting a pretty comprehensive picture just with what you are doing now”), or felt that this question could be left to the expertise of the evaluator. Some of the CEO respondents felt that they needed more time to think about the question. However, a number of suggestions were made regarding the project evaluation.

The evaluation questions of greatest interest related to organizational change
Many suggested questions focused on evaluation of project impact within the RHAs. The emphasis on questions related to organizational impact was more pronounced in 2003. Some of the suggestions in this category included:
• Related to organizational change, what have been the strategies (if any) that have been employed, lessons learned?

• What is the capacity being developed at the RHA level...that we are doing our job, things are not left with one or two people. We are notorious for that.

• The question is: are we really using it? Are we using the dissemination plans that we have drawn up? Examples and evidence of what we have done and how.

• If the project has increased the impact of the Centre’s work on the RHAs.

• What I don’t have a good sense of is the uptake. Lots of activity, but what is the impact? Lots of meetings, but what are the outcomes?

• Asking people if they have utilized it in planning – anecdotal examples of how they have done that.

• Have RHAs evolved over the 5 years to be more evidence-based?

• What were the actual results, deliverables, what impact did it make?”

• Does working routinely with the MCHP become a part of RHA culture?

Some respondents made suggestions about how best to undertake assessment at this level. While some descriptive approaches were suggested (e.g., “How each of us is using the information back home”), most respondents focused on measuring project outcomes. Many responses focused on “before and after” measurement. The key questions that team members were interested in addressing at this time focused on change, within the RHAs, in use of research over time:

• How are reports used in the region? How many reports are used? How do regions include information in planning? Incorporate reports in planning?

• How are The Need to Know activities incorporated into RHA work? Does this change over the years? How does use of research in strategic and operational plans change over time? Is more reference made to research in planning documents?

• How does information flow throughout RHAs? Does this change over time?

• What are some specific examples of how research has been translated at a regional level?

Specific mention was made of the potential of comparing the Community Health Assessment (CHA) planning documents over time: it was suggested that what data was used for planning in the first (1997) and current CHAs could be compared, including how much MCHP data was used. Evaluation methods suggested included written surveys to key decision-makers within the regions, before-and-after interviews/focus groups within the regions, and document review (e.g., documents related to strategic planning or the Community Health Assessment processes).

A number of individuals – including several of the CEOs – were interested in identifying regional characteristics associated with progress in this area (e.g. does staff turnover, or having a specific research “unit” affect RHA ability to use research or the impact of the project?).

**Ongoing monitoring and evaluation of activities is seen as valuable**

Participants continued to stress the importance of regular feedback on what was working well in the project, and what was most useful to project participants. Several commented that feedback from the team should be continued: workshop evaluations and regular interviews were specifically mentioned as important and useful.
• On an ongoing basis, that what we are doing is still useful.
• From an RHA perspective, what works and what doesn’t. How it has helped in planning, what has been most useful.
• What the majority of people think are the strengths of the project, how to improve the process, particularly with the RHAs.

Several commented positively on the role that the evaluation had played to date (“I am seeing changes coming out of the evaluation”, “Still thankful about a continuous evaluation process.”) and indicated that the evaluation was viewed as participatory and interactive.

**Sustainability of project activities is of increasing concern**

Another key issue emerging in 2002, and receiving more emphasis in 2003, was that of sustainability of project activities. This issue was identified as a key evaluation question by all stakeholder groups.

• ...what happens afterwards – does it just get dropped or is it inherent to the process? Does it get into the workings of the organization? Will it be carried on or just die?
• If, when the project is over, there is the same quality of RHA useable data available, whether there is a change in generic research when the project is over.
• To see if there is an ongoing partnership between the Centre and RHAs.
• If we’re going to be training and sustaining this in the regions, could we get recommendations of optimum ways to do that? Who is the best person to lead? What are the characteristics of regions that make the most progress, what is done to make this succeed? What is needed to make more support available?
• The whole area of what happens next. Have we developed a network, will the Centre do another Atlas in five years or what? One way to evaluate success is to see if the project is ongoing. If there is a plan in place, it would continue.

**There was active interest in learning from the perspectives and activities of other RHAs and other stakeholders**

The questions of greatest concern of the CEOs were related to learning what was being done in other RHAs. Some commented that they hoped that findings on the experiences of other regions would be shared (“The range and scope of projects undertaken in other regions”; “Impact overall on how RHAs are dealing with research data throughout the project”; “What are others doing in areas of research and what value did they find from the project?”). One person commented that it would be useful if – through the evaluation – an overall inventory of how information was used in health planning could be developed.

Informants from all groups were interested in the understanding the perspectives of other stakeholders. In 2002, a number of the RHA team members were interested in the perspectives of CEOs; this question did not emerge in 2003, perhaps reflecting the feedback from the CEO interviews. The perspective and experience of Manitoba Health was of concern to some RHA team members, and RHA perspectives were of interest to some within Manitoba Health (e.g., “some feedback on RHA thoughts on Manitoba Health participation in the project. Did they learn anything? Did it change their perspectives on Manitoba Health?”).
A range of other questions were proposed
Other questions, proposed by fewer respondents, included those related to knowledge translation (“how to measure KT”), website use (“how much, and for what purposes, is The Need to Know website used?”), and issues of replicability in other regions. Two individuals had questions related to economic evaluation, although this question was also linked to measurable impact in the regions (e.g. “There has been a lot of money spent on the project – what is the bang for the buck? What are the RHAs exactly taking away with them, what they will do with it in four years?”).

It was also suggested that there should be a focus on less successful aspects of the project (“I’m more interested in reports that identify deficiencies. The parts of the project that haven’t met expectations. What is not working well. Are there conflicting roles of the Centre with Manitoba Health?”)

There were some differences in proposed evaluation questions a) between stakeholder groups and b) over time.
The evaluation questions posed by RHA and Manitoba Health stakeholders were consistent with, and appropriate for, the project activities. However, as early as 2002 (one and a half years into the project) their questions had a different focus than those of MCHP researchers and project staff. Those interviewed from MCHP were more interested in measuring the extent to which the project met its original objectives (“Did it meet its objectives, and to what extent”)? Project staff were particularly interested in the use of the deliverables developed by the Team and in the success of team meetings (issues that they could affect directly); whereas RHA and Manitoba Health team members focused more on the impact of the project on decision-making with the RHAs. As noted above, the greatest interest expressed by the CEOs related to learning about and from other RHAs.

In 2002, several informants were interested in questions related to dissemination and impact of deliverables at the RHA level (e.g. Whether information has been disseminated within regions vs. “stopping with The Need to Know person”; how “useable” the deliverables were to the RHAs and Manitoba Health; how easy it was to present the deliverable findings to people in the community; how the regions used the deliverables; and whether the results were credible to stakeholders). In 2003, several suggested that the issue of dissemination be revisited, and greater emphasis was placed on issues of change within the RHAs and on project sustainability.

There were several suggestions for methods to be used in evaluation
Several respondents suggested that one of the best ways to measure change at the individual RHA level would be to review how information was used (and what information was used) in the health planning and Community Health Assessment processes. Others suggested comparing the information presented to, and used, by RHA boards, and analyzing annual reports for evidence of research use. Analysis of web site use was also suggested, as was an annual/biannual survey or focus group.

Some of the respondents stressed the importance of qualitative research methods to address the questions of concern (“Whether or not there is direct quantitative evidence is not as important to me … As long as it is useful to them, I don’t think you need quantitative analysis”).
Several respondents recognized that any changes noted could not necessarily be attributed to the project. Others identified the dilemma of measuring change at an organizational rather than individual level.

**METHODS**

**KEY INFORMANT INTERVIEWS**

Key informant interviews with team members were conducted in the fall of 2002, and again in fall/winter of 2003-2004. Most of the 2002 interviews took place in September and October, with a small number occurring over the summer or early in 2003. Most of the 2003 interviews took place over a period from October-November 2003, with a few conducted as late as February 2004. In addition, a few interviews with new members took place over the summer of 2003.

In 2002, all the official team members were invited to participate in these interviews, and in 2003 (as the “official” membership of the team had expanded), all regularly attending members were included. A total of 15 individuals participated in interviews in 2002 (this included a group interview with Manitoba Health representatives), with additional informal discussions held with project staff. A total of 17 RHA team members, and five Manitoba Health team members were interviewed in 2003/2004. There were a total of three people from these two groups who chose not to participate, or did not respond to an invitation to participate, in 2003. Those interviewed included new participants who were interviewed for the first time, and experienced team members who were, by 2003, participating in their third interview. Some of the 17 RHA informants were interviewed more than once, as the policy was to interview new members as soon as possible after they joined the team. All first interviews were in-person, as were most of the 2002 follow up interviews. However, in 2003, most interviews were conducted by phone. This was more convenient for many participants, and sufficient rapport had been established to make this an effective format.

In the winter of 2003/2004, all project staff and a sample of other staff from MCHP were also invited to participate in interviews. A total of 12 MCHP staff participated; all of these interviews were in-person and took place in the MCHP offices. Those interviewed who were not project staff had had some role with the project (e.g. presenting at workshops), had some contact with team members (e.g. attending team suppers), or were able to provide an important perspective based on their role within the Centre.

Interviews were open-ended, semi-structured, and used an interview guide format – while topics and issues were determined in advance, the actual wording and sequence of questions was determined during the interview (Patton, 2002). While a different interview guide was developed for each stakeholder group, and for “new” rather than “old” members, many of the questions were similar for all groups. The interviews were intended to provide a confidential environment for feedback on project progress and to encourage input into both

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1 Issues related to consent and confidentiality are discussed in the 2002 Evaluation Report.
project design and development of project theory. Most interviews took approximately 45 – 75 minutes.

Key informant interviews were conducted with the CEOs (and some additional informants suggested by the CEOs) of the rural and northern health authorities in December 2002. These were telephone interviews scheduled at the convenience of the respondents. Following a presentation by the evaluator to the CEOs at the September 2002 RHAM (Regional Health Authorities of Manitoba) meeting, each of the CEOs was sent an email invitation providing brief background information on the project and outlining the purpose of the interviews. This was followed by a telephone call to schedule the interview. Interviews ranged from 15 to 45 minutes with most taking about 25 minutes. Questions focused on CEO perceptions of the project, identified strengths and weaknesses, and suggestions for both project development and project evaluation. A total of 13 individuals, including all the CEOs, participated.

Members of the Advisory Committee were also invited to participate in interviews at this time. There was good response to this invitation; however, some advisory members who had been interviewed in other roles declined to participate as they felt they had already had sufficient opportunity for input. All Advisory committee members did, however, participate in at least one interview.

Notes were taken of all interviews, which were then transcribed. As interviews were not audio-taped, no long narratives were captured, although short comments were transcribed verbatim.

**POST-TEST SURVEY**

The first administration of the post-test survey took place in October 2002. All current members participated in the survey; however, paired analysis was restricted to those who had also participated at the pre-test survey (June 2001). Some additional questions were included in the post-test survey to address issues that had arisen during the first year and a half of the project (See Appendix K). Analysis of quantifiable responses was undertaken using appropriate statistical techniques, while open-ended questions were analyzed separately. Findings were merged with the 2002 interview analysis. In general, the post-test questionnaires were consistent with findings from the interviews.

**WORKSHOP EVALUATIONS**

Anonymous written evaluations were collected after each team workshop (see Appendix L for the evaluation format). Questions focused on usefulness/interest of workshop sessions at both the personal (What workshop topics or sessions did you personally find the most interesting?) and professional (What workshop topics or sessions did you find the most useful to your role in RHA planning and decision-making?) levels. These evaluations were collated and then analyzed to determine most and least successful aspects of the workshops and to identify suggestions for change. Results were incorporated into the report on each team meeting prepared by the evaluator.
There was good participation in completing these evaluations. On occasions where a lower number of evaluations were returned, the evaluator sent a follow-up reminder email to all team members, encouraging them to complete the form. Because of the consistently positive feedback received through workshop evaluations during the first year, the evaluator had some concern that the questions were not sensitive enough to identify negative feedback. However, the strongly worded negative feedback to one of the two workshop days in June 2002 indicated that the forms were in fact effective for identifying both negative and positive responses. Workshop evaluations have continued to indicate an extremely high level of satisfaction with workshops, and participants regularly use these evaluations to suggest changes or additional topics. Comments received through key informant interviews indicate that participants feel that concerns and suggestions raised through these workshop evaluations are addressed by project staff.

Written evaluations are also completed for the orientation sessions for new members; a similar format is used as for workshop evaluations.

Simple written evaluations of the Rural and Northern Health Care days were also collated. In 2003, changes were made to the evaluation form which requested respondents to indicate their role within the RHA (e.g. board member, management, staff, etc): this categorization allowed separate analysis of team members and other attendees. In addition, debriefing meetings that included the MCHP staff who were involved as facilitators, were held following each Rural and Northern Health Care Day. Notes were taken of these meetings by both the project evaluator and the research assistant.

PARTICIPANT OBSERVATION/DOCUMENT REVIEW

As was the case in the first year of the project, the evaluator attended all team workshops, team planning/debriefing meetings, Advisory Committee meetings, and two of the three orientation sessions for new members. Presenting at national conferences and attending conferences with members of The Need to Know team provided additional opportunities for participant observation. Several comments, questions, requests for resources, or invitations to participate in larger consultations/evaluations were received as a result of an increasing national profile, and allowed the evaluator to gain insight into perspectives of a larger constituency – including a number of researchers, health region staff, and project directors from other provinces, as well as research funders.

However, unlike the first phase of the project, the evaluator was not involved in planning meetings with Manitoba Health, many other activities that may be the result of, or influenced by the project (e.g., the Winnipeg and Manitoba Health Days), or in many presentations about the project (e.g., presentations to the CEO network, or on-site at RHAs).

Similarly, while the evaluator continued to monitor project correspondence, there is some indication that in this area also she may not be aware of all activities. For example, some events have come to light where she later became aware of requests for information to a project staff person, but was not originally copied on the communication.
UNOBTRUSIVE MEASURES

A number of unobtrusive measures (e.g. monitoring of web-site hits and reports ordered, attendance at team workshops) were added to the evaluation in this phase of the evaluation. While limited information was obtained through monitoring of hard copy reports (this dissemination had not been previously tracked, and there had been changes in how information on the reports was disseminated at about the same time the project was established), useful information was obtained through monitoring of web site use. The Senior Systems Analyst was responsible for monitoring and analyzing this data.

FEEDBACK STRATEGIES

As in the first year, evaluation activities were made explicit and each activity had a feedback phase. For the 2002 key informant interviews, like those conducted in 2001, separate reports were developed for each of the main stakeholder groups and circulated privately to those groups for feedback. This step (which provided each of the stakeholder groups with the opportunity to review the conclusions together as a team and to give individual feedback before the final report was distributed) was considered important for developing trust in the evaluation process, providing additional opportunities for participation, and modelling research principles.

This additional feedback phase was not incorporated into the development of the report based on the 2003-2004 interviews, as feedback from the team at the February 2004 meeting indicated that participants did not feel that separate reports were necessary at this time. However, they did wish to continue the practice of reviewing the combined report before it was made public, and this report has been reviewed by the team before being released.

In addition to the feedback strategies related to project evaluation (circulation of preliminary reports to each stakeholder group, regular reports at team workshops, opportunities for evaluation of each workshop), strategies were also designed to facilitate input into theory development. This included sharing emerging insights with the team at team meetings and the participation of the team in critiquing the draft article “Demystifying Knowledge Translation”.

STRENGTHS AND LIMITATIONS OF EVALUATION DESIGN

As indicated in the 2001-2002 Evaluation Report, the evaluation has been limited to a time series design, a method that provides only moderate internal validity. Some of the methods used in the evaluation rely on the same source of information (e.g. both the survey and the key informant interviews are based on self-report). Important threats to validity include those related to history and maturation. In this project for example, increasing emphasis on use of evidence in planning has resulted in a number of other initiatives (promoted by individual regional health authorities, Manitoba Health, and research funders for example) that could also be contributing to some of the changes observed over the life of the project. There are, therefore, major challenges in determining whether any observed increase in use of research in planning could be attributable to the project alone, to the project in conjunction with other influences, or would have occurred to an equal extent if the project
had not been in existence. There is a risk of error in either direction. First, there is the risk that one may incorrectly attribute results (events, activities, attitudes or knowledge) to the intervention of The Need to Know project (e.g., Senior management of an RHA may have already initiated changes to increase use of evidence in planning; educational events provided through the Community Health Assessment Network (CHAN) may account for increased knowledge of research concepts; greater networking around the Community Health Assessment process may account for improved relationships). On the other hand, indirect (particularly unintended) results of the project may be overlooked.

An additional challenge, (which would likely occur in many other KT projects), is that The Need to Know project was only one activity of the Project Director. Activities that she had been responsible for before the project began (e.g., development of “The First Nations Report”, and the interactive approach to the Rural and Northern Health Care Days), would have had consequences even had the project not been undertaken.

The growth of the project also presents other challenges. As the evaluator was not included in several recent events related to the project (e.g. presentations to RHA CEOs or with the Winnipeg/Manitoba Health Days), the evaluation does not address these additional activities. While regular key informant interviews provide the opportunity for team members to share concerns or highlights of such events, not all attendees at these events would be included. As the project broadens in scope, it is likely that there will be ongoing difficulties in monitoring all activities and communication. One of the risks of incomplete coverage is that the evaluator may be more likely to be informed of positive than of negative interactions, although the regular interviews with participants can be expected to identify major incidents or concerns.

Due to resource constraints, there has been limited opportunity to date to incorporate strategies to address many of the evaluation questions proposed by stakeholders that relate to organizational impact.

A number of measures were, however, taken to address some of the limitations inherent in the evaluation design. First, a multi-method design was employed, incorporating both methods triangulation and triangulation of sources. A variety of methods (key informant interviews, pre- and post-test survey, workshop evaluations, participant and unobtrusive observation) were employed at regular intervals over the time period. Information was gathered from many different sources (RHA team members, RHA CEOs, Manitoba Health staff, Advisory Committee members, MCHP staff involved with The Need to Know project, MCHP staff not involved with the project, community members and researchers across Canada who are involved in knowledge translation). The open-ended nature of questions posed in key informant interviews also helps identify unintended or unanticipated results of the project.

Second, the collaborative approach to evaluation provided additional strength to the design. The evaluation was made explicit to the team. Team members were encouraged to provide input into the evaluation questions, and to make suggestions regarding appropriate methods. Preliminary conclusions (about both project evaluation and knowledge translation theory emerging from the project) were circulated to the team for review, analysis and feedback before reports were finalized.
Third, consistent modelling of commitment to confidentiality provided an environment where a variety of perspectives could be safely shared.

**FEEDBACK TO PRINCIPAL INVESTIGATOR**

The evaluator provided documentation and assessment to the principal investigator immediately following each team meeting, along with a collation and analysis of workshop evaluations. She also attended and participated in all planning meetings. Approximately twice a year (one time in conjunction with the key informant interviews) she submitted an updated list of recommendations. Some observations and suggestions were shared immediately (e.g. if there were difficulties with an aspect of the team meetings).

If specific issues or suggestions raised by team members could be linked to a specific individual (or it appeared that there would be benefit to the Project Director in hearing directly from the person making the suggestion) the evaluator asked for permission to take forward suggestions to the principal investigator on their behalf.

**ROLE AND IMPACT OF EVALUATOR**

As indicated in the 2001-2002 Evaluation report, the evaluator identified some initial discomfort with her presence, although by end of the first year (spring 2002), there was evidence of greater comfort with both the evaluator and the explicit evaluation process. There appears to be continued good acceptance of, and support for, the evaluation. Although optional, participation in the key informant interviews remained high. Several participants volunteered positive comments about the evaluation. (“The evaluation is important, it is anonymous, safe. People trust you”. “Evaluation is helpful; I’m starting to see it as more useful after reading the report. I’m starting to get an appreciation of qualitative research that I didn’t have before.” “I like the anonymity of the interview, but you can see your comments in the report. Sometimes you think it is only you that feel this way, but then see that everyone else does but doesn’t say so”). Others stated that they were learning about evaluation through involvement in evaluation activities (“it is a learning process for me – not relying on only written evaluation, but observing, multiple methods”).

In spite of evidence of increased comfort and confidence in the evaluation, there continued to be an association of the evaluator with MCHP. While, as described in the 2001-2002 report, the evaluator had an arms length contractual relationship with the Manitoba Centre for Health Policy, many participants in discussion often referred to MCHP as “you” while speaking to the evaluator (e.g. “I think you guys have done a wonderful job”), indicating that she continued to be seen as closely aligned with the Centre. This was also sometimes reflected in comments from academics not involved with the project, some of whom were somewhat sceptical of the strongly positive reports of project satisfaction and impact. She was also occasionally directly questioned as to whether she was truly objective (or “owed” it to the MCHP to give a positive evaluation).

In contrast, the project staff team did not view the evaluation as positively. In some instances, staff interpreted concerns or suggestions for change brought forward as the evaluator’s personal opinion, and it was sometimes necessary for her to remind project staff
that her input reflected the confidential input of all team members, not a personal opinion. The role of the evaluator as an “active” team member (e.g., as a participant in team planning meetings, and in presenting at team meetings) appears to have contributed to this occasional role conflict.

FINDINGS FROM THE 2002-2004 EVALUATION

OVERALL SATISFACTION WITH THE PROJECT

All methods indicate that overall satisfaction with the project remains extremely high. Attendance at team meetings has been excellent, there has been no avoidable turnover of representatives, and there were requests from the regions to include additional participants. Workshop evaluations remain consistently positive. The three “rounds” of interviews conducted with Team members (summer/fall 2001; fall 2002, and fall/winter 2003) indicate steadily increasing confidence, engagement and satisfaction of participants (“just getting more and better”). Findings are consistent across both methods and stakeholder groups.

In both 2002 and 2003, participants were asked for their perspectives on the most important accomplishments of the project. Two key themes emerged in response to this question. The first is the development of relationships between team members (and stakeholder groups), the second relates to selection, development and completion of deliverables. Also identified as an important accomplishment was the increase in confidence of team members in their research-related role.

DEVELOPMENT OF RELATIONSHIPS BETWEEN TEAM MEMBERS

By fall/winter of 2002, the greatest accomplishments identified by all project stakeholder groups members were those of networking, team-building and relationship-building (“Reports are fine and dandy, but this is what is more important”). The role of the project in contributing to improved relationships continues to be identified as a key accomplishment in 2003-2004. The respondents that noted changes in relationships over this time period felt “that relationships are even stronger”.

Relationship change and development was explored in four areas: between RHAs and the Manitoba Centre for Health Policy; between RHAs and Manitoba Health; between Manitoba Health and MCHP; and among RHAs themselves.

Relationships between RHAs and MCHP

By fall 2002, there was strong consensus that there had been great improvement in the relationship between the RHAs and MCHP2. Some participants commented that they had no

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2 As noted in the 2002 Evaluation Report, when they joined the project in 2001, many RHA team members were skeptical about the project and often held less than positive views of researchers, who were often characterized as “aloof”, “distant”, or “not in touch with the real world”.
personal or regional/MCHP relationship prior to the project (e.g., one person commented ‘I’d venture a guess that no one knew of the Centre’s existence and what it was about before the project’).

Other comments focused on how the relationship had changed. One person commented that before the project “the idea of sitting around and chatting with researchers (was) very intimidating.” Another talked about the relationship being more personal (“there are real live people, it’s not just ‘the Centre’”). Being able to put faces to names; the ability to network and share ideas; feeling “connected”; understanding the roles of individuals in the Centre; and having MCHP staff participate in workshops were all highlighted as benefits that were not present before the project. The relationship was described as “comfortable”, “more familiar, more informal, more open”. Appreciation was given for the welcoming atmosphere created: “making us feel special, they make us feel valued”.

It was clear from several of the comments that the project has changed the image of MCHP among participants.

- It allows MCHP to show “how useful they can be”.
- Before, the Centre was “always seen as doing work for Manitoba Health, an offshoot that was out of reach for the rest of us”
- The relationship is hugely better – the Centre always had a veil of mystery about it and now it’s been lifted.
- I didn’t know I could phone, didn’t know I could approach people.
- I am coming to understand the resources available and what questions are appropriate for the Centre to deal with.
- Prior to the project, I would not have picked up the phone. I didn’t have the confidence.

A number of respondents noted that one of the concrete results of this improved relationship was greater contact with MCHP. Several commented that they now had no hesitation in phoning or emailing anyone at the Centre if they needed to, although they wouldn’t have done this before the project. These statements are consistent with results reported on the post-test survey. Review of the post-test surveys (October 2002) indicates that respondents are reporting both greater contact and greater confidence in contacting MCHP. All respondents in October 2002 (compared to only 7 of 11 in June 2001) had sought information from the Manitoba Centre for Health Policy. Six respondents in 2002, compared to none in 2001, indicate that the MCHP would be first contact for a specific research question or problem. 10 respondents described their knowledge of MCHP as “Excellent” or “Good”, compared to only 4 in 2001. Nine team members (compared to three in 2001) reported having contacted the MCHP regarding “a question, suggestion, or problem related to research in your RHA”. More importantly 91% of respondents in October 2002, compared to 27% in June 2001, stated that they “would definitely” contact MCHP staff with a question, problem or suggestion (p<.004). These self-reports from RHA team members are consistent with MCHP staff reports of requests for information and guidance.

Key informant interviews indicate that, by 2003/2004, confidence in these relationships had improved even more. There was also some evidence that the positive attitudes were being generalized beyond the project staff, or even the MCHP (e.g. one person commented ‘I feel connected with the U of M (University of Manitoba) in a way I wasn’t before”).
However, less effect was observed at the regional level. Some of the new team members joining the project reported being unaware of the project – even though it had been in existence for two years – before they were invited to join. Others found it hard to judge if the relationship development had extended beyond the individual relationships forged by team members. These issues are discussed in more detail in Section 2.7.

The “comfort” and confidence expressed by RHA team members is mirrored in comments made by MCHP staff (e.g., “I personally feel quite comfortable to call anyone”; “(s) is just one of us”). One staff person gave an example of following up a question with a region directly because she had a contact there, commenting that before the project she would have “just stopped with the answer I got from Manitoba Health”.

**Relationships between RHAs and Manitoba Health**

While the RHAs had little or no awareness of MCHP before the project began, all had well-established relationships with Manitoba Health. Unlike the MCHP-RHA relationship, which is focused on data and research, the Manitoba Health-RHA relationship has many other dimensions (e.g. funding, policy-setting and accountability). The relationships related to research creation, dissemination and utilization (the focus of *The Need to Know Project*) are therefore situated within this larger context.

How relationships between Manitoba Health and the RHAs were described by participants evolved over time. In the first two years of evaluation, there was less consensus on whether the project had resulted in a change in relationships between the regions and Manitoba Health, as many RHA team members already knew and had worked with some of the Manitoba Health participants. About half the respondents in 2002 felt that there had been no change in relationships, although a couple of these moderated their response on further reflection: (“No, not for me… I guess that’s not totally fair – because of information they have given, they have given me a better understanding of their role, data sources, and what they can provide”; “It hasn’t changed, but I’m glad I got to know (name of Manitoba Health staff) – that’s really important.”

Others felt that there had been a change, though some there were more hesitant in their response (“I guess we have – anytime you have a chance to meet face to face with people you talk to on the phone, that helps with the relationship”; “I never had a lot of contact, so it has enhanced my understanding”). Others commented that “gearing up” for the Community Health Assessment process would have contributed to improved relationships with individuals even if *The Need to Know* project was not underway.

The opportunity to get to know Manitoba Health staff as “team members” in a more relaxed setting – one which was to some extent independent of the formal roles assumed when participating in provincial networks – was perceived as a great benefit of the project (“Have gotten to know some people more, it makes me feel much more comfortable with them. There are opportunities for more team building, more camaraderie, we’re a team’, whereas at CHAN (the Community Health Assessment Network) it’s more to get a job done”; “It’s been good to get to know (name of staff)”. Others stressed the opportunity to get to know “what types of information are available”, although some continued to feel that “we don’t know what to do with a lot of stuff (from Manitoba Health), don’t know what a lot of it means”.

By 2003, these relationships were reported to have strengthened even more, and there was a change in how relationships were described. Many respondents were more strongly positive about the relationships that had developed with individual Manitoba Health team members (“especially between Manitoba Health and RHAs. I’m really feeling that that is coming along gangbusters” “I’m inclined to see Manitoba Health as more of a partner than before”). Some also reflected on these positive relationships within the context of the larger Manitoba Health-RHA relationships – suggesting that the increasingly confident relationships with Manitoba Health team members as “colleagues” may be having a beneficial impact beyond the scope of the project. Some credited the project with providing an increased appreciation of the realities (and stresses) of the responsibilities of Manitoba Health staff.

Manitoba Health team members also identified the improvement of relationships as a major accomplishment. Respondents felt “better connected” to the RHAs and (parallel to comments made by RHA team members) stated that they had a better understanding of their concerns and issues. (“I understand their concerns and perspectives better, there is more balance”; “I’ve learned, not just though the project, that there is a high frustration level, the project has confirmed it, with computer systems, lack of empowerment, workload, staffing, all these impact time for research”; “I understand the frustration of RHAs when their priorities are not picked up by government.” “I know the disparity between Manitoba Health and MCHP data poses challenges for RHAs”). Manitoba Health team members felt that the project had helped build trust, and that RHA team members were now more likely to take initiative in contacting the Manitoba Health staff that they had met through the project. (This perception was confirmed by RHA team members).

**Relationships between MCHP and Manitoba Health**

Relationships between MCHP and Manitoba Health staff involved in the project also indicate steady improvement. There were more established relationships between the MCHP and Manitoba Health before the project began; however the strongest connections prior to the project were at the “director” rather than the “staff” level.

Similar perspectives are expressed by both Manitoba Health and MCHP informants:
- More positive, even than a year ago, steady improvement, less siloing, less competition, we work together to address issues.
- Manitoba Health and MCHP were disconnected (at the staff level); there was duplication. Now we have more communication…so there is more collaboration. I see the difference in two years. The Need to Know gave us the opportunity to see they can work together.
- Feel there is a very open door between us and the Centre now. Not so many mysteries around the Centre. Personally don’t feel any barriers — at that table. We have built a culture — feel a collaborative spirit between (group) and them.

Some of the improvement appears to be the result of increased opportunities to meet and participate in joint activities, some of which may well have occurred without the project (“I see more interaction with them, but I’m not sure if it’s because of the project or whether it would have developed anyway – due to other initiatives outside of the project and just that I’ve been working here x years longer”). However, there is also evidence that the relationships have benefited not only from increased contact, but also from the type of relationships promoted by the project. There was acknowledgement that in the past there may have been hesitation or avoidance related to including MCHP in some initiatives. It was stated that this was no longer the case.
Manitoba Health team members felt that the project had helped create positive working relationships. The theme of MCHP staff being “real” (and likable) people once you had the chance to meet them was also found in this stakeholder group, indicating that preconceptions about organizations, not only about “researchers” were also being challenged by the project.

It is unclear what the benefits of this stated improved collaboration will be to the regions. The identification by all parties of difficulties some regions have in accessing and using data provided by Manitoba Health provides one opportunity for concrete collaborative action that may have direct implications for improved service to the RHAs.

Relationships among RHAs
In 2002, there was some variability in the extent to which the project was perceived to be contributing to improved relationships among RHAs. Most respondents stated that the project had resulted in improved relationships between RHAs, although perceptions of the extent of this improvement varied from mild to “absolutely, very valuable”. A number of benefits were observed: learning that similar issues and concerns were shared; finding out what was going on in the regions and “who is doing what”; sharing ideas; and knowing how to connect with people. Some of the variability in response appeared linked to the extent to which individual respondents were already participating in other Manitoba networks (such as the Community Health Assessment Network). A few felt that relationships among RHAs were about the same, that there was already a good relationship established through various committees, or that the project simply provided “more opportunities to share and network”. Other respondents valued the opportunity to interact with staff who are not part of these regular networks (e.g. the Medical Officers of Health).

There was however, significant change in this area by 2003, with a greater number of respondents identifying the establishment of a network of peers across the province as a highlight of the project (“the big thing is the relationship between RHAs”. "Now I have a key contact in every RHA in the province…I know who to follow up with and refer to this contact a lot…It’s a gateway into every RHA"). For many, these contacts had developed into personal friendships (“Relationships and friendships have been developed that extend beyond The Need to Know team”). In other words, the emphasis had shifted from the benefits of improved relationships with the MCHP (although these continued to be stated in highly positive terms), to an emphasis on the benefits of this expanded collegial network.

A key theme emerging from discussion of relationships among all these partners was the removal of barriers to cooperation which had an impact extending past the boundaries of the project. 

I have a better appreciation of the challenges different RHAs feel – not so much negative staff attached to funding decisions – like why (name of RHA) gets so much money. Now I know what they are dealing with…There is a real sharing, not the territorial piece…People are not hesitant to showcase what they are doing in fear that people will do the same thing. Previously, my experience was that things were more competitive. It is promoting KT outside of The Need to Know in different directions. It’s been a catalyst for so much more return on investment.
A Positive “Team” Dynamic
The result of these improved relationships has been a sense of “team” that transcends any of these specific areas of improvement; and participants often refer to the “team” as a positive collective that includes all partner groups (e.g., “I’m really proud of the team. There is a real partnership and such a nice one”; or “The team dynamic is working really well, things are happening among team members we don’t even know about until later”). One respondent described the greatest accomplishment of the project as “An even greater sense of team purpose, ability to work together”.

SELECTION, DEVELOPMENT, AND COMPLETION OF DELIVERABLES

Although relationship development continued to be highlighted as an important accomplishment, by the time the 2003 interviews were conducted there was greater emphasis on the accomplishment of the work completed on the deliverables (“The number one thing was the production of the deliverable. This was huge”). (Post-test survey results also indicate that deliverable development was one of the components felt to be most important to project success.) Many respondents identified the completion of the first deliverable as the greatest accomplishment of the year; others focused more on the process – emphasizing the accomplishment of coming to agreement on the process for selection of the second and third deliverables, and the topics to be included.

As outlined in the previous section, the first deliverable (The Manitoba RHA Indicators Atlas: Population-Based Comparisons of Health and Health Care Use) was completed in June 2003, disseminated, and is currently being used in the regional community health assessments. The Winnipeg Regional Health Authority (which is not one of the project partners) requested a similar report for its regions and districts; this was successfully negotiated. The topics of both the second and third deliverables (Patterns of Regional Mental Health Disorder Diagnoses and Service Use in Manitoba: A Population-Based Study, and Patterns of Sex Differences in Health Status, Health Care Use, and Outcomes of Care: a Population-Based Study for Manitoba’s Regional Health Authorities) have been agreed upon. The development of the second deliverable (The “Mental Health Report”) is proceeding well and with good support and enthusiasm from all partners: the scheduled date of release is fall 2004. One of the unanticipated findings in developing this report was that MCHP staff – who had doubts about the “do-ability” of a research report on the topic of Mental Health services – reported finding the process extremely interesting, and discovering information in the data that they were previously unaware of (“It’s very interesting. I was worried from the get-go that we wouldn’t be able to say much. I was proven wrong – there are a lot of indicators”). Some Manitoba Health team members also report the same excitement related to “discovering” new information through development of this report. Monitoring of email communication indicates thoughtful feedback on initial drafts is being received from RHA team members (sometimes in collaboration with the mental health staff in their regions), Manitoba Health, and members of the Mental Health working group associated with the deliverable.

