McMaster University

National Collaborating Centre for Methods and Tools

Centre de collaboration nationale des méthodes et outils

Building capacity for evidence-informed public health

# Following-up with Cohort 2 Knowledge Broker Mentoring Participants

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## List of Acronyms

EIDM – Evidence-informed decision making

KB – Knowledge brokering

NCCMT – National Collaborating Centre for Methods and Tools

## Executive Summary

This report documents the impact of the Knowledge Brokering (KB) Mentoring Program on health units that participated in Cohort 2, which ran from January 2017 to June 2018. Twenty-five employees from five Ontario public health units participated in half-hour phone interviews in January and February 2019, about six months after they had completed the program. Interviews were conducted with participants (16), managers (5) and health unit directors (4).

The interviews revealed that the KB Mentoring Program was highly successful in increasing capacity for evidence-informed decision making (EIDM) and furthering EIDM practices. Participants reported a range of outcomes including increased confidence, knowledge, skills and connections. These are the cornerstones of increased capacity. The KB Mentoring Program was seen as a major contributor in furthering the use of evidence in public health practice. Because of the program, these five health units are now engaging in a range of evidence-based practices including conducting additional rapid reviews, doing more critical appraisals of evidence and requiring evidence be included (and documented) in program review and planning.

The health units have operationalized EIDM supports in a variety of ways, including dedicated staff positions, working groups, training, standardized processes and resources such as guidebooks, frameworks and online portals. In some cases, participants have become champions for EIDM and are directly engaged in supporting others to do EIDM. In other cases, additional staff have been hired to take on this role. While the KB Mentoring Program was not the only agent of change in these health units, it was widely seen as helping move the organizations forward in their EIDM journeys in a more consistent, efficient and effective way. Participants offered high praise for the program.

Respondents mentioned a number of challenges in furthering their EIDM journeys and additional supports that will be required. They also suggested how the KB Mentoring Program can be improved. NCCMT should review these suggestions and determine which can be implemented to improve the program and which can be addressed through other means.

## About the KB Mentoring Program

The National Collaborating Centre for Methods and Tools (NCCMT) launched the KB Mentoring Program in 2014 to advance the uptake and use of evidence-informed decision making (EIDM) in the public health sector in Canada. To date, two cohorts have been run: Cohort 1 from 2015 to 2016 and Cohort 2 from January 2017 to June 2018.

The program combines in-person and online support to train public health practitioners to develop knowledge and capacity in the theory and practice of EIDM. The training involves an initial EIDM organizational assessment using the Canadian Foundation for Healthcare Improvement's *Is Research Working for You?* Health units then select participants for the training, which consists of 10 in-person training days spread out over three sessions; course readings; individual and group critical appraisal practice; monthly webinars; and the support of an EIDM mentor. As part of the program, each health unit conducts a rapid review.

The KB Mentoring Program has two objectives:

1. To assess and assist public health units in developing organizational capacity for EIDM, and
2. To build individual capacity of selected staff to function as "internal" knowledge brokers in EIDM practice.

## Methodology for Follow-Up Evaluation

Staff from the NCCMT contacted all Cohort 2 health units to ask about their interest in participating in this follow-up evaluation. All five health units agreed and each provided contact information for five individuals (participants, managers and executives). The health units varied in size and are located in eastern and southern Ontario. Half-hour phone interviews were conducted with 25 people. Sixteen people were participants in the KB Mentoring Program and nine people were managers or executives at the health units. The NCCMT reviewed and approved the interview questions (see Appendix A). All participants consented for the interviews to be recorded and written transcripts were produced. The transcripts were analyzed using a general inductive approach (Thomas, 2006), which involved organizing the data into themes and sub-themes based on each area of inquiry. The remainder of this report presents the findings within each area of inquiry.

## Program Benefits

A range of public health staff participated in the program and all reported benefits. In this cohort, one health unit chose to send managers and only one front-line staff to the training to better support integration of EIDM into the work of the unit.