It is important to note that the development of each report consists of many separate components (initial consultation with each CEO/region regarding topic priorities; reaching agreement as a team on the topic of the deliverable; consulting within the region on indicators/questions to be included in the deliverable; reaching agreement as a team on these questions/indicators; reviewing and critiquing drafts; developing a dissemination plan;
implementing the dissemination plan; and promoting use of the information contained in the report within RHA decision making). An early project activity – definition of districts within regions – has also been important component in both development and interest in the deliverables. Evaluation of each of these components is described in Section 2.6.1, pages 47-54.

CHANGES IN ROLE AND CONFIDENCE OF TEAM MEMBERS

The third most commonly cited accomplishment was the growth in knowledge and confidence and of RHA team members, and the increased responsibility they are taking for the project. While this accomplishment is related to the positive team dynamic described on page 36, the emphasis placed by team members on their knowledge and confidence indicates that this issue should be discussed separately.

Expectations of Project and Role
As discussed in the 2002 Evaluation Report, the 2001 interviews identified significant confusion among RHA team members regarding expectations of their role. As a result, the project directors had taken a number of steps over the year to address these concerns.

The increased comfort expressed by team members regarding their role in the project, already identified in the 2001-2002 report, has continued to develop. By fall of 2002, team members’ expectations of the project were much clearer. When asked whether their expectations of the project had changed, the majority of respondents commented that their expectations at the beginning of the project had been unclear: that they either had no expectations, few expectations, or that expectations were “open”. Those who identified specific expectations (learning more about MCHP; getting the first deliverable done and having input into it; networking) generally stated that they had been met. One person stated that involvement in the project “was everything I hoped for”; another that “I wouldn’t have thought I would have enjoyed it so much”. Responses to the 2002 post-test survey also indicated that participants felt clear about their role and expectations (Eight of 12 respondents indicated that they were very clear about expectations of RHA team members, while four described themselves as “somewhat clear”).

Others stated that their expectations had increased since the project had begun. Many of these increased expectations related to expectations of oneself as a team member (“increased ownership of my role with the team. Now I have expectations of myself”; “Have gotten higher – what I need to put into it, expect to do or learn.”). Others spoke more generally of heightened expectations of what they would get from the project (“When it started I thought it sounded interesting but now I think it has great potential for supporting evidence-based planning. When I go there I expect to learn something”; “Now I’m looking forward to using more, learning more about research”). One person stated that they now had higher expectations of how deliverables should be done in future.

Confidence in Knowledge of Research Concepts
By October 2002, participants were reporting somewhat higher confidence in their understanding of research concepts. Results of the pre/post-test questionnaire indicated that
self-rated confidence related to understanding of health-services epidemiologic research concepts had increased (20.5 to 25.8, p<.0001). Terms and concepts for which the greatest change was noted included many of the terms and concepts covered in the “Research 101” team workshop sessions (incidence/prevalence, rates, premature mortality, population-based analysis, measures of socio-economic status, and potential of administrative data for planning purposes). The 2003 interviews, combined with observational methods, indicate that this confidence has continued to increase, with “a wider understanding of research and its application” – often reflected in “not feeling intimidated” by researchers or research.

Project staff also commented on RHA team members’ ease in dealing with complex research projects. (“There was one point, I think it was on the second day, the level of conversation in the room had just elevated, they were really talking the talk, had a handle on the right kinds of questions to ask”).

The role of the RHA team members as facilitators for the Rural and Northern Health Care Day in October 2003 provided an additional opportunity for the evaluator (and other participants) to observe the knowledge (and confidence exhibited in this knowledge) displayed by team members. The evaluator noted that it would not have been possible for a stranger to determine which of the facilitators were MCHP staff and which were RHA team members – in fact, in some cases the RHA facilitator was clearly more knowledgeable about the data – its strengths, limitations and implications – than were some of the junior researchers. Similarly, it was discovered that some of the new members initially felt intimidated by their RHA team colleagues because they assumed from their experience with team discussion that most had a Masters degree or a Ph.D. in research (this was not the case).

Confidence of Team Members in Their Role
This increasing confidence of team members in their knowledge of research concepts is also reflected in increasing participation in research activities within both The Need to Know project and in other research related forums such as CHAN (Community Health Assessment Network) or national conferences.

• When I hear the team members talking, it’s just amazing. At CHAN and the other networks they are just blossoming. They have the confidence to say what they know, and ask for what they need. Perhaps that is what capacity building is.
• …I would not have even thought that I could sit down beside these researchers and have an intelligent conversation with them, nor actually use any of the research that was produced.

In 2002, however, there were differences between the extent to which RHA team members felt confident participating “as a team member in workshops” (11 of 12 described themselves as “very confident”, and one as “somewhat confident”); and confident in the role of “promoting greater use of research for planning purposes within your RHA” (3 described themselves as “very confident”, 8 as “somewhat confident”, and 1 as “not that confident”). These findings mirror the differences found between the levels of reported effect of the project (where change in “How I do my job” appears to lag behind the individual learning reported (see section 2.6.0).

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3 Participants were asked to rate themselves on each item as not at all confident (given a score of 1), somewhat confident (2), or very confident (3). Each respondent’s scores were summed to create an overall confidence measure for each time period. The differences over time were then tested for significance.
However, although RHA team members continue to report challenges in taking a lead role in their regions (as indicated, for example, by some reluctance to contact the CEOs directly), it appears in some regions that the project may also be providing team members with increased opportunities (“I had initial conversations with (CEO) re Deliverable #3 so now I have the opportunity to meet in person. Someone at my level wouldn’t normally have the opportunity to do that.”)

**Increasing Role in Project Leadership and Direction**

The increased engagement and confidence of team members has resulted in more direction from team members on priorities for the project (“people are not just there as observers any more, they are really participating and are not afraid to participate”). Several participants continue to express interest in more time for analysis, interpretation, and discussion of research results in workshops; and identify problems related to data that they would like the project to assist with (e.g., better understanding of Manitoba Health data, more consistency between data sources).

RHA and Manitoba Health team members are regularly requested to contribute their expertise and insights in team meetings. One role is to act as presenter and/or facilitator for specific sessions at team meetings. Since June 2002, the following workshop sessions have incorporated the skills and expertise of team members.

- **June 2002** (Sue Crockett, NorMan Health Region). Quality Scorecards
- **October 2002.**
  - (Deb Malezdrewich). Presentation on Manitoba Health Data.
  - Team members served as co-facilitators at Rural and Northern Healthcare Day.
- **February 2003** (Jody Allan, Assiniboine). Research Utilization Models
- **June 2003.** (Bev Cumming, Brandon). Facilitated “Research in RHAs” discussion.
- **October 2003.** Rural and Northern Healthcare Day.
  - Presentation on *The Need to Know* team by North regions, South regions, and Manitoba Health representatives.
  - Team members acted as lead facilitators for regional discussions.
- **February 2004.** (Catherine Hynes, NorMan). Participation in Poster making workshop (sharing ideas based on successful work in this area).

The role of team members in presenting and facilitating at team meetings has been positively received. Team meetings also provide the opportunity to share expertise and highlight RHA achievements through activities such as presentations on dissemination plans, reports on conferences attended, or in general discussion.

Although the North/South/Manitoba Health meetings are held in camera, it has been observed that by 2003/2004, more time was spent in these meetings than at the beginning of the project, and that the representatives have been bringing clear recommendations forward to the Advisory Committee. Inclusion of the team representatives in planning for team meetings (the first such meeting was held in December 2003) is to continue.

**Addition of New Team Members**

Although, by early 2002, team members were expressing greater confidence and engagement in their role with the project, there were a number of difficulties noted with the role of
“unofficial” team members. This role was not well-defined. Team members sometimes reported that unofficial representatives felt “left out”. They reported that they did not get all the information that “official” members got (e.g. confidential drafts of deliverables in development). Concerns about the need to increase capacity at the organizational level – expressed by both team members and the RHA CEOs – also created pressure to increase the total number of representatives from each RHA. Concerns were also expressed about the vulnerability resulting from relying on only one person from each region.

As a result, a decision was made in early 2003 to increase to two the number of “official” representatives from each RHA, and most RHAs have taken advantage of this option. Benefits and expectations are now the same for all team members: all are expected to attend team meetings, engage in “homework” activities in their regions, and represent the project in related activities. Several “new” members already had some exposure to the project as the optional “unofficial” representative. However, they reported a change with being made official (“I feel better, more a part of the team. (We) work closely together, but there was a distance before”). Other team members were completely new to the project. Most of these new members were somewhat anxious about their role in the team when they first joined (“Initially I felt behind, forever catching up”), but report greater confidence at this point (“I was confused at first but it all makes perfect sense to me now”).

The formal orientations for new members, described in Section 1.1.1, were well evaluated. Initially only “new” members were invited to attend, but feedback from some of the “unofficial reps” who joined as the second team member (including those from Manitoba Health) indicated that many of them also wanted the opportunity for formal orientation (“Don’t assume we have the background”). As a result, the orientation session was also made available to these participants.

There was good support from all stakeholders for the decision to expand the team, and confidence that the new team members have been incorporated well. While initially proposed to help ensure continuity in case of staff turnover, the greatest benefit to an additional member identified by many RHA respondents is that of providing increased support and potentially greater impact at the regional level. For example:

- The key thing with a second person, it helps me bring the message home. Increased support. Practical and moral support, sharing the workload.
- Have another person to bounce ideas off of, back you up at meetings.

An additional observable benefit is the addition of an often vastly different perspective brought by the new member regarding the same RHA. Participation of the new member has sometimes identified potential areas of regional activity not previously addressed. This suggests that continuing to increase the number of regional staff who are aware of, and involved in, project activities (through strategies such as site visits and Rural and Northern Health Care Days) could result in expanded benefits.

With the exception of occasional room crowding and the challenges of ensuring that all have the opportunity to participate in discussions, few respondents identified any disadvantages to

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4 Due to the amalgamation of the Marquette and South Westman health regions, the Assiniboine RHA already had two established members at the time this decision was made.
the increased team size. A few respondents, including some CEOs, mentioned the resource/cost demands of sending the second representative, but felt that this was a worthwhile investment. A potential disadvantage of the additional representative identified by project staff was that there might be “a temptation to have one person skip out on parts (of the team meetings) because you are sure that there is someone covering for you”, although to date there is not evidence of this.

Role and Participation of Manitoba Health Team Members
Interviews conducted at the end of 2002, indicated that some respondents wondered whether Manitoba Health Representatives felt that they were “part of the team” or if they felt “like add-alongs”. The 2003 interviews also indicated that sometimes Manitoba Health representatives did feel that activities were directed towards the RHA team members (e.g. some interpreted the agenda item entitled RHA facilitator training at the October 2003 workshop, to mean that it was not necessary for them to attend this session, even though the Project Director had intended that they would act as facilitators for the Manitoba Health table.) While there was indication in recent interviews that some of these concerns had been addressed (“I see there have efforts to include Manitoba Health, it’s hard to know how they feel.”; “There seems to be a conscious effort to include (MB Health) in various activities, more in the forefront, not just hang-ons”), there remains continuing interest in ensuring that project activities include appropriate roles and opportunities for Manitoba Health team members.

OTHER ACCOMPLISHMENTS

Other accomplishments identified by evaluation participants included:
a) the increased attendance at Rural and Northern Health Care days;
b) the role played by The Need to Know team members at these days (“the sophistication of the day is astonishing, in just two years how it has matured.”);
c) the emergence of The Need to Know project as a prototype for interaction between academics and community partners;
d) the continuity of attendance; and
e) the increased profile of MCHP outside of Winnipeg.
In addition, one person identified signs of impact at the regional level (“Increased connection between research and policy.”)

SUMMARY

There is a great deal of consensus between all stakeholder groups on the accomplishments of the project. By 2002, the development of relationships was perceived as the greatest accomplishment; it appears that the development of a cohesive team has played an important role in achieving the most commonly identified accomplishment of 2003 – the development of the deliverables. A number of other accomplishments were also highlighted – including the growth in research knowledge and confidence of team members.
SPECIFIC PROJECT COMPONENTS

The Need to Know project consists of several distinct components. As indicated in the 2001-2002 report, in addition to overall assessment of the extent to which the project has met its objectives and participant expectations, it is also important to evaluate each of the components separately. This section, therefore, reviews evidence related to the effectiveness of each of the components.

TEAM WORKSHOPS

All respondents reported high satisfaction with the team workshops, the majority describing themselves as “very” or “extremely” satisfied. Several also commented on how well organized the workshops were (“I’ve never been to anything so well organized and that makes you feel so welcome”). Workshop evaluations remain consistently positive and the majority identified the team meetings as one of the most important components of the project in the post-test survey.

The majority of participants did, however, qualify their response to make an exception of the CCHS workshop in June 2002. While this was viewed as an anomaly for which the Project Director was not responsible, one person did comment on the importance of ensuring that the project continued to respond to participants’ interests and needs. The lower level of satisfaction reported for some other workshops that were not offered by project staff or other MCHP researchers highlights other important issues related to meeting effectiveness. “In house” workshops provide the opportunity for the Project Director to tailor presentations to the interests and level of the group, and to pre-screen presentations. The same option is not available for workshops that are “contracted out” to others. This suggests that one factor in the success of team meetings is the direct and consistent involvement of the Project Director. It also highlights the importance of reflecting adult education principles (including responding to the interests and knowledge of participants) in knowledge translation activities.

Attendance at meetings has been excellent; complete absences have been noted only in the occasion of illness: partial absences (e.g., a few hours) remain uncommon, and are generally the result of conflicting work commitments. As indicated in the previous section, the only loss of members has been related to team members leaving their employment at the RHA – this is another indication of high satisfaction. Some members have stated that they schedule their vacation in order not to miss the team meetings.

Topics of highest interest are those related to either a) deliverable development and analysis, or b) skill building workshops (e.g. Survey Development 101). These “101” sessions were in most cases delivered by the Project Director and developed or adapted specifically for this group. Computer-related sessions receive a more variable response, although they also have a positive rating.

The variability in satisfaction with computer-related workshops may be partly attributable to the differences in computer confidence/skill reported by participants. Some participants...
continue to report lack of confidence in their computer skills, although the overall self-rating
improved from 2001-2002 (6.4 to 7.45, p<.02). Another issue – acknowledged by both staff
and team members – may be the challenge related to bridging the gap between the
instructors – who have generally high computer-related knowledge – and the RHA team,
some of whom have limited exposure. (“X is very good at what (s)he does, but I just don’t
understand her”; “those aren’t necessary the people to do the workshop – they take things for granted and
gloss stuff over”). Some respondents suggested that more time was needed to solidify skills
developed in the workshops. One response to this suggestion was the provision of an
extended practical session at the February 2004 workshop (making a poster using
PowerPoint).

Another aspect of team meetings, highlighted by a number of participants, is the opportunity
to hear directly from researchers about recent research, or research in progress (“Their reports
then seem more complete, there is something about it that makes it real somehow”; “If it hadn’t been for the
presentations, I would have read the summary, not the whole reports, would have filed them, now the reports
are more personal”). A number appreciated the “heads up on reports that were being worked on”, as
well as the opportunity to identify individual researcher areas of expertise, and develop
confidence in knowing who to contact for particular issues. Another commonly identified
highlight was the inclusion of guest speakers – appreciation was noted not only for the
presentations themselves, but for the opportunity to network with individuals that they
probably otherwise would not have met.

Use of adult education principles, the “quality of teaching”, “fabulous teaching ability”, and the care
put into planning of workshops continued to be identified as key elements. In addition,
several respondents commented on the atmosphere of the workshops and the opportunity
for networking they presented. (“the camaraderie, the enthusiasm”, “being made to feel welcome”,
“getting to know what people do”, “people are able to speak freely and openly”). Several commented that
they “look forward” to meetings, in contrast to some other regular meetings they participate
in. (“As the date gets closer, I actually start looking forward to it”; “a treat to be involved”).

The opportunity to discuss issues with peers was also considered of importance and some
respondents indicated that they would like even more time than has been allocated to date
for discussion (e.g. discussing deliverables). The most recent workshop (February 2004) has
begun to implement these changes, and there is continuing expression of interest in ensuring
appropriate time for discussion (e.g. one respondent stressed that is was important to “give
people the opportunity to critique, offer feedback, not just rubber stamp” the deliverables).

Some respondents commented on the advantages of scheduling the workshops “back to
back” with other provincial meetings attended by several of the participants, the format
adopted to date. However, it was also acknowledged that this can be tiring, and that time
was needed in the day to “catch up” on RHA business. Lunch hours are used for
personal/RHA business by some participants, and a decision was made to end the workshop
days somewhat earlier in recognition of the needs of team members to remain in
communication with their regions.

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5 Participants were asked to describe their level of computer related skill in three areas as none/poor (given a
score of 1), adequate (2), good/excellent (3). Each respondent’s scores were summed to create an overall self-
rated ability measure for each time period. The differences over time were then tested for significance.
It is important to note that the team meetings are central to all other project activities. Aspects of all project objectives are addressed in team meetings (creation of new knowledge, development of RHA and researcher capacity, and communication, dissemination and application of research). They are the focus for creation of new knowledge as they provide the setting for selecting the research topics, determining report content and focus, critiquing drafts of the reports and analyzing and interpreting the data. They are the setting in which most of the “capacity building” of both RHA team members and researchers takes place. Even the website depends on computer-related workshops and practical demonstrations at the team meetings. Team meetings are also a forum for discussion and development of strategies for dissemination and application. Most importantly, the atmosphere generated at the meetings has been fundamental to achieving the relationship and network development identified as a key project accomplishment.

The “Team Suppers”
On the first evening of each team meeting, a supper meeting is held at a Winnipeg restaurant. Several respondents made comments to the effect that they never would have thought these “social” events could have been so important. While many had the initial response that these were “nice to do” (a “perk”), they have emerged as an important component in their own right. As one participant observed: “To see that kind of rapport – I think it is in large part due to the social evening. It’s brilliant. Worth whatever it costs. The first time I went, I have to say that I thought ‘gee, this is a lot of money’. But it’s worth every penny, the cohesiveness that’s resulted”. Similarly, one of the MCHP staff said: “I can see now (the Project Director’s) emphasis on the dinners. I thought at first it was a little odd. Now I see the point of it”.

Given the costs of social events for a large group, such activities may be the first ones “trimmed” from a research budget. However, if, as indicated by this project, development of trust and genuine interpersonal relationships is essential to effective collaborative research, then strategies must be developed to facilitate and reinforce such relationships.

Suggestions for Future Workshops
The number of specific suggestions for workshop topics made by participants has decreased since the project began. Comparison of responses to the pre- and post-test survey indicate that in 2001, a total of 30 suggestions were given in response to the question “On what topics related to health research and RHA planning do you require information at this point in time?” compared to only eight in October 2002. Given the high satisfaction expressed with the workshops, and positive comments made regarding the responsiveness of the project to providing coverage of topics identified as priorities by the team, this may indicate that many specific needs have been addressed. During the key informant interviews, some participants commented positively on the responsiveness of project staff to concerns and recommendations made by team members regarding the team workshops. This included adding topics identified as priorities by team members (e.g. Ethics 101), and allowing longer time periods for discussion (“fewer topics, more depth”). The positive rating given to almost all workshop sessions can be partly attributed to this responsiveness.

At this point, many suggestions for future workshops focus on helping the RHAs address challenges related to facilitating change in the regions. This is consistent with comparison of pre-test (June 2001) and post-test (October 2002) responses to the question What are you hoping will be accomplished through this Need to Know process? In 2001, most responses focused on
individual learning (e.g. *to explore how we can understand and use our RHA data*), or on development of deliverables (e.g., *increase the data that is available for RHA research/decision making process*). Only three of 10 respondents who participated in both the pre and post-test survey focused directly on development of capacity at the RHA level. Among the same respondents in 2002, eight of the ten gave responses that focused on change at the RHA level (e.g. “My region plans based on evidence”; “Decision-making will be evidence-based”).

Collation of suggestions (from workshop evaluations, key informant interviews, and unsolicited suggestions) has identified the following topics as being of greatest current interest:

- **Organizational capacity building and research** (This issue is discussed in section 2.7.0). This includes developing more RHA responsibility for “carry through” of project activities (e.g., establishment of working groups; looking at methods that would lead to incorporating *The Need to Know* processes into RHA activities; or identifying strategies – additional to the Community Health Assessment process – of linking project activities to regional needs and activities).
- **Manitoba Health Data** (making it more “user friendly”, “how to read it”, “comparability”, “guidebook for Manitoba Health reports”, “definitions”).
- **Deciding on and planning site visits**. This issue is discussed in section 2.5.3.
- **Revisiting dissemination planning**.
- **Taking it to the next step; interpretation of data** (“Take a topic and give an example of where the information is found and how it is used. E.g. on diabetes. Bringing in other kinds of research, other studies. How to bring all this stuff together”; “People are looking for, getting into the interpretation – what does this mean for our region?”; “Training in how to interpret data, that is a gap”).
- **Strengths and limitations of various types of research** including inherent biases (“deciding what methods to use”; “how much weight to give to different kinds of data”). There was some concern that the team be exposed to a broad variety of research, and not simply focus on research of immediate direct interest to the RHAs.

As this list indicates, many of these requests relate to the challenge of actually applying (or utilizing) research, and increasing organizational awareness and capacity at the regional level. Other issues have implications for organizational change in other systems (e.g. suggestions related to Manitoba Health data). The focus of greatest interest in skill development is that of “interpretation of data”.

Other areas of interest included: a) information and access to Aboriginal Health data; b) more information/discussion about mental health concepts and data (e.g. challenges in mental health data, differences between this and CCHS data, difficulties in merging data.); c) facilitator training (both related to skills in working with groups and preparation specific to mental health concepts) in preparation for Rural and Northern Health Day. In addition, one or two requests were received on the topics of d) Searching out literature when evaluating a program or change, e) effective lobbying, g) more advanced research concepts, and f) computer skills (e.g. Excel).

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6 More time for planning for facilitation with the RHA team members was also identified as an interest of some MCHP researchers.
In terms of format, there was a general sense that the template that had evolved for the team meetings was effective, and that the right balance had been achieved in topics, time and format. However, the theme “more depth, fewer topics”, which the staff team has begun to respond to, requires ongoing attention. Many participants find the discussion time the most valuable, and want more time allocated to discussion (e.g., “we’re just getting into these really good discussions, and then the time is up and we’ve moved into something else — O.K., but not so interesting. I would like to see more flexibility in the agenda — this is what we’re about”). Such comments appear to reflect the growing confidence and engagement of the team, less need for “one way transfer of information”, and greater interest in ensuring time for discussion and interaction.

There is interest in continuing to have regular reports on recent and upcoming research activities from the researchers involved. Felt to be equally important are sessions where participants “can learn from other RHAs” – suggesting that the opportunities for leadership from RHA team members could be expanded even more. Several participants, not only new members, requested regular reviews (or reminders) of key statistical/research concepts throughout the sessions (“ensure the way we are reading the data is correct; how to do analysis and compare it with other data if that doesn’t say the same thing”, “a little review before data presented”). There is also an interest – particularly on the part of Manitoba Health members – in having equivalent activities for all partners (i.e. assignments that are not appropriate only for the RHA team members but where all partners, including Manitoba Health and MCHP have a role).

Rural and Northern Health Care Days
The relationship between The Need to Know team and the Rural and Northern Health Care days is not clear cut. These research days were established before the project began, and had already adopted the format that has continued with the addition of The Need to Know team members. However, it is less clear that the continued growth in numbers of attendees would have occurred to such an extent without the participation of project team members. There was a significant increase in attendance corresponding with the initiation and development of The Need to Know Project, as indicated in the graph below.

Attendance at Rural and Northern Health Care Days 1997-2004
From the perspective of *The Need to Know* team itself, the Rural and Northern Health Care Days are of importance as they provide a forum for dissemination of research, an opportunity for RHAs to discuss research with other from their region, and the potential to promote greater organizational-level participation (addressing some of the concerns raised by RHA team members). For the 2002 Rural and Northern Healthcare Day, team members assisted with facilitation of the regional discussion “tables”; in 2003 they played the lead facilitator role. The importance of Rural and Northern Health Care Days was noted by a number of RHA team members, and there was positive response to their role as facilitators (“it elevates my role as a Need to Know person by having us be facilitators”).

These Rural and Northern Health Care Days are positively evaluated by both *The Need to Know* team and other RHA participants, with almost no recommendations for change. In 2003 there was record attendance, written evaluations were very positive and observation of the session indicated a high degree of interest and attentiveness (“Did you notice – you may not have – that you didn’t hear pagers or cell phones ringing. People weren’t running out to take messages; they weren’t working with open briefcases. I saw their attention”). Both MCHP staff and the RHA team members expressed positive perceptions of the role the RHA team members played as lead facilitators – this demonstrated to researchers the capability of the team. One MCHP staff person assigned as a facilitator commented that she “didn’t need to do anything” – the RHA team members were capable of facilitating the groups by themselves.

Several aspects of the day were found to be useful – a key factor appeared to be provision of an opportunity for staff and board from a region to sit down together in discussion of research (which may be difficult for senior staff to find time to do on a regular basis):

- I found that some board members and others could suggest causes. I got insights from them. Generally we never meet in those kinds of groups.
- It provided an uninterrupted forum away from the crisis and everyday demands. Otherwise the reports would just sit in a heap.
- What it did for us, we could sit together at one table. The board chair was so enthused about the session; he gave a report at the next board meeting, and that was a big step.
- It’s not often that we have the opportunity to have a dialogue with board members.

As indicated earlier, this successful format has also been adopted for equivalent days with both the Winnipeg Regional Health Authority and Manitoba Health.

**DEVELOPMENT OF DELIVERABLES**

Development of the three project deliverables is central to the project. As indicated earlier, this component is composed of many distinct activities.

**Definition of Subregion Boundaries**

One early activity undertaken by the project, which has been essential to the positive reception (by the team and within the RHAs) of the RHA Atlas, was the process of defining regional sub boundaries or districts⁷. Awareness of the importance of this activity, positively

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received by the team at the time, has grown and there continues to be discussion of the advantages and limitations of current district definitions. For some participants, the “the greatest benefit” of the RHA Atlas was to “get district level data”. Comments indicate that several regions are “discovering” new things about their region because of this district level data, and that this new information is being considered in planning. For example, one region had originally declined to make any district subdivisions. When, after discussion with The Need to Know staff, it divided the region into three districts, data analysis revealed that residents of one district were significantly less healthy, and showed different patterns of service use. This provided important information for health service planning.

Consultation in the Region
Consultation – about either the topic of the deliverable, or the actual development of the deliverable – appeared quite variable among RHAs. Some team members reported that they had not done any consultation (either with CEO or with mental health staff on the second deliverable) even though this was an expectation of the project. (“I decided that the timing was really bad, decided to leave it for now”. “I went up through my direct boss, it gets up that way”). The 2002 post-test survey asked whether team members had consulted with their CEOs as requested for one of their assignments. Only three of 11 had done so at that time; and only six of 11 had consulted with anyone within their region. This was reflected in a failure to get back to the project staff team (on suggested topics for example) by the assigned deadlines, and staff concern that they were “not hearing back from the regions”. Reasons given for failing to consult included both time constraints and lack of clarity about the activity. However, the key informant interviews conducted at around the same time indicated that some team members lacked confidence in approaching the CEOs. The experience of consultation (and reasons for lack of consultation) were not discussed in the team meetings, and the extent to which RHA level consultation is occurring is an issue that requires monitoring.

At the time of the 2003 interviews, most – but not all – RHA team members reported meeting with the Mental Health Director/manager of their region, and several reported meeting with other mental health staff. For some consultation was limited to one meeting, while others reported maintaining ongoing contact. The degree to which consultation within the RHA was being used as a strategy to raise awareness and interest in the deliverable within the regions also seemed variable.

Selecting the Topics and Indicators
For several respondents, it was the process of “agreeing on deliverables”, and the discussion of the “pros and cons” of choosing them that was the greatest achievement. In general, participants were satisfied with the process of selection of the 2nd deliverable (“The Mental Health Report”), the process for which was described in the previous section (1.1.0.2). Many had no concerns or suggestions (“couldn’t think of a better process”). There was a general feeling that there had been good opportunity for discussion and participation in development of the first deliverable (“a lot of input into selection of indicators, and the opportunity for preview of results as they were being generated and offer insights on preliminary interpretation”). Some respondents commented positively on the strategy of bringing in speakers to address the potential of the various topics. Some specifically referred to their expectation of the role MCHP should play in the selection process because of their research expertise. “The Centre needs to decide what’s doable” one person commented. Most respondents felt that “everyone had had the chance for input”; that
the selection of a topic was “democratically done”; and that the group “never felt we had particular topics stuffed down our throats”.

However, some suggestions were made for planning selection of the third deliverable. It was discovered that not all respondents were clear on how the first deliverable had been selected (it had been decided by the CEOs as the original funding proposal was being developed), and some of the respondents interviewed before the selection of the second deliverable expressed concern about the process for coming to consensus on the research topics. Those interviewed following the workshop were generally satisfied with the process, although some felt that the project could have developed a process that required greater consultation within the regions.

One RHA team member felt that there should have been an additional opportunity to consult following the October 2002 workshop – “at the shortlist stage”, and had concerns about “voting on behalf of the organization”, without the opportunity to check back with her RHA. Another felt that there should have been more opportunity for discussion within the group before the voting took place; that the process was too rushed for a good understanding; and at least one person felt pressure to agree with the majority. Comments made by respondents indicate that they felt it was important for project staff to:

1. Increase opportunities for consultation and discussion within the region prior to selection of the third deliverable (Greater attention to this was paid in selection of the third deliverable); and
2. Ensure adequate time for discussion of alternatives within the workshop session in order to continue to demonstrate commitment to collaborative planning and mutual learning.

Even though there were a greater number of potential topics proposed for the third deliverable, the process of selection (a refinement of the process used in selection of the second deliverable) went smoothly. This may be due in part to the greater awareness by participants of process to be employed: while there may have been variation in the degree of internal consultation within each RHA, team members were aware of the both the expectation of consultation, and were given time (and reminders) to do so. At the October 2003 meeting, the question of whether groups such as the RHA CEO group (RHAM) or HPSFN (Health Programs and Services Executive Network) should be consulted was raised. Discussion of this issue, both in the larger workshop and in the North/South/Manitoba Health groups, resulted in agreement that the consultation was to occur within each RHA, with the final recommendation coming from The Need to Know team itself.

While most informants highlighted the importance of reaching agreement on the topics of the deliverables, some respondents also highlighted the achievement of “coming to agreement on such a large number of indicators”; “Going through what we really need to know about mental health”.

**Review and Critique of Reports**

Review and feedback on draft sections of reports by team members between team meetings also varied considerably between RHAs – a minority of team members gave feedback by the dates requested by project staff. Significant time was allocated to discussion of the drafts in team meetings. These sessions generated a great deal of discussion, suggestions, and enthusiasm, and were generally the most positively evaluated sessions of the two-day workshops.
Dissemination of “The RHA Atlas” (Deliverable #1)

Development of dissemination plans
In preparation for release of “The RHA Atlas”, each team member was asked to develop a dissemination plan for her organization. As a result of this activity, several RHAs developed plans for their regions, and MCHP added contacts to its distribution list based upon input from RHA Team members. (Manitoba Health also incorporated a round-table discussion of “The RHA Atlas” and a 1½ hour discussion on internal dissemination and application of research reports in their March 2004 Manitoba Health Day).

However, the key informant interviews indicated that there was great variability in the extent to which regions developed and implemented these dissemination plans, and in the strategies for dissemination used in each region. Some team members reported using the region’s “standard process” (which is in some cases was quite limited), and acknowledged that they had not made much progress on the dissemination plan. Others referred to implementing the dissemination plan they had developed. Some gave examples of their personal efforts to promote dissemination, while others played no direct role. Some appeared to feel constrained by the factors related to how information was managed within their RHA (“The CEO decides what gets passed on”; “Hasn’t been much taken up yet except by the VP and CEO”).

The 2002 Rural and Northern Health Care Day served as important means of dissemination, as all attendees were given copies, and the RHA Atlas was the topic of both the morning presentation and the RHA table discussions. The extent to which staff in the regions were made aware of the report (and may have taken action to order more) may reflect the initiative of some of these attendees, not simply action taken by The Need to Know team members through their dissemination plans.

Dissemination of reports and data files
A number of difficulties were experienced in determining the number of hard copies of the RHA Atlas that were distributed, and in comparing this with distribution figures for other deliverables. Systematic attempts to track MCHP deliverable distribution were only established in 2001, and there are still difficulties in obtaining accurate numbers. There is some indication that the actual number of hard copies distributed may be declining, as more users access PDF files from the MCHP and The Need to Know websites.

2000 copies of the RHA Atlas (the first collaborative research report) were printed in June 2003, with just over a thousand remaining in stock by February of 2004. From April 2003-March 2004, this report made up 49% of all MCHP reports distributed.

There are also a number of difficulties experienced in tracking website hits. While the number of “downloads” of specific files can be monitored, it is unclear what each “hit” represents. Some deliverables come as partial downloads. In addition, some of the requests represent hits from search engines during routine scanning, and from other random and periodic access to files.

A total of 1485 successfully competed downloads or requests were documented for the RHA Atlas from June 2003 to February 2004. A total of 574 requests were made for the
report on *The Need to Know* secure web site. As this area of the web site is password protected, any use of these files can be attributed to team members.

The RHA Atlas was made available publicly on the MCHP web site on June 12, 2003. There was a quick uptake of the report as the highest number of completed requests for the report (688) was received in June. The number of requests then declined steadily until October 2003, following which they remained stable at about 45 per month. The immediate demand may indicate the effectiveness of actions taken to improve dissemination (e.g. updated contact lists and email notification adopted by MCHP, and dissemination plans developed and implemented by team members), as well as the timeliness and relevance of the report to provincial activities – specifically the Community Health Assessment process. Other MCHP deliverables released in 2003/04 resulted in a range of from 298-500 web requests in the first month, falling to an average of 45 requests a month within two months after release. The total number of requests for the RHA Atlas was exceeded only by those received for the “First Nations report”, a report of national interest. (It is important to note, however, that the First Nations report is saved in multiple files, with the result that there is very likely “over counting” – total downloads may, therefore, not be higher than those received for “The RHA Atlas”).

There is evidence that the release of “The RHA Atlas” was followed by more detailed examination of data – in other words, that the release of the report (dissemination) promoted research use (interpretation) within the regions. While demands for “The RHA Atlas” peaked in June 2003 (the month the report was released), requests for data files related to the report (5853 requests from 730 hosts over the period of April 2003-February 2004) peaked in the following October. Requests rose from a low of 195 in June to a high of 2117 in October, at which point they fell to around 300 a month. The “lag” between report release and access of data files is the pattern one would expect – first the report is read, there is then more in-depth investigation of the data behind it. This suggests that the reports and data files are being used for ongoing exploration of regional and district data.

There was a noticeable increase in requests for both the reports and data files in September/October 2003. This coincides with the fall Rural and Northern Health Care Day (held on October 7); it may also reflect a return to regular planning activities following the summer holiday months.

**Response to dissemination of The RHA Atlas**

In spite of the evidence related to report dissemination, many RHA team members felt that a better job could be done with dissemination for the second deliverable and several suggested that this topic should be revisited before the Mental Health Report was released. Some were disappointed that the deliverable had “not filtered down more”.

- **We stalled out – did well coming into planning and evaluation. I think we should have accompanied it.**
- **We need to revisit dissemination before the Mental Health deliverable is released.**
- **We need to look at where we want to go, identify key points of how to hook them in. Time is needed to get to know what’s in it.**
- **They (Management) had the impression that it was distributed, but we know it doesn’t always get done – it stops at management.**
Many would say that they did distribute reports but this was often in the form of CIRC (circulation) folders; people didn’t necessarily pay attention.

Some respondents specifically identified physicians as a group that should be included in dissemination planning. As, in some cases, team members did not have the authority to implement the dissemination plan, the issue of dissemination was acknowledged as one that required an organizational level response. This issue is discussed in more detail in section 2.7.

Some team members were disappointed in the media coverage “The RHA Atlas” received, and are hoping for more attention to this issue as “The Mental Health” report is released (“Being prepared to have media attention was a big thing. It was a bit disappointing that we weren’t called, but this was the first time”). It was also suggested that as the Mental Health report was a “different kind of report”, it required different kinds of planning for its dissemination.

Use of Reports
In spite of concerns about dissemination, many team members feel that the RHA deliverable is used more than a similar report would have been. The collaborative process used in its development is one reason given for this:

- It’s made us use it. I think of all the reports that are just shelved. Without the project the reports wouldn’t have been viewed as valuable.
- If we just got it through the mail, we may not have paid so much attention to it.
- The report was just a bunch of paper before: this made it come alive.

However, another key factor in use of “The RHA Atlas” appears to be its central role in the provincial Community Health Assessment (CHA) process, and the support given it by Manitoba Health staff (“In our unit we see two significant resources for the RHAs – the Atlas is one. We expect them to use it; we refer to it. In all communication the Atlas is mentioned”).

Some team members gave specific examples of how The RHA Atlas was being used: as may have been predicted, the general perception was that use of the reports was facilitated by the “connect with the CHA process”. As – as was noted in the 2002 Evaluation report – the staff team made a concerted effort to complete “The RHA Atlas” deliverable ahead of the originally scheduled release date in order to meet revised timelines established by the province, it is useful to note that the Atlas was indeed central to this activity.

- At the board retreat, we are using it a framework for the Community Health Assessment. It’s the basis of the media package we are putting together.
- Portions of the report are going to each of the planning teams. The plan is that these teams will be ongoing, need a plan to build capacity within those who are now excited by the process.
- We used it to prepare for the performance deliverables for Manitoba Health.
- In meeting with regional health managers. We are using it extensively.

Some team members also gave examples of how they used the resource in their own work. One person stated that she always carried the Atlas with her – “It’s amazing how often questions come up and I find I refer to the Atlas”.

Response from Manitoba Health
Manitoba Health team members were generally as positive about “The RHA Atlas” and the process of developing it as were the RHA team members. Much of this support appeared to be attributable to its direct use in the Community Health Assessment process, and the fact that having the Atlas available “made Manitoba Health’s job easier”.

- It was wonderful because it preceded our profile document...helped in getting the regions up to speed—all that had been done by the project. When our document came out, they had an appetite for it already, the feedback has been very good, and I think that’s because they were ready.

There was, however, acknowledgement that there could have been greater or dissemination of the report within Manitoba Health itself. (As previously described, the March 2004 Manitoba Health Research Day highlighted this issue). Some team members relied on “standard dissemination” within their unit; however others described their own dissemination plan—e.g. distributing it to program areas. Some respondents also report using it in a variety of ways—not just for Community Health Assessment activities but also in activities such as preparation of advisory notes.

Response from MCHP
In general there is good support for the deliverable and the process of its development from MCHP staff. For example:

- My impression is that it (The RHA Atlas) was comprehensive and user-friendly. The Mental Health deliverable is topical because of the national reports.
- The greatest accomplishment? The release of the deliverables, getting through it and getting the buy in from the RHAs.
- People have a lot of questions, these must be addressed. There is a need to establish credibility. It’s (The RHA Atlas) a perfect starting block, it gets attention, then people can move to the next level.

However, it is important to note that a number of MCHP researchers not on The Need to Know team expressed some reservations about the RHA Atlas:

- Very rote. Not much to be learned re: preparation and analysis, doesn’t lend itself to other innovations. Is it holding back methodology? That is my personal bias but I see the need for similarity for ease of interpretation.
- Cookie cutter template, but this is appropriate.
- The Atlas is not put together the same way as other centre deliverables. I do have some quibbles with it the way it stands. There are two kinds of things involved—RHAs looking at themselves and also comparing themselves with other RHAs. When doing the Atlas these things go by the wayside, they are not highlighted. It needs more interpretation, action options. Indicate what now needs to be considered. I think I know why (it wasn’t done), didn’t want to be presumptuous. But it’s a gap. Another part that is missing is an overview—where areas or the same or different—the big picture. This may mean that it takes more time, to meet with and discuss with the group, make one’s own observations and recommendations.

Staff involved in development of the deliverable also discussed some of the challenges in producing the report. (“They (the RHAs) are so starved for information; they didn’t want to drop anything. But I wouldn’t make dramatic changes; we’re doing a better job this time of data management”).
Project staff also seemed aware of some of the concerns of other MCHP researchers. There was reference, for example, to “getting constant static about the size of the deliverables from Centre staff”. The differences in response to “The RHA Atlas” by some MCHP researchers and the reception of it by Manitoba Health and the RHAs appear to reflect some of the differences in priorities between researchers and intended users of research.

It is important to ensure that researcher concerns are addressed as the project continues, and to resolve differences in perspectives in ways that contribute to research that is both high quality and “accessible” to users. There is some evidence that the project is providing an environment where the “tension” between researcher and user priorities can promote creative responses that result in increased quality of research, as illustrated by the following example provided by one of the project staff.

One of the statisticians/programmers was not content with how age/sex adjusted rates were being used, and how differences were being tested, in analyses for the Mental Health report. During the course of development of the report, she realized that her way of analyzing data was of little practical use to planners, and so developed a methodology to statistically model the rates to adjust for age and sex, while at the same time maintaining simple statistical testing approaches that would be understandable by planners. The result is that, although the graphs “look the same” as those used in the RHA Atlas, they are supported by a much more complex methodology. This method will be incorporated into the third project deliverable.

The Role of Relationships in Deliverable Development

Analysis of response to the work on the project deliverables highlights the inter-relatedness of “relationship development” and “deliverable completion”. Many participants believed that the positive relationships developed over the first year of the project were essential to the success of the work on the deliverables. Several identified the selection of the topic of the second deliverable as a critical point in project development. This is because, while it became evident in the discussions that “Mental Health” was not the choice of the Principal Investigator (in fact she had a number of concerns about proceeding with it), when this topic emerged as the priority of the team, the project staff proceeded with it without question or complaint. The decision to respect the group process and the topic resulting from it was interpreted by many on the team as a demonstration that the MCHP was “serious” about collaboration, and that the partnership was genuine. (“I have to say that it’s wonderful that (the Project Director) allowed us to choose the Mental Health deliverable when it wasn’t her first choice. It showed the Centre’s commitment to the project.”)

Summary

A great deal of pride was expressed in the product of the completion and release of “The RHA Atlas” (“It’s not just lip service, I feel like we are really stakeholders.”; “I’m amazed it’s come to this stage. I’m impressed with the work of the Centre, finding out what’s available”).

Workshop evaluations also indicate that the sessions that are consistently most highly evaluated are those related to discussion and analysis of the deliverables. That the “hard work” of developing the research reports is rated most important and interesting (both personally and professionally) indicates that although relationship development is of
importance, participants are not evaluating the project positively simply because they are having a “good time”.

A number of factors appear to have contributed to the enthusiastic support of “The RHA Atlas”, and the evidence of its incorporation into assessment and planning activities. These include:

- its immediate relevancy to the province-wide Community Health Assessment activity (“from information to real life, synergism between the Community Health Assessment and Need to Know”);
- the emphasis placed by Manitoba Health on the deliverable;
- the collaborative approach which allowed team members to identify questions and indicators to be included in the report, and to review and critique drafts;
- provision of a forum for information-sharing and regional discussion that included Board, management and staff of the RHAs (provided through Rural and Northern Healthcare Day); and
- growing awareness, confidence and skill of the team members in using research.

The RHA Atlas was also described by some participants as providing a framework for “ways of looking at data”. It will be important to monitor whether the team is also able to develop other “ways of looking of data” and to assess other kinds of research. The interest expressed by participants in gaining skills related to community surveys and qualitative evaluation suggests that a broader understanding is being promoted through the project.

There is continuing interest and enthusiasm for the work on the deliverables, which provide the focus and structure for other project activities (“Last year I was concerned about sustaining momentum. I don’t feel that way now – the new deliverables keep things going”). The context for development of the second and third deliverables is quite different than that of “The RHA Atlas”. Topics were selected by the team itself (which should increase interest and ownership); they are more specific in content (which would be expected to affect the target audience); and they are not clearly linked to specific, mandatory activities (which suggests that additional strategies to promote utilization may be needed). This suggests that planning for dissemination, interpretation and application of each deliverable requires a specific approach and may present specific challenges.

WEB SITE AND WEB-BASED APPLICATIONS

Reported Use of Project Web Site
In general, respondents report relatively little use of either the MCHP website or The Need to Know secure website, although there is significant variability in this regard – with some team members using it regularly, and some almost never accessing it.

The majority of those interviewed in the fall of 2002 reported that they had not accessed the secure website since the previous June, even though they were informed that draft tables would be available on the site for review. Many reported difficulties in accessing the secure site, or stated that did not know how to do so, particularly since the access code had been changed (“I know there was a password, I didn’t get around to getting organized, finding out”). A few
had never checked the site. However, greater use was reported (both in interviews and in the 2002 post-test survey) from the beginning of the project. For example, in October 2002 only two, compared to six respondents in 2001, reported not having accessed the MCHP general site – this figure included new team members.

Much the same pattern was reported in the 2003 interviews. A minority of RHA respondents stated that they accessed the site regularly. These users reported finding the data valuable. However, in spite of a number of computer-related session incorporated into team workshops – which were designed to increase skill and confidence in working with computers and the Internet – many respondents continue to use the site little or not at all.

A new component to the web site, introduced in 2002, was *The Need to Know* Bulletin Board. There was an introductory workshop given on using a Bulletin Board, and some assignments (e.g. identifying potential topics for the third deliverable, commenting on an assessment tool), were based on its use. There was however, little participation in these assignments. While some respondents saw potential for, and were interested in, the Bulletin Board; at the time of the 2003 interviews most participants had not used it. Many stated that they would be more likely to phone or email a specific individual than use a Bulletin Board.

Reasons given by team members for low use of the web site included:

- lack of response from IT support at the regional level;
- limited IT infrastructure which made access difficult and time consuming;
- being “locked out” of the web site, or forgetting or losing instructions for access. (The “unofficial” Manitoba Health staff had never had access.)
- time/workload demands; and
- low level of computer related skills.

Perhaps a more important factor affecting use is the fact that internet use is not part of the regular work day of many team members. In spite of computer-related workshops, for some participants the web site remains an uncomfortable and inconvenient way of getting information.

Key factors affecting internet use by specific individuals appear to be a) their role within the organization, b) previous computer-related skill, c) time constraints, and d) logistical barriers (e.g. difficulties with internet access).

Some reported that difficulties related to workload and office Internet access had resulted in logging in to the site from home. However, the vast majority of requests from the secure website (for data or reports that required a password) occurred between 8:00 a.m. and 6:00 p.m. Monday Friday, suggesting that team members are making use of *The Need to Know* website during their working day. More activity outside of office hours is noted for the public area of the site – it is possible that some of this activity is the result of team members accessing public areas of the site from their home computer.

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8 Assessing The Need to Know website and overview of PubMed search techniques (February 2003); Practice in using a Bulletin Board (June 2003); map and poster making (October 2003), poster making (February 2004).
Monitoring Project Web Site Activity

Some of the challenges identified in monitoring web site activity in order to assess report dissemination (pages 50-51) also create difficulties in determining the extent to which team members use *The Need to Know* site. With the exception of activity on the password protected areas of the site, requests from *The Need to Know* team members cannot, in most cases, be differentiated from requests from other sources due to the use of dynamically assigned Internet addresses and the common use of firewalls and/or proxy servers that mask the originating host.

Prior to the official release of “The RHA Atlas”, draft copies of the report and early copies of data files were available through the secure web site for comment and input from team members and the deliverable Working Group. From April to June, 2003, there was an average of 135 requests for the RHA Atlas data, most of which can be attributed to team members. In June, the data came “on line” publicly through the University of Manitoba, with the result that there was a dramatic decline in the number of requests to *The Need to Know* server for these files. As it would be easier to access data from the public site (and some team members did not have ready access to their password) some requests from team members may have been directed to the public site at this time.

Importance of Web-based Project Component

Given the relatively low use of the web site, one question explored with participants was their perspectives on the importance of this component. A minority (from all stakeholder groups) see it as one of the more important project components (“*The piece most important is the ability to have access to data. The ability to go in and manipulate it, this is very important*”). Some stressed the potential role the website could play in dissemination (the reports can be downloaded directly from the site, and additional tables/graphs are available). This suggests that the web-site may play an important role in dissemination once there is awareness of report availability, as well as facilitate dissemination beyond provincial boundaries. The importance of the web-site to the public profile of the project was also highlighted. The presence of a professional website was viewed by some respondents as giving credibility to their efforts within the region (“*As far as profile goes, it’s enormous. Websites are often seen as showing sophistication, the status of a project. Around the region it helps support the work of the project*”).

The majority of participants in the key informant interviews, however, felt that it was relatively unimportant (“*Not hugely important to me*”; “*To me personally, not at all*”; “*2 out of 10 – not the glue that holds the project together*”; “*necessary but not important*”; “*It has come down in priority as the project has developed*”). Response to the post-test survey, however, indicated that while a lower priority than other components, the website was still felt to be necessary. One person suggested that the site was of “*low priority right now because we can get together in person. It may become more important if this changes*”. However, others indicated that the senior staff in the regions were “*not web-based*”, and that “*most of us don’t work that way*”.

Project staff agreed with the relatively low importance placed on the website, although some expressed some surprise at the low level of interest (“*Well, in spite of how computer orientated the world is supposed to be, I’m surprised areas so remote don’t see it as more important*”). Some were hoping that the project would in future address the “technology” a bit more.
**Strategies for Promoting Use of Web-based Applications**

Computer training sessions are well evaluated but appear to have limited impact on subsequent use. The limited time allocated to these workshop sessions in the past, combined with a lack of immediate opportunity to apply knowledge learned, appear to be a contributing factor. A change to this format of short computer workshops made at the February 2004 team meeting (this workshop provided an extended session for training on poster making, with individualized follow up and support) requires evaluation.

Most respondents did not feel that the project could do much to increase web site use. Many stated explicitly that the problem lay with the RHAs, not with the project (“it’s nothing to do with the project”; “everything has been done to make it as easy as possible”). Respondents also indicated that they felt comfortable contacting identified project staff if that was necessary. Many identified steps that they felt they needed to personally undertake (“It’s a matter of each person taking the time; I need to set up a phone meeting and have (name) walk me through it”).

A few respondents, however, did suggest that more time could be spent in workshops to familiarize people with the website, and/or have practice sessions in finding data and using it for a specific purpose. Others suggested that when changes were made, or new information made available, it would be useful to make follow-up calls to see if there were any access problems. In 2003 it was discovered that information on changes made to the password/security of the secure site had been mislaid by some participants, and they had not yet followed up with staff to re-establish access. This suggests that regular contact by staff may encourage greater use by addressing problems as they arise.

At this point, it appears unlikely that many team members will adopt web-based approaches such as use of the Bulletin Board. Generally, access to web-based information does not appear as important a component to the project as originally envisioned.

**SITE VISITS**

The “site visit” component of the project has not, to date, been well developed. In 2002, several respondents stated that they were unclear about the concept of site visits. Earlier in the project some felt that site visits referred to technical support for computer link up. (“My understanding at first was that this meant that the techies would come up, didn’t think this was a need. Now though we’re talking about looking at something completely different.”). As offers were made by the Project Director to make presentations to the regions, this perception changed, and many team members understood that site visits were limited to these kind of speaking engagements, and did not realize that they could include more than this.

Many respondents emphasized the importance of having project staff “come out to the regions”, and felt this component required more development. This was also described as part of relationship development, as it was felt that this would allow RHAs to “all really get to know the researchers and Centre, break down walls”; “We would get a lot out of them and academics would get a sense of what RHAs really like”. Another benefit of site visits was described as providing support for the RHA team members (as one person commented, one “can’t be a prophet in your own country”).
A number of respondents felt that having a speaker for such events as AGMs, while appreciated, was of limited usefulness, and that this was “not the best forum” for the work that needed to be done. It was felt that these events did not reach many people, and that sometimes the people who could most benefit did not attend. Several commented that one-time visits were not that effective – that there needed to be continuous contact (“There are problems with presenting data and then leaving, people don’t know how to use it”). Some stressed the importance of an organization-wide approach and the need to allocate a longer period of time, which would involve more people and cover more topics. Options might include work with staff (not only executive but other staff, including those who have responsibility of data management and statistics), the RHA Board, and perhaps the larger community.

While some felt that more information-sharing regarding the project (and project accomplishments) would be useful, others stressed that “site visits” should be issues-based. Some proposed knowledge translation workshops; others proposed specific research topics. Still others focused on skill development (e.g., skills in interpreting and applying data to one’s own region, basic statistics, epidemiology, or research methods).

Following these interviews in 2002, some time was allocated to discussing site visits in team meetings; however there has not been further development of this component. The 2003 interviews, which took place after the latest of these discussions (where some team members had described the site visits as “a travelling road show”), showed continuing interest in this area, and a number of different options were proposed. It was clear that, in general, the RHA team members felt that site visits should be more than having the opportunity to invite a “guest speaker”, even though these past activities were well evaluated. Many respondents suggested that it was now time for site visits to be further developed, and several expressed the opinion that site visits could help management become more aware and engaged in research use. One person went on to say that this was not a criticism that the site visits hadn’t happened before, but that certain things needed to be done before the project was ready to proceed with this component.

Several potential models for site visits emerged from these discussions:

a) **A mini “Rural and Northern Health Day”,** which would basically repeat the activities of the Rural and Northern Health Care Days, but at the regional level. It was proposed that this approach would promote greater awareness and participation, particularly of program staff.

b) **An intensive “travelling road show”**. This model would involve development of a series of modules on different topics and for different audiences. This “package” would be formally announced to, and promoted within, the regions. RHA team members would play a key role in deciding which topics would be of most interest, tailoring sessions for each region, and coordinating logistical planning. They would also assist with facilitation. These intensive site visits could be up to 2-3 days long. Unlike the “mini Rural and Northern Healthcare day”, this approach would also include workshops/planning sessions to address some of the organizational barriers to dissemination and application of research.

c) **A train the trainers approach.** After training, The Need to Know team members would act as educators and resource persons within their region. Those promoting this approach highlighted the disadvantages of relying on MCHP for what were seen to be regional responsibilities (“I don’t want to feed dependency on the Centre”…a train the trainers
model would be preferable”). This model would require ongoing support from RHA leadership.

A number of different variations on these three basic approaches were also discussed. Rather than focusing on individual RHAs, regional approaches were suggested as one strategy to encourage idea sharing and collaboration. Any of the models could be adapted to combine several RHAs within the same provincial area where travel was feasible (One informant described this as “the Saskatchewan model”). Other participants stressed the importance of a team-by-team approach, focused on staff within a particular area (e.g. long term care or Public Health).

The RHA CEOs also expressed interest in site visits. Much of the support appeared to result from the positive experiences resulting from having the Project Director make presentations to the regions (e.g. “very positive, some ‘wow’ related to how poor health status was, the other response from the board chair for example, was: what are we going to do with this information? (Another RHA) has contacted us as well, about the First Nations report; we are talking about working together on that.”)

When interviewed in 2002, some CEOs suggested that site visits would best be linked to the deliverables, or to the Community Health Assessment process. Other suggestions related to concrete assistance on organizational issues such as dissemination (“Need to figure out how information flows and the best way to make information flow, have someone come out and critique how it flows, need some expertise on that”), or restructuring to promote research related capacity (“Should we have a decision support unit, how should information be organized?

Different targets for these interventions were identified by different informants. CEOs tended to focus more on the importance of including board members, while team members focused more on staff (both management and front line). There were also differing perspectives on the level of interest that would be shown by RHA senior management to the offer of these site visits – suggesting that careful planning, including feedback from senior management would be essential for success.

At this point, development of site visits appears to the project component most in need of attention. It is also the one component that has potential for increasing the impact of the project within the regions. However, there is not at this point consensus on either the most appropriate model or how best to proceed. This suggests that adequate time is required in the context of team meetings to develop a shared vision and establish a plan for implementation.

**HOMEWORK ASSIGNMENTS**

There was considerable variation in the extent to which respondents reported that they had completed homework assignments: responses ranged from “all”, to “none”. However, when asked about the usefulness and appropriateness of homework assignments, there was agreement that this was an important component. (Only one respondent to the post-test survey felt that homework was relatively unimportant; four reported that it was somewhat important, five very important, and one, essential).
With few exceptions, even those who had not completed many of the assignments felt that they were a good idea (“it is useful, stretches us and challenges us”; “it’s realistic – you are not asking for a lot”; “there are reasons for all the tasks”). Homework was commonly recognized as an important strategy for moving participation in the project beyond “just sitting there and taking information in”, as it would spur participants to “take the information and do something with it”. A number commented on the importance of homework in “bringing things full circle”; “bridging the Sunday to Sunday mentality”; “allow(ing) for continuity between workshops”; and ensuring that team members “don’t leave and forget”.

Respondents who had not completed the assignments usually explained that this was a function of time demands (and “work practices” that resulted in working to specific deadlines). It was observed by one person that because of this, people might not do homework “unless they have to”, suggesting that deadlines and “checking up” would be a good idea. Some commented that they thought there would have been more homework, and a few commented on the benefits of putting an “onus” on people to do the homework in order to reflect well on the region.

Support for homework assignments remained constant in 2003.

- It’s very important, keeps the project alive, keeps us engaged.
- I might procrastinate but (the Project Director) shouldn’t feel like it’s over and above what people should be doing, it should be integrated into what we do, it fits.
- I didn’t (do homework all assignments) earlier on, but I generally do now. Nothing is asked that is not appropriate.
- It helps me work through other issues. Take one step back, and look at other important things. It’s not too much, the amount is less than I originally anticipated.
- Some people feel it’s too much. I think some of it is OK, it makes it useful. What is the point of sitting in meetings – if I understand the intent of the project it is to translate knowledge – this makes the homework O.K.

However, while there was even greater awareness of the links between homework activities and their area of greatest concern – promoting change at the organizational level – participation in homework activities remains variable. Often feedback needed by project staff is not received by agreed upon deadlines, necessitating follow up reminders. Workload was the most commonly cited reason for not completing the activities.

In the 2003 interviews, a number of respondents in RHAs who were sending two team members indicated that they were “dividing up” the homework tasks between them. Others referred to the second member as a source of support, which made it more likely that these assignments would be completed (“In the past it was a burden, I wasn’t doing it. Homework is much easier now that there are the two of us”). As the “homework” is designed – and recognized – as one strategy to help address the organizational barriers to increased use of research, it will be important to monitor the involvement in homework activities and determine both the advantages and disadvantages of sharing assignments. Analysis of the relatively low response to the task of consulting within the regions indicated that in some cases team members may not feel confident in knowing how to proceed. Having a partner to support and help plan interventions may provide the potential for more organizational level interventions.
Project staff have expressed hesitancy in suggesting activities outside of the team meetings – the approach has been to “minimize work in between sessions and maximize the two days we are together”. This is an approach that is appropriate for team building and for increasing the “capacity” of individuals; and shows respect for the time demands of team members. It may – given the emphasis placed by RHA team members on the importance of organizational change – be time to review this approach, and to focus on activities that promote and facilitate change with the RHAs. It may also be useful at this time to consider reframing “homework assignments” as “RHA activities”, and expanding the attention given to project activities that take place outside of meeting time.

**THE NEED TO KNOW NEWSLETTER**

In 2002, RHA team members were asked about the project newsletter. Most, but not all, team members had distributed the copies of the newsletter they had received. Respondents reported that the population health committee, the regional management team, VP of planning, CEO, Community Health Assessment teams, individuals in senior management, “head office”, and team members in one’s own department, had been the recipients of the newsletters in various RHAs. Some were unsure “what had happened” to the newsletters they had forwarded. One person suggested that it would be useful to have a one or two page summary on *The Need to Know* Project for broader distribution, perhaps in electronic form that could be tailored to specific needs. Another inquired about the possibility of emailing the newsletter. This issue was not revisited in the 2003 interviews, and the newsletter was not mentioned by the vast majority of respondents.

**ONE-ON-ONE SUPPORT FROM MCHP STAFF**

One-on-one support and guidance from MCHP staff to RHA team members was not initially one of the project components. In fact, at the time the project began in 2001, there was some concern within MCHP that the project might result in demands to which staff would not, or should not, be able to respond. On the other hand, one of the needs identified by the RHA team members in the pre-test survey was an MCHP “contact person” who could provide information and suggestions. Although one staff person was initially assigned to this role, this model did not continue. Instead, the project developed (and kept updated) a contact list, which identified particular areas of expertise and interest of MCHP staff, Manitoba Health contacts, and the RHA team. Team members were encouraged to contact appropriate project staff for any questions, and there was regular contact on some topics. For example, the research assistant provided individualized assistance and feedback to regions in creating their posters, and several requests for clarification or assistance were also received regarding computer/software/internet issues.

Several team members reported contacting project or other MCHP staff for information or guidance on research related issues within their regions. In two cases, needs identified by the regions and directed to the project resulted in resources being made available through MCHP to the regions. (“I didn’t know how to do the sample. (The Project Director) committed one full day of (name)’s time to help. I couldn’t have done it without her”; “(Name of MCHP staff member) is
coming up to do SPSS training"). It is interesting to note that while the RHA team members identified their use of these contacts as resulting from The Need to Know project, the source of the requests were not as clear to the MCHP staff who responded to them. Some were only able to estimate the total number of requests they had received from the regions, and did not know if The Need to Know project had been the “route” for the request.

The evaluator also received questions related to client satisfaction assessments, planning an evaluation, focus groups, ethics, and consent. While this contact with project staff is reported to be helpful to RHA team members, further evaluation is required to determined overall satisfaction with this approach.

ATTENDANCE AT CONFERENCES

As outlined in Section 1.1.4, attendance and presentations at relevant conferences is another funded component of the project. To date, potential conferences have been identified either by team members or by project staff, and individuals have applied to attend on a case-by-case basis. However, at the March planning meeting, it was suggested that a more strategic approach could be adopted – proactively identifying occasions where there would be the greatest benefit for the project.

Two major benefits of conference attendance to The Need to Know project have been identified. First, the visibility of the project at national conferences has heightened awareness of the project, its activities and accomplishments, and has resulted in a number of requests for additional information, consultation on project design, and requests for copies of both “The RHA Atlas” and the Evaluation report. This has resulted in national exposure and information sharing that would have been unlikely to occur in the absence of designated funding.

Secondly, both project staff and the RHA team members report great benefit from this participation, particularly the opportunity – within a national arena – to reflect on what they have learned. This has resulted in increased confidence. As one participant commented “As a health planner, it was a real eye-opener for me to be in a symposium with mainly researchers….Two years ago, would I have felt comfortable in this environment? Not likely. As I sat and listened to the various presenters, reality hit about how much I have learned and grown over the past two years”.

IMPACT OF THE PROJECT

LEVELS OF IMPACT WITHIN RHAS

The effects of the project were explored from various perspectives and at several different levels. The first perspective focused on the impact on RHAs at three levels: individual learning; how team members did their job; and finally, on how planning was done in the individual participant’s RHA.
Personal Learning
All respondents indicated that the project had resulted in personal learning: Many responses to the question of whether they had learned anything from the project were highly enthusiastic (“Oh yeah, absolutely!”; “Oh, God, I’ve learned all kinds of things. Yes, definitely, lots!” “I’d say a lot!”, “All kinds of benefits”). A strong theme in 2002, the emphasis of the importance of the project to personal learning continued in 2003:

- I wouldn’t have the knowledge if I wasn’t involved in this program. To do analysis of surveys, I wouldn’t be there without The Need to Know on some exposure on how to do things right.
- We have more tools and are more involved in thinking about what we need to know more about. An opportunity to think about things.

Analysis of responses suggests that this personal learning can be described in three categories:

Factual learning: learning related to research concepts, research findings
In reflecting on the knowledge they had gained through the project, many respondents focusing on learning related to research concepts and methods. Others identified the awareness of actual data related to their regions – that many had previously been unaware of – as important learning. For example, one person said “I’ve learned so much about my region” Another observed, “Even information to use at my job, information that gets stored in your mind. It’s been a prime source of professional development.”

It is this type of learning that is most often the objective of capacity building activities. However, analysis of participant responses found that from the perspective of RHA team members, two other types of learning were as, or even more, important.

Learning where to find, and how to access, data.
Another important type of learning related to increased awareness of where and how to locate the information participants needed on a particular topic. This was described as, “learning what data is there,” “where to find data” and “how to access it”. Some respondents highlighted the importance of networking and personal connections as an important aspect of “access”. These connections were described as making the research “real”.

Several mentioned that learning about MCHP and the scope of research it generated was very useful (e.g., “Knowing the Centre is there – before I had no idea of its structure, the scope of its activity”; “what the Centre can offer, actual reports”; “I know way more about administrative data and the data repository than I ever did before”), suggesting that the area of greatest confidence in this area is with MCHP data.

Changing attitudes to research and one’s relationship to research
An important theme emerging from many of the interviews was that of a change in orientation to research, to researchers, and to one’s role and interest in using research. This “learning” was exemplified by statements such as:

- I think I look at data and information differently now. I’m not totally daunted. Now I can have an intelligent conversation with planners.
- Now, there is a confidence in knowing what my team needs, stuff I should be passing on.
- I’m beginning to see the importance of how to get the research to people.
• (The project has) “furthered knowledge and appreciation for health research”
• (Now I) “more value the work done by the Centre”.
As indicated in the following section, it may be this mode of learning that is having the greatest impact.

Impact on “How I do my Job”
There was less consensus on whether the project has had an effect on how participants did their jobs, although evidence of impact at this level has increased steadily since the project began. In 2002, some respondents stated that the project had had no effect on how they did their job, although a couple of these indicated that they were “beginning to see how it will”. Some were unsure whether there had been changes, or – while identifying changes – were not sure how much of this could be attributed to the project.

More than half of the respondents did, however, identify some effects, though not with the same certainty as they described their growth in individual learning. The most commonly identified effect related to how they thought about issues – this observation was then linked to how they then undertook their responsibilities:

• I think involvement has broadened my thinking. Before I would stay that I was able to think about our RHA as a whole, but now I think more provincially and more broadly about health, whereas before I focused more on health services.
• (The project) has taught me to ask more questions and not just accept status quo. I think more in research terms and look for evidence for decisions – not just because this has always been done.
• How I approach tasks is much broader than a couple of years ago. I understand all the things I should look at, and am learning about where other information is.
• (The project has) made me look at evidence a lot more closely and helps me explain to others why evidence-based planning is important.
• I have a little bit more confidence in the data because I know where it’s coming from and know its limitations. If someone challenged me before, I couldn’t answer because I didn’t know where it came from. Now I have confidence.
• Bringing in other things, checking the internet, looking at Centre reports.

One person stated that the project had affected her job “hugely”, as now she focused more on the research aspects of her job.

Review of the pre and post-test survey results indicated that there may have also been changes in the use of information. By 2002 there had been a significant increase in the use of MCHP research reports, with 72% of team members reporting using six or more reports per year, compared to 18% at the beginning of the project (p<.015), and with the median number of reports accessed increasing from three to seven (p<.025) over the first year and a half. All 11 respondents in October 2002 – compared to three in 2001 – reported using MCHP information for “reports or presentations for RHA board/CEO”. Increases were also noted in the use of MCHP information for strategic planning activities, staff education activities, community presentations, and preparation for research projects. Some Manitoba Health team members also reported increased requests for information (“An increased expectation from the regions for information from the ministry, that’s more work for us, but I think its good that they are requesting more. It shows they recognize the importance of getting the facts first”).
The building of RHA Team member capacity has contributed to the decision of some team members to pursue further studies. One is working on her Masters, in an extension of the Mental Illness project. A second applied to the “EXTRA” program for regional planners interested in pursuing graduate work. Others have begun to take graduate courses as “occasional students”.

Change at the Organizational Level

Support for The Need to Know project
In 2002, when asked about the commitment of their RHA to the project, most team members responded that this support was similar to the level of commitment and interest at the beginning of the project. One commented that she saw more “awareness” than commitment, and another stated that the level of commitment was “the same, and that’s not a lot”. Others stated that even vice presidents may not know who The Need to Know representative is for their region.

A few had a perception of somewhat more RHA commitment and linked this to increased credibility of the project. However, as observed by one of these respondents, more support and knowledge did not necessarily translate into allocation of resources. Many indicated that the time for project activities was not “protected” (“I go home - The Need to Know is at the bottom of the pile, it is always the squeaky wheel that gets the attention…I work to deadlines, if I knew I had one day every month for The Need to Know, I would be more likely to protect the time…”). Both RHA team members and the CEOs acknowledged that the .25 FTE to be allocated to research that was identified in the original proposal was “just not happening”. One respondent raised the question of whether an RHA may want to be involved because The Need to Know was a high-profile project, rather than because of a commitment to using research in decision-making.

Interest and support from CEOs appeared to differ significantly among RHAs. Some CEOs were identified as being very supportive; others as having shown little interest, or even being “leery about the time” allocated to the project. It is interesting to note that, in 2002, the CEOs reported higher awareness and support than was perceived by the RHA team members. The reasons for this are unclear. It could be that because questions about larger organizational involvement had been asked of the RHA team members some months earlier, there may have been more effort taken to disseminate information within the RHAs since the interviews took place. Other explanations could also be explored. For example, it may be that the RHA CEOs are more knowledgeable about the project than some of the representatives were aware, or that the wording of the questions may have introduced a positive response bias.

In 2003, more RHA team members reported growth in support and interest in the project from senior levels of their organization (“more respect, more interest in the deliverable”; “more from senior management and the board has shown some interest – I’ve been teleconferenced into some meetings”).

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9 The objective of this program, offered through CHSRF, is to produce health services professionals who are equipped and motivated to improve the quality and effectiveness of the health system through use of research, and to encourage them to act as agents of change within their organization. http://www.chsrf.ca/extra/index_e.php
The addition of a second team member was also seen as helpful (“There is more support, not just because of the second person, but how it was handled made the issue bigger”). Increased regional attendance at Rural and Northern Health Care Days was also presented as evidence of greater awareness and support.

**Expanding impact of The Need to Know team members in some RHAs**

By 2003, data from the key informant interviews revealed that more of the RHA team members were making a link between the influence the project had on how they did their job, and organizational use of research in decision-making (although this appeared to be affected by the specific role of the team member within the organization).

- I’m the person who does the planning and I’ve felt very helped by the data available.
- I guess we’re at the point where now we have the data and we can compare, I have been able to pass some of this on the board of directors and to senior management.
- Indirectly (it has had an impact) as I am on staff, give help to organizational capacity that way – I use the reports, I use them in explanations so it informs the organization in general.