> *When we agreed to participate we were really focused at that time on implementing evidence-informed decision making within our health unit. This was before the Ontario Public Health Standards were finalized, where evidence-informed decision making is a strong component. So we'd already determined as a health unit it was something that we were very interested in, but not just in terms of developing some internal capacity and skill*

*set, but developing the strategy to roll it out across the health unit, actually have all our programs and divisions apply evidence-informed decision making over a period of time. So recognizing that that was the case, we were not entirely sure that by sending a team of exclusive front-line staff, yes, they would learn the process, but they wouldn't necessarily be able to take that process and understand how we would then incorporate that into work and what sort of resources would be necessary and how you would then develop that into a strategy for rollout across the health unit. So that was why I and another manager participated in the program directly. (Manager Participant)*

All other units sent front-line staff only.

The list below shows the positions across interview participants. As the interviews were conducted with 16 of the Cohort 2 participants, it is likely that other types of public health professionals also attended.

Dental hygienists
Epidemiologists
Family health specialists
Health promotion and research analysts
Librarians
Public health inspectors
Public health nurses
managers
Directors

## Building Capacity for EIDM

Every respondent mentioned at least one way in which they benefited from the program. Participants spoke about increased interest, increased expectations, increased knowledge and enhanced connections both within the health units and between units.

Participants reported increased knowledge in a range of areas:

- The importance of EIDM
- The importance of framing a good research question
- The importance of using different types of evidence
- The importance of doing critical appraisals
- How to conduct searches
- How to do critical appraisals
- How to do a rapid review
- The time required to do a rapid review
- The EIDM model
- The concepts and tools used in EIDM
- The challenges in EIDM
- The quality of evidence
- How to help others
- How to implement EIDM

## Support for EIDM

The program enhanced or supported a range of EIDM behaviours, including:

- Looking at the evidence base of existing programs or guidelines;
- Asking for evidence for new initiatives or decisions; and
- Being more critical of all research/evidence.

The program also supported the development of a number of standardized practices across the health units:

> *With this new approach, people are trying to follow a more systemic, more rigorous process, so that it's less likely to be questioned in its validity in the way that it was done. (Participant)*

> *Specifically, it would be the systematic way to approach a research review. In the past, if I was asked to do what we call literature review, we didn't really have any way to process, to do that, here in our health unit. I suspect that those in my role would go at it differently. So, having the training, the knowledge broker training, really helped us develop a systematic way of doing a research review, which ensured that it's being exemplified across departments. I think that was definitely a major benefit of going through the training—now being able to take that systematic process of doing the work and bringing it back to share with our colleagues. (Participant)*

> *We've developed an approach for the department, and it's very heavily influenced by NCCMT and everything we learned in the knowledge brokering training. So definitely I'm doing a lot more training. And I know my messaging is consistent with, let's say, another knowledge broker in a different department who might be doing similar consultation. So that feels good, yeah. (Participant)*

> *It made a big difference in the way I listened to things that were presented either in the news or things that I read. It gave me an immediately discerning sense of when people were sort of spouting off research or saying, "This is researched." It made me look much more closely and be more discerning, and then to look deeper into things if I was interested in what*

Several examples were provided of EIDM in practice:

> *We are in the process of doing a program review here at our health unit and I'm in charge of the safe water program. Part of that was critically looking at what we do and then making any suggestions on what we want to either change, eliminate or revise in our program. In order to do that, I had to look at some evidence of why I want to do this. So, for example, for safe water I looked at how we educated the public about private well water testing and I started doing some research on what are the best methods of getting education to the public about a public health matter. I was able to use that to pull from articles, critically appraise them and take some of those suggestions from those articles and make recommendations for my program. (Participant)*

> *One of the things was how we communicated. We kind of educate our public in pretty similar ways. We put stuff up on our website, we provide pamphlets and stuff like that, but*

*we don't take into consideration that different people have different levels of taking in that education. So we looked at geographical area, behaviour, what issues affects them, populations. I found a couple of articles that had a good amount of information that we can start looking at and based on that we decided as a group, not just out of my program, but into a lot of the program, to think about risk communication and try to prioritize what needs to be sent out to the public and the best methods of sending that out to the public. (Participant)*