Others reported that because of the project, the organization was using their skills in related areas:

- The director of (department) in (name of region) has asked me to do a review of services.
- It’s started to…there is probably more encouragement to go out and do stuff.
- Managers look to us for the information they need.

Some of the RHA team members reported on action they had taken to increase organizational awareness and encourage greater use of research; however for most RHAs these plans appear to be in the preliminary stages:

- It hasn’t been on the agenda, but we have integrated it into other things that we do. But since the last meeting I’ve been thinking of making a better effort to highlight it.
- I consulted with (CEO) – I plan to talk more about it now I am in corporate office.
- Since I became a member, The Need to Know is now a regular agenda item at senior management.

However, these impacts were not noted in all RHAs, and some respondents indicated only that they raise issues in context, indicating reliance on the initiative of individuals rather than organizational change.

**Changes in how the RHA makes decisions**

A few respondents indicated that they felt their RHA was already “on the road” in their use of research before the project began (“The CEO is into that (research) so it automatically had good funding”; “There has been a big change from a year ago. The Need to Know has not contributed to the change (internal reorganization) but it is a tool, useable, understandable, I think it will contribute to change, how we make decisions”). However, even in these RHAs there was some indication that there may be a limited number of people involved in research-related activities, as new team members were sometimes unaware of the project until they were invited to join.

In 2002, several respondents gave a qualified or hesitant “yes” to the question of whether the project had affected how the RHAs undertook planning. For some the only “change” reported was that reports on project activities were made at meetings or in writing. Others
identified as a change a greater use of MCHP and DSS\textsuperscript{10} reports, or the fact that they were sometimes asked for information and reports by the CEO or other staff. In 2003, more of the team members were reporting evidence of change at this level. Many identified the increased participation of RHA board and management at Rural and Northern Health Care Days as both an example of change, and explanation for the change. Others highlighted the importance of “The RHA Atlas” in increasing the credibility and profile of the both the project and MCHP.

- The Need to Know is part of regional progress; it’s had an impact on planning. At the board level what stands out for me, last years rural day had three people, this year there were 12. …Now we see more commitment at higher levels. At the table (at Rural and Northern Health Care Days) people were understanding how to read the graphs, and seeing the importance of the data. …I see changes in our organization. People know about the Centre now. I always report on The Need to Know at senior management. I haven’t done much to date at the managerial level, but now we have the dissemination plan in place, so people are more aware.
- Might have more (support) because some tangible things are coming out of it – the deliverables.
- Probably a few more people are using research and looking for it. There’s much better participation in Rural and Northern Days, then when they return they are looking for research.
- People are starting to think “how do we use the information?” – it seems to be moving more through the organization.
- A year ago, most of senior management didn’t know about The Need to Know. After (the last Rural and Northern Health Care Day), X said to come and share with the board. It is really being profiled.
- Just looking at the numbers of board and staff at Rural and Northern Day. Also the Community Health Assessment retreat, the number who participated and a lot of data we used there came from the Atlas.

One informant felt that greater awareness of the importance of research related functions had led to creation of a job position with research responsibilities.

In many cases, change was noted not so much in the specific activities undertaken – but rather there was a sense that the same activities were being conducted differently. For example, after commenting on one initiative that she felt would have occurred without The Need to Know project, one participant observed “The difference is how we are focused – on evidence, and with a focus – a framework and implementation plan”.

Some observed that when changes occurred it was difficult to know whether, or how much, of any observed change could be attributed to project activities. As there were other initiatives occurring at the time, it was difficult to “tease out” the effects of The Need to Know contribution.

- There is greater information, but from a number of different places, not just the Centre.
- I’m not sure if as a result of the project or suggestions from Manitoba Health – when we submit health plans we use more evidence.

\textsuperscript{10} Reports generated by the Decision Support Unit of Manitoba Health.
However progress in this area continued to be variable, with some RHAs reporting little progress:

- I’ve never heard the deliverable discussed at meetings: nobody knows about them.
- (x) said “my god, I didn’t know we had this information on the regions”.
- Not yet. Maybe in small little areas – a few managers are more receptive to data, are not just relying on anecdotal reports. I need to develop that more.
- People are out there (in the regions) who don’t know the project exists.
- No I don’t, but I think these things take time.
- We are probably not doing a whole lot.
- Can’t say we gotten too much farther on that than just our planning team.
- We’re only just getting there, the first step was including the two people. Having to do the dissemination plan was good, but we need to focus on that.

In general MCHP and Manitoba Health staff expressed more confidence in change within the RHAs at this level than did the RHA team members themselves. This confidence was expressed in comments such as:

- I think there has been trickle over into other groups. People at Rural and Northern Day seemed to have a better understanding.
- It is really a project people have been integrating into their work...I see that. I feel the health plans are coming in with more evidence, they are well documented and the requests supported.
- I think more is going on than we are able to measure through the project...subtle things, changes in ways we are not even aware of. Maybe at another level there is unconscious change.

Similarly, the CEOs reported greater change than the RHA team members, with the majority identifying change at the organizational level within their RHA. The two most common impacts cited by CEOs were:

- Greater awareness of what information was available, and “what’s going on” (including greater awareness of the Manitoba Centre for Health Policy); and
- Easier and greater access to needed data (“Having a resource base there and available to us”). Other benefits of the project reported by CEOs included a better understanding of research; a greater appreciation for how information was “put together”; more interest in MCHP reports; better links with the MCHP assisting the RHA to identify issues and work on solutions; increased participation in Rural and Northern Health Care Days; improved planning; and development of RHA specific data. However few reported any changes in how the RHA undertook planning.

Even those RHA team members who identified some change in their organizations emphasized that they believed much more needed to be done – this is reflected in the number of respondents who identified issues of organizational capacity building and change as the greatest challenges facing the project. This issue is revisited in section 2.7.0.

**IMPACT OF THE PROJECT ON OTHER NETWORKS AND COMMITTEES**

**Provincial Networks and Committees**

In 2002, some respondents noted differences between project team meeting and meetings related to other networks. The context of The Need to Know meetings – where the three
stakeholder groups met as partners in a new initiative – was felt to facilitate creation of an environment that was conducive to relationship development. As one respondent commented: ‘We meet in other committees but this (The Need to Know) is a non-threatening environment, more open to sharing – not vying for different programs, so its a different atmosphere”.

By 2003, several participants were commenting on the role the project had played in changing the way business was being conducted in some other networks and activities. Expectations for Manitoba Health workshops were reported to have increased. One person referred to this as “raising the bar” regarding how meetings would be conducted and what participants jointly expected to result from them. Another aspect of impact has been the “importation” of some learning and tools (e.g. indicators for the Indicators Working Group) to other bodies.

- I definitely see that it has affected in two ways: (the committee) is more able to do a lot more with respect to data analysis, there is an emerging set of expertise. And we couldn’t have done this (developed indicators) without Need to Know expertise. It’s had an impact on provincial networks.
- I believe these people are a lot more able and willing to bring forward ideas and suggestion. For example, at CHAN (the Community Health Assessment Network) – the telephone health assessment. They recognize that they have an understanding of what’s involved but don’t know everything, e.g. asking about sample size, they have more awareness now of all the components that should be considered.
- It has had an effect on the Planning Network. There are many Need to Know on that, and what they have learned has been transferred to building capacity on the network…..It will leave a legacy that we couldn’t have imagined.

The overlap of The Need to Know team members with the provincial Community Health Assessment Network was also identified as helpful, particularly by Manitoba Health and RHA representatives. It was suggested that provision of “a huge forum for sharing and building knowledge” through the project had assisted in developing an atmosphere of sharing and trust on the Community Health Assessment Network, and provided participants with background information and skills that helped move the process forward.

As suggested in the comments above, this somewhat unexpected finding may reflect the “critical mass” of project team members who are also members of these provincial networks. This is very different situation than would be found within any particular RHA, where there is a maximum of two team members. Others stressed that there were other factors to be considered related to these changes (e.g. initiatives taken by Manitoba Health) but that The Need to Know project had “accelerated the process”. These findings also suggest that the additional resources made available through the project have resulted in wider impacts than were identified in the original proposal.

Manitoba Health

Although there was consensus regarding improved relationships between the Manitoba Health team members and the other project partners, there is less evidence that the collaboration involved in The Need to Know project has had much impact at the organizational level, although some impacts were reported.

In addition to recognition that the project had contributed to some provincial networks, some Manitoba Health team members felt the project had made lives of some staff easier, as
it had contributed to greater capacity within the regions to understand and use research, and to reflect this knowledge in requests and reports to the department (“we don’t have to try and figure out how we are going to defend the request”; “it’s opened up lines of communication between RHA reps and Manitoba Health”). One person felt that the “the kind of data we’re providing to the regions has changed. It’s more population based and more complex. We do it now because we know they can handle it, and also realize the importance of providing information to the regions”. Others felt that there was more support from within the department since the release of the RHA Atlas, and a higher profile (“they see how important the results of the project are for the practice of the RHAs.”; “I used to always have to explain the project, now people usually know about it”). Concrete examples were given of how “The RHA Atlas” was used as resource (“liaisons said that they had used the information in reviewing health plans, to validate what the regions were saying”).

There is some indication that greater awareness of MCHP resources by Manitoba Health team members may be assisting with dissemination within the department. For example, the unit responsible for patient safety is making a listing of all relevant MCHP reports for the Manitoba Health Patient Safety Committee.

However, it was generally felt that more needed to be done within the health department, particularly related to dissemination of information (specifically the MCHP reports that they funded). This was one of the topics addressed at the 2004 Manitoba Health Day.

**IMPACT ON ACADEMICS**

*The Need to Know* project is designed not only to “build capacity” within RHAs, but also among academics. This section reviews the evidence of impact both at the level of the sponsoring organization (the Manitoba Centre for Health Policy), and other academics.

**Impact on MCHP**

The same three levels of project impact (personal learning, “how staff do their job”, and impact at the organizational level) can also be explored within MCHP. The same progression of change is observed – enthusiastic support by those staff directly involved in the project for the learning they have experienced, followed by somewhat less report in change for how one does ones job, and limited evidence for change within the larger organization.

*The Need to Know* staff team

The most recent phase of the evaluation has identified strong support for collaborative research among researchers and some other MCHP staff directly involved with the project. The level of enthusiasm expressed by RHA team members was mirrored in the response of project staff – the project appears to be providing at least as much benefit to them as the RHAs. Concerns or hesitations about perceived “risks” of the project (outlined in the 2001-2002 Evaluation Report) are no longer evident. Commitment to collaborative research and knowledge translation activities appears directly related to the extent of staff involvement with the project – the greater the direct contact, the fewer the hesitations, and the greater the interest.

Like the RHA team members, students employed by the project identify *The Need to Know* project as source of learning, although what is learned is described differently:
a) the importance of community research partnerships and team building activities; (“how to work with people; what I have learned – in order to have a successful model – need to invest in time, the importance of establishing those relationships and develop comfort”);

b) recognition of the expertise of community partners (“People on the RHA team know a whole lot more about a bunch of things than a lot of people at the university”);

c) the reality of applying research to planning in a real world situation (e.g., “Hecticness of RHA jobs”);

d) the identification of barriers to research understanding and use (“it was an AHA! Experience – realizing that there were 78 graphs and RHAs had to look through all 78 to get a picture”);

e) respect for advance planning (“you can almost be sure things will go well if you plan enough in advance”);

f) learning to trust instincts (e.g., “reading body language at meetings.”)

g) Knowledge translation principles (“you read about it in the literature, but I’m involved in a project where it is working and the behind the scenes events that make it successful”).

Some mentioned that project activities had direct application to course work or had reinforced research concepts learned through coursework.

The staff team also reported that the project had had an effect on how they did their jobs – and not just because much of their job was focused on project activities (which would be expected).

At the very least, trusting my instincts, questioning data, not letting it go. Also, I would not have previously thought I would have been interested in writing up a program with this much participation – researchers are concerned about losing control, or that this will result in bad or inappropriate research – but this is an interesting example of how things worked well… If you set things up right you can meaningfully involve people AND have good research, especially in fields like data analysis. It is a good thing for me, and to admit that people out there have some incredible input. I never would have believed we could have brought people up to speed on this so well – that it works as well as this, that they know what will and will not work. We had so much concern about that in the beginning….It’s opened my perspective.

Several made unsolicited comments related to the impact of their involvement in the project on personal job satisfaction: this was also observed by others within the Centre (“the high degree of commitment … staffers are emotionally tied to the project in ways we don’t see people tied to other research projects – there is so much personal interaction, trust building”).

Impact on MCHP

As described by one informant “the degree of change is exponentially related to the distance from the project”. Those not on the project staff team who have had some contact with the project have more awareness and see more benefits to the project than those with little or no involvement. This involvement is generally related to direct work on the deliverable, making presentations at team meetings or Rural and Northern Health Care Day, or acting as a resource on a particular issue.

• I think the project shows a sophisticated understanding of how non-academics think.
Certainly, though I’m not necessarily applying it in my own research. (Name) has a very good manner of bringing information to the level of the people without talking down to them. This takes skill; I’m more sensitive to that now.

Other researchers, it’s indirect – when (they come into) the group, they think differently.

People are looking at The Need to Know as a resource for valid input and as a credible network. So if they need expertise they call (the Project Director). There are still some researchers who work very isolated though.

More awareness of the RHAs, closer contact with them. It makes me feel guilty that there are not more RHA-specific analyses.

People at the Centre have been very impressed that people can be taught, over time to find the information that they need…astonished at the potential of people to know. This tells the Centre that “getting people to know” is really important. In the past the contact has mainly been with high level people, with a focus on policy decisions. This is different; it is more about program implications. I’m not sure people have realized the difference.

I’m more aware of what happens outside of Winnipeg.

The ability of MCHP to provide the appropriate administrative support when the assigned project staff person was unexpectedly unavailable just before the February 2004 team meeting was also suggested as evidence of organizational support.

Some respondents reported a small number of requests for information or suggestions generated by the project. All these respondents felt that the requests, which with few exceptions were less than half a dozen in a year, were appropriate and manageable. Others reported no contact outside of the actual team meetings. It should also be noted that “large” deliverables, such as “The RHA Atlas” may require more work on the part of programmers.

Some MCHP staff felt that the use of the “template” developed for the Rural and Northern Health Days for the WRHA and Manitoba Health was evidence of organizational change, and that the project had provided MCHP with a model for consulting with the community. It was also observed that some staff were also putting more time into tracking deliverables and website hits. Greater use of “Working Groups” as a result of the project was also identified by some, although others felt that this practice was already in place before the project began, and were only used if they weren’t “too burdensome” (“There are working groups but that has always been the case. I don’t know if the Centre could handle more when keeping up core academic work”).

Others, however, did not feel that the project had had much effect, and project activities were seen by some as separate from the work of MCHP. Collaborative approaches to research within the centre were still described as “discretionary”, reflecting individual preferences and work styles. Some were unsure even if expanding the successful templates to Manitoba Health and the WRHA would have been undertaken if the project director hadn’t “pushed it”, suggesting that there is still reliance on individual initiative.

Not sure that it is actually. As a group we should take more effort with researchers to let them know about The Need to Know project and its success.

Don’t think it has changed drastically.
• There were other significant changes at the same time – such as moving offices (combining two different team cultures) – I don’t think you can say which of the things affected the change.
• I never hear anyone talk about it.

There also remains some confusion about the intent of the project – some researchers seeing it as focused on developing a speciality related to rural and northern health, others as designed to build “capacity” in the regions, still others as focused on Knowledge Translation. Not all researchers felt well informed about the project. This lack of clarity and consensus appears to result in some hesitation about the project. One researcher commented “The mission of the Centre is to do policy-related research, not create researchers. Is it the purpose of the centre to build capacity? I think not.”

It is also unclear what the relationship of the project is to other MCHP activities. There continues to be some confusion between Rural and Northern Health Care Days and the project, and some concern about the administrative demands generated by both the Rural and Northern Health Care Days and the team meetings. There were also difficulties identified in “sorting out the work on the deliverable and what is The Need to Know as a project”.

Use of working groups or other collaborative approaches often appears to be viewed as too time consuming, rather than as a strategy for increasing quality and relevance of research. Some RHA team members have expressed a hope that other deliverables from the Centre could learn from the project, and concern about whether there will be sustainable changes within the Centre after the project ends. At the time the latest round of MCHP interviews was conducted there appeared little evidence of such discussion with MCHP.¹¹

Some difficulties were experienced at the administration level because of the success of some project (or project-related) activities and the work involved in sponsoring team meetings and the Rural and Northern Health Care Days. (e.g., “there are different reactions to the flurry of work around the workshops – some positive, some negative. I think there needs to be more total ownership. Not just this is the project, but more of a Centre thing. The admin thing needs to mesh better”).

Impact on the Larger Academic Community
There is, to date, limited evidence of the impact of the project on academics who are not involved in MCHP. As indicated in section 1.1.3, there have been a number of academics who have participated in working groups for deliverable development, made presentations to team meetings, or attended the team suppers. However, the evaluation has been unable to assess the impact of this involvement, although informal feedback has been positive.

There is an established contact with the WRTC (Western Regional Training Centre), with invitations for project staff to speak at student workshops, and the opportunity for students to attend Rural and Northern Health Care Days. As of March 2004, it is reported that one WRTC student has been placed in a practicum in one of the rural RHAs.

¹¹ In April 2004, however, on the suggestion of the Project Director, an invitation was sent by MCHP to all RHA team members inviting those who were interested to participate in Working Groups for upcoming MCHP deliverables. The invitation included recognition of the advantages to researchers of such community involvement.
There has perhaps been greater contact with academics outside of Manitoba as a result of presentations at conferences and participation in national consultations (Appendix G). The project was well-represented at the November 2003 CIHR/IHSPR national conference. A poster on the project evaluation (“Evaluating the effectiveness of knowledge translation projects: A “utilization focused” approach”) won second prize in the poster competition, and many inquiries and requests for additional information were received by those staffing the poster displays.

Some of the response to the project from academics is received second hand – e.g. some MCHP staff reported “very positive, more than positive comments related to the fact that The Need to Know is innovative, a great model”, identifying academics attending the CIHR conference, staff of CHSRF, and WRTC as some arenas where this feedback has been obtained.

CURRENT CHALLENGES

At the same time that stakeholders were surveyed regarding their perceptions of the accomplishments of the project, they were also asked about areas in which they felt greater attention was needed over the coming years.

Some individuals had few suggestions. As one team member commented: “I have trouble answering this kind of question when I am pleased with how things are progressing”. In general, suggestions for increased attention in certain areas were not a criticism of activities undertaken to date, but rather a thoughtful reflection on direction and priorities for the future.

ORGANIZATIONAL CAPACITY-BUILDING

Team members identify the major challenge facing the project at this time as affecting change in how the organizations they work with make decisions (“my concern – real long term value is to affect change in the region.”; “We need to build organizational capacity, not just one person. We need some discussion about that as a team”). This concern was highlighted in answers to two questions in the key informant interviews (areas needing attention over the coming year; and how well the project had addressed capacity building at the organizational level), as well as in response to a question about perceived challenges included in the 2002 post-test survey. Generally less emphasis was placed on organizational change by MCHP informants than by RHA and Manitoba Health team members.

As indicated in Section 2.6.0.2, most respondents were not content with the level of impact the project has had to date within the RHAs. There was also (in 2002 when this question was explored in depth) evidence of limited communication between RHA team members and their CEOs around The Need to Know project. Questions were asked about contact with the CEO in a couple of ways. In the follow-up survey questions (October 2002), participants were asked whether they had undertaken the specific task of consulting with the CEO on the selection of the topic of the second deliverable (a homework assignment from June 2002). Only 3 of 11 team members reported that they had done so. Reasons for not consulting included time constraints, difficulties in scheduling, forgetting, and being unsure
about the assignment. Further exploration in the key informant interviews, indicated that many team members had some hesitation in approaching the CEOs.

As the CEOs of the RHAs signed on as “partners” to the project, active follow-up on the project and role and activities of the representative (s)he had selected, might be expected. In the post-test and follow-up survey questions participants were asked whether the CEO had asked for information either on The Need to Know project, or on evidence-based research. During the interviews, the majority of respondents indicated that they had not been asked for any reports related to the project by their CEO, although some had initiated contact – either as part of the homework or in the course of general reporting. A somewhat higher proportion reported, through the post-test survey that they had been asked for reports or updates on the project (7 of 12). Five had been asked for information or input on evidence-based research by the CEO, with one reporting requests from Board members, and 4 from other members of the executive team.

Another indication of potentially low organizational development was the limited accommodation made by the regions to support project activities. Reports of the RHA team members were congruent with those from the CEOs – few regions reported having instituted official reporting requirements; had added updates on project activities as a regular senior management/board agenda item; or had taken steps to ensure that protected time was made available to their designated representatives.

There was additional discussion of this question in 2003. Many felt that the project was only now ready to take on the larger issue of organizational rather than individual “capacity-building” related to research, and that team-building and individual capacity-building was required before the project could move to this stage. (“But thinking back, my capacity had to be built to this level before the other could start. Now it’s up to me.”) This was mirrored by a comment from a new member who stated: “I’m not yet confident, feel I have to learn first as an individual.”

Barriers to Organizational Change
A number of barriers to this organizational change were identified. Many of the barriers were attributed to time constraints and work demands of staff. Several RHA team members reflected on how – in spite of the enthusiasm they took back with them after each workshop – the “crises” of day to day operation forced research, or developing strategies for greater use of research, to the back burner (“The pattern is always the same, we are as enthused as can be, then come home. I don’t know what to do about that. Demands on time are ridiculous”). A few recognized that this may be a reflection of organizational priorities (“Time is the biggest challenge, perhaps interest as well – the attitude that it is just some person’s job – just go off and do it”; “There’s the issue of being busy, but there is also a matter of setting priorities”; “The Need to Know is very important to me, but from their side of the desk it can be sort of “whatever”). Very few felt that their time on the project was “protected” in any way – while senior management was viewed as supportive in principle to the project, team members were often expected to participate in The Need to Know or other research activities in addition to other responsibilities.

Others felt that a key issue was awareness raising and skill development related to research and its importance on a larger scale within the regions. For example, some felt that many staff in their region were unaware that research was, or should be, part of their
position responsibilities. Many of these respondents were hoping that site visits would help increase capacity of more individual staff members.

However some RHA team members felt that there were also other barriers to change – and some questioned the commitment of the leadership of their organizations to look at these questions seriously:

- It’s more rhetoric – I’m not sure people really want change.
- I’m not sure there is the will to change.
- In our RHA, planning is not the priority.
- If we give it to the managers, (The CEO) thinks it will be passed down, but I know for a fact it’s not. There’s no infrastructure to get it out and about.
- I’m not allowed to talk to the Board, and the CEO chose not to invite them.

There has not been the opportunity to assess the accuracy of these perceptions. The 2002 interviews found important differences in perspective between CEOs and project team members on the question of CEO awareness and support, suggesting that similar differences on this question may also exist. However, even the perception by staff of the regions that there may be reluctance to actually implement evidence-based approaches to planning presents a concern.

An issue emerging in a few interviews (including those with RHA CEOs) relates to the constraints placed on RHA decision-making. Decisions (such as hospital closures for example) may be constrained by both commitments made by provincial politicians and by community expectations and preferences.

There was also general recognition by RHA team members that this work of organizational development within the regions could not be taken on by MCHP staff:

- The rest is up to us. We haven’t really utilized the component for site visits. Also at Rural and Northern Healthcare days a number of people registered and didn’t show. I need to get to the bottom of it.
- (The deliverable) was widely disseminated – now there are people waiting for me to take the lead.
- This area is so specific to the organization, it is hard for the Centre to take responsibility for it. Organizations have their own culture: you can’t change it from the outside.
- Right now accountability all lies with the Centre – this needs to change. At what point are WE influencing things?
- The impetus must come from participants; starting to look at capacity building at the organizational level.

However, although the team felt generally that much of the work of “organizational capacity building” was their responsibility, many were clearly hoping that the project could play a role in helping them (“I see the project with a role in increasing capacity with management teams and regional people”; “This is the responsibility of the RHA reps, but we need help to figure out how to do that”). One person stated “it’s a big responsibility – the expectation that we to back to our RHAs. I find it very intimidating”. Specific challenges included: “to really work on knowledge translation”; “to figure out how to get at decision makers”; “to facilitate evidence-based decision-making”; and “to look at tangible ways of getting information to the regions”.

Effective Activities Undertaken to Date
Five specific activities undertaken by the project were already identified as helpful:

a) having the regions develop their own dissemination plan (although many felt more needed to be done on this);
b) expanding the project to allow a second team member from each region;
c) provision of Rural and Northern Health Care Days;
d) development of reports (the “deliverables”) that focused on issues of concern to the regions;
e) some of the “homework” activities; and
f) regular communication between the Project Director and the RHA CEOs.

One person commented that the project has already done a lot by involving people from each region (“champions”) and that the project “makes us more aware and in the process this pushes the agenda forward”. Many felt that site visits could also play a more important role than had been developed to date.

A number of other suggestions were made as to how the project could perhaps help in affecting change at the organizational level. These included:

- **Addressing the issue of site visits.** These would include workshops or in-services within the regions (as described in section 2.5.3). Site visits were felt to be a crucial component in the next phase of project development and one opportunity built into the project proposal that has the potential to support the organizational level response identified by team members.

- **Providing training and/or consultation** on related topics (e.g. how information moves within a system).

- **Providing support and consultation for RHA team members** in “getting out and about to do presentations”.

- **Formalizing communication and networking** between the project and other groups in the same way that this had been done with the CEOs. For example a number of team members commented on the positive response of the CEO network to regular updates (“CEOs like it when (the Project Director) goes to the CEO table”) and felt this should also be done with other groups (VPs, the Health Programs and Services Executive Network, the Medical Officers of Health, the Planning Network) to “address the gap between the CEOs and The Need to Know team members”.

- **Developing strategies for increased CEO involvement.**

- **Developing strategies to increase the profile of The Need to Know project and MCHP** within the regions (site visits, a PR plan, media and other coverage around release of deliverables).

- **Ensuring that project activities “hook into something RHAs have to do anyway”** (in the same way that the first deliverable linked to the required work of the Community Health Assessment).

- **Developing working groups of team members** to address some of the challenges facing the project.

- **Providing high-profile opportunities for RHAs to showcase their accomplishments** related to evidence based decision-making and utilization of research (i.e. create a level of “competition” where each RHA would not want to be
seen as lagging behind the others in this area). Rural and Northern Health Care Days were one forum suggested for doing this.

- **Continuing to question team members on what they are doing to address organizational issues.**
- **Revisiting the dissemination plans** developed in 2002.
- **Conducting brainstorming sessions** (“how are we going to extend capacity – get members ideas on their roles”).

A few recognized that there may be some risks to the project if more attention was placed on issues of organizational dissemination and decision-making; that these actions might conceivably erode some of the support established by the project to date (“There may be a risk of pushing dissemination plans and broader distribution of the information – the project might shoot itself in the foot”). Those expressing such concerns were those who identified leadership as a barrier to change.

Project staff expressed some hesitation about what their role should be at this point:

- A certain degree of anxiety. I don’t know how to deliver what they say they want – organizational capacity building. It is clear and profound, but fantastically difficult to do.
- I don’t take ownership for what happens beyond team meetings and deliverables. My job is delineated – it’s capacity building. Their job is different.
- I don’t think we have the expertise to make recommendations in terms of decision-making structures. It could be a component of the project, but it involves another kind of collaboration with experts in the field.
- The question is: how do you translate that knowledge of what you’ve learned into action, into your job? I’m not sure that that translation happens. It may depend on the role each has within the organization, whether they have power.

**Organizational Capacity Building within MCHP**

The gap between Manitoba Health and RHAs, compared to MCHP, related to awareness of organizational capacity-building may be widening. MCHP staff generally focus on capacity-building as it relates to community partners. Few MCHP informants interpreted the general question on capacity-building to apply to MCHP, focusing instead on the need for organizational change within the RHAs. MCHP respondents also placed less importance on organizational-level barriers than did the other partners.

While RHA team members focused on the need for organizational change within their own organizations, some respondents also highlighted the need for change within MCHP. (“We need to influence the Centre – regions need to help researchers in reaching the need to change”). Some respondents continue to look for reassurance that true collaboration will continue even after the project is completed (“how researchers do business, may fall back on old ways of doing things that aren’t RHA friendly”).

Although The Need to Know project was viewed positively within MCHP, and often credited with contributing both to the increased profile of the Centre and improved relationships with Manitoba Health, as indicated earlier (section 2.6.2.0) some MCHP staff felt that little change had occurred at the organizational level. Some identified the absence of rewards within academia for collaborative research as an important challenge, and felt that
researchers might be forced to choose between doing good collaborative research (and effective knowledge translation) and achieving success in academia.

Within MCHP, the collaborative approach to research continues to be seen by many as an “extra” rather than core work of the organization. For examples, work with regions (e.g. representing the project) has often been viewed as something that should be delegated to junior staff. This is an issue that should be addressed in development of the “site visits” component of the project – as the evidence from the project to date is that one of the factors contributing to the success of the project is the direct participation of experienced and high profile staff.

**OTHER CHALLENGES IDENTIFIED**

Several other of the challenges identified by the team also relate to issues of organizational change or institutionalization of project activities into other structures.

**Sustainability**

As indicated by the emphasis given to sustainability in the suggested evaluation questions, ensuring sustainability of project activities in some form is seen as a priority, especially as the project moves into the second half of its five-year mandate. There were also concerns that the relationships developed through the project not be lost after it was completed.

One strategy already undertaken by The Need to Know staff team – with the support of the RHAs and Manitoba Health – is the submission to CIHR proposal for funding for related projects.

However, several informants link the issue of sustainability directly to that of “organizational change”. (“The question is: will it be sustained? Is there the leadership in the regions to make it happen?”) “Buy in at the higher levels” was seen as key for sustainability, for as one respondent commented, “unless the project is extended beyond The Need to Know team, it will be short lived”.

**Greater Attention to Provincial Networking**

In both 2002 and 2003, some team members suggested that more work was required to establish formal networks and to continue to develop the profile of the project within the province. Some linked this to the issue of sustainability (“More coordinated with other events in the province, make the structural links more permanent”). Formal communication channels (not simply the informal links established by project team members who might be members of both groups) were suggested for groups such as the Health Programs and Services Executive Network and the provincial Planning Network. Some informants specifically identified physicians as one group that should be incorporated – and suggested developing formal relationships with both the Office of the Medical Officer of Health (and the provincial network of MOHs), and with physicians practicing in the regions.

Team members also recognize the value of ensuring that appropriate networks are established related to the specific topics of deliverables (e.g. mental health and gender), with some feeling that more could have been done in this area (“its important that we have good links or they may not value the results”).
More Attention to the Roles of Manitoba Health and MCHP
As indicated earlier, the focus of project attention has been, appropriately, on skill building and organizational change within the RHAs. There is now some concern that attention also be directed towards other partners. It is suggested by team members that MCHP should be looking at “how the Need to Know can affect other projects”; should encourage all researchers to “think beyond the perimeter”; and look at specific questions and formatting options that would make other reports of more interest to the RHAs. Some within MCHP also identified the additional administrative responsibilities taken on by the Project Director (now Acting Director of MCHP) as another challenge, as there is some concern that her additional responsibilities may result in less time and attention available for project development.

Other respondents suggested focusing more on what the project could mean for Manitoba Health – both related to the roles that Manitoba Health team members could play, and in a larger sense, what Manitoba Health could learn from the project. It was suggested by some informants that appropriate use of evidence was needed as much within government as within the regions.

Continuing Training and Education Opportunities for Team Members
Both RHA team members and the CEOs recognized The Need to Know project as an important source of professional development. Two issues for further development were identified. The first was creating strategies for project learning and activities to receive some kind of recognized credit. The Project Director has made the offer that those interested in achieving credit have the option of arranging a reading course with her. In addition, some participants have indicated an interest in formal university courses, if they were to be offered through tele-health, or in intensive time blocks in order to address distance barriers. One person commented that the University as a whole, not just the MCHP, had expertise and resources that could be utilized more.

- **More accessible courses.** I’ve heard there are quite a few people interested in courses but they can’t drive to Winnipeg. Every region has a tele-health set up, need to look at capacity of that for education. There is also a U of M site at Brandon.
- **Need to find a way for the knowledge they are gaining from this process to be acknowledged.** (e.g. credits towards a masters or Ph.D.). There is little opportunity for graduate work and this is a management need. We are losing a colleague to (name of other university) as they offer a degree online. What a waste. That is one way to build capacity, have a recognized program.

It appears that, through The Need to Know project, the Department of Community Health Sciences has the opportunity to explore innovative ways of providing access to educational programs, and department expertise to areas outside of Winnipeg.

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12 Term used widely in the province to refer to the division between Winnipeg and the rest of the province.
SUMMARY

This section has summarized the design and methodology used in the project evaluation for the 2002-2004 time period. It also described both the accomplishments of the project, and the challenges now facing its development; and assessed the contribution of specific project components to project progress.

There is a high level of support for the project and the specific activities undertaken to date. Development of relationships and networks among project partners; selection, development and completion of the project deliverables; and increased confidence of team members were highlighted as the greatest accomplishments. The greatest challenges, identified by RHA members of The Need to Know Team, are not related to further building the capacity of individual team members, or to participating in, and disseminating the results of, their collaborative research projects – both issues that The Need to Know project has been able to effectively address. They emphasize instead the need for strategies to increase research utilization within their RHAs, and to affect change in how decision-making is conducted.

The next section summarizes some of the findings of The Need to Know project related to effective strategies for knowledge translation.
SECTION 3: “WHAT WORKS” IN KNOWLEDGE TRANSLATION?

One of the most exciting aspects of The Need to Know Evaluation has been the role it has played in the development and refinement of knowledge translation (KT) theory. As all stakeholders were active in the evaluation and had the opportunity – through methods such as key informant interviews and explicit feedback processes – to contribute their perspectives and insights, the project has been in a position to reflect on “what works” in KT from both academic and community perspectives. This enabled the team to be an active partner not only in guiding project development, but also in contributing to development of theory regarding effective knowledge translation. The development and circulation of an article entitled “Demystifying Knowledge Translation – what researchers can learn from the community” was an important aspect of this discussion.

COMPONENTS CRITICAL FOR PROJECT SUCCESS

The evaluation confirms many of the proposed characteristics of effective KT identified in the literature. The key finding from The Need to Know project evaluation is that the most important factors in effective KT are relationship-based, confirming the emphasis placed by other authors on face-to-face contact and early involvement of stakeholders (Birdsell, et al, 2002; Roberts, 2000; Broner et al., 2001; Barwick et al., 2002; Lomas, 2000). However, the evaluation also suggests that there are limitations in how these principles are commonly interpreted. It identified a common theme that connects the various components of KT – the quality of relationships developed between the research partners. A summary of these components is found in Appendix M. Key issues identified through the evaluation are discussed in more detail below.

RECOGNIZING THE EXPERTISE OF COMMUNITY PARTNERS

When the draft article was distributed for comments, it received positive comments from a number of team members. The most positive comments were received on a short section entitled “Making the links: or What our mothers told us about KT”. Because this seemed to strike a chord with so many participants, the section is reproduced here in full:

…. the concepts inherent in KT (if not the terms themselves) are not unknown to us. In fact, many of the principles have their roots in other disciplines and life experiences. From the field of adult education we have learned the importance of involving learners in selecting topics of interest to them, and of their active participation in the learning process. We know that teachers who treat adults as passive “students” who have a lot to learn from “experts” are rarely welcomed or effective. Plain English writing is urged in a number of settings (from instructions for programming a VCR to health education materials) to increase effectiveness of communication with the public. We have learned from communications specialists that if you want someone’s attention, it is helpful to tell them a story. From the field of public relations we are reminded that there is a difference between advertising and public relations or marketing. Telling people what you think they should buy (or want to know) is not as effective as identifying their needs and interests, then designing a product or service to meet those needs.
There are principles that we understand from our own life experiences that are even more compelling. We understand that if people treat us with respect, consult us on issues that concern us and show simple good manners, we are more likely to want to deal with them. We know that we are more likely to ask for help from someone we know and trust than from a stranger; that if people act in a trustworthy way, we are more likely to believe what they tell us; and that if we have a good experience, we are more likely to go back in the future. We recognize that people who monopolize the conversation are not much fun to be with; that we like to do things that are fun; and that if we find activities unpleasant, frustrating or simply a waste of time, we are less likely to get around to doing them. We also learn that if we want action, we have to involve the people who have the power to make it happen, and that sometimes it’s not what you know, it’s who you know. These “common sense” principles, which we apply to personal relationships and business dealings, are also fundamental to KT initiatives.

This highlights the reality that KT principles are NOT “new”; that they are well understood within many disciplines (if by another name). As importantly, what is most important to effective knowledge translation is not the “techniques” employed, but rather the philosophy towards working with community partners. An underlying respect for community partners as capable peers, and willingness to recognize community expertise, allows development of authentic partnerships. While the project has, to date, been successful in achieving such partnerships, the common expressions of surprise by academics at how quickly team members were able to develop research-related capacity suggest that researchers, on the whole, may underestimate the capacity, existing knowledge, and unique insights non-academic partners may bring to the research partnership.

RESPECTING RESOURCE AND TIME LIMITATIONS OF COMMUNITY PARTNERS

Through *The Need to Know* project, the research team gained an appreciation of the often intense resource limitations faced by the RHA participants, including the multiple demands they juggle on a day-to-day basis. This awareness must be translated into a demonstrated respect for the time of participants and a commitment to ensuring that there is real benefit to research participation. While the KT literature recognizes the need for financial support for collaborative activities (Canadian Health Services Research Foundation, 1999; Birdsell et al., 2002), this awareness may focus on the need for an adequate research budget to enable academic researchers to engage in collaborative KT initiatives. It is necessary to ensure that the time and resource demands on community partners receive equal attention. This means not only covering the financial costs of participation of community partners, but also respecting the time of busy professionals, and ensuring that their time is not wasted – that there are benefits to participation.

DEVELOPING TRUST

As indicated in the 2001-2002 evaluation report, a number of team members initially expressed scepticism about *The Need to Know* initiative, and this lack of confidence extended to research itself. By the end of the first year, these concerns had been addressed, with a high level of trust and confidence expressed by the RHA team members in the project. As the
project progressed, participants became even more frank about some of their previous
preconceptions regarding researchers, their usefulness and accessibility. This feedback
confirmed the observation that university researchers are often viewed as elitist in their
approach (Canadian Health Services Research Foundation, 1999), and suggests that all KT
projects should be prepared to find similar attitudes among their community partners. Lack
of interest in research activities may not be the result of ignorance of the benefits of research
(as is commonly assumed in the literature), but an experience-based response based on past
interaction. As experienced managers, community team members were also acutely aware
that too often the rhetoric of “partnership” was simply that – rhetoric. Some community
participants were not at first convinced that they were to be treated as full partners.

At the end of the day the question will be: How honest are we about the collaboration? Or will the
Centre just listen to what it is interested in doing?” “Will the Centre actually “hear” what the
RHAs need – will they listen?

These comments were not based on previous experience with this research organization – in
fact most had no direct experience with MCHP at all. Rather, they were an expression of a
generalized lack of confidence in researchers, their agendas, and the potential benefit of
research to the community.

The first task facing the project was, therefore, to address the concerns that many
community partners had about research and its relevance to their work. It was also necessary
to demonstrate that the partnership was genuine, and that there was a commitment both to
authentic participation and to addressing research questions of concern to the RHAs. This is
a radically different conception of KT than one that simply focuses on transfer of
information from a research expert to the community practitioner (Broner et al., 2001).

IT TAKES TIME

Much of the work on knowledge transfer and dissemination tends to focus on specific
activities, implying that KT can be accomplished through time-limited, well-defined
activities. However, if KT depends on the quality of relationships developed between
researchers and community partners, long-term strategies may be required. The Need to Know
project found that time was required to build trust, develop a shared culture (including a
shared language), identify common priorities, undertake collaborative research and plan
together what should be done with the results of this work. Time was also needed for
participants to “grow into” the project – to clarify their roles and to feel confident in what
was expected, and what the potential of the project could be. A year and a half into the
project participants were making statements such as “I’m just now starting to catch on, it’s starting
to jell”; “I’m taking ownership of the project compared to a year and a half ago”; or "I finally have a sense
of what I’m doing”. Such comments, along with others expressing concern about the
limitations of “one-off” educational events, reinforce findings from the literature that
ongoing relationships and continuity of educational opportunities are important for KT
(Kramer & Cole, 2002). While it may be realistic for the project to plan specific short-term
activities in the future, these will be built on an established basis of trust, and within a shared
“culture”.
RELATIONSHIPS AND LEARNING

As outlined in Section 2, three kinds of learning were identified through the project:

- factual learning (e.g. research concepts, findings of specific research projects);
- how to locate and access needed information; and
- a change in how research is viewed, and one’s relationship to it.

Of these, the third category may be the most important. It has been recognized that research may change attitudes and approach (Davis & Howden-Chapman, 1996), and attitudes to research may affect its use (Stetler, 1994). Our findings suggest that the relationships developed with researchers may be key to this attitude change.

Research may be used in instrumental, conceptual or symbolic ways (Lavis et al., 2002). It appears that research may be more commonly used in indirect (or conceptual) ways than in applying specific studies to specific decisions, and so there may be more utilization of research in policy-making than is recognized (Hanney et al., 2001). Our research suggests one reason why this may be so. Unlike factual learning, a transformation of one’s view of oneself in relation to research is empowering in the true sense of the word. Changes resulting from this increased confidence may lead to greater openness to research and its potential usefulness — and so “what is learned” about research may be more immediately usable even by those who may lack the authority for direct implementation.

- I think involvement has broadened my thinking. Before I would say that I was able to think about our RHA as a whole, but now think more provincially and more broadly about health, whereas before I focused more on health services.
- It has taught me to ask more questions and not just accept the status quo. I think more in research terms and look for evidence for decisions — not just because this has always been done.
- How I approach tasks is much broader than a couple of years ago. I understand all the things I should look at, and am learning about where other information is.

This conceptual use of research may be less rewarding to researchers (as “their” research may not be used directly, and perhaps not as they intended); it may be, however, of most long-term benefit. With more positive attitudes to research and its benefits (as well as its potential misuse), community team members become creative partners in research implementation, not simply conduits through which research flows towards predetermined targets. It may also contribute to the extent to which planning and policy-making is generally “informed” (Lavis et al., 2002).

MOVING BEYOND INDIVIDUAL CAPACITY BUILDING

At the same time that The Need to Know project has highlighted the importance of individual relationships, another critical theme has emerged. How do those involved in KT move their learning into the decision-making arena? Once the RHA partners became confident in their role as team members, they quickly identified what to all the stakeholders has emerged as the greatest challenge to project success. There is a big gap between increasing the capacity of individual RHA team members, and actually influencing how research is used for planning purposes within RHAs (one goal of the project). Challenges are found at a number of levels.
The RHA team members themselves do not have the authority to implement change within their regions. A change in organizational processes and structure may be needed in order to better support evidence-based decision-making (Rosenheck, 2001). Although researchers may not view these organizational issues as their responsibility, without assistance at this stage, community partners may not be able to use the research generated (Davis & Howden-Chapman, 1996).

While the barriers faced by health authorities in utilizing research have received little attention (Marshall, 1999), some barriers may be systemic in nature. For example, there may be limits on decision-making authority granted to the regions by the provincial health department (Lomas et al., 1997). It is therefore necessary to ensure that discussion of appropriate action be geared to the level of decision-making authority of community participants.

As outlined in Section 2, The Need to Know project evaluation has identified four levels of project impact. The first level, that of individual learning of project team participants, is one that the project has been able to effectively address. There has also been progress reported at the second level of impact (“how I do my job”). In general, changes at this level appear to be at the level of conceptual use of research rather than application of specific findings – i.e. participants reported that their involvement in the project affected how they understood and responded to problems (“I think I look at data and information differently now. I’m not totally daunted. Now I can have an intelligent conversation with planners”).

However, at the mid-way point of the five-year project, participants continue to report less impact at the third level: changes in how RHAs make decisions. The project is only beginning to address this level of KT, which is also more difficult to evaluate since many factors may contribute to such change. The greater impact reported at the level of provincial committees and networks likely reflects the “critical mass” of participants who are also part of The Need to Know project; overlap between the focus of these committees and the project; and the relatively simple structure and clear mandate for decision-making of these committees compared to those of the RHAs.

**THE CONTINUED IMPORTANCE OF THE “PERSONAL FACTOR”**

While relationship factors (such as personal contact and trust) are consistently identified through the literature as key factors in KT (Innvaer et al., 2002; Hanney et al., 2003; Lavis et al., 2002; Lomas, 2000), the experience of The Need to Know project suggests that the importance of “personality” in KT has not received sufficient attention. The importance of the quality of interaction (and the values expressed through such interaction) may help explain why some efforts at interaction have little impact (Lavis et al., 2002), and why many diverse approaches to the linkage role are effective. If the key issues in effective KT relate to the ability to gain trust and facilitate participation, then whether the linking role is a project investigator, an identified knowledge broker (CHSRF, 1999), a “credible messenger” (Kramer & Cole, 2002), a “charismatic leader” or a “research transfer officer” (Canadian Population Health Initiative, 2001), may be relatively unimportant. It may be instead “the personal factor” (Patton, 1997) – often overlooked in evaluation activities – that is the crucial research variable, rather than which “model” of KT is adopted, or the specific
activities in which participants are engaged. This “personal factor” is as much an issue of character (relying on respectful and ethical behavior) as of personality. It is more than “being nice” – it requires attention to the “political” and value issues related to decision-making and control. Organizational commitment is therefore required.

One essential requirement is for the research team to begin with a genuine commitment to collaborative research and respect for the contributions of community partners. It is also necessary for them to ensure that the appropriate networking and interpersonal skills are in influential positions on the research team. The “personal factor” is also important, however, in selection of other partners. Although much thought and preparation was put into creating a welcoming and collaborative environment, it has been suggested that the project “lucked out” in terms of who was selected by each of the partner groups to represent them. This indicates that one of the most important criteria for selecting effective team members is their ability to work in a collaborative manner with their peers. This “qualification” should be included in discussion of participant selection; it may also be advisable to build in an assessment process early in project development.

It has become common to describe some of the differences between researchers and community partners in terms of two different cultures (Ginsburg & Gorostiaga, 2001; Lomas, 2000). This two-cultures hypothesis describes the different worlds in which researchers and decision-makers work, and employs the principles of intercultural understanding. Our work supports the contention that human values, ethical principles, and dynamics of power may be more important than the two-cultures hypothesis (Ginsburg & Gorostiaga, 2001), and that the challenge in KT is to develop and strengthen a shared culture.

Implications for Research Organizations
These findings have implications for research organizations as well as for individual researchers. While interpersonal skills are recognized as important in many professions (e.g. teaching, sales), they have historically not been required of researchers. A highly skilled researcher, with the credentials to gain research funding, may be quite inexperienced in development of networks, or in group building and facilitation. Research organizations that are committed to KT must ensure that they have the right “personalities”, as well as appropriate skill sets in key positions on the research team (Buckeridge et al, 2002). They must be prepared to take “relationship” seriously, reprioritizing functions within the organization if necessary, and ensuring adequate resourcing and valuing of these functions.

THE ROLE OF WEB-BASED SOLUTIONS
This project indicates that despite the attraction to researchers and funders of web-based solutions for research dissemination, there may be serious limitations to this approach in some settings. Other researchers have found that the provision of elaborate software opportunities does not necessarily translate into use by local health researchers and practitioners (Chiasson & Lovato, 2000). Face-to-face contact – and the development of trust – may be pre-requisites for transfer of knowledge using technology (Roberts, 2000). Additionally, depending on the community partners of interest, internet use may not be a preferred (or acceptable) approach to information sharing.
ADDRESSING BARRIERS WITHIN ACADEMIA

The experience of *The Need to Know* project also confirms the observations of several authors regarding barriers to collaborative research within academia. Often, in spite of a stated commitment to collaborative research, researchers may be apprehensive about participation of community partners (Buckeridge et al., 2002; Birdsell et al., 2002; Broner et al., 2001), which may be perceived as handing over control of the research agenda. Consequently, community involvement may be limited to advisory or feedback roles, with participation carefully managed in order to lead community partners to approve already identified priorities. Community partners can, however, differentiate between token and genuine participation; partnership requires meaningful involvement in setting priorities and selecting topics.

Initially, there was concern from within MCHP that community partners may not be able to understand the potential and limitations of administrative data, and some apprehension about the decision-making process itself. There was also apprehension that the project may generate inappropriate demands on the organization. These concerns turned out to be unfounded. The topic selected for the second collaborative research project, although not one preferred by the principal investigator, was quite appropriate for administrative database research methods. If the project had not been prepared to allow the RHA partners to select their priorities, the relationship developed to this point could have been negatively affected. The research topics themselves may not be as important as the process used to decide them and the relationship developed between the researchers and users (Broner et al., 2001; Mohrman et al., 2001).

However, presentations made by project staff to graduate students have identified – along with much positive interest – some stiff resistance to aspects of collaborative research among some researchers in training. In addition, within MCHP there has been limited uptake of collaborative research approaches, which tend to be viewed as discretionary, and often as time consuming.

Some of the response to the first project deliverable (“The RHA Atlas”) demonstrates the potential of real tension between researcher and user priorities (see discussion in section 2.5.1.7). Even though the topics for the three research reports have been successfully negotiated within the framework of *The Need to Know* project, it cannot be assumed that such processes will be well enough established to ensure that such approaches continue after the project ends and additional funding to support KT activities is no longer available. Even though there is increasing recognition of the benefits of collaborative research and KT initiatives, there is an expectation that they require additional resources, not that they can be incorporated into ongoing activities.

A further challenge will be the extent to which the research organization itself is able to extend the learning of individual project staff to the benefit of the larger organization. While there is a need for organizational infrastructure to support and ensure integration of KT into the work of the organization (Canadian Health Services Research Foundation, 1999), few organizations dedicate resources to enhancing this internal capacity (Lavis et al., 2003). Many research organizations respond by vesting this responsibility in one or more individuals. As a result, organizational planning and priority setting activities may remain unaffected by the
KT knowledge gained by specific individuals. This is the same issue that challenges the achievement of KT objectives among community partners. The dynamics of decision-making within research organizations must therefore be given the same attention as the decision-making practices of community partners.

In addition, several researchers highlighted the lack of rewards within academia for undertaking authentic collaborative research and knowledge translation activities. These activities continue to carry relatively little weight in hiring, promotion and tenure decisions (Lomas, 2003). There are also reported difficulties within Canada in having KT articles published in peer-reviewed journals, which is an essential requirement for success within academia.

Broadening the Concept of Capacity-building

The Knowledge Translation literature suggests that many KT initiatives begin with the intent of building capacity among community partners, with less emphasis on the need to build capacity among researchers. Inherent in this approach is an often unrecognized assumption that researchers alone are the experts on research, and the necessary learning is all on the side of the community. The Need to Know project indicates, however, that collaborative research has the potential to result in significant learning on the part of researchers. This learning may include: improved knowledge of the communities studied; what kind of research is most useful; the role of community consultation in ensuring quality and explaining unanticipated outcomes; and understanding how research is utilized in the community.

One of the risks of the common “one-directional” approach to capacity building is that unless researchers recognize that they too have something to learn, it is unlikely that they will be open to the idea that they may have “got it wrong” – either by focusing on an issue that is not important to users (or one where the community will tell you they already have the answers), or by misinterpreting the findings. It is not enough to do research in relevant areas (Mohrman et al., 2001), or to provide a forum for sharing information, collaborating on projects and joint exploration of findings. Respect for the expertise of community partners must be demonstrated throughout the research process. A willingness to learn from community partners requires not only good interpersonal skills, but also “humility” about one’s own competence and a willingness to engage in joint learning on an ongoing basis (Tervalon & Murray Garcia, 1999).

The Need to Know project suggests that KT activities may challenge researchers in several ways: to make changes in “how they do their jobs”, to find time for consultation; and to learn skills that are not necessarily taught in graduate programs or rewarded in academia (Canadian Institutes of Health Research, 2002; Canadian Health Research Foundation, 1999). The excitement generated among researchers associated with The Need to Know project suggests that younger researchers may be quite receptive to this kind of learning if they have the benefit of an environment where it is facilitated and rewarded, and that many of those who have the opportunity to participate directly in well-managed collaborative research projects will be encouraged to adopt more consultation in their own research. However it may be more difficult to convince researchers who have well-established (non-collaborative) work styles or who lack such direct contact, of the benefits of collaborative approaches.
ISSUES FOR REPLICAION

Section 2c in the 2001-2002 Evaluation report identified issues for replication in early stages of development of similar projects. Through evaluation of 2002-2004 activities, some of these original recommendations can be strengthened and additional suggestions made:

THE RESEARCH TEAM

The increasing evidence of the importance of the “personal factor” suggests that research organizations sponsoring collaborative research activities must ensure that appropriate skills in facilitation, adult education, networking and communication are present in influential positions on the research team. It is also recommended that the sponsoring research organization spend time preparing for the project by exploring (and challenging) assumptions about working with community partners.

INCORPORATING STRATEGIES AND RESOURCES FOR ORGANIZATIONAL CHANGE

The continued importance placed by the project’s community partners on organizational barriers to research use, suggests that effective KT models should recognize and incorporate strategies to address the potential impact of organizational-level factors, and not rely exclusively on education and training of individuals.

SELECTION OF REPRESENTATIVES

Given the importance of the “personal factor” in project success, the ability of team members to work collaboratively with peers and those from other systems emerges as one of the most significant characteristics for consideration in participant selection.

Another key issue related to the impact of project activities is the role and position of team members within their organization. As one informant observed:

A lot depends on the rank and position of the person within the organization. If they are not an integral part of management...people will then just do their own thing. The issue is not so much who they send, but the skills and position they have within the organization. Need to... have a regular opportunity to address the management team. Need some kind of formal method or it will depend too much on personalities.

If, for some reason it is not possible or feasible for organizations to designate an individual in such a position, one alternative would be for management to ensure that appropriate reporting (directly to the CEO/senior management) is established, and that other strategies (e.g., having a report on project activities as a standing agenda item for all senior management meetings) are instituted to facilitate dissemination and impact.
Other factors have also emerged as having an impact on the ability of selected representatives to have an impact within their own organizations – other personality factors (e.g. how “outgoing”, persuasive, and assertive a person might be); current workload; informal connections with the CEO and senior managers; personal interest in research; and whether the staff person is located in “corporate office”. Interestingly, the individual’s previous research training appears to be of less importance.

Some informants felt that the “process (of participant selection) needs to be looked at”. It was clear from the CEO interviews that more discussion and direction would be beneficial to those selecting team members for similar projects, as the RHAs struggled with the decision and often made their decisions based on different criteria. Some team members initially were concerned that they were not the appropriate choice, although many have since changed their minds. (“At first thought I was not the most appropriate, but now think I am the right choice”; “Speaking personally, I’m happy about the way things shook down”). Most were content with the selection and some specifically commented that they liked “the mix” of individuals in the group, suggesting that it would not be as interesting if individuals were all in the same position. The role of Medical Officers of Health as team members was the source of some discussion. On the one hand they were seen as often the most appropriate in terms of role and educational preparation. On the other hand, as employees of Manitoba Health, it was recognized that they had “no authority, no budget”, “don’t have anyone reporting to them so can’t make things happen”, and they could “make suggestions but it is not (their) decision” about what happens.

**SUMMARY**

Several factors have been identified as critical to effective KT. Many of the elements identified relate to quality of relationships. *The Need to Know* project has found that the most crucial KT principles are well understood by a lay audience and can be easily communicated. Greater challenges may lay in convincing researchers that these “common sense” principles are fundamental to KT, and in having research organizations prioritize the non-academic functions of KT activities. Theory building around KT is not the exclusive domain of researchers. It is essential that community research partners participate in theory development, not only to ensure that their expertise is included, but also to assist researchers in developing expertise in this area.
SECTION 4: CONCLUSION AND RECOMMENDATIONS

To date, The Need to Know project has made good progress towards, or has already achieved, all of its objectives and in many cases exceeded the expectations of the partner groups. It has evolved to gain the enthusiastic support of all partners, and has generated research that is viewed as important and useful to the rural and northern health authorities. In spite of minor differences in perspective, there is impressive consensus on the part of all stakeholders regarding satisfaction with the project and its activities, project accomplishments, and key challenges now facing the project.

A REVIEW OF EVALUATION FINDINGS IN LIGHT OF THE CONCEPTUAL MODEL

Project objectives are described in three areas: development of new knowledge; development of RHA relevant capacity; and communication, dissemination and application of research.

NEW KNOWLEDGE DEVELOPMENT

In terms of “new knowledge development”, progress has been achieved in two areas. The first is the development of research relevant to northern and rural health authorities – a clearly articulated goal of the project. The first collaborative research project (The Manitoba RHA Indicators Atlas: Population Based Comparisons of Health and Health Care Use (Martens et al., 2003) was completed on schedule. This report included indicators identified by the team, and analyses based on districts defined by each RHA through The Need To Know project. The project evaluation identified a high degree of satisfaction and engagement with the process. This report, according to both RHA and Manitoba Health Team members, is making an important contribution to current regional Community Health Assessment activities. The usefulness of the indicators is also reflected in the adoption of several of these indicators by a provincial quality indicators working group. The success of the first research project also led to a request by the Winnipeg Regional Health Authority (WRHA) to produce a parallel report to the RHA Indicators Atlas, using Winnipeg’s districts.

A process for developing consensus on the topics of the remaining deliverables (including strategies for consultation within each RHA) was developed in conjunction with The Need to Know team. The second deliverable (Patterns of Regional Mental Health Disorder Diagnoses and Service Use in Manitoba: A Population-Based Study) is well underway, with drafts of specific chapters now circulating to team members for critique and input. A fall 2003 completion date is anticipated. At the February 2004 meeting, the group came to consensus on the topic of the third research activity – an exploration of male/female differences in health, health

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1 The goals and objectives of the NTK project are outlined in the 2001-2002 Evaluation Report, and summarized on pages 20-21 of this report. Note that in the first year, changes were made to the conceptual model in light of this evaluation.
care use, and outcomes. There was an even higher degree of confidence in the process used to select this deliverable than there was for the second research collaboration.

A second area of knowledge creation and development relates to the contribution of the project to research on knowledge translation (KT). The participatory nature of the evaluation has enabled the project to actively include community partners in the development of KT theory, resulting in unique insights as to “what works” in KT. These include: a) comparison of common interpretations of KT principles and inclusion of aspects that require greater emphasis (Appendix M); b) identification of “modes” of learning of importance to KT, and their roles in promoting evidence-based planning (page 64) and c) various levels of impact of KT initiatives (pages 63-66).

DEVELOPMENT OF RHA RELEVANT CAPACITY

The conceptual model includes three sub-categories within the goal of development of RHA-relevant capacity – accessible information, training of RHA Team members, and training of academics.

Accessible Information
The first collaborative research project (“The RHA Atlas”) incorporated input from the team, contributing to a user-friendly content and format. Review and analysis of the report was highlighted at the October 2003 MCHP Rural and Northern Health Care Day, contributing to increased awareness of the report, and to effective dissemination. It also assisted the RHAs in understanding the implications of report findings for their region. This report is available in hard copy, and in PDF file on the MCHP and Team websites (www.umanitoba.ca/centres/mchp/ and www.rha.cpe.umanitoba.ca).

The Need to Know project has expanded its definition of “accessible information” to include more than availability and user-friendliness of research reports. RHA team members stress the importance of having access to researchers with a variety of expertise, in order to help locate print resources, identify researcher areas of expertise, or simply act as a general resource and support. Team members report (and demonstrate) a high level of confidence in approaching MCHP researchers for assistance. Workshop sessions on such topics as web-based literature searches, and using resources available through the university library system have increased the capacity of team members to access a broad array of information.

Training RHA Team Members
Within the category of training RHA team members, the evaluation has identified three types of learning that have been accomplished through the project: a) factual learning (research concepts and content of reports); b) how to locate and access information; and c) a change in perspective related to research, researchers, and one’s relationship to research (empowerment). Preliminary evidence from the project evaluation suggests that the latter may be most important.

Most of the project activities are organized around the two-day The Need to Know team meetings, held three times a year in Winnipeg (one day of the fall workshop is held in conjunction with the MCHP Rural and Northern Health Care Day). By the end of the first
year, these workshops were extremely highly evaluated, and positive evaluations have continued. Team members are playing a greater role in identifying training gaps, and are requesting that more time be directed to the interpretation of research. The building of capacity among RHA team members has encouraged some to pursue further studies.

Several other indicators of the effectiveness of this “capacity-building” can be identified. Self-reports indicate that participants are no longer intimidated by researchers, and feel that they can participate confidently in local planning activities as well as research forums and conferences. There is significant improvement in self-rated understanding of research concepts (pre/post test survey, 2002). Team members have also effectively taken on the lead facilitation role at the Rural and Northern Health Care Days.

Training for Academics
The most recent phase of the evaluation has identified strong support for collaborative research among researchers and other MCHP staff directly involved with the project. Concerns or hesitations about perceived “risks” of the project (outlined in the 2002 Evaluation Report) are no longer evident. The learning identified through such involvement in this project includes: a) the importance of community research partnerships and team building activities; b) recognition of the expertise of community partners; c) the reality of applying research to planning in a real world situation; and d) the identification of barriers to research understanding and use.

Feedback from graduate students involved in the project is extremely positive and indicates that their role in the project is not only contributing to their increased understanding of concepts and principles of knowledge translation, but also a greater commitment to collaborative research in the future. Some appreciation of the benefits of collaborative approaches is expressed by established academics who have a role with project deliverables or in team workshops. There is also evidence that effective strategies are being implemented to share project findings with academics beyond the sponsoring university. The models for both the project and the project evaluation have received inquiries from a number of provinces. Team members (including in recent months, RHA team members) have presented several poster, oral and workshop sessions at national workshops, and articles on the project have been submitted for consideration in peer reviewed journals.

COMMUNICATION, DISSEMINATION, AND APPLICATION OF RESEARCH
The final project goal relates to communication, dissemination and application of research. By the end of the second year, all stakeholder groups had defined the development of networks and relationships as the greatest accomplishment of the project. This continues to be highlighted as an essential component in project success. By the end of the first year and a half, the strongest relationship development was reported between MCHP and the RHAs, and between RHA team members themselves. Since then, relationships between Manitoba Health and both MCHP and the regions have also strengthened. Regular contact among RHA Team members between the regularly scheduled team meetings is now being reported, as are an increased number of requests to Manitoba Health.
The Need to Know team members participated in development of dissemination plans for the first project deliverable, and further work on dissemination planning is planned for summer 2004. There is evidence that a greater number of requests have been received for “The RHA Atlas” than many other MCHP reports.

Although there are two years remaining in the project, some of the project objectives have been accomplished. The “templates” for the team meetings (and Rural and Northern Health Care Days) as the framework to support project goals and activities has worked exceptionally well – only regular monitoring (including maintaining strategies for input and evaluation) is now required. The effectiveness and acceptability of the model used for the MCHP Rural and Northern Health Care Days has led to the same template being used for equivalent workshops for the Winnipeg Regional Health Authority and Manitoba Health.

**PARTNER EXPECTATIONS – MOVING TO “THE NEXT LEVEL”**

The project is now at the point where it is facing a major decision. While there is exceptionally high support for project activities to date, additional objectives identified by team members by the end of the first year of project operation have grown in importance. Many of the team feel that attention should now be directed towards the challenges of promoting greater use of research in planning within the regions. It is affecting change at the organizational level – not the development of research-related skills, or production of useful research – which the team now identifies as the greatest challenge. As one informant commented, “the collaboration has been very successful. The next half (of the project) should focus on what is being done at the regions in terms of using evidence”. A major challenge, therefore, is to determine to what extent the project will seek to address these additional expectations, as they relate to areas where the MCHP is admittedly not an expert, and were not explicitly envisioned – or funded – as part of the original project proposal.

The activities that can be well supported by the “team meetings” are the ones that have been most successful, and for which the most positive evaluations are obtained. One option for the project would be to limit initiatives in this area to team meetings, focusing on providing a greater number of activities to support the RHA team members in their role of facilitating organizational change. Such a response would likely result in some changes at the organizational level over time, especially if the enthusiasm generated to date can be maintained. There is, however, the possibility that such responses may not meet the growing expectations of team members.

Another option would be, in addition to designing specific sessions as part of team meetings, to investigate redirecting project resources towards supporting and enabling team members to further develop strategies for organizational change (e.g., focusing on site visits). As one MCHP staff member observed, “I worry about doing less than we could…a little worried as we move forward that we progress beyond the educational process”. An additional advantage of taking this “next step” is that it would facilitate further development of KT theory. Little research to date has focused on addressing barriers to KT at the administrative level – the level of concern to this project.
A third option, which could be combined with either of the alternatives described above, would be to seek funding for an additional project to address the challenges faced within RHAs and the other partner organizations. Any such initiative, like The Need to Know project itself, would require collaboration of community partners in design and implementation. In addition, it would require a higher degree of involvement from the regions (and from MCHP and Manitoba health were they to be included), than has been required to date.

RECOMMENDATIONS

RECOMMENDATION #1: STAY THE COURSE

Many recommendations resulting from this phase of evaluation relate to continuing activities and strategies that have been demonstrated to be effective. The following areas have been well developed and are positively evaluated by all stakeholders. The major recommendations for these components are to “stay the course”. While ongoing monitoring is recommended, and there may be minor adaptations needed, the project appears to have found an effective template in the following areas:

- Team meetings as a focus for project activities,
- Rural and Northern Health Care Days,
- Strategies for evaluation of team meetings and other direct project activities,
- Selection of, and MCHP/RHA team member collaboration on, project deliverables,
- Provision of learning opportunities for graduate students.

Excellent progress has also been made, by this midway point, in the following areas, which require only continued attention and development:

- Transfer of project findings to the academic community,
- Contribution to KT theory and practice (inclusion of community partner perspectives),
- Impact on related planning activities (e.g., provincial networks).

RECOMMENDATION #2: ADDRESS PARTICIPANT INTERESTS IN “MOVING TO THE NEXT LEVEL”

Recommendations related to organizational development do not indicate any failure of the project – rather they reflect additional opportunities that are emerging based on the successful evolution of the project to date. The first recommendation in this area is to:

- Develop and implement strategies for collaborative evaluation of alternatives for promoting and facilitating “organizational capacity building” within RHAs. These alternatives are outlined on the previous page.

2 In June 2004, a funding submission, From Evidence to Action, was submitted to CIHR. This proposal is designed to address organizational barriers to research use.
Within the framework established by this process, it is recommended that the project:

- Develop strategies for assisting RHA team members to address organizational barriers to increased use of research for planning purposes.
  - Conduct a planning/brainstorming session to develop strategies for greater RHA involvement. (For example it could be proposed to the CEOs that The Need to Know team members from all regions make a presentation to their senior executives on implications of project research for the regions.)
- Develop strategies for education and involvement of CEOs, VPs and regional senior management. These could include such alternatives as:
  - Sharing with the CEOs at a RHAM (Regional Health Authorities of Manitoba) meeting, the barriers identified by The Need to Know team members and discussing strategies to address them.
  - Developing and disseminating a list of concrete suggestions that CEOs can undertake to support the RHA team members.
  - Undertaking a province-wide assessment of regional supports/models for promoting use of research within the RHAs and circulating findings to CEOs.
    - Consider developing a mini-Atlas of best practices related to evidence-based planning for the NTK team (performance indicators) for comparison between regions.
    - Highlight individual RHA accomplishments in high profile settings (e.g. Rural and Northern Health Care Days).
- Develop strategies to increase MCHP awareness of the implications of organizational-level change for research organizations, and encourage adoption of organizational responses.
  - Ensure that MCHP advisory board, researchers and management are made aware of participants’ expectations and concerns.
  - Develop lists of indicators of organizational change.
  - Review issues (such as administrative support, format of deliverables, and relationship between project and centre) identified in key informant interviews.
- Develop strategies to support the efforts of Manitoba Health team members to facilitate increased organizational awareness and responsiveness.
  - Conduct evaluation and follow-up of Manitoba Health Day.
  - Assess needs and interests of Manitoba Health team members.
  - Assess, in conjunction with Manitoba Health team members, potential areas for additional linkage and communication.

ADDITIONAL RECOMMENDATIONS

The following recommendations are based on issues of concern at the time the report was written (March/April 2004), and reflect suggestions emerging from the evaluation process. Unlike the previous section (which identifies major trends in project development) these recommendations are updated every four to six months.
Site visits
Many team members identify the development of site visits as crucial at this point in project development. The “site visits” are one funded component of the project which has the potential for addressing – at least to some extent – some of the issues related to organizational development identified by The Need to Know team. As the RHA team members recognize that much of the responsibility for action lies with them, it is also essential that the planning strategies for the project be expanded to support and facilitate greater participation of team members, and that the insights and expertise of the team are fully utilized.

Recommendations:

- Prioritize development of the site visit component of the project and its potential for organizational capacity building.
- Allocate adequate time in team meetings to discuss and develop effective models.
- Consider additional collaborative strategies for development of these models (e.g., working/planning groups).

Project Evaluation
The evaluation strategy has been effective for evaluation of participant satisfaction of project activities, and for ensuring input of stakeholders. As the evaluation was not a component of the original proposal, however, it has not been allocated the resources to undertake a larger evaluation of impact at the organizational (particularly the regional) level. As the evaluation component has played an important role in development of project activities, and in development of KT theory, it is important that it continues to evolve with the project.

Recommendations:

- Revise the evaluation plan in response to future decisions made regarding project scope and emphasis
  - Redirect resources to areas of greatest concern.
- Make more explicit the links between the evaluation and implications for practice.

Sustainability
As the project passes the midway point, there is increasing participant interest in a focused strategy for ensuring sustainability of project activities.

Recommendations:

- Establish an intersectoral working group to develop a draft strategy for ensuring sustainability of project activities.
  - After review by the project team and the project Advisory Committee, take forward this strategy for discussion to all stakeholder groups.
- Develop and implement strategies for increased involvement of regional senior management.
  - Continue with presentations to CEOs; use these presentations not only for updates but for specific messages related to organizational support.
  - Develop additional strategies for regular and formal communication with CEOs and senior executive (e.g. tools/info sheets).
  - Develop a strategy for orientation of new members of regional senior management to the project.
• Develop strategies to establish and strengthen external networks.
  o Generate a list of suggested networks, and develop a networking strategy in conjunction with *The Need to Know* team (e.g. HPSEN, Planning Network, MOHs).
    - Assign official liaison persons for each group/sector.
  o Incorporate consideration of physician role into planning for dissemination and site visits.