*What we actually do is we use the NCCMT model for evidence-informed decision making in public health and actually build our project charter based on four components to help inform our decision making with respect to this. So as we've moved through this, we looked at the research related to this and we did a literature review to look for the gold standard in research in this area. We came up with two, one from the UK and we're just incorporating the Ontario Public Health guidelines for it. Then we also took a look at what community health issues in local context are, like what is state of school readiness in our community and we do ECI and our kindergarten parents' survey. (Health Unit Executive)*

## High Praise for the Program

Numerous positive comments were made about the program:

*I just want to state that I really enjoyed taking the program and I would definitely recommend it to any other health units that are thinking about it. I was quite pleased with the work and would do it all over again. (Participant)*

*It was a great course. I really loved all of it. It was very well organized. (Participant)*

*All I would say is that it was a very worthwhile course. I was very happy to have taken it. And, like I said, it was a very timely course in the wake of some of the changes we had from our protocols and within our health unit. I hope that we're able to send more people out to do the course and build capacity in our health unit. (Participant)*

*Just it was such a great experience. I loved it. I was very fortunate to be a part of it and I think it's a really important topic. And, the NCCMT was so professional and we learned a ton of things. It was just a great experience. (Participant)*

The comments centred on the value of the in-person days, the mentors and the facilitators. One person who had previously completed the online modules commented on the value she got from the course where she was able to "*actually go through the process*" (Participant).

## Strategies to Implement EIDM

It is clear that the program directly benefited the participants. In line with the first objective of the program, it also supported the health units to spread EIDM across the organization. The health units chose to operationalize EIDM through a range of approaches. At the time of the interviews, all health units described their journeys as "works in progress." Some units were further along

than others. The strategies planned or implemented involved different combinations of designating EIDM champions, creating working groups, capacity building for staff on EIDM (usually through NCCMT training modules or in-house training by program participants), establishing dedicated EIDM positions, developing resources or guides, developing processes or undertaking specific projects. Interestingly, different terms or frameworks were used to operationalize EIDM across the health units. For example, one health unit integrated EIDM into a leadership framework, a second used a program planning framework, while a third has developed a knowledge-to-action framing.

Not all the health units were able to move forward with their plans to implement EIDM. Some are waiting for specific positions to be filled (e.g., a key leadership position or the KB staff position) before proceeding further with their implementation plans. One unit underwent a merger just as the program was ending and is only now in a position to move forward with EIDM. So far, they have formed a KB working group and this group will be tasked with developing an EIDM strategy.

There was a range of EIDM implementation strategies used across the health units. Of the five health units, two have a dedicated staff position, four use resources or processes, two have done more training, one has champions, and three have implemented a working group.

## Effect of Not Taking the Training

When asked to speculate on what might have happened in their EIDM journeys if participants had not participated in the KB Mentoring Program, participants talked about how things would have been more difficult, would have taken longer, would not be as systematic or effective, or would not have moved forward. These all speak to the program having made a difference.

| Challenge | Illustrative Excerpt |
|---|---|
| **Not as far along** | *I like learning in online modules, but it's so easy to be like oh, I'll just do it next week or I'll just do it another day, I have something more important right now. So, having that time where it's like no, you just have to do this, I think really helps push it forward. So, where we would be now I don't know, but I don't think it would be exactly where we are now. (Participant)* |
| **Poorer quality** | *I think it would have happened to a small degree, but I don't think it would have been happening in the amounts and at the quality that it is right now. I think it's great that people come and ask the knowledge brokers questions about how to do things the way we were taught by the NCCMT to do them. (Participant)* |
| **Less interest** | *I think the promotion of what we've been doing has really sparked a lot of interest in people. So, I think it would have been more of a side-of-the-desk kind of thing. It would have been happening, but I don't think it would have been happening as well as it's happening right now. (Participant)* |
| **More struggling** | *Yeah, I actually thought about that before. Before the training had started, like I said, we were going down that path kind of, but we didn't totally land on EIDM before that. We were looking to see what else was out there and I think this just kind of gave us that* |