**Team Meetings**
In order to maintain the high level of effectiveness and enthusiasm generated to date, it is necessary for team meetings to evolve to meet the expectations generated by a mature and active network.

Recommendations:
• Continue with team meetings as a focus for project activities.
• Maintain an emphasis on:
  a. Adult education approaches,
  b. Extended time for discussion,
  c. Continued opportunities for regular input into workshop topics and format,
  d. Emphasis on relationship development, including “team suppers”,
  e. Active role of RHA experts in workshop presentation/facilitation.
• Ensure adequate time for discussion of deliverable selection, review and analysis of results.

**Deliverable Development**
There is a high level of satisfaction with both the content and the process of the project deliverables. However, interviews revealed that continuing attention is required in some areas.

*Consultation:* There are varied degrees of attention paid by individual RHAs to consultation within the region.

Recommendations:
• Communicate to CEOs/senior executives expectations of consultation required within the regions.
• Formalize reporting back and group discussion of consultation undertaken to enable sharing of effective strategies.

*Dissemination planning:* There are important differences among RHAs in breadth and effectiveness of dissemination strategies used for the last deliverable.

Recommendations:
• Prioritize review of dissemination strategies at the June 2004 team meeting.
• Collate list of effective practices.
• Consider developing a suggested list for distribution for each deliverable.
Interpretation and application of research: Many participants have identified the need to develop additional skills related to interpretation of research and application to specific health areas.

Recommendations:
- Develop activities to increase participation/feedback during development of the project deliverables.
- Allocate sufficient time in workshops for these activities.
- Explore strategies to encourage greater responsibility for reviewing penultimate version by RHA team members.

The Mental Health Deliverable: Participants have identified specific issues related to the development of the Mental Health deliverable.

Recommendations:
- Formalize links/network with the network of provincial mental health managers.
- Develop strategies for including mental staff in planning, dissemination and application of the deliverable.
- Ensure links are made with CCHS data (e.g., differences in definitions, what should be included).
- Provide appropriate training in mental health concepts prior to the October 2004 Rural and Northern Health Care Day.
- Review and revise the dissemination plan for the regions and the province.

New Team Members
There is good support for adding additional team members, but some concern about continuing to add members as the project moves past the half-way point.

Recommendations:
- Have discussion on merits of continuing to add new members as the project passes the mid-way point.
- Incorporate into the selection criteria for new team members the role/ability of selected representatives to have direct communication with CEO/senior executive, and increase the profile of the project throughout the region.
- Continue to monitor participation of “sole” representatives, and plan discussion activities to ensure that they do not feel isolated in workshop activities.

Additional Opportunities for Individual Capacity Building
The project has identified interest on the part of RHA team members in additional educational resources and receiving recognition for skills they develop through the project.

Recommendations:
- Provide information on the EXTRA initiative, and explore the potential of this program to support RHA team members.
Facilitate The Need to Know team formally communicating their concerns regarding development of more flexible educational opportunities for rural and northern residents to Community Health Sciences/University of Manitoba.

Revisit the issue of potential of university credit for team participation.

Continue to include in team meetings opportunities to meet researchers, university faculty and external experts.

Web Use/ Computer Skills
Use of the project web site remains highly variable. More discussion is required to identify needs and interest in the needs for computer training and support, as distance requires reliance on the website to support some of the discussion, feedback, and decision-making around deliverable development.

Recommendations:
- Conduct immediate phone follow-up to ensure that all members are able to access the project website.
- Review, and re-evaluate with team members, optimal time allocation/format for teaching computer related skills.
- Consider establishing a working group to address strategies/feasibility of increased use.

Role of Manitoba Health
Manitoba Health team members are still perceived by some as having a somewhat different, and more peripheral role in spite of reports of improved personal relationships.

Recommendations:
- Design, where possible, homework assignments and workshop activities in a way that there is a clearly worded active/equivalent role for Manitoba Health team members.
- Conduct follow-up with Manitoba Health on key issues:
  - Role and expectations of Manitoba Health team members,
  - What project could do to better meet their needs as participants,
  - Strategies for further communication with other Manitoba Health staff,
  - Expectations re: North/South/Manitoba Health meetings.

Conference Attendance
There is concern from some team members that the “project is running out of time”, and that opportunities to attend conferences might be missed. There is also concern that conference attendance should be planned strategically to maximize the benefits of conference attendance to both the project and the regions.

Recommendations:
- Develop a strategy for identifying and prioritizing support for conference attendance.
- Review expectations of attendees when attending conferences; consider providing this in written form.
**Homework**

“Homework” activities provide one mechanism for supporting organizational development activities.

Recommendations:
- Continue with homework assignments.
- Plan assignments with a view to a) facilitating organizational involvement/change, and b) increasing the likelihood that *The Need to Know* “protected time” be supported at the organizational level.
- Consider communicating information on homework assignments on a regular basis to RHA CEOs.
- Explore benefits of reframing “homework” as organizational development activities.

**Advisory Committee Meetings**

The role of the Advisory committee related to project activities is somewhat unclear, and there is some lack of clarity on the role of some representatives.

Recommendations:
- Clarify role of Manitoba Health representatives on Advisory Committee.
- Review terms of reference and expectations/satisfaction with role of Advisory Committee members.

**Rural and Northern Health Care Days**

Rural and Northern Health Care Days have been identified as an important mechanism for dissemination and increasing organizational awareness.

Recommendations:
- Continue with format developed for these days, including participation of *The Need to Know* team members as facilitators.
- Ensure that new MCHP “resource persons” are adequately oriented to the project, the content and objectives of each deliverable, and that appropriate time is allocated for joint planning.
- Continue debriefing sessions with MCHP staff following the workshop.
- Develop, in conjunction with RHA team members and CEOs, strategies for linking Rural and Northern Health Care Days to regional planning/decision making.

**General Project Development**

As the project develops and team members indicate interest in a greater role in planning, alternate methods of participation can be explored.

Recommendation:
- Explore the potential of “working groups” of team members to develop/direct specific topics and address identified issues affecting project development.
SUMMARY

The Need to Know Project has made excellent progress in meeting its original objectives, and has achieved a high level of support from project partners. Some of the key activities (e.g., team meetings) require only ongoing monitoring in order to ensure that participant interests continue to be incorporated. Collaborative approaches to research and evaluation have made an important contribution to the development of knowledge translation theory.

At this point, the project faces an important challenge – responding to the increasing interest on the part of team members in addressing organizational barriers to use of research in planning and decision-making within RHAs, and to institutionalizing best practice in collaborative research and knowledge translation best practice within MCHP. A number of suggestions for further development have been identified through the evaluation process. How, and to what extent, the project will address these issues has important implications for further development.
REFERENCES


APPENDICES

Appendix A  Terms of Reference: Team Members
Appendix B  List of Team Members, Investigators and Staff (March 2004)
Appendix C  Agendas of The Need to Know Meetings (June 2002-February 2004)
Appendix D  Media coverage
Appendix E  MCHP Staff and Other Contributions
Appendix F  Working Group Membership, Project Deliverables
Appendix G  Conference Attendance
Appendix H  Project Publications, Presentations and Site Visits
Appendix I  Homework Activities
Appendix J  The Need to Know Newsletter
Appendix K  Post-test Survey, 2002
Appendix L  Evaluation Forms
Appendix M  What Have We Learned from The Need to Know Project about KT?
Background: *The Need to Know Project*

*The Need to Know* project is an applied research project funded by the Canadian Institutes for Health Research, Canada’s major funder of health research. It was funded on the basis of a proposal developed by Patricia Martens and Charlyn Black and reviewed for scientific merit in a national competitive review of research projects. It is one of nineteen successful projects funded in a competition of 179 proposals, announced January 2001, in a competition focusing on Community Alliances for Health Research (CAHR).

The project has three major goals (Figure 1):
1) to create new knowledge directly relevant to rural and northern regional health authorities (RHAs), both in Manitoba and as a model for the wider community;
2) to develop useful models for health information infrastructure, as well as for training and interaction, that will increase and improve capacity for collaborative research interaction; and
3) to disseminate and apply health-related research so as to increase the effectiveness of health services, and ultimately the health of RHA populations.

Figure 1: **Conceptual model of MCHP/RHA/Manitoba Health collaboration:**

*The Need To Know Knowledge Translation Model*

Three major research projects – identified as topics of high priority during discussions with the three stakeholders of the project, those being rural and northern RHAs, Manitoba Health, and the Manitoba Centre for Health Policy – will create new knowledge and provide a foundation for the collaborative research process. The first of these projects focuses on comparative analysis of health and health care utilization patterns of RHA regions and sub-regions, and over time. The
The second project focuses on comparative analyses of mental health indicators. The third project focuses on male/female differences in health, health care use and health outcomes. In addition to the new knowledge created with these three research projects, The Need to Know project supports interaction with RHA planners and decision-makers, and provides training, capacity-building, information, and support for active application of research findings.

The Need to Know RHA Team
Originally, each CEO of the eleven (ten as of July 2002) non-Winnipeg RHAs was requested to select one official designate for the RHA Need to Know Team. Designates were defined as “senior-level people in the administrative teams, possibly medical officers of health, community health assessment directors, or advisors to the CEO” (CAHR proposal, page 17). Each RHA agreed to make this position available up to a .25 FTE basis for community health assessment work and involvement with The Need To Know Team. Appointees were selected to serve for the five-year term of the project. Based upon the positive response from RHAs, and from the first year’s evaluation report by Sarah Bowen, the recommendation was brought forth in February 2003 to include up to two official designates for each RHA. One designate is funded through the original CIHR grant monies, and the other through the RHA. As well, the Winnipeg RHA will designate one liaison person to the project Team meetings, who will abide by the same terms of reference as the other RHA Team members.

Responsibilities of RHA Team Members
- To facilitate development of collaborative working relationships between the RHA and MCHP
- To attend all workshops, and participate in activities related to The Need To Know Team
- To ensure that information on the project, its objectives, and activities is conveyed in a timely manner to the leadership of the RHA
- To develop a dissemination strategy for research materials and related information for the RHA
- To represent research priorities, concerns, and interests of the RHA through project activities
- To provide skills and resources acquired through the project to regional planning and research activities
- To maintain, on behalf of the RHA, project resource binders and other research material generated through the project
- To ensure that confidentiality of materials provided through the project is maintained
- To represent, and assist in the promotion of, the project at the regional level
- To provide feedback on activities and strategies proposed by the project
- To bring issues of concern related to the project to the attention of the appropriate member of the MCHP project staff team in a timely fashion.

Benefits
All travel, accommodation and other workshop costs for three two-day workshops per year in Winnipeg are covered for one RHA designate by The Need to Know project. In addition, the project will cover costs for two approved conferences per RHA outside of Manitoba over the term of the five-year project. Laptop computers, and computer support assistance related to The Need to Know project, is provided per RHA Team member. The second designate from the RHA will have all expenses covered by the RHA, with the following exceptions: (a) meals provided at the meeting; (b) all handouts and binders for the team’s work; and (c) transportation.
costs for the remote RHAs (Nor-Man, Burntwood and Churchill). The latter expense coverage by the project was agreed upon through the Advisory Committee motion dated October 8, 2002: “moved that funding for a second person’s airfare be provided for each RHA, if the driving time was more than five hours in one direction, travel budget permitting” (Karen McClelland/Noralou Roos).

**Terms of appointment**

Each team member is selected to serve in this position for the length of the project. Should a member be required to resign from this position, it is expected that (s)he will:

- Inform the Project Director and the RHA CEO at the earliest possible opportunity
- Facilitate the selection and orientation of a replacement. The final decision of the Team member is made by the RHA CEO. The orientation of new members is organized by MCHP project staff.
- Ensure that the official project binders, *The Need to Know* computer, and related materials are appropriately forwarded to the new representative.

Each new team member will be required to communicate with the Project Director as to the need for and attendance at an orientation session.
Appendix B:
List of *The Need to Know* Team members, Investigators and Staff (March 2004)

**RHA TEAM MEMBERS**

**Assiniboine RHA:**
Jody Allan, Manager of Regional Planning
Faye White, Manager of Regional Planning

**Brandon RHA:**
Bev Cumming, Executive Director, Planning & Evaluation
Nancy McPherson, Population Health Planner/Analyst

**Burntwood RHA:**
Mieke Busman, Regional Coordinator, Quality Improvements, Risk Management and Patient Safety
Marion Ellis, Director, Health Programs

**Central RHA:**
Dr. Shelley Buchan, Medical Officer of Health
Donna Champagne, Director of Community Health Assessment

**Churchill RHA:**
Margaret Fern, Director of Community Services

**Interlake RHA:**
Tannis Erickson, Health Systems Analysis Manager
Doreen Fey, Vice-President of Planning

**Nor-Man RHA:**
Sue Crockett, Director, Planning
Catherine Hynes, Community Development Worker

**North Eastman RHA:**
Dr. Eilish Cleary, Medical Officer of Health
Bonnie Frith, Manager of Quality

**Parkland RHA:**
Maggie Campbell, Director, Program Planning & Evaluation
Connie Chapen, Regional Coordinator - Quality and Risk

**South Eastman RHA:**
Patti Fries, Quality Risk Manager
Betty MacKenzie, Public Health Program Manager

**WINNIPEG RHA LIAISON**
Val Austen-Wiebe, Director, Performance Reporting
MANITOBA HEALTH TEAM MEMBERS

Deborah Malazdrewicz, Manager of Decision Support Services
Lorraine Dacombe Dewar, Director of Community Health Assessment/Regionalization
Valdine Berry, Consultant, Accountability, Monitoring and Evaluation
Shahin Shoostari, Consultant, Regional Support Services
Heather Spalding, CHA/Health Planning Consultant
Shirley Dzogan, CHA/Health Planning Consultant
Rachel McPherson, Acting Senior Statistical Analyst, Health Information Management

MANITOBA CENTRE FOR HEALTH POLICY

Project Staff
Director of the Project: Dr. Patricia Martens
Research Coordinator: Randy Fransoo*
Research Assistants: Elaine Burland*, Laurel Jebamani*
Senior Systems Analyst: Charles Burchill
Planning Coordinators: Darlene Harder, Linda Kostiuk
Website Development and Software Support: Eileen Pyke

Evaluation Coordinator
Sarah Bowen*

Key Investigators
Drs. Les Roos, Noralou Roos, Jan Roberts, Charlyn Black

* Graduate Students in the Department of Community Health Sciences, 2002-2004.
Objectives:

- To review graphs for the RHA 2002 deliverable and provide insight into related documents
- To distribute the Evaluation Report document
- To discuss specific dissemination strategies within and between RHAs, MCHP and Manitoba Health
- To understand benchmarking and how this relates to RHA planning
- To discuss topic areas for the second research project
- To understand the Canadian Community Health Survey and how the data can be accessed and used by RHA planners

Monday, June 3, 2002
Location - Room 405, 4th Floor, Brodie Centre

Agenda:
8:00 - 8:30 am Coffee & muffins
8:30 - 8:50 am Introduction and Evaluation Report (Pat Martens & Sarah Bowen)
8:50 - 10:00 am RHA 2002 report critiquing (Pat Martens, Randy Fransoo, Elaine Burlsand, Laurel Jebamani)
9:15 - 9:30 am Coffee break
10:00 - 10:15 am Coffee break
10:15 - 11:30 am Putting your mouth where your money is: Dissemination Strategies (reports from the RHAs, MCHP and Manitoba Health)
11:30 - 12:00 pm Update of activities and discussion with North and South people re advisory board member
12:00 - 1:00 pm Lunch
1:00 - 2:00 pm Benchmarking (Dr. John Millar)
2:00 - 2:15 pm Coffee break
2:15 - 3:15 pm Benchmarking continued (Dr. John Millar and Sue Crockett)
3:15 - 4:15 pm Putting on the NTK Thinking Caps: Deliverable #2
4:15 - 4:30 pm Closing comments and homework (Pat Martens)
6:30 pm - Dinner meeting at the Royal Crown Revolving Restaurant, 83 Garry Street, 30th Floor
(Walking distance from Delta Winnipeg or parking available in their parkade - enter off alley between Fort Garry Place and Fort Garry Hotel, machine issues ticket & you pay at pay station before returning to car)

For further information about the workshop please contact the Planning Co-ordinator, Linda Kostiuk at (204) 789-3721 or e-mail: Linda_Kostiuk@cpe.umanitoba.ca

Tuesday, June 4, 2002

Canadian Community Health Survey Training Workshop
by Statistics Canada and Manitoba Health
Co-sponsored by NTK project funding and Dept. of Community Health Sciences
Theatre B, Basic Medical Sciences Bldg.
730 William Avenue, University of Manitoba, Bannattane Campus

Agenda:
8:30 - 9:00 am Coffee & muffins
9:00 - 4:30 pm See CCHS workshop agenda for details.

APPENDIX C
Objectives:

- To discuss interpreting and using specific data provided by Manitoba Health to RHAs
- To discuss topic areas for the second research project
- To learn about encouraging a pleasant work environment
- To preview and critique the RHA 2002 deliverable data
- To become familiar with the two MCHP reports highlighted at the Rural and Northern Health Care Day
- To learn facilitator skills for the Rural and Northern Health Care Day
- To brainstorm about organizational capacity building

The Need to Know...

and interaction, that will increase and improve capacity for collaborative research interaction.

3. To disseminate and apply health-related research so as to increase the effectiveness of health services and ultimately the health of RHA populations.

Activities:

1. To complete three research projects – defined as priorities by the 11 rural and northern RHAs of Manitoba – that create new knowledge in population-based health services research with direct policy and planning implications.

2. To provide opportunities for increased interaction between academic researchers and RHA “local health researchers” in relation to the three research projects, by collaborating in the setting of priorities for topics, in the development of indicators, and in the application of the information within the context of policy-making and decision-making for the rural and northern RHAs.

3. To provide explicit training opportunities for RHA researchers and their colleagues to learn how to use and interpret data to support decision-making.

4. To provide training opportunities for individuals in academic settings to learn to do academic research in a collaborative and community-relevant environment.

5. To develop information infrastructure that will provide a foundation for RHA dissemination activities and ongoing collaboration between MCHP and the RHAs.

6. To provide support for intensive interaction that will lead to dissemination and application of the research.

Monday, October 7, 2002
Location - Room 405, 4th Floor, Brodie Centre

Agenda:

8:00 - 8:30 am  Coffee & muffins
8:30 - 8:40 am  Introduction (Pat Martens)
8:40 - 10:00 am  Manitoba Health Data (Deb Malazdrewicz)
10:00 - 10:15 am  Coffee break
10:15 - 12:00 noon  Deliverable # 2 (overview from selected guests plus group discussion)
12:00 - 12:45 pm  Lunch
12:45 - 1:00 pm  Fish Video
1:00 - 2:00 pm  Deliverable # 1 report
2:00 - 2:15 pm  Coffee break
2:15 - 3:30 pm  Facilitator Training
3:30 - 4:00 pm  Organizational Capacity Building (Sarah Bowen, Pat Martens)
4:00 - 4:15 pm  Closing comments, homework and post test (Pat Martens)

6:30 pm - Dinner meeting at Tiffani’s Restaurant, 133 Niakwa Road, 17th Floor
(Map included in meeting packages distributed October 7th)

Tuesday, October 8, 2002
Ninth Annual
Rural and Northern Health Care Meeting
All Day - Theatre B, 2nd Floor, Basic Medical Sciences Bldg., 730 William Avenue
University of Manitoba
Bannatyne Campus

8:00 - 3:15 pm  See Rural and Northern Health Care Meeting agenda for details.

For further information about the workshop please contact the Planning Co-ordinator, Linda Kostiuk at (204) 789-3721 or e-mail: Linda_Kostiuk@cpe.umanitoba.ca

“The Need to Know: Collaborative Research by the Manitoba Centre for Health Policy, Rural and Northern Regional Health Authorities, and Manitoba Health”

This is funded by the CIHR through the Community Alliances for Health Research Program.

Goals:

1. To create new knowledge directly relevant to rural and northern regional health authorities, both in Manitoba and as a model for the wider community.

2. To develop useful models for health information infrastructure, as well as for training

and interaction, that will increase and improve capacity for collaborative research interaction.
The Need to Know: Collaborative Research by the Manitoba Centre for Health Policy, Rural and Northern Regional Health Authorities, and Manitoba Health

This is funded by the CIHR through the Community Alliances for Health Research Program.

Goals:
1. To create new knowledge directly relevant to rural and northern health authorities, both in Manitoba and as a model for the wider community.
2. To develop useful models for health information infrastructure, as well as for training and interaction, that will increase and improve capacity for collaborative research interaction.
3. To disseminate and apply health-related research so as to increase the effectiveness of health services and ultimately the health of RHA populations.

Activities:
1. To complete three research projects – defined as priorities by the 10 rural and northern RHAs of Manitoba – that create new knowledge in population-based health services research with direct policy and planning implications.
2. To provide opportunities for increased interaction between academic researchers and RHA “local health researchers” in relation to the three research projects; by collaborating in the setting of priorities for topics, in the development of indicators, and in the application of the information within the context of policy-making and decision-making for the rural and northern RHAs.
3. To provide explicit training opportunities for RHA researchers and their colleagues to learn how to use and interpret data to support decision-making.
4. To provide training opportunities for individuals in academic settings to learn to do academic research in a collaborative and community-relevant environment.
5. To develop information infrastructure that will provide a foundation for RHA dissemination activities and ongoing collaboration between MCHP and the RHAs.
6. To provide support for intensive interaction that will lead to dissemination and application of the research.

For further information about the workshop please contact the Planning Coordinator, Linda Kostiuk at (204) 789-3721 or e-mail: Linda_Kostiuk@cpe.umanitoba.ca

Wednesday, February 5, 2003

Agenda:
8:30 - 9:00 am Coffee & muffins
9:00 - 10:15 am RHA deliverable (Pat Martens, Randy Fransoo)
10:15 - 10:30 am Coffee break
10:30 - 11:00 am So what’s up, team? - sharing stories about conferences and site visits
11:00 - 11:30 am Site visit discussion - brainstorm the possibilities
11:30 - 12:00 pm Terms of reference discussion
12:00 - 1:00 pm Lunch - Buhler Atrium (1st flr behind elevators)
1:00 - 2:15 pm Stats 101 (Pat Martens) and Computer 101 (Eileen Pyke) concurrent sessions
2:15 - 2:30 pm Coffee break
2:30 - 3:45 pm Stats 101 (Pat Martens) and Computer 101 (Eileen Pyke) concurrent sessions
3:45 - 4:00 Homework & Closing remark (Pat Martens)
4:15 - 5:00 Advisory Committee Meeting - Room 409

Agenda:
8:00 - 8:45 am Coffee & muffins
8:45 - 9:15 am Introduction and State of the Union (Pat Martens)
9:15 - 10:30 am - Exploring Knowledge Translation (Sarah Bowen, Elaine Burland) - RHA discussion
10:30 - 10:45 am Coffee break
10:45 - 12:00 noon Research Utilization and organizational Change (Jody Allan, further discussion and planning by RHA/Manitoba Health/MCHP)
12:00 - 1:00 pm Lunch - Buhler Atrium (1st flr behind elevators)
1:00 - 2:15 pm Mental Health deliverable discussions (including a brief presentation on MHMIS database by Christine Ogaranko)
2:15 - 2:45 pm Coffee break, followed by meeting with North and South RHAs, Manitoba Health and MCHP
2:45 - 4:00 pm Mental Health deliverable continued

6:00 pm - Dinner meeting at Bailey’s Restaurant, 2nd floor, Board of Governors Room, 185 Lombard Avenue

Tuesday, February 4, 2003

Location - Room 405, 4th Floor, Brodie Centre

Agenda:
8:00 - 8:45 am Coffee & muffins
8:45 - 9:15 am - Exploring Knowledge Translation (Sarah Bowen, Elaine Burland) - RHA discussion
9:15 - 10:30 am - Exploring Knowledge Translation (Sarah Bowen, Elaine Burland)
10:30 - 10:45 am Coffee break
Objectives:
- To discuss the process for making a decision on the next deliverable topic
- To discuss plans for the upcoming 10th annual Rural and Northern Health Care Day
- To acquaint team members with the Western Regional Training Centre
- To discuss findings & recommendations of the evaluation report
- To learn about ethical considerations as they relate to research in regions
- To discuss research use in RHAs, and to refine the model of research utilization
- To work collaboratively on the Mental Health deliverable
- To learn how to use the medical library
- To learn how to design a survey for health research

Monday, June 9, 2003
Location - Room 405, 4th Floor, Brodie Centre

Agenda:
8:00 - 8:45 am Coffee & muffins
8:45 - 9:15 am Introduction and general discussion (Pat Martens)
9:15 - 9:45 am WRTC and its connection with NTK (Elaine Dunn, Anita Kosynskiy, Norma Buchan)
9:45 - 10:30 am Ethics 101 (Alan Katz)
10:30 - 10:45 am Coffee break
10:45 - 12:00 pm Research in RHAs and homework reports (Bev Cumming)
12:00 - 1:00 pm Lunch - Buhler Atrium (1st flr behind elevators)
1:00 - 2:30 pm Mental Health deliverable discussion (Carolyn De Coster, Pat Martens)
2:30 - 2:45 pm Coffee break
2:45 - 3:30 pm Conference reports (Shelley Buchan, Randy Fransoo)
6:00 pm - Dinner meeting at Café Carlo, B - 243 Lilac Street, (North of Corydon), Tel: 477-5544

Tuesday, June 10, 2003

Agenda:
8:30 - 9:00 am Coffee & muffins
9:00 - 10:00 am Evaluation reports and findings (Sarah Bowen)
10:00 - 10:30 am Coffee break plus North/South/Manitoba Health meetings
10:30 - 12:00 pm Library searches 101 (Neil John Maclean HS Library - 2nd floor)
12:00 - 1:00 pm Lunch - Buhler Atrium (1st flr behind elevators)
1:00 - 2:30 pm Library searches 101 (Neil John Maclean HS Library - 2nd floor)
2:30 - 2:45 pm Coffee Break
2:45 - 3:00 pm Homework, plans for Rural Day, Closing (Pat Martens)
3:15 - 4:15 pm Advisory Committee Meeting - Room 409

For further information about the workshop please contact the Planning Co-ordinator, Linda Kostiuk at (204) 789-3721 or e-mail: Linda_Kostiuk@cpe.umanitoba.ca

“The Need to Know: Collaborative Research by the Manitoba Centre for Health Policy, Rural and Northern Regional Health Authorities, and Manitoba Health”

This is funded by the CIHR through the Community Alliances for Health Research Program.

Goals:
1. To create new knowledge directly relevant to rural and northern regional health authorities, both in Manitoba and as a model for the wider community.
2. To develop useful models for health information infrastructure, as well as for training and interaction, that will increase and improve capacity for collaborative research interaction.
3. To disseminate and apply health-related research so as to increase the effectiveness of health services and ultimately the health of RHA populations.

Activities:
1. To complete three research projects – defined as priorities by the 10 rural and northern RHAs of Manitoba – that create new knowledge in population-based health services research with direct policy and planning implications.
2. To provide opportunities for increased interaction between academic researchers and RHA “local health researchers” in relation to the three research projects, by collaborating in the setting of priorities for topics, in the development of indicators, and in the application of the information within the context of policy-making and decision-making for the rural and northern RHAs.
3. To provide explicit training opportunities for RHA researchers and their colleagues to learn how to use and interpret data to support decision-making.
4. To provide training opportunities for individuals in academic settings to learn to do academic research in a collaborative and community-relevant environment.
5. To develop information infrastructure that will provide a foundation for RHA dissemination activities and ongoing collaboration between MCHP and the RHAs.
6. To provide support for intensive interaction that will lead to dissemination and application of the research.
Objectives:

- To discuss the process for making a decision on the next deliverable topic
- To learn facilitator skills for the 10th annual Rural and Northern Health Care Day
- To learn how to create a map
- To learn how to create a poster
- To work collaboratively on the Mental Health deliverable

**Monday, October 6, 2003**

**Location - Room 405, 4th Floor, Brodie Centre**

**Agenda:**

- 8:00 - 8:45 am Coffee & muffins
- 8:45 - 9:00 am Introduction (Pat Martens)
- 9:00 - 9:30 am Discussions re Deliverables #2 and #3, authorship, evaluation tool
- 9:30 - 10:00 am North, South, and Manitoba Health meetings
- 10:00 - 10:15 am Coffee break
- 10:15 - 12:00 noon Mental Health Report
- 12:00 - 12:45 pm Lunch - Buhler Atrium (1st flr behind elevators)
- 12:45 - 2:30 pm Poster making and Mapping workshops (Elaine Burland, Laurel Jebamani)
- 2:30 - 2:45 pm Coffee break
- 2:45 - 3:45 pm RHA facilitator training

**6:00 pm - Dinner meeting**

Vivere Ristorante Mediterraneo
3 - 433 River Avenue (just East of Osborne)
Tel: 949-2485

Map available in handouts.

**Tuesday, October 7, 2003**

**Tenth Annual Rural and Northern Health Care Meeting**

**Theatre A**

Basic Medical Sciences Bldg.,
730 William Avenue
University of Manitoba
Bannatyne Campus

**Agenda:**

- 8:00 - 8:45 am Registration and continental breakfast (concours area)
- 8:45 - 9:00 am Introduction - Theatre A
- 9:00 - 9:30 am The Need to Know Team - collaborative research by non-Winnipeg RHA's, MCHP and Manitoba Health
- 9:30 - 10:00 am RHA Indicators Atlas
- 10:00 - 10:20 am Coffee Break in the concourse area
- 10:20 - 12:00 noon Facilitated workshop in the J.A. Hildes concourse area (each RHA will have a designated table)
- 12:00 - 12:40 pm Lunch in the concourse area
- 12:45 - 1:45 pm Rural Canada: From Strength to Strength (Ray Bollman)
- 1:45 - 2:00 pm Coffee Break
- 2:00 - 3:00 pm An overview of ongoing MCHP Research
- 3:00 - 3:15 pm Concurrent Mapping Session (Room 412)
- 3:15 - 4:15 pm Advisory Committee Meeting - Room 409
- 3:15 - 4:15 pm Mapping Session in 412

**For further information about the workshop please contact the Planning Co-ordinator, Linda Kostiuk at (204) 789-3721 or e-mail: Linda_Kostiuk@cpe.umanitoba.ca**

**The Need to Know: Collaborative Research by the Manitoba Centre for Health Policy, Rural and Northern Regional Health Authorities, and Manitoba Health**

This is funded by the CIHR through the Community Alliances for Health Research Program.

**Goals:**

1. To create new knowledge directly relevant to rural and northern regional health authorities, both in Manitoba and as a model for the wider community.
2. To develop useful models for health information infrastructure, as well as for training and interaction, that will increase and improve capacity for collaborative research interaction.
3. To disseminate and apply health-related research so as to increase the effectiveness of health services and ultimately the health of RHA populations.

**Activities:**

1. To complete three research projects – defined as priorities by the 10 rural and northern RHAs of Manitoba – that create new knowledge in population-based health services research with direct policy and planning implications.
2. To provide opportunities for increased interaction between academic researchers and RHA “local health researchers” in relation to the three research projects, by collaborating in the setting of priorities for topics, in the development of indicators, and in the application of the information within the context of policy-making and decision-making for the rural and northern RHAs.
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5. To develop information infrastructure that will provide a foundation for RHA dissemination activities and ongoing collaboration between MCHP and the RHAs.
6. To provide support for intensive interaction that will lead to dissemination and application of the research.
Objectives:

- To work collaboratively on the Mental Health deliverable
- To discuss the next deliverable topic
- To learn basic quantitative research methods /program evaluation concepts & skills related to health services research
- To discuss findings & recommendations of the evaluation report
- To learn about the Quality of Care Indicators Report as it relates to physician practices
- To review poster making skills learned at October 2003 workshop and create a poster relating to a pertinent finding from the RHA Indicators Atlas

**Monday, February 2, 2004**

**Location - Room 405, 4th Floor, Brodie Centre**

**Agenda:**

- 8:00 - 8:45 am Coffee & Muffins
- 8:45 - 9:00 am Introduction (Pat Martens)
- 9:00 - 10:00 am Discussion of deliverable #2: The Mental Health Report (Nancy McKeen, Pat Martens, Randy Fransoo)
- 10:00 - 10:15 am Coffee break
- 10:15 - 11:15 am Mental Health Report (cont’d)

**Monday, February 2, 2004**

**Objectives:**

- To work collaboratively on the Mental Health deliverable
- To discuss the next deliverable topic
- To learn basic quantitative research methods / program evaluation concepts & skills related to health services research
- To discuss findings & recommendations of the evaluation report
- To learn about the Quality of Care Indicators Report as it relates to physician practices
- To review poster making skills learned at October 2003 workshop and create a poster relating to a pertinent finding from the RHA Indicators Atlas

**Monday, February 2, 2004**

**Location - Room 405, 4th Floor, Brodie Centre**

**Agenda:**

- 8:00 - 8:45 am Coffee & Muffins
- 8:45 - 9:00 am Introduction (Pat Martens)
- 9:00 - 10:00 am Discussion of deliverable #2: The Mental Health Report (Nancy McKeen, Pat Martens, Randy Fransoo)
- 10:00 - 10:15 am Coffee break
- 10:15 - 11:15 am Mental Health Report (cont’d)

**For further information about the workshop please contact the Planning Co-ordinator, Darlene Harder at (204) 975-7796 or e-mail: Darlene_Harder@cpe.umanitoba.ca**

**Tuesday, February 3, 2004**

**Agenda:**

- 8:00 - 8:45 am Coffee and Muffins
- 8:45 - 9:45 am Evaluation reports and findings (Sarah Bowen)
- 9:45 - 10:15 am North, South & MB Health meetings
- 10:15—10:30 am Coffee Break
- 10:30 - 12:00 noon Poster making workshop Part I (Elaine Burland, Laurel Jebamani)
- 12:00—12:45 pm Lunch—Buhler Atrium (1st flr behind elevators)
- 12:45—1:45 pm Poster making workshop Part II
- 1:45—2:00 pm Coffee Break
- 2:00—3:00 pm Quality of Care Indicators of Physician Practices (Alan Katz)
- 3:00—3:15 pm Closing remarks
- 3:15—4:15 pm Advisory Committee Meeting (Room 409)

**Tuesday, February 3, 2004**

**Agenda:**

- 8:00 - 8:45 am Coffee and Muffins
- 8:45 - 9:45 am Evaluation reports and findings (Sarah Bowen)
- 9:45 - 10:15 am North, South & MB Health meetings
- 10:15—10:30 am Coffee Break
- 10:30 - 12:00 noon Poster making workshop Part I (Elaine Burland, Laurel Jebamani)
- 12:00—12:45 pm Lunch—Buhler Atrium (1st flr behind elevators)
- 12:45—1:45 pm Poster making workshop Part II
- 1:45—2:00 pm Coffee Break
- 2:00—3:00 pm Quality of Care Indicators of Physician Practices (Alan Katz)
- 3:00—3:15 pm Closing remarks
- 3:15—4:15 pm Advisory Committee Meeting (Room 409)

**For further information about the workshop please contact the Planning Co-ordinator, Darlene Harder at (204) 975-7796 or e-mail: Darlene_Harder@cpe.umanitoba.ca**

**The Need to Know: Collaborative Research by the Manitoba Centre for Health Policy, Rural and Northern Regional Health Authorities, and Manitoba Health**

This is funded by the CIHR through the Community Alliances for Health Research Program.