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| | *answer, this is where we need to go. So, I guess less time spent floundering and trying to figure out where we want to be. I feel like we're farther in the process now than we would be without doing the training. And I also say that because I think being there for the actual in-person training sessions was dedicated time for us to do the doing and learn things. (Participant)* |
| **More difficult** | *I think it would've been a lot more difficult. Even though we are aware of some of the guidelines for evidence research and stuff like that, a lot of our health units still haven't had training in it. So I think without (the training) it would be a little bit more difficult to do some of the requirements that our organization is now requiring us to do, such as program planning and work plans and stuff like that. (Participant)* |
| **Less confidence** | *I don't know if we would be as far along in our approach without doing that. We certainly wouldn't be as confident in recommending, for example, "You need to do a critical appraisal." It was always assumed people were doing that, but there was never any training here. It was very loose. Now we're a lot more confident in recommending certain processes. (Participant)* |
| **Less knowledge** | *Or not had the same, I think, level of insight into what the skills are that we needed. Kind of a situation of not knowing. You know, you don't know what you don't know. So I think that that's probably what would have happened. (Participant)* |
| **Fewer tools** | *Well, we definitely wouldn't have the guide. And obviously we wouldn't have had the rapid review, I'm not quite sure who would have done it for sexual health. (Participant)* |
| **Unsure how it would have been done** | *I think it is supported through and important to our positions here, so I think it would have, in some shape or form, it would have been discussed. And there probably would have been more done about that, about incorporating evidence into decision making, but I'm not sure what route that they would have gone. (Participant)* |
| **Lack of systematic approach** | *You know, not taking a systematic approach and really just kind of throwing that out and taking whatever appealed to us, or what kind of proved our points. We certainly still have places where we're doing that, and it's a very hard thing to get away from, but I think in a lot of ways this training has kind of pointed us in the direction of trying to avoid pitfalls like that. (Participant)* |
| **Headed in wrong direction** | *You know, I think I would have tried to keep going ahead, especially in my own little department if you will. But I think we might have even headed in the wrong direction of cherry picking the literature. (Participant)* |
| **Lack of importance/ Fallen off radar** | *Yeah, I think that's really what has helped is that we've been kind of that constant nagging voice. I think that if we hadn't have done it, the training, myself and others, I think, it would have been something that mostly fell off the radar or that we were as a whole trying to do it more ad hoc than anything else. (Participant)* |
| **Unchanged practice** | *Well I'd probably carry on the way I was doing. (Participant)* |

## Challenges in EIDM

Participants talked about the challenges to implementing EIDM. The most frequently mentioned challenges were finding time to do the work and turnover in staff. Many participants talked about the challenge of finding time for the program itself; others also mentioned finding time for their new roles. Every health unit mentioned that at least one person participating in the program had left the unit or moved to another position. For some units where the participants were expected to act as supports for the entire health unit, this put them at a disadvantage. One person suggested that more people from each health unit should attend the training to compensate for the expected attrition. Another health unit is hoping to send a second group of staff to Cohort 3.

The table below outlines additional challenges to implementing EIDM, along with illustrative excerpts.