**Goals:**

1. To create new knowledge directly relevant to rural and northern regional health authorities, both in Manitoba and as a model for the wider community.
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**Activities:**

1. To complete three research projects – defined as priorities by the 10 rural and northern RHAs of Manitoba – that create new knowledge in population-based health services research with direct policy and planning implications.
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4. To provide training opportunities for individuals in academic settings to learn to do academic research in a collaborative and community-relevant environment.
5. To develop information infrastructure that will provide a foundation for RHA dissemination activities and ongoing collaboration between MCHP and the RHAs.
6. To provide support for intensive interaction that will lead to dissemination and application of the research.
Surgeries up, health improves in province

North catching up, health regions study finds

By Mia Rabson

A comprehensive report on the health of Manitobans released yesterday suggests they are having more surgical interventions and pointed to some positive indicators of health in the province's North.

The report by the Manitoba Centre for Health Policy compares different regions in Manitoba. It includes statistics on 68 different health indicators such as the number of doctor visits, incidence of disease, mortality rates, pharmaceutical usage, child health, and the number of surgeries performed by type.

Patricia Martens, lead author of the Manitoba Regional Health Authority Indicators Atlas, said the study is designed to give rural and northern health authorities a good idea of where they should focus their policy and program planning, and how their own region compares to others across the province.

"They wanted to get a really good picture of how health was improving, and where it is not improving," Martens said.


Generally more surgical procedures are done now, compared to the earlier part of the 1990s. For example, between 1991 and 1995, there were about 0.5 heart bypass surgeries done per 1,000 people, a number that rose to 0.7 between 1996 and 2001. In Northern Manitoba, the rate nearly doubled from 0.38 to 0.71.

Martens said these rates are adjusted to account for the aging population, so the increases are not just due to the fact we have an older population now.

She said it is interesting to note not only vast differences in health between the various regions but also within each region.

Premature mortality rates, or the number of people who die before age 75, have generally gone down across the province. In the early 1990s, about 3.5 of every 1,000 deaths was premature. In the latter half of the decade that fell slightly to about 3.2.

Not surprisingly, Martens said, the highest rate of premature death occurs in northern Manitoba, with the Burntwood and Northern Manitoba regional health authorities showing rates of 4.7 and 4.6 respectively. South Eastman had the lowest rate at about 2.8.

While Northern Manitobans still have the highest incidence of health problems, especially diabetes, high blood pressure and heart disease, Sue Crockett, director of planning for the Northern Manitoba RHA, said there are some positive signs, including a lower premature mortality rate. In the Nor-Man RHA, the rate dropped from 5.5 to 3.5.

"That is the single best indicator to measure health," Crockett said. "I think it shows the programs of prevention are starting to pay off."

Nor-Man also saw a significant drop in infant mortality rates, from 8.5 per 1,000 births to about 4.6 per 1,000 births.

mia.rabson@freepress.mb.ca
APPENDIX E: CONTRIBUTIONS OF MCHP STAFF AND OTHERS

Does not include contributions of RHA representatives (see page 39) or The Need to Know Project staff team.

Presentations to The Need to Know Team meetings

June 2002
Presentation on Benchmarking: John Millar (CIHI).
Dissemination strategies used by MCHP: Carolyn de Coster (MCHP).

October 2002
Manitoba Health Data. Wendy Doight, Rachel McPherson (along with Deb Malazdrewich).
Background presentations to support decision-making on selection of second project deliverable. Renee Robinson (Brandon University), Jane Griffiths (Manitoba Health), Annette Wilborn (Manitoba Health), Margaret Haworth – Brockman (Prairie Women’s Centre of Excellence), Margaret Shultz, Lorraine Decomb-Dewar (Manitoba Health), Alan Katz (Department of Community Health Sciences).

February 2003
MHMIS Data: Christine Ogaranko, Manitoba Health.
Description of Mobility and Mental Health Utilization Study: Lisa Lix (MCHP).
Participation in discussions for development of mental health deliverable: John Walker (St Boniface Hospital), Christine Ogaranko (Manitoba Health), Carolyn de Coster (MCHP), Renee Robinson (Brandon University), Charles Burchill (MCHP), Marni Brownell (MCHP), Eckhard Goerz (Eden Mental Health Centre).

June 2003
Presentation on the Western Regional Training Centre: Anita Kozyrski, Elaine Dunn (Community Health Sciences).
Ethics 101: Alan Katz (MCHP).
Participation in discussion of development of Mental Health Deliverable: Christine Ogaranko (Manitoba Health), Eckhard Goerz (Eden Mental Health Centre), Renee Robinson (Brandon University), John Walker (St. Boniface Hospital), Dan Chateau (MCHP), Okechukwu Ekuma (MCHP), Carolyn de Coster, (MCHP).
Predictors of Suicide: Dan Chateau (MCHP).

October 2003
Participation in discussion of development of Mental Health deliverable: Christine Ogaranko (Manitoba Health), Okechukwu Ekuma (MCHP), Renee Robinson (Brandon University).
February 2004
Participation in discussion of development of Mental Health Deliverable: Eckhard Goerz (Eden Mental Health Centre), Jan Trumble-Wadell (WRHA), Renee Robinson (Brandon University).
Suicide and Suicidal Behaviour: Nancy McKeen (MCHP)
Quality of Care Indicators: Alan Katz (MCHP).

Presentations at Rural and Northern Healthcare Days (Includes The Need to Know Team Staff).

October 2002:
Keynote presentation: Steven Lewis: How do you know if you’re an evidence-based decision-maker;
Panel Discussion: Jackie Haliburton (Central RHA), Noralou Roos (MCHP), Reg Toews (South Eastman RHA).
Estimating PCH Bed Requirements: Carolyn de Coster (MCHP)
Health and Health Care Use of Manitoba Seniors: Verena Menec (MCHP).
Computer/Web-site orientation: Elaine Burland, Randy Fransoo.

October 2003
The Manitoba RHA Indicators Atlas. Patricia Martens (MCHP).
Rural Canada: From Strength to Strength: Ray Bollman (Statistics Canada).
Patterns of Health Care Use and Cost at the End of Life: Verena Menec (MCHP).
Diagnostic Imaging Data in Manitoba: Assessment and Implications. Bill Leslie, Faculty of Medicine, University of Manitoba.

Deliverable Development (see also Appendix F for Working Group members)

Co-authors with The Need to Know team members: Natalia Dik, Leonard MacWilliams, Shelley Derksen, Randy Walld, Carmen Steinbach, Matt Dahl.

Deliverable #2: (ongoing) Patterns of Regional Mental Health Disorder Diagnoses and Service Use in Manitoba: A Population-Based Study
Co-authors with The Need to Know team members: Nancy McKeen, Carolyn de Coster, Okechukwu Ekuma, Heather Prior, Dan Chateau, Renee Robinson, Colleen Metge.
Other Assistance, Leonard McWilliam, Marni Brownell, Carmen Steinbach, Eilish Cleary, Pat Nicol, Alan Katz, Janine Harasymchuk, Dr. Kurt Sakum.
Deliverable #2: (ongoing) Patterns of Regional Mental Health Disorder Diagnoses and Service Use in Manitoba: A Population-Based Study

Eckhard Goerz, CEO Eden Health Care Services/Eden Mental Health Centre
Dr. John Walker, Director, Anxiety Disorders Program, St. Boniface General Hospital
Christine Ogaranko, Policy Analyst, Mental Health Branch, Manitoba Health
J. Renee Robinson, Lecturer, Nursing and Health Studies, Brandon University
Dr. Jan Trumble-Waddell, Director, Population Health Quality and Decision Support Div., Winnipeg Regional Health Authority
Dr. Marni Brownell, Manitoba Centre for Health Policy
Dr. Lisa Lix, Manitoba Centre for Health Policy
Dr. Nancy McKeen, Manitoba Centre for Health Policy

Deliverable #3: Patterns of Sex Differences in Health Status, Health Care Use, and Outcomes of Care: a Population-Based Study for Manitoba’s Regional Health Authorities.

Dr. Patricia Kaufert, Department of Community Health Sciences, University of Manitoba
Margaret Haworth-Brockman, Executive Director, Prairie Women’s Health Centre of Excellence
Peri Venkatesh, Faculty of Nursing, University of Manitoba
Lissa Donner, Researcher
Dr. Frank Martin, MD BSC BSc(Med) CCFP FCFP MClSc MEd
Kathie Love, Manitoba Health
Dale Brownlee, Manitoba Health
Dr. Jan Trumble Waddell, Winnipeg Regional Health Authority
Dr. Jan Roberts, South Eastman RHA.

- Jody Allan, Assiniboine RHA
- Margaret Fern, Churchill RHA
- Val Berry, Manitoba Health
- Lorraine Decomb-Dewar, Manitoba Health
- Sarah Bowen. Evaluation Coordinator
- Elaine Burland. Research Assistant
- Randy Fransoo, Research Coordinator
- Patricia Martens, Project Director

CIHR, CAHR/IHRT Networking Workshop April 29-May 1, 2002, Ottawa
- Tannis Erickson, Interlake RHA
- Patricia Martens, Project Director

- Albert de Villiers, Burntwood RHA
- Sarah Bowen, Evaluation Coordinator*
- Charles Burchill, Senior Systems Analyst
- Elaine Burland, Research Assistant*
- Randy Fransoo, Research Coordinator*
- Patricia Martens, Project Director*

The Canadian Centre for Analysis of Regionalization and Health's "2nd Annual Conference on Health Care Regionalization in Canada", Montreal, Quebec. (March 7-9th, 2003).
- Shelley Buchan, Central RHA*
- Margaret Fern, Churchill RHA
- Lorraine Decomb-Dewar, Manitoba Health

Health Statistics Data Users Conference, September 7-9, 2003, Ottawa
- Tannis Erickson, Interlake RHA

- Sarah Bowen, Evaluation Coordinator*
- Elaine Burland, Research Assistant*
- Randy Fransoo, Research Coordinator*
- Patricia Martens, Project Director*

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1 Funded through CIHR
Maggie Campbell, Parkland RHA  
Sue Crockett, Nor-Man RHA  
Margaret Fern, Churchill RHA  
Sarah Bowen, Evaluation Coordinator*  
Elaine Burland, Research Assistant*  
Laurel Jebamani, Research Assistant  
Patricia Martens, Project Director*  
Randy Fransoo, Research Coordinator

CCHAR Effective Region Size and Design, March 12-14, 2004, Vancouver  
Bev Cumming, Brandon RHA  
Sue Crockett, NorMan RHA  
Lorraine Decomb-Dewar, Manitoba Health

UPCOMING
Heather Spalding, Manitoba Health*  
Eleish Cleary, North Eastman*  
Patti Fries, SouthEastman  
Betty MacKenzie, South Eastman  
Sarah Bowen, Evaluation Coordinator*  
Elaine Burland, Research Assistant*  
Randy Franso, Research Coordinator*  
Laurel Jebamani, Research Assistant*  
Patricia Martens, Project Director*

*Poster or oral presentations

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1 Partially funded through CIHR
APPENDIX H: PUBLICATIONS AND PRESENTATIONS
2001-MARCH 2004

Peer-Reviewed Journal Publications and Reports:


Poster and Oral Presentations

Accepted (As of March 30, 2004)


**Oral and Poster Presentations**


Buchan S, Burland B, Martens PJ, Black C. *The Need To Know*: Collaborative Research by the Manitoba Centre for Health Policy, the Rural and Northern Health Authorities and Manitoba Health. The Canadian Centre for Analysis of Regionalization and Health's "2nd Annual Conference on Health Care Regionalization in Canada", Montreal, Quebec. (March 7-9th, 2003). (presented by Dr. Shelley Buchan, RHA Team member from Central RHA)


Martens PJ. Health and health care services use of rural and northern Mantobans – Do they differ from urban rates? Community Health Sciences Colloquium Series, University of Manitoba, Winnipeg MB (Nov. 2, 2003).


Martens PJ. Tried and true ideas … Writing a winner for CIHR. Lakehead University Seminar, Thunder Bay, Ontario (July 17, 2003).

Media Interviews related to the release of the first Team project (the RHA Indicators Atlas):
Kathy Hansen, CJOB radio, Winnipeg (June 12, 2003)
Mia Rabson, Winnipeg Free Press, Winnipeg (page A5, June 13, 2003)
Myron Love, Medical Post (discussed report June 16, 2003 for an article)
Canadian Centre for the Analysis of Regionalization and Health webserve

SPECIFIC INVITATIONS RELATED TO THE PROJECT:

Member of Steering Committee (chaired by Dr. S. Bornstein, Memorial University, Nfld):
Rural Indicators Workshop. St. John’s, Newfoundland/Labrador (October 10-11th, 2003).

The Annual MCHP Rural and Northern Health Care Days:
- Martens PJ. The RHA Indicators Report 1999. October 1999. This was the impetus behind writing the proposal for The Need To Know project, with an interactive format of RHA people and MCHP researchers in round-table discussions. I organized this first interactive workshop day.

Manitoba Health. Winnipeg, MB. (September 17, 2002).
**Topic:** Martens PJ. The Need To Know Team – an overview for Manitoba Health personnel.

RHA CEO Network. Winnipeg, MB (September 11, 2002)
**Topic:** Bowen S and Martens PJ. The Need To Know Team – evaluation report.

RHA Board Chairs Network. Winnipeg, MB (September 12, 2002)
**Topic:** Martens PJ and Bowen S. The Need To Know Team – What is this and how does this involve Boards of Directors of Manitoba’s RHAs?

Central Regional Health Authority Board and Executive Meeting, Portage La Prairie, MB (June 26, 2002)
**Topic:** Martens PJ. The First Nations Report
Nor-Man Regional Health Authority Board and Executive Meeting, The Pas, MB (June 12, 2002)

**Topic:** Martens PJ. The First Nations Report

**Contact:** Sue Crockett, Director of Planning, Nor-Man RHA


**Topic:** mentoring students. Giving a talk about my own research: *The Need To Know* Team, The First Nations report – collaborative research with policy planners and decision makers.

MCHP Advisory Board Meeting. Winnipeg, Manitoba (May 10, 2002).

**Topic:** Martens PJ. *The Need To Know* update of project.

**Topic:** Martens PJ. The First Nations Report

CIHR meeting of the Community Alliances for Health Research projects. Ottawa, Ontario (April 30, 2002).

**Poster presentation:** Martens PJ, Black C. *The Need To Know* Team: A Manitoba Knowledge Transfer Model. Tannis Erickson, Team member from Interlake RHA, also presented the poster.

Get to Know Research at Your University. ‘Five Under Five’ Lecture Series by the University of Manitoba Vice-President of Research Office. Winnipeg, Manitoba, the Art Gallery (January 20, 2002)

**Topic:** Martens PJ. Do Rural and Northern Manitobans Have Different Health Needs than City-Dwellers?

MCHP Advisory Board Meeting. Winnipeg, Manitoba (November 1, 2001).

**Topic:** Martens PJ, Black C. *The Need To Know* update of project.

**SITE VISITS**

**Parkland Regional Health Authority** Annual General Meeting. Dauphin, Manitoba (November 22, 2001)

**Topic:** Martens PJ, Kozyrskyj A. How healthy are Parkland’s children? An overview of regional child health indicators.

**Nor-Man Regional Health Authority Board and Executive Meeting,** The Pas, MB (June 12, 2002)

**Topic:** Martens PJ. The First Nations Report

**Contact:** Sue Crockett, Director of Planning, Nor-Man RHA

**Central Regional Health Authority Board and Executive Meeting,** Portage La Prairie, MB (June 26, 2002)

**Topic:** Martens PJ. The First Nations Report
Interlake Regional Health Authority. Selkirk, Manitoba (October 16, 2002)

**Topic:** Martens PJ. *The Need To Know* Team, and Knowledge Translation. Internal Management Committee Meeting.

**Topic:** Martens PJ. What do Interlake’s people look like? Health and health care use patterns. The public Annual General Meeting for Interlake RHA.

Assiniboine and Brandon Regional Health Authorities. Souris, MB (November 20th, 2002)

**Topic:** Martens PJ. The First Nations report: a discussion of the implications for the people of the Assiniboine RHA. This was a community forum at 1:30 pm.

**Topic:** Martens PJ. The health and health care use of Registered First Nations people living in Manitoba. This involved the Boards of Directors (joint meeting) for Brandon and Assiniboine RHAs.

Churchill RHA Board of Directors’ meeting. Churchill, MB (February 25, 2003)

**Topic:** Martens PJ. The First Nations report: implications for the people of the Churchill RHA.
APPENDIX I: HOMEWORK ASSIGNMENTS

June 2002
- Access the graphs on the website
  - Critique graphs over the next two months
  - Suggestions for cross-reference?
- Post a message on the bulletin board
- Look over the evaluation report
- Have a meeting with your CEO (and others if necessary) to discuss deliverable #2.
- Register through Linda K. for the Halifax conference if you wish to go.

October 2002
- February 2003 NTK Meeting
  - Brief (5 minute max.) presentation on your RHA:
    - What would need to change in your organizations for research to be used appropriately (what are the barriers?).
    - What is the role of the NTK project in helping overcome these barriers?
    - What skills, support or information do you as a NTK team member need to help deal with these barriers?
- Deliverable #2 Bulletin Board consensus
  - Eileen P. will phone each NTK person to make sure all of us can “find our way” to the Bulletin Board.
  - Pat Martens will inform NTK team by email as to the dates of discussion, if consensus is required (we need a decision by October 31, 2002).
- RHA 2002 report coming downstream!

February 2003
- June NTK meeting
  - I may be calling on some of you to be involved with the planning for June
- Deliverable #2 Bulletin Board discussions
  - The need to refine the questions - we’ll be in touch!
- RHA 2002 report coming downstream!
  - Proof-read the draft - get back to Pat Martens and Randy Fransoo within the next TWO WEEKS if you see problems
  - Be prepared to report on how you met your goals upon which you decided at the Feb. meeting
- the new PCH Bed Projections deliverable
  - A good place to start with trying out dissemination plans for your RHA … report back about its uptake?
June 2003

- RHA 2003 Report/dissemination plans
  - Analyze weaknesses and strengths in the current dissemination plan (use the RHA report as your case study).
  - Rough out a strategy for structural organizational change both for this deliverable and to improve dissemination of deliverable #2.
  - Report on concrete interventions that you have undertaken (or have in process).
- Survey research in practice
  - Critique the CHSRF tool for validity, question wording, content and appropriateness for your organization.
- Brainstorming process about deliverable #3??
- Mental Health – bulletin board discussion about Chapter 5.

October 2003

- Brainstorm deliverable #3 topics with your CEO and others.
- Mental Health
  - Discuss preliminary results in your RHA with the relevant people (connect with the Mental Health people of your region, at a minimum).
- Poster
  - Finish and send it to us for printing.

February 2004

- Deliverable #3 continued discussions
  - MCHP will work on the DM approval, and the ethics approval. We will send you a generic description of the deliverable (broad-based).
  - MCHP will also send you out any relevant documents for this deliverable.
  - Once we have the generic description and the documentation, each RHA/MH/MCHP can start discussions as to the questions to include in the analyses (start brainstorming) – will email you to begin the process.
- Mental Health Report
  - Look over the preliminary graphs and the written chapter (to be sent in the next week).
  - Please email Pat Martens with any feedback AS SOON AS POSSIBLE (end of February).
- Evaluation
  - Feedback on evaluation report as requested.
  - Feedback on assessing organizational change.
- Practice doing your research design aerobics (just kidding).
MCHP Data Being Used for Regional Planning

The development of contextual, valid, policy-relevant and user-friendly health services research requires collaborative researcher/decision-maker interaction. The “Need to Know” knowledge transfer model outlines three major activities that are essential to this collaborative research process, including the dissemination and application of research. The following is an illustration of some current applications of MCHP data.

The first involves MCHP, the province’s 11 rural/northern regional health authorities (RHAs) and Manitoba Health. In preparation for the next community health assessment (CHA), a CHA Network subcommittee is developing a list of indicators to be used in the RHA profile documents. These indicators will include information from the MCHP follow-up report to Comparative Indicators of Population Health and Health Care Use for Manitoba’s Regional Health Authorities: A POPULIS Project. Following the community consultations, RHAs will prepare comprehensive CHA reports to be submitted to Manitoba Health and to be used by Boards for strategic planning purposes.

MCHP data is also being used in the RHA of Parkland. MCHP’s report Assessing the Health of Children in Manitoba: A Population Based Study is being incorporated into Parkland’s regional overview data, which is in turn used for strategic and operational planning. RHA representatives were first presented with information from this report at MCHP’s Rural & Northern Health Care Day (Sep 17/01). For the members from the Parkland RHA, this report raised some interesting flags. For instance, the report indicated that children from certain RHAs (including Parkland) were more likely to be hospitalized for lower respiratory tract infections and injuries than the average Manitoba child. In an effort to disseminate this information more widely, arrangements were made for two of MCHP’s researchers (Patricia Martens & Anita Kozyrskyj) to present an overview of this report at Parkland’s Annual General Meeting. Highlights of the presentation were included in the region’s Community Links newsletter. Copies of the presentation as well as the written report were distributed to all Parkland regional team leaders, including the Maternal Newborn Team.

The MCHP website has also proven to be a valuable information source. A member of the NTK Team is Connie Chapen, Parkland’s Regional Coordinator of Quality and Risk Management. She finds it helpful to be able to access region-specific MCHP data via the website. Moreover, she appreciates the flexibility this offers in terms of being able to format the information according to individual need.

You can access MCHP’s website at www.umanitoba.ca/centres/mchp.

Overview of NTK Team Meeting #3

The Need to Know Team met for its third team workshop January 15 & 16, 2002.

Things got underway with the NTK Advisory Committee meeting, during which committee members discussed the latest draft of the Terms of Reference for committee and team members.

Following the meeting, team members convened for the afternoon session. This consisted of updates regarding the progress of the project, the evaluation report and work still to be done on the project.

Steve Mitchell from CIETcanada presented information regarding the use of maps for evidence-based regional planning.

The day concluded with a dinner meeting at the Tavern in the Park at the Assiniboine Park Pavilion.

Day #2 began with an intensive discussion of health indicators, including a review of those to be used in the (Continued on page 2)
### Conference Overview

**Regionalization in Health Care: What’s Really Working?**

Several members of the Need to Know team attended the national conference “Regionalization in Health Care: What’s Really Working?” in Vancouver this February.

Conference workshops and sessions covered a wide variety of topics related to regionalization. Attendees could choose between two pre-conference workshops: (i) Using CIHI performance indicators (an applications-oriented session conducted by the Canadian Institute for Health Information) and (ii) Public participation methods (an overview by researchers from Quebec and Ontario, including deliberative and survey applications).

The full-day program opened with presentations from the Commissioners of Saskatchewan (Ken Fyke) and Quebec (Michel Clair) summarizing the findings from each province’s recent public health system review.

Concurrent morning and afternoon sessions followed. People could choose between (i) Service integration through organizational change in Alberta: what does it take? and (ii) Provincial-regional devolution of authority: is it working to improve effectiveness and accountability? in the morning session. In the afternoon, the choices included (i) Is regionalization necessary for service integration? the experience of different provinces and (ii) Accounting and responding to regional populations: strategies and issues for urban and rural situations.

The day came to a close with the International Panel Lessons from Italy and the UK: has regionalization improved health care? and the Keynote Debate Is regionalization improving health status? Should regional health authorities be held accountable for health status?

The conference was sponsored by the Canadian Regionalization Research Centre in an effort to share knowledge on regionalization and to build its membership and network. The Centre’s HEALNet funding expires March 2002 and will be replaced with a membership fee. For more information about membership and fees call 1-800-804-6814.

Need to Know team members attended the conference as part of the NTK project’s mandate—local health researchers are entitled to attend two conferences over the five years of funding—either to pursue further training or to share information nationally or internationally.

**NTK Team Official Team Members:**

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<th>Betty MacKenzie (South Eastman)</th>
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Celebrating Our First Year: Team Meeting # 4

This June, the ‘Need to Know’ (NTK) team celebrated its first year together. Team meeting #4 began with a report from Sarah Bowen, the project’s evaluation co-ordinator. MCHP team members then presented a behind-the-scenes look at the work involved in the 2002 Deliverable. This was followed by reports from the RHAs, Manitoba Health and MCHP team members on the information dissemination strategies currently in use. Special guest speaker Dr. John Millar from the Canadian Institute for Health Information (CIHI) presented information on ‘Benchmarking’, followed by Sue Crockett’s report on ‘Quality Scorecards’ - developed by and being used in Nor-Man RHA to monitor the progress of strategic plan implementation. The meeting concluded that evening at the Royal Crown Revolving Restaurant with the celebration of our ‘first birthday’. A cake featuring a map of Manitoba and all of its Regional Health Authorities (RHAs) marked the occasion.

Much has been accomplished since the beginning of the project in 2001. The 2002 Deliverable - the first of three research reports to be completed during the project’s five year duration - is nearing finalization. The topic for the second report is currently under discussion and will be decided soon.

Team members have received computer and research training as part of the regular team meetings. This has helped them to access and make use of information available of the project’s secured website. Members have also had the opportunity to attend different conferences relevant to the project as well as their jobs.

The project has also facilitated the information dissemination process. Co-director Pat Martens has received various invitations to present information to several RHAs. Team members have been very active in creating, implementing and reporting on different dissemination strategies used in their own RHAs. Several members have also mentioned that involvement in the project has helped to increase communications within and between RHAs.

Getting the Word Out…..

NTK Co-Director Pat Martens has been very busy assisting in the knowledge transfer process. She has received many invitations to speak to Boards of Directors, Internal Management and AGMs throughout Manitoba, including the RHAs of Nor-Man (June 2002), Central (June 2002), Parkland (November 2001), the Interlake (October 2002) and a joint meeting with Assiniboine and Brandon RHAs (November 2002).

MCHP researchers would love to speak on any reports of relevance to your RHA planning needs. Just contact us!
New Access to NTK Website for Non-Team Members

Access to the NTK secured website has recently been expanded. While some parts remain restricted, non-team members can now check out certain sections of the website, including agendas and presentations from past meetings, newsletters and valuable resource links.

NTK team members must now provide a userid and password to access the secured sections of the website. This information was emailed to team members in July 2002. If you have any questions or need help accessing information of use in your RHA, contact Eileen at MCHP. You can reach her via email (Eileen_Pyke@cpe.umanitoba.ca) or phone (204-975-7768).

So Long Debbie....

On behalf of the entire NTK team, we would like to wish the best to Debbie Nelson. She is leaving her position as Director of Professional Practice and NTK representative in Burntwood RHA to work in the North Eastman RHA. Her work as the NTK Northern Representative on the Advisory Board was most appreciated.

NTK Team January 2002: (from the left) Pat Martens, Linda Kostiuk, Betty MacKenzie, Eileen Pyke, Randy Fransoo, Sarah Bowen, Tannis Erickson, Eilish Cleary (and Cormac), Jody Allan, Shelley Buchan, Sue Crockett, Bev Cumming, Debbie Nelson, Faye White, Deborah Malazdrewicz, Valdine Berry
The fifth team meeting for The Need to Know project was held October 7, 2002. As usual, the day was full of engaging presentations and discussions.

Deborah Malazdrewicz’s presentation on the Decision Support Services division at Manitoba Health focused on their role in the organization, their background, the types of reports and data they work with and information about the ‘Working Indicators Group.’ In an effort to decide on the topic for the second of three deliverables to be produced in collaboration with The Need to Know team, various guests were invited to give presentations on topics under consideration. Renée Robinson (Mental Health), Jane Griffith (Diabetes), Annette Willborn and Margaret Haworth-Brockman (Gender/Women’s Issues) Lorraine Dacombe Dewar (Public Health Data), and Alan Katz (Health System Indicators; Primary Care quality indicators) were among the presenters. Other suggestions for topics included adolescent pregnancy, emergency medical services and intervention effectiveness. Following the presentations, a vote was taken and mental health was overwhelmingly chosen as the suggested topic for the next deliverable.

During lunch, members were invited to watch “The Fish Video”, a short film on ways of enhancing happiness and creativity in the workplace, and how this benefits employees and employers. If anyone is interested, two books relating to the video have been acquired by MCHP and are available for loan.

The afternoon began with an update on Deliverable #1, followed by questions and comments from team members. The deliverable is on schedule and will probably be released by spring 2003. This project focuses on RHA indicators of health and health care use - both between and within RHAs, and over two time periods. In preparation for the facilitated workshop at the Rural and Northern Health Care Meeting the following day, NTK team members received ‘facilitator training.’ This involved a brief overview of the two reports to be discussed and tips for facilitating group discussion. Marni Brownell summarized the report Why is the Health of Some Manitobans Not Improving? and Pat Martens discussed The Health and Health Care Use of Registered First Nations.

The Need to Know team attended the ninth annual Manitoba Centre for Health Policy’s Rural and Northern Health Care Meeting the following day. Pat Martens and Marni Brownell each presented a synopsis of their research, followed by the facilitated workshop - representatives from each RHA formed groups to discuss the implications of the reports for their RHA. The NTK team members helped facilitate their RHA’s round table.

The afternoon session opened with a presentation by Steven Lewis (How do you know if you’re an evidence-based decision-maker?) followed by a panel discussion, including Reg Toews, Noralou Roos and Jackie Halliburton. Thanks Steven—this was a real “crowd pleaser!” The meeting wrapped up with overviews of ongoing MCHP research: Nursing Home Beds in 2020: More? Fewer? Just Enough? (Carolyn DeCoster) and Manitoba Seniors: Living Longer; Living Healthier? (Verena Menec). Both are available on MCHP’s public website: www.umanitoba.ca/centres/mchp
The third national Health Research in Rural and Remote Canada conference was held in Halifax, NS, October 24-26, 2002. Several members of The Need to Know team attended the three-day information-packed forum, including Albert de Villiers - MOH Burntwood and Churchill RHAs.

The conference opened with Dr. John Humphries’ keynote address “Progress over the past decade in Rural Health in Australia - lessons in workforce issues, service provision and consumer satisfaction.” Concurrent session topics included population and community health, physical and work environments, clinical research, aboriginal health, health care organization, and children’s health.

Contributions made by NTK team members included presentations by Pat Martens (Learning from Linkages: Health and Healthcare Use Patterns of Manitoba’s Registered First Nations People), Sarah Bowen (What Works in Knowledge Translation? Evaluating Manitoba’s “Need to Know” Project), Randy Fransoo (Which Indicators and Which Borders? Population-Based Information for Manitoba’s Regional Health Authorities) and a poster presentation by Elaine Burland (The Need to Know: Collaborative Research by the Manitoba Centre for Health Policy, the Rural and Northern Health Authorities and Manitoba Health).

Rural Health Research Conference:

Welcome New NTK Members

On behalf of the Need to Know team a warm welcome goes out to Bonnie Frith who is now a joint team member. Bonnie will be sharing the position with Eilish Cleary representing North Eastman Regional Health Authority.

We would also like to welcome Val Austen-Wiebe who will be joining the team as an observer representing the Winnipeg Regional Health Authority.

We look forward to seeing our team members at the next NTK meeting February 4th and 5th, 2003.

F.Y.I.

• NTK team meetings for 2003: February 4th & 5th; June 10th & 11th; October 6th & 7th.

• 1st NTK Deliverable to be released Spring 2003

• Are you interested in a career in Health Services Research? For information about the “Western Regional Training Centre in Health Services Research (WRTC) contact Elaine Dunn: (204)789-3368 or edunn@ms.umanitoba.ca

• Mark your calendar for the next MCHP Rural and Northern Health Care Day, Tuesday, October 7th, 2003. All are welcome.

NTK Official Team Members:

RHA Members:

Pam Seitz
(Burntwood)
Margaret Fern
(Churchill)
Bev Cumming
(Brandon)
Tannis Erickson
(Interlake)
Jody Allan
(Asiniboine)
Sue Crockett
(Nor-Man)
Eilish Cleary
(North Eastman)
Bonnie Frith
(North Eastman)
Connie Chapen
(Parkland)
Shelley Buchan
(Central)

NTK Health Members:

Deborah Malazdrewicz
Lorraine Dacombe Dewar
Valdine Berry

MCHP Project Staff:

Pat Martens (Co-director)
Charlyn Black (Co-director)
Sarah Bowen
Randy Fransoo
Elaine Burland
Laurel Jehamani
Charles Burchill
Linda Kostiuk
Eileen Pyke
Darlene Harder

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We look forward to seeing our team members at the next NTK meeting February 4th and 5th, 2003.
The sixth The Need to Know meeting took place February 4th and 5th, 2003. It was an intense but productive two-day session, focusing predominantly on (i) the second NTK research project—the Mental Health deliverable, and (ii) the process of knowledge translation and research utilization at the organizational level.

Following Pat Martens’s always-entertaining opening remarks, the morning session got underway with presentations from different team members on various aspects of knowledge translation. Sarah Bowen, the project’s evaluation coordinator clarified many of the confusing terms and concepts associated with knowledge translation in her presentation, “What do we mean by “Knowledge Translation.”” For example, distinctions were made between ‘knowledge transfer’ (the one-way passing of knowledge), ‘knowledge exchange’ (sharing knowledge), and ‘knowledge translation’ (making knowledge understandable and accessible) which are often erroneously used synonymously.

Elaine Burland’s presentation, “How Does All This Fit Together: Collaborative Research and The Need to Know Project,” tied these concepts together and showed how they relate to the project.

The homework assignment from the preceding meeting was then discussed. The topic this time was the barriers and challenges to research utilization at the RHA/organizational level. Each team member provided feedback regarding organizational barriers, ways in which the NTK project could help overcome barriers, provide support and information, and build needed skills. Many issues were raised including a need for more resources (time, money and human), more training opportunities, building organizational capacity and facilitating organizational attitude change. Jody Allan (Manager of Regional Planning, Assiniboine RHA) followed with her presentation, “Research Utilization and Organizational Change.” This focused on using evidence at the regional level and examined factors affecting knowledge transfer, showing different utilization models and how all this applies to The Need to Know project.

After a WONDERFUL lunch served in the glassed-in Buhler Atrium (thanks to campus catering), Christine Ogaranko (Policy Analyst, Mental Health Branch, Manitoba Health) presented information on MHMIS—the Mental Health Management Information System. This is one of the data sources for the next NTK deliverable—the Mental Health Report. MHMIS is managed by Manitoba Health and was implemented in 1990 across all regions, collecting information on individuals’ use of different types of mental health services. For more information see Deliverable #2: The Mental Health Report (p.2). The day ended with a dinner meeting at Bailey’s Restaurant in Winnipeg’s Exchange District. The theme this time was a game on planning for a disaster, which highlighted the fact that a TEAM makes better decisions than an individual.

The second day began with a progress report for the first NTK deliverable—“The Manitoba RHA Indicators Atlas: Population-Based Comparisons of Health and Health Care Use.” It is complete and scheduled to be released in June. Members then updated the rest of the team with information about activities since the last meeting, (e.g., summaries from conferences attended, site visits from MCHP staff, etc.). The afternoon was spent alternating between concurrent skill-building sessions on statistics and computers. If all the smiles are any indication, a good time was had by all!
One of the major activities of The Need to Know Project is the creation and development of new knowledge, which involves the completion of three research projects during the course of the project. The Mental Health Deliverable is the second of these three projects. This topic was decided on the basis of extensive discussions with and consensus of The Need to Know Team. The co-principal investigators are Drs. Patricia Martens and Carolyn De Coster.