| Challenge | *Illustrative Excerpt* |
|---|---|
| **Dealing with emergent issues** | *For the emergent things that we deal with, we're not going to read article upon article upon article upon article, right? We're not going to do that, you know, two weeks' worth of investigation, looking at different research articles and all that stuff, we need like quick, easy ones that are like, whatever, when we're making decisions, not for planning and things. (Health Unit Supervisor)* |
| **Lack of clout** | *So it's just—it wasn't like the right people, I think, was … what's that triangle, the right people, the right environment and the right framework? That's the three rights, right, so it's like—those three rights and if the three triangles are good, if the three apexes are good, then you're sailing, but it's the right leader, that's what it is. The right leader, the right environment and the right … yeah. (Health Unit Supervisor)* |
| **Resistance** | *I know initially, [the KB participant] would come to our meetings and she would say, "this is where we are" and she'd have like a little presentation and she'd say, "this is where we are and this is how you do evidence." But I know adult learning and if people don't see what the benefit is for them, they don't care. They don't care. And if it doesn't mean for them—so if they all had a project at the end, it was for them to do this, if they were actually going to do something, if they would pay attention to it, if it means something to them, but the fact that they go in and then they have somebody that teaches them, it caused actually some animosity and it caused a little bit of grumbling at our meetings because you see people in my team meetings are pissed off, they're like "God" like [argh], because they don't care. It doesn't mean anything to them. So you know, that to me—that was not the right—but we were told they had to go to these meetings and you know, as passionate as she was about presenting the information of all this stuff that she's learned, nobody cared. (Health Unit Supervisor)* |
| **Struggling with other types of evidence beyond research evidence** | *The community preferences, the local context and that. The one thing that I found that we struggled here with when we were doing the knowledge-to-action approach, because a lot of the knowledge broker training was very research focused and on critical appraisals, we felt like some of those other bubbles, we felt a little* |

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| | *unfamiliar with or like what do we do with these. And I totally understand why, if you had to focus on any of those bubbles, research would probably be the number one thing, because it's a lot more universal, while the local context, the political preference, that's going to be very specific to every health unit, right? (Participant)* |
| **Not using skills** | *If you don't use the knowledge that you gain from health research methodology, I had a background in it but it had been five or six years since I'd done any of it, so reviewing all the different methodologies was really good and always reviewing the clinical appraisal tools and how to interpret, you know, odds ratios. I mean, if you don't do that regularly, it's gone. So it was good for us to review that, and we're finding, even now, a year after the program, that we're having to go back to the NCCMT modules to even hone up those skills again, if it's not something that if you use regularly, that it certainly disappears, that knowledge. (Participant)* |

## Suggested Improvements

While virtually all respondents were very positive about all aspects of the training, respondents were able to offer suggestions for improvement.

*I thought it was great. I think the number of days was definitely needed. And the stuff that they used was great. The content was great. They tried to pick material that was really geared toward what we were doing and seeing in our everyday jobs. So it was very relevant and kept us on task, which was great, and interested. (Participant)*

The table below outlines specific suggestions for each program component.

| Component | Suggestions for Improvement |
|---|---|
| **Rapid review project** | • Better communicate time expectations.<br>• Stress the importance of figuring out a good topic and ensure buy-in from management.<br>• Have flexible timelines for completion.<br>• Help people plan for the hard deadline.<br>• Have more check-ins along the way:<br>*It was just kind of left up to us to check in with our mentor person as we needed. And so, something maybe a little more structured would have kept us a little more on track. (Participant)* |
| **Monthly webinars** | • Better communicate time expectations.<br>• Ensure strong facilitation to encourage participation.<br>• Offer additional webinars after the program ends.<br>• Focus on other topics beyond critical appraisal.<br>• Hold them at times other than lunch hour.<br>• Provide documentation of the factors that were considered in the ratings: |

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|---|---|
| | *The one thing that I felt was missing was kind of looping back so, that if you weren't able to attend or if you missed something in the discussion, there wasn't really a loop back—with the I'm going to say correct answers if you will—from the discussion that we did. So, basically it was set up that you would read the article in advance and critically appraise the article beforehand and there would be discussion on the line about oh, I gave this one a four or you gave this one a six. Let's talk about that and what do we land on in the end and there was never really that kind of loop back on okay, so this is what, you know, we as experts in this would give it. It was like sometimes we resolved it over the phone and sometimes we didn't and it would have been nice to have that documentation so we would move that forward and use that knowledge to share that with others when they're going through these processes. (Participant)* |
| **In-person days** | • Allow teams to stay extra days to have dedicated time to work on rapid review with ready access to mentors.<br>• Accommodate teams at different stages of their rapid review.<br>• Re-think the open structure of the final session:<br>*We talked about this as a group a couple of times. So I would say the first two times we went to McMaster it seemed highly organized and there was a lot of, you know, didactic presentations, and we came home with lots of resources. The last time we went, it was more our mentors meeting us where we were at because we found that the different groups from different health units were at very different places. So some had lots of staff changeover, some people had changed their questions a few times, and just because of where we were all at, we were in very different places, there was no formal presentations or any sort of training, and it was just, we can help you if you need help.*<br>*So we found our last two or three days—I can't remember the timeframe—when we were there, that we basically spent most of the time just working independently, and that didn't seem like a very good use of time. We felt like we could have maybe stayed here and done that and teleconferenced in for that. So it definitely seemed much more formal at the front end and not so much at the end. (Participant)* |