The tentative topics to be covered in this report include (i) the prevalence of specific disorders in Manitoba (e.g., schizophrenia, depression, and substance abuse), (ii) information about MHMIS (the Mental Health Management Information System), (iii) resource use for persons with mental disorders and (iv) rates of suicides and suicide attempts.

For this project, The Need to Know team is joined by a working group of experts on mental health, to serve as resource people for specific mental health issues and database use. The working group consists of Eckhard Goerz (CEO, Eden Health Care Services, Eden Mental Health Centre), Dr. John Walker (Director, Anxiety Disorders Program, St. Boniface General Hospital), Christine Ogaranko (Policy Analyst, Mental Health Branch, Manitoba Health), Renée Robinson (Lecturer, Nursing and Health Studies, Brandon University), Dr. Marni Brownell (MCHP) and Dr. Lisa Lix (MCHP).

Welcome to all the new members just joining the NTK team! Each RHA is in the process of designating a second representative to join the NTK team. This will contribute to greater support and continuity for the team. New members will receive orientation training this June, and then it’s full steam ahead!
This summer’s Need to Know meeting incorporated an array of topics, including a number of “101 Sessions” designed to help NTK team members continue to build the skills necessary for interpreting and using data to support decision-making.

As with every meeting, team members had the opportunity to work collaboratively on several project components. The first activity involved the ‘homework’ assignment from the previous meeting. Each team member presented an outline of their organization’s information dissemination plan in terms of who needs to get the information, how it is used, how it ‘moves’ in the organization and the most effective method(s) for reaching specific stakeholders. Following the presentations, team members worked together to create a list of ‘best practice’ guidelines to follow when disseminating information in their region.

Other collaborative activities included discussion of (i) issues relating to the project’s second research report (the Mental Health deliverable), (ii) preparations for the upcoming 10th Annual Rural & Northern Health Care Day, and (iii) findings and recommendations from the project’s evaluation report.

Team members who had attended conferences since the previous meeting reported on conference highlights and information relevant to the NTK team.

101 sessions focused on the areas of ethics, library searches and survey research. Dr. Alan Katz, former chair for the University of Manitoba Health Research Ethics Board, presented information on guidelines for RHA research, including requirements for ethical review, balancing harms and benefits, and informed consent. In the Library 101 session, team members learned about services available through the University of Manitoba’s Health Sciences Library, including useful search strategies using PubMed. The Survey Research 101 session gave members an opportunity to design their own mini-survey. This exercise provided insight into the issues associated with survey design and how this affects subsequent analysis (see page 2 for more on surveys).

Other information included training opportunities in health services research available through the Western Regional Training Centre, presented by Dr. Anita Kozyrskyj (see below for more details).

The dinner meeting at Café Carlo gave team members a chance to critique an instrument used to identify mediation styles—but not before we had to use it to determine OUR OWN styles! There was no shortage of laughter and surprising results.

The Western Regional Training Centre (WRTC) for Health Services Research: A Collaborative Training Initiative

The Western Regional Training Centre (WRTC) is a collaborative training initiative for graduate students at the University of Manitoba, Department of Community Health Sciences and the University of British Columbia, Department of Health Care and Epidemiology.

The overall goal of the program is to increase the number of health services researchers who have been trained to meet the research needs of a wide array of health-care policy makers.

WRTC builds on the multidisciplinary education offered by these departments by providing opportunities for applied training and funding for qualified students.

WRTC is also creating linkages with other regional training centres, university departments (e.g. The Manitoba Centre for Health Policy and The Need to Know Team) and health-care decision-makers as a means of further enriching the program. A recent WRTC survey of health-care decision-makers in Manitoba (Feb 2003) revealed that the most needed skills for students were in the areas of research methodology (e.g. survey design, focus group facilitation) and data analysis. Moreover, the survey helped to establish an important connection between the WRTC and provincial decision-makers.

See the FYI section of this newsletter for WRTC contact information.
Designing your own survey seems easy at first—just think of some questions to ask participants, right? Wrong! There is much more to the design of a good survey than meets the eye. The following are some of the important points to keep in mind (from Woodward & Chambers, 1983):

**Do’s**

- Keep wording simple, direct and familiar
- Make questions clear and as specific as possible
- Ensure that questions apply to all respondents
- Do a pre-test to ensure the survey is both valid (i.e. measuring what it intended to measure) and reliable (i.e. are questions interpreted similarly by all respondents?)

**Don’ts**

- Avoid double questions (e.g. Do you agree with putting in more screening procedures and rehab services?)
- Avoid double negatives (e.g. Lack of funding is not a problem for our RHA)
- Avoid questions that are too demanding (e.g. Rank the top 20 difficulties faced by your region)
- Avoid biased questions, such as those that mention only some alternatives (e.g. How should doctors be paid; by salary or government transfers?)

MCHP Hallway and New Paintings

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**NTK Team Members:**

RHA MEMBERS:
- Jody Allan
- Faye White (Assiniboine)
- Bev Cumming
- Nancy McPherson (Brandon)
- Albert de Villiers
- Jim Bentley (Burntwood)
- Shelley Buchan
- Donna Champagne (Central)
- Margaret Fern (Churchill)
- Tannis Erickson
- Doreen Fye (Interlake)
- Sue Crockett
- Catherine Hynes (Nor-Man)
- Edith Cleary
- Bonnie Frith (North Eastman)

MANITOBA HEALTH MEMBERS:
- Deborah Malazdrewicz (Manager of Decision Support Services)
- Lorraine Dacombe Dewar (Director of CHA & Regionalization)

MCHP PROJECT STAFF:
- Pat Martens (Director)
- Sarah Bowen (Evaluator)
- Randy Fransoo (Co-ordinator)
- Elaine Burland (Research Assistant)
- Laurel Jehamani (Research Assistant)
- Charles Burchill (System Analyst)
- Linda Kostiuk (Planning)
- Eileen Pyke (Website/Software)
- Darlene Harder (Planning)

**F.Y.I.**

- The first NTK Deliverable—The Manitoba RHA Indicators Atlas: Population-Based Comparisons of Health and Health Care Use was released in June 2003. The following month, the pdf version of this report on the website received over 22,000 hits. Contact MCHP for copies @ (204) 789-3805 or visit the MCHP website (see above for URL).
- Are you interested in a career in Health Services Research? For information about the “Western Regional Training Centre in Health Services Research” (WRTC) contact Elaine Dunn: (204) 789-3368 or edunn@ms.umanitoba.ca

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New MCHP Art Highlights Manitoba’s Diversity

The long hallway leading to the Manitoba Centre for Health Policy has been given a facelift. This summer, 12 new oil paintings were added, each background a different colour of the spectrum. Together these represent the diversity of Manitoba’s population and physical geography, and illustrate the broad determinants of population health—social support, education, employment, physical environment and healthy child development.

These paintings were done by local artist and recent graduate of the University of Manitoba’s School of Art, David Macri. Funding was provided through the generosity of a private donor.
The tenth annual Manitoba Centre for Health Policy (MCHP) Rural and Northern Health Care Days was very well attended. Participation has steadily been increasing since its inception in 1994, and this year there were over 140 representatives in attendance from the regional health authorities (RHAs) in Manitoba, including CEOs, VPs, Board members and service providers.

The focus of this year’s meeting was the newly released MCHP report The Manitoba RHA Indicators Atlas: Population-based comparisons of health and health care use. Following an oral overview of the report, each RHA gathered to discuss relevant findings and to profile the health care needs of their region.

Other presentations included The Need to Know project overview by some of the team members (Lorraine Dacombe Dewar, Sue Crockett and Bev Cumming) and Rural Canada: From Strength to Strength (Ray Bollman, Statistics Canada). In the afternoon concurrent session, participants could attend either (i) a presentation highlighting two of the many ongoing MCHP research projects (Patterns of Health Care Use and Cost at the End of Life, Dr. Verena Menec et al.; and Diagnostic Imaging Data in Manitoba: Assessment and Applications, Dr. Bill Leslie) or (ii) a workshop on using Excel for making RHA maps.

Rural and Northern Day followed the regular fall The Need to Know team meeting, which took place the preceding day. As usual, this was an action-packed session. The day’s activities were focused on (i) collaborative work on deliverable #2 - The Mental Health Report, (ii) discussion of the process to be used for deciding on the topic for the upcoming third deliverable, and (iii) facilitator training for team members in preparation for a discussion of the RHA Atlas with other representatives from their RHA at Rural and Northern Day the following day. Members also attended a workshop on using (i) PowerPoint to make full-size posters and (ii) Excel to create RHA maps that can be incorporated into these posters.

The dinner meeting was held at Vivere Ristorante Mediterraneo in Osborne Village. RHA CEOs and Board Chairs were invited to attend. With her typical creativity, Project Director Pat Martens managed to work in a review of basic statistics using team scores from the ‘pick-up-sticks’ competition!

Conference Re-caps from Newfoundland, Saskatoon & Montreal

Representatives from The Need to Know Team attended three conferences this fall. Project Director Pat Martens and team member Maggie Campbell from the Parkland Regional Health Authority attended a Canadian Institutes of Health Research-sponsored workshop in St. John’s Newfoundland/Labrador October 9th and 10th to discuss rural indicators of health.

The second conference - the Fifth International Symposium Future of Rural Peoples: Rural Economy, Healthy People, Environment, Rural Communities - was held in Saskatoon (October 19–23). Each day was packed with sessions and posters pertaining to issues affecting rural people, communities, economics and the environment.

The third conference - Strengthening the Foundation: Health Services and Policy Research and Canadian Health Care - was held in Montreal (November 22–24). This was the inaugural national symposium for the Institute of Health Services and Policy Research (IHSPR). Canadian researchers and health care system policy makers and managers were brought together to discuss the roles of health services and policy research in an effort to resolve the most urgent issues affecting health care and service delivery.

The Need to Know project was well represented at these two conferences. In Saskatoon, there were two presentations and two posters highlighting the project. Pat Martens presented information about the differences between rural and urban health and health care use in Manitoba, and Sarah Bowen spoke about lessons that researchers can learn from the community about ‘knowledge translation’. Poster topics focused on the meaningful ‘stories’ that can be generated from analysis of health indicators (Randy Fransoo) and The Need to Know project results to date (Elaine Burland, Sarah Bowen and Pat Martens).

Pat Martens also presented at the Montreal conference Influencing Health Policy: What Works? Learning Along the Road and three project-related posters were accepted for entry into the poster competition: (i) Health and Health Services Use of Rural and Northern Manitobans: Do They Differ from Urban Rates? (Pat Martens et al.), (ii) Evaluating the Effectiveness of Knowledge Translation Projects: A Utilization-Focused Approach (cont’d).

The Need to Know Team Member Sue Crockett—Montreal Conference November 2003
Conference Re-caps (cont’d)

(Sarah Bowen & Pat Martens) and (iii) The Need to Know Project: A Work in Progress (Elaine Burland, Sarah Bowen & Pat Martens). Congratulations to Sarah who won second place for her poster!

Team members from two Regional Health Authorities also attended the Montreal conference—Sue Crockett (Nor-Man) and Margaret Fern (Churchill). In her conference summary report Sue emphasized how being part of The Need to Know had contributed not only to her understanding of research, but to her greater use of research in daily work. Sue also mentioned feeling more comfortable at the conference than she would have before joining The Need to Know Team - “As I sat and listened to the various presenters, reality hit about how much I have learned and grown over the last two years thanks to The Need to Know Team.”

Poster Making 101

Posters are an excellent method for conveying a lot of information in an eye-catching way. The Need to Know team members took part in a poster-making ‘how to’ session at the October meeting. The following outlines the basic steps and tips for making a poster:

- using PowerPoint, choose a blank slide from the auto-layout menu
- size the width and height of your slide using ‘page set-up’ under the file menu (the largest possible is 56 in x 56 in, but your choice should depend on the paper sizes available where you will have your poster printed)
- in the ‘slide master’ view, use auto-shapes to create a background for your poster; you can format your background by adding color, texture and/or patterns
- in the ‘normal’ view, use textboxes for putting text onto your poster
- insert pictures, maps and any other information to help explain your topic
- use a font that is at least size 24 (you should be able to read all text on your poster from 3 to 4 feet away)
- stick to common font styles such as Times New Roman and Arial (others may be incompatible with the printer’s and get reformatted during the printing process)

An easy-to-follow poster-making manual is available on The Need to Know website:
http://www.rha.cpe.umanitoba.ca/education resources/poster workshop
Deliverable #3 Topic Decided: *The Need To Know* Meeting #9

The focus of The Need to Know Team meeting #9 (February 2nd & 3rd, 2004) was to decide on a topic for the third and final deliverable for the project. Numerous possible topics were discussed by the Team. In the end, an overwhelming majority selected ‘gender differences’ as the topic for the final Need to Know deliverable. Work on it is already underway - Team members are working to compile a list of specific indicators to be included in the report.

Other meeting business included continuing discussions about the second Need to Know deliverable - The Mental Health report. The session started with a presentation on suicide by Dr. Nancy McKeen, a new researcher at the Manitoba Centre for Health Policy (MCHP) and newest member to The Need to Know team. Team members, including the mental health working group discussed results and report progress to date. The Mental Health Deliverable is set to be released this fall (2004).

Sarah Bowen, the project’s evaluation coordinator, presented an evaluation update. Some of the highlights included team members’ increased understanding and use of research, and increased confidence using population health terminology.

*Other meeting business included continuing discussions about the second Need to Know deliverable - The Mental Health report.*

**RHA Indicators Atlas Highlighted at Manitoba Health Day**

The inaugural Manitoba Health Day was held this spring at the Deer Lodge Centre in Winnipeg (March 10, 04). This day-long session provided an opportunity for Manitoba Centre for Health Policy and Manitoba Health staff to get together and share knowledge and experiences.

This day, modeled after Rural and Northern Health Care Days, featured *The Manitoba RHA Indicators Atlas: Population-Based Comparisons of Health and Health Care Use*. Facilitated roundtable discussions followed a project overview by Dr. Patricia Martens. Each group examined a different chapter, and then presented a summary their shared insights to the whole group.

Three other Manitoba Centre for Health Policy reports were also highlighted. Dr. Sharon Bruce presented work-to-date on the Patient Safety Deliverable. Dr. Anita Kozyrskyj presented work on two pharmaceutical deliverables. The first, *Pharmaceuticals: Therapeutic Exchange and Pricing Policies* focused on issues surrounding generic drugs and different proposed pricing policies. The second pharmaceutical deliverable is currently underway, and looks at high cost/high frequency pharmaceutical users in Manitoba.

The day closed with a presentation from Louis Barre, Director of Health Information Management at Manitoba Health, in which he outlined the process by which MCHP deliverables are decided upon.

Feedback from Manitoba Health staff was very positive. It is likely that this will become an annual event.
Manitoba Centre for Health Policy (MCHP)

Brodie Centre
University of Manitoba
4th Floor, Room 408
727 McDermot Avenue
Winnipeg, MB
R3E 3P5

MCHP website: www.umanitoba.ca/centres/mchp
(link to The Need to Know website from here)

Program Evaluation 101: Quantitative Research Methods

Thinking of evaluating a program? Here are some basic decisions to make before starting out:

• choose your study design (cross-sectional or longitudinal)
• choose your design features (experimental or observational)
• decide what measurements will be made and whether one or more groups will be measured. (Fitz-Gibbon & Morris, 1987)

- pre-test & post-test
  (with randomly selected control group or a selected similar comparison group)

- pre-test & post-test
  (with no comparison)

- time series

Choice of method will depend on available resources and evaluation goals: are you trying to find out if (i) program X has caused any changes (internal validity) or (ii) study results are applicable to the real world (external validity)?

Highlighting The Need to Know Project

The Need to Know project will be well represented at the Canadian Public Health Association’s 95th Annual Conference this year in St. John’s Newfoundland, June 13-16, 2004. This year’s theme is Population Health In Our Communities. Five posters and two oral presentations related to the project have been accepted.

The 2004 Provincial Health Conference & Exhibition (September 29 & 30) will be held in Winnipeg at the Convention Centre. This year’s theme is Partnerships and Balance: Today’s Choices—Tomorrow’s Outcomes. Several Need to Know project posters abstracts have been submitted for consideration. Contact Elaine Burland (see top) for general conference information which will be available in June.

Several Need to Know project abstracts have also been submitted to The Fifth Canadian Rural Health Research Society Conference to be held in Sudbury, Ontario (October 21-23, 2004).
APPENDIX K:

POST-TEST SURVEY 2002
EVALUATION OF THE “NEED TO KNOW” FOLLOW-UP QUESTIONNAIRE
OCTOBER, 2002

Introduction

The intent of the baseline questionnaire administered in June 2001 was to help MCHP (Manitoba Centre for Health Policy) investigators develop a better understanding of:

a) the kind of information most needed by staff of the Regional Health Authorities (RHAs) for planning purposes;
b) what resources are being used by the RHAs now;
c) the best ways of providing needed information; and
d) how useful the resources provided by the MCHP to date have been to RHA staff.

This follow up questionnaire will be used to evaluate the effectiveness of the project in meeting its objectives. Additional questions have been added in order to update the survey, and gather information on key issues identified through the first year of the evaluation.

Information gained from the questionnaire will be used to plan future research activities; set future workshop agendas; assist in ongoing development of the NTK project, and help the MCHP present research in the most useful and accessible format.

Consent for Participation

This questionnaire is one activity in the “Need to Know” Evaluation project. Your participation in this activity is completely voluntary, and your decision to participate will be confidential.

Please fill out this questionnaire and place it back in the envelope provided. Please also sign and return the consent form separately, indicating with a yes or no above your signature whether you consent to participate in this activity. If you do not consent to this activity, your questionnaire will be destroyed and will not be read.

You will note that your questionnaire and envelope are coded with a number. Results of the questionnaire are confidential. Only the Study Coordinator or Principal Investigators will be able to link your name with the questionnaire. Information on individual questionnaires will not be shared with, or disclosed to, any other person.

This questionnaire is expected to take approximately 20 minutes to complete.
EVALUATION OF THE “NEED TO KNOW” FOLLOW-UP QUESTIONNAIRE: October, 2002

Current sources of research support/information

1. Over the past 6 months, where have you sought sources of information for health planning purposes?
   - Conferences
   - Professional journals
   - Health Canada
   - Manitoba Health
   - Manitoba Centre for Health Policy and Evaluation
   - Colleagues
   - Academic faculty
   - Identified experts in the field (please specify) _____________________________
   - Websites other than MCHP (please specify)_____________________________
   - Other (please specify)________________________________________________

2. How often are you required to locate health information for RHA planning or reporting purposes?
   - A few times a year
   - About once a month or so
   - More than once a month
   - Once a week or more
   - Daily

3. If you had a specific research question/problem who would you be most likely to contact first?
   - Supervisor or colleagues within your RHA
   - Manitoba Health staff
   - Manitoba Centre for Health Policy and Evaluation
   - Colleagues outside of your RHA
   - Academic faculty
   - Identified experts in the field
   - MHINET (MARN Health Information Network)
   - Other (Please specify)________________________________________________
4. Did you know about the existence of the MCHP before you were informed of this Need to Know project?
   __ Yes
   __ No

5. How would you describe the role of the MCHP?
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

6. In general, how would you rate your knowledge of the role of the MCHP?
   __ Excellent
   __ Good
   __ Adequate
   __ Poor
   __ I don’t really understand what they do.

7. Have you ever contacted staff at the MCHP regarding a question, suggestion, or problem related to research for your RHA?
   __ No (go to question 8)
   __ Yes

7a) If you answered yes to the last question:
   If you have contacted the MCHP in the past, how did you contact them?
   Check as many as apply.
   __ email
   __ phone
   __ workshop, meeting or public gathering
   __ letter
   __ Other ____________________________________________________________________
7b) Did you get the assistance you needed?

- Yes
- Somewhat
- No (please go to question 8).

Comments __________________________________________________________

____________________________________________________________________

____________________________________________________________________

7c) How was this information provided? (Check as many as apply).

- in person or phone conversation
- email communication
- provision of reports (hard copy)
- referral to website information
- Other (please specify) ______________________________________________

Comments __________________________________________________________

____________________________________________________________________

____________________________________________________________________

8. If you had a question, suggestion, or problem related to research for your RHA in the future, how likely would you be to contact staff of the MCHP?

- I’ve never thought of doing it
- Not likely
- I might, depending on the question
- Probably
- I would definitely contact them
- Other (please explain) ______________________________________________
Current use of MCHP resources

9. Approximately how many times have you used MCHP reports or information over the past 2 years?
   __ None (Go to question 11)
   __ Once or twice
   __ 3 – 5 times
   __ 6-10 times
   __ More than 10.

10. Which of these MCHP reports are you familiar with?
    __ POPULIS: Providing Health Information to RHA planners (1999)
    __ Assessing the Performance of Rural and Northern Hospitals (2000)
    __ The Health of Manitoba’s Children (2001)
    __ Comparing the Costs of Care in Manitoba’s Hospitals (2001)
    __ How Manitobans use Prescription drugs (2000)
    __ A look at home care in Manitoba (2001)
    __ Do some clinics see sicker patients? (2001)
    __ Changes in Health and Health Care Use by Manitobans, 1985-1998 (2001)
    __ Observations on Winnipeg Hospital Observation Units (2002)
    __ Hospital Beds in 2020 – Will we have enough? (2002)
    __ Other (please list) __________________________________________

11. Approximately how many reports produced by the MCHP have you read?_____

12. In what format did you access these reports? Please check all that apply.
    __ Full Reports (hard copy)
    __ Executive Summaries of Reports (Hard copy)
    __ Web – based information
    __ Not sure, can’t remember
13. Have you attended a workshop offered by the MCHP any time over the past three years?

__ No (go to question 14)
__ Yes

Which of these did you attend? (check as many as apply)

__ RHA day 2001
__ RHA day 2000
__ RHA day 1999
__ Other __________________________________________

**MCHP Website assessment**

*These questions relate the general MCHP web site, not the secure NTK site.*

14. Have you ever accessed the general MCHP web site?

__ No (Continue with 14a).

14a) If you have never accessed the web site, why is this?

__ Wasn’t aware of it
__ Don’t have internet access
__ Just began my position
__ Didn’t think it would have the information I needed
__ Need orientation on how to use it
__ Other __________________________________________

(Please go directly to question 15)

__ Yes, but only since I became involved in this project (continue with question 14b)

__ Yes, prior to becoming involved in the “Need to Know” project (continue with question 14b).

14b) How many times have you accessed the general MCHP web site over the past month?

__ None
__ 1-2 times
__ 3-4 times
__ 5 or more times
14c) Were you able to find the information you were looking for?

- No, never
- Some of the time
- Most of the time
- Always

Comments_________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

14d) How would you rate the quality of information on the website in general?

- Excellent
- Good
- Fair
- Poor

Comments_________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

14e) How would you rate the usefulness of the general MCHP web site information for RHA planning purposes?

- Very useful
- Somewhat useful
- Not that useful
- Not at all useful

Comments_________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
14f) How would you rate the “user – friendliness” of the general web site?

__ Very difficult to navigate and use
__ Somewhat difficult to navigate and use
__ Quite easy to navigate and use
__ Very user friendly

Comments ___________________________________________________
________________________________________________________________
________________________________________________________________

14g) How would you rate the usefulness of the following sections of the MCHP general website?

<table>
<thead>
<tr>
<th>Section</th>
<th>Not used/ don’t remember</th>
<th>Not useful</th>
<th>Somewhat useful</th>
<th>Very useful</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GENERAL WEBSITE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCHP reports</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Powerpoint shows</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RHA information</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concepts and Definitions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCHP information and annual reports</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supercourse in Epidemiology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epidemiology in Health care course</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Search feature</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Links</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RHA INFORMATION (GENERAL SITE)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Profiles (Excel spreadsheets)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Powerpoint presentation</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Reports</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Physician service area information</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statistics Canada links</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
These questions relate to the secure NTK web site.

14h) Approximately how many times have you logged on to the NTK secure website since the project began?

__ None (skip to question 15)
__ (Fill in number)

14i) Please rate the usefulness to you of the following components of the secure website?

<table>
<thead>
<tr>
<th>Component</th>
<th>Have not used/don’t remember</th>
<th>Not that useful</th>
<th>Somewhat useful</th>
<th>Very useful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project information and activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact lists</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meeting agendas, presentations and photos</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Draft tables</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NTK newsletter</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bulletin board</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resource links</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments________________________________________________________

_________________________________________________________________

14j) How would you rate the “user – friendliness” of the secure website?

__ Very difficult to navigate and use
__ Somewhat difficult to navigate and use
__ Quite easy to navigate and use
__ Very user friendly

Comments________________________________________________________

_________________________________________________________________
15. How have you used the information you have accessed from the MCHP? Check as many as apply.
   — Have not used MCHP information
   — Reports or presentations for RHA board/CEO
   — Strategic planning activities
   — My own general knowledge and awareness
   — Staff education activities
   — Community presentations
   — Preparation for research projects
   — Other

16. To your knowledge, do staff of your RHA access the MCHP web site?
   — Don’t know
   — Yes, they access it regularly
   — Yes, they access it occasionally
   — They access it rarely or never

Comments
Terms and concepts used by MCHP

Staff of the MCHP often use specialized terminology that may not be commonly used in everyday planning activities. The intent of these questions is to determine which terms and concepts may require more explanation in reports and presentations.

17. Have you ever taken any courses in Epidemiology, research methods, or Biostatistics?
   __ No
   __ Yes. Please specify__________________________________________________

18. Please rate your confidence in using each of following terms, concepts or topics.

<table>
<thead>
<tr>
<th>Term</th>
<th>Very confident</th>
<th>Somewhat confident</th>
<th>Not at all confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidence/Prevalence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rates (“crude” rates)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Standardized rates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statistical comparison of rates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confidence Intervals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premature Mortality rates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population-based vs facility-based analysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measures of socioeconomic status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potential of administrative data for planning purposes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limitations of administrative data for planning purposes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

18b) What terms or concepts would you like to have covered in subsequent workshops?______________________________________________________________
________________________________________________________________________
Current need for research-related information/support

19. What kinds of assistance for RHA planning do you feel is needed by your RHA at this point in time? Check all that apply.

__ No assistance is necessary at this time
__ Web accessible information
__ A contact for discussing problems and helping locate information
__ Orientation or training in interpretation of research findings
__ Orientation or training in applying research findings
__ Computer support
__ Computer training
__ Other. Please explain. ____________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

20. How would you describe your current level of computer-related skill in the following areas?

<table>
<thead>
<tr>
<th></th>
<th>None-Poor</th>
<th>Adequate</th>
<th>Good-Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>General computer operation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spreadsheets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Web navigation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
21. On what topics related to health research and RHA planning do you require information at this point in time?

a) _____________________________________________

b) _____________________________________________

c) _____________________________________________

d) _____________________________________________

e) _____________________________________________

f) _____________________________________________

__ None, don’t know

Comments_______________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

The “Need to Know” Project

22. What are you hoping will be accomplished through this “Need to Know” process?

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

_______________________________________________________________________
23. From your perspective, what is the greatest challenge facing the project over the next year?

___________________________________________________________________

___________________________________________________________________

24. What are you personally hoping to learn as part of this “Need to Know” project?

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

25. At this point in the project, how clear are you regarding expectations of RHA team members?

__ Very clear
__ Somewhat clear
__ Not that clear

Comments ___________________________________________________________
___________________________________________________________________

26. At this point in the project, how confident are you in participating as a team member in team workshops and activities?

__ Very confident
__ Somewhat confident
__ Not that confident

Comments ___________________________________________________________
___________________________________________________________________

___________________________________________________________________
27. Please rate the importance of each of the following components of the NTK project in meeting project objectives:

<table>
<thead>
<tr>
<th>Component</th>
<th>Not at all important</th>
<th>Relatively unimportant</th>
<th>Somewhat important</th>
<th>Very important</th>
<th>Essential to project success</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presentations made at team meetings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workshops and discussion at team meetings</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>NTK Website</td>
<td></td>
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<tr>
<td>Provision of laptop computers</td>
<td></td>
<td></td>
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<tr>
<td>Homework assignments</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Opportunity to attend conferences</td>
<td></td>
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<tr>
<td>Visits to RHAs by MCHP staff</td>
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<tr>
<td>Social networking opportunities (e.g. dinners)</td>
<td></td>
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<tr>
<td>Development of deliverables</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Knowledge of MCHP staff and resources</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Participation in rural and northern health days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please insert)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

28. Which three project components do you feel are most important?

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________
RHA involvement in research activities

29. How would you rate your own RHA in its current use of evidence-based research? Would you say that your RHA uses research in planning

[ ] Most of the time
[ ] Some of the time
[ ] Occasionally
[ ] Not very often
[ ] Almost never

Comments ____________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

30a) Has the CEO of your RHA asked you for reports or updates on the Need to Know project?

[ ] No
[ ] Yes.
   How many requests have you received?____

30b) Has any one else in the organization asked you to give a report on your work with the project?

[ ] No (skip to 30c)
[ ] Yes

Who has asked you for this information?

[ ] Board
[ ] Executive
[ ] Other staff (specify)____________________________________________________


30c) How many times have you provided information to Board or Executive on the Need to Know Project?

- None
- As part of homework assignments only
- (fill in number)

Comments: __________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

31. Have you been asked for information or input on evidence based research by your CEO, executive or Board?

- No (skip to question 32)
- Yes

Approximately how many times has your involvement been requested? Please fill in the number of requests received from each of the following:

- your CEO
- Board members
- Members of the executive team

Comments: __________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

32. How confident do you feel in the role of promoting greater use of research for planning purposes within your RHA?

- Very confident
- Somewhat confident
- Not that confident
- Not at all confident

Comments: __________________________________________________________
33. Comments

Please use this space, or the other side of this page, to make comments and suggestions, or to provide any other information you feel may be useful to this process.

Thank you for taking the time to complete this questionnaire. Please place it in the envelope provided and seal the envelope. Please also remember to return your consent form.
SUPPLEMENTARY QUESTIONS

These questions are a follow up to questions in the post-test questionnaire. Responses will be kept confidential. Participation is voluntary. Responses will be used to plan future workshops and assignments.

Facilitator training:

1. a. How confident did you feel in your role as facilitator for your region at the Rural and Northern Health day before the Tuesday session began?
   __ very confident
   __ somewhat confident
   __ not that confident
   __ not at all confident

1. b. How confident did you feel in your role as facilitator for your region at the Rural and Northern Health day by the end of the Tuesday workshops?
   __ very confident
   __ somewhat confident
   __ not that confident
   __ not at all confident

Comments_______________________________________________________________

2. To what extent did the training sessions on Monday help you prepare for your role as facilitator in the Rural and Northern Health day? (You may check more than one response)
   __ I felt fully prepared
   __ I would have liked more time to prepare
   __ I would have liked more information
   __ I would have liked more opportunity to practice skills
   __ Other___________________________________________________

Comments_____________________________________________________

3. Do you think that acting as a facilitator for Rural and Northern Health days is a useful role for RHA team members?
   __ Yes, very useful
   __ Yes, somewhat useful
   __ No, not that useful
   __ No, not at all useful

Comments:
4. What changes would you suggest for preparing facilitators for Rural and Northern Health days in the future?

Organizational Capacity Building:

5. Since the June workshop, did you discuss with your CEO the potential topics for the 2nd deliverable?
   __ Yes (go to question # 6)
   __ No (go to question #7)

6. How useful was this activity?
   __ Very useful
   __ Somewhat useful
   __ Not that useful
   __ Not at all useful

   Comments:___________________________________________________________

7. What were the barriers that prevented this activity? (you may check more than one response)
   __ Time constraints
   __ I forgot
   __ Difficulties in scheduling
   __ Lack of interest from CEO
   __ Unsure about CEO reaction
   __ Unsure about assignment
   __ Other

   Comments;___________________________________________________________

8. Did you consult with any other individuals or groups within your RHA on topics for the 2nd deliverable?
   __ No
   __ Yes (Please list)__________________________________________________

Thank you for taking the time to complete these questions
Please return to (Contact information removed)
1. What workshop topics or sessions did you personally find the most interesting?

What topics or sessions did you find the least interesting?

2. What workshop topics or sessions did you find the most useful to your role in RHA planning and decision making?

What topics or sessions did you find the least useful?

3. What topics required more workshop time?

What topics needed less time?

4. Were there any topics you would have liked to have had covered, but were not included?

5. If we were to run a similar workshop again, what could we change to make it better?
“The Need to Know”

Orientation Evaluation

6. What aspects of the orientation did you find the most useful?

What did you find the least useful?

7. What topics required more time?

What topics needed less time?

8. Were there any topics you would have liked to have had covered, but were not included?

9. What additional background material would you have found helpful to have before the orientation?

10. If we were to provide a similar orientation again, what could we change to make it better?
## APPENDIX M: WHAT HAVE WE LEARNED FROM THE NEED TO KNOW PROJECT ABOUT KT?

<table>
<thead>
<tr>
<th>Necessary Components</th>
<th>Common Interpretation</th>
<th>Greater emphasis needed on…</th>
</tr>
</thead>
</table>
| Creation of environment of interest in, openness to relevant research | - It is necessary to provide a setting for KT to occur  
- Lack of interest or uptake is due to lack of knowledge, awareness (or even active resistance) of Community Partners | - Need for confidence/trust-building between community and researchers:  
  - Confidence in researchers  
  - Confidence in research  
  - Confidence in benefits of research |
| Opportunities for collaborative research (Lavis et al., 2002) | It is useful for researchers to consult with, involve community in their projects | - Community partners have their own priorities and interests (CHSRF, 1999)  
- Communities have expertise that researchers do not have  
- Based on past experience there may be suspicion by community partners of being used (“managed community participation”)  
- In many cases community partners are less well resourced than researchers; even if financial costs are covered, there must be practical benefits to participants |
| Shared vocabulary, conceptual base (Davis & Howden-Chapman, 1996) | Researchers need to help build “capacity” of community partners related to research  
Researchers need to learn to communicate in a more “lay friendly” way | - Researchers need to learn from the community about the usefulness and validity of research  
- Community partners have expertise related to KT  
- Communication should be “two-way” not unidirectional  
- Language may play a role in creating and maintaining barriers  
- Research bodies may not have necessary skills “in house” and may need to expand their skill base (Lavis et al, 2002) |
| Forum for sharing | In person contact is important (Lavis et al., 2002; Hanney et al, 2003, Lomas, 2000, Birdsell et al., 2002, Barwick et al, 2002; Hanney et al 2003) | - The quality of in-person contact is important. Attention must be paid to personalities (not simply activities, process and structure)  
- Informal opportunities for networking are needed  
- Research organizations may not have in house expertise related to facilitation, network building |
| Understanding of research findings | - “Capacity building” among community partners is required to help them understand research and its importance  
Once potential users understand the information, mission is accomplished | - Without development of trust, there may be suspicion of both results and “agenda” behind the research  
- Researchers may need help from community in “making sense of” findings, opportunities for critical feedback and researcher education are needed  
- Most research not presented in accessible format  
- Several different “kinds” of learning are involved in KT  
- Understanding is only one step in KT. |
| Understanding of implications for practice | Implications and necessary responses will be evident once research reports are understood | - KT requires that findings be interpreted and applied in a specific setting |
| Application/utilization of research | Researchers should encourage research use but are not responsible for next steps | - Without assistance with this stage, community partners may not be able to proceed (Davis & Howden -Chapman, 1996)  
- There appear to be progressive levels of research impact, all must be addressed |