A number of suggestions were made about the program as a whole.

| Specific Topics to Include | Communication, Delivery and Logistics | Expand Audiences or Offer Additional Training |
|---|---|---|
| • Other bubbles beyond research<br>• Adaptability and transfer | • Provide realistic expectations for time commitment.<br>• Ensure research question is of value to the organization. | • Training for leaders<br>• KB Training 2.0<br>• A refresher course<br>• Other cohorts from the same health unit |

| | | |
|---|---|---|
| • Next steps after critical appraisal<br>• How to prioritize different types of evidence when needed<br>• How to implement EIDM in organizations<br>• How to innovate and use evidence | • Stress the importance of developing a good research question.<br>• Ensure organizations provide dedicated time to work on the course and rapid review.<br>• Inform participants of requirement to conduct a rapid review.<br>• Condense the course.<br>• Inform participants that the main focus is on research evidence. | • A larger cohort from each health unit |

Participants also provided suggestions about other things NCCMT can do beyond the program, such as:

- Holding check-ins after the program/refresher, and
- Creating a repository of rapid reviews.

## Further Support for EIDM

Respondents were able to articulate a range of supports that would further their own EIDM and EIDM across their organizations. The most frequently mentioned supports that would further EIDM were:

- Management buy-in
- Training more people
- Dedicated time, and
- Hiring dedicated staff.

The table below outlines the full list of supports required to further EIDM.

| **Support to Further EIDM** | ***Illustrative Excerpt*** |
|---|---|
| **Provide accountability** | *I think accountability for it. Some way of rating our progress or keeping in touch with NCCMT and getting assessments of where to improve. An external auditing mechanism or external accountability that's prepared to kind of take a look at what you're doing and compare it to what would be expected and provide some very individualized suggestions. It might be helpful instead of moving ahead and doing whatever they think is the right answer. And check-ins around that and kind of what the deliverables have been and some reference back to the training where things may have fallen down a bit. For me, everything feels important these days, but I actually think this is hugely important, so that's why it really should have sort of a different level of accountability. (Health Unit Director)* |

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|---|---|
| **Encourage champions** | *I think what I've learned from it is that it certainly can be done without really taking other things off your plate if you make it a priority. I think that that's kind of what it has to be: you have to have people in the organization making it a priority, and that's kind of what's kept it going here is us and a few other people kind of making this development important to them. So I think that's kind of one of the big things overall I've figured out with this program and it's why I continue to do it the way that I am. (Participant)* |
| **Focus on culture change** | *I'm not so sure the culture's going to change as quickly as I want it to. (Participant)* |
| **Embed in health professional training** | *I think if this information could be embedded in some of the health professional training that they're coming into the workplace with some of this information that we're not having to train and up-skill. I think the sooner they learn it the better. When I think about my nursing training, I do remember doing critical appraisal and going through those exercises but not to the depth of the evidence-informed decision making process. (Health Unit Executive)* |
| **Integrate into existing processes** | *Or if that's through making sure that the framework is built into the decision making framework that we're working on, leadership development stuff that we're working on, the day-to-day work that we do and so on. So I think it's just having a consistent approach to that. (Health Unit Executive)* |
| **Hire dedicated person** | *So you do need the dedicated resources, which we have repurposed from FTE to be able to do that. Now I think the expectation probably from a lot of the staff is going to be, "Well this person is actually going to do it for me." Whereas she's more of a coach and facilitator to kind of help them do it. We really need to empower. I think health promoters are very well-positioned in the organization to be able to do this type of process. It should be iterative. They just take a work plan and they go on what they think they know or they look at another health unit. They don't necessarily do that lit review to point them in the right direction to make the best decision. (Health Unit Executive)* |
| **Maintain relationship with mentor** | *Maintaining a relationship with our mentor, who is Maureen, will be helpful. It has been already, because she came into the training and she sort of has a good sense of the organization. So, maintaining that relationship would be really important. (Participant)* |
| **Ensure management buy-in/support** | *I think for us what's really important is senior management and middle management to get buy-in, which is why we tried to do a management forum. Because I think if there's no buy-in from them it's very hard for front-line staff to do some of this work if, you know, 90% of your time is already taken with other things. There's no allotment of time and resources for this kind of work. So I think a lot of management would need to sort of—they might not necessarily have to know all the ins and outs of how you do every step of the way, but I guess it's important to drive the point home on why this is important, why this is better in the long run. I guess when you're deciding to start, stop or modify any program or service, that if you have this evidence or these reviews done to back this up, you're less likely to be, you know—not necessarily make the wrong decision, but something that's not grounded in* |

| | |
|---|---|
| | *evidence. So if it turns out that it doesn't work you have nothing, no leg to stand on, because you didn't even look to the evidence. (Participant)* |
| **Provide more access to peer reviewed lit** | *Then, actually, the other thing I would say for resources is, unfortunately, we have a very limited access to—we do have some, but mostly very limited access to peer review literature. (Participant)* |
| **Provide more longer-term planning** | *So, thinking about, in the next six months, in the next year, where might we be? What decisions might we need to make at that time and, thinking, it's more of that long-term planning, but not really long-term, a more longer-term planning than immediate planning. I think that that would really benefit. (Participant)* |
| **Train more staff** | *I think if we had more KB workers or more people that were training in KB it would probably be a lot more helpful. But at this time it's just the four of us, so it's a little bit difficult. (Participant)* |
| **Provide a refresher** | *Yeah, I can see a time come where we might want to get people a refresher or we might want to do some training, you know, kind of for all staff. (Health Unit Manager)* |
| **Review modules** | *I think we've all stated aloud too that the modules, it would be good to review the modules and sort of keep up that way, and then to share those pieces with people that are interested. (Participant)* |
| **Ensure others see the value** | *I think we need to demonstrate examples of where we use this and make the decisions. I think we need to showcase those. So I think by doing a knowledge-to-action showcase would help us, who are not the early adopters, to say "Hey, you know what? That actually did get some traction and it was kind of interesting and, yeah, it did try to come up with some solutions. Maybe I'm interested in looking into that after all." (Health Unit Director)* |
| **Provide support from NCCMT** | *Continuing to have the centre available as a resource is important. (Health Unit Manager)* |
| **Provide more training** | *I think the big thing is going to be training people and making sure that it's kind of front of mind when it comes time to starting a program, deciding maybe you need to stop running a program or whatever the case may be. And making sure that this is the way that we should do it so, we're all kind of making decisions the same way. I think training is the biggest thing. We don't know what the training module is going to look like, whether people will just do the NCCMT course online or what it will be, but I think that's our key piece right now. (Participant)* |
| **Provide dedicated time** | *I guess time away from your day-to-day work, time constraints. In order to do the research, in order to compile some type of project isn't something that belongs alongside the daily work that staff do is feasible. So, time away from what they do, whether a designated day a week or however that may look, I'm not quite sure. But some time given in order to do this type of work is important. (Health Unit Manager)* |
| **Provide tools** | *But one of the tasks she had been given is to figure out what templates do people need to always be filling out, how do we store that information? We floated a couple ideas around, but I think we need to hone in a little bit more on the process before we can figure out what that can look like. (Participant)* |

One person mentioned that change will just take time:

*I'm a believer that change happens over time, especially if you're thinking about culture change. It's not going to happen by sending five to 10 people to one session or a multiyear session and that we need to continuously find ways to embed that thinking into an organization, into the fabric of the organization. (Health Unit Executive)*

These suggestions are very much in line with what is known about effective implementation strategies. This is an area where NCCMT can do further KT work to support organizations to develop evidence-based implementation plans for EIDM. One person suggested providing information on what other organizations are doing:

*Maybe just how people are bringing EIDM into their workplace and what kind of ideas they've had, what things have worked and what haven't worked. Just so, we can kind of learn from each other and not try something that someone else has already tried and was unsuccessful with, you know. (Participant)*

## Summary and Conclusions

This report presents the findings of follow-up interviews with Cohort 2 KB Mentoring Program participants and health unit managers and executives. The interviews were conducted to uncover the impact of the KB Mentoring Program and obtain suggestions for improvements. The interviews took place about six months after the program ended (the program ran from January 2017 to June 2018).

The interviews revealed that the KB Mentoring Program was highly successful in increasing capacity for EIDM and furthering EIDM practices, the two main objectives of the program. Participants reported a range of outcomes including increased confidence, knowledge, skills and connections. These are the cornerstones of improved capacity. The KB Mentoring Program was seen as a major contributor in furthering the use of evidence in public health practice. Because of the program, these five health units are now engaging in a range of evidence-based practices including conducting additional rapid reviews, doing more critical appraisals of evidence and requiring evidence be included (and documented) in program review and planning.

The health units have operationalized EIDM supports in a variety of ways, including dedicated staff positions, working groups, additional training, standardized processes and resources such as guidebooks, frameworks and online portals. In some cases, participants have become champions for EIDM and are directly engaged in supporting others to do EIDM. In other cases, additional staff have been hired to take on this role. While the KB Mentoring Program was not the only agent of change in these health units, it was widely seen as helping move the organizations forward in their EIDM journeys in a more consistent, efficient and effective way. Participants offered high praise for the program.

Respondents mentioned a number of challenges in furthering their EIDM journeys and additional supports that will be required. They also suggested how the KB Mentoring Program can be improved. NCCMT should review these suggestions and determine which can be implemented to improve the program and which can be addressed through other means.

## References

Thomas, D.R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation*, *27*(2), 237–246.

# Appendix A – Interview Questions

KB Mentoring Initiative

Preamble: Thank you for agreeing to speak with me today. I would like to talk to you about what has happened around KB or EIDM in your organization since you (or your staff) took part in the KB mentoring initiative. With your permission, I would like to tape record our conversation, which should last about 30 minutes. Only the transcriptionist and I will listen to the tape and then it will be destroyed. We will produce a written transcript or notes of our conversation. The information you provide will be collated with the responses from others involved in the KB mentoring initiative and included in one or more evaluation reports. Any excerpts from our conversation that are included in the reports will be presented so that they cannot be traced back to you or your organization.

Are you comfortable with taping our conversation?

1. What is your role in the health unit or your job? Are you in the same role as when you took the training?
2. How many other people from your health unit took the training? How many are still with the health unit?
3. What is your connection to the KB mentoring initiative (participant, manager of participant, director of participant, staff of participant)?
4. What has happened because of your involvement in the KB Mentoring Program?
    a. To your own practices?
    b. Within your organization (processes or policies developed or implemented)?
    c. Probe – can you point to something that is done differently because of the KB Mentoring Program?
5. What was the value of KB mentoring initiative in your organization's EIDM journey? (how KB initiative made a difference, e.g., provided tools, provided a process, provided an impetus, provided protected time, etc.)
6. Given what has happened since you were engaged in the initiative, do you have any suggestions for what could have been improved in the KB mentoring initiative?
    a. Any suggestions for monthly webinars, workshops (# of days, content) or the rapid review project?
7. What would further support EIDM in your organization?
8. How important has NCCMT's support or resources been in furthering EIDM? What would have happened if they did not exist or you did not take the training?
9. Anything else to share about the KB mentoring initiative?