PKT | July 5 webinar Q&As

1. *Is the Action Cycle the same as that used by the NCCMT?*

KTA and the NCCMT, (as well as Getting to Outcomes (GTO)), are different models; but, if you compare them there are many overlapping similarities.

2. *What is the difference in uptake after dissemination activities vs. implementation activities?*

There is 1-2% change in bahaviour when using dissemination strategies while there can be 10% change in bahaviour when using a broad range of implementation strategies (Grimshaw, 2004)

3. *Can you give an example/case study for adaption?*

We work with the WHO to identify challenges to implementing postpartum hemorrhage guidelines in low- and middle- income countries . One recommendation in the guideline is the use of misoprostol for those who experience postpartum hemorrhaging. Misoprostal can also be used in abortion procedures. Some of the countries we work with have outlawed the use of misoprostal because they don't want it available to be used for abortion procedures, even though it is recommended for other procedures outside of abortion. Therefore, the postpartum guideline that recommends misoprostal cannot be implemented in these countries ; we need to adapt the recommendation as they don't have access to the drug.

4. *Do you know of any "how to" guides that would help to operationalize the KTA framework?*

A useful book to consult about the KTA is: Straus, Sharon E., Tetroe, Jacqueline, & Graham, Ian D. (Eds.). (2013) *Knowledge translation in health care: moving from evidence to practice.* Wiley Blackwell.

Also, our PKT course focuses on how to operationalize the steps of the KTA process model. Please contact Melissa Courvoisier (courvoisierm@smh.ca) for course information.

5. *Would a guideline be similar to an Evidence-informed, Theory-driven program (ETP)?*

We see a guideline, or more specifically the guideline recommendation, as defining the desired practice change. We know that simply disseminating a guideline does not bring about behaviour

change and produce outcomes; therefore, we need to have strategies to support the implementation of those guidelines to produce the desired outcomes. The ETP includes both the guideline recommendation and the related strategies to implement the recommendation, and they are linked together using behaviour change theory.

6. *What role does community engagement play in the KTA Model?*

We see community engagement as playing an important role in two different parts of the KTA:

1)Identify and consult with key stakeholders at the beginning of program development.

2) Community engagement during program implementation, especially if you choose strategies that rely on community engagement (i.e., community of practice).

7. *Is there a field within KT that studies how to reduce harmful/stigmatizing practices specifically?*

Quite a few researchers within the mental health field are looking specifically at the stigma piece.

There is a lot of research on harmful practices, which is categorized as de-implementation/de-adoption. This research focuses on the process of stopping things we know are harmful.

8. *How does the quality improvement (QI) PDSA cycle relate to KT models such as the KTA?*

We see QI and KT as being highly compatible, particularly in organizations that have a tradition or history of using QI practices. The big difference we see between QI and KT is that QI focuses on the process of change and seeks to find efficiencies in that process. KT, on the other hand, starts with evidence and focuses on how to get that evidence into practice.

9. *How does your course compare to the sick kids KT course?*

The Sick Kids KT Course focusses on dissemination, tailoring information to local audiences, and effectively utilizing media to disseminate information. The PKT course at St. Mike's focuses on how to create a program that supports practice changes to produce outcomes in an organizational context.

10. *How does KT tackle siloing, entitlement to unlimited funding, cultural resistance, turf wars, political motivations, and weak policy leadership?*

KT addresses these in two different ways: 1. addressing organizations that are not ready to implement, but need to; and 2. addressing leadership that is not on board.

KT is a new and emerging field and therefore there is not a lot of evidence on best ways to deal with these situations, but there are a few helpful studies/resources such as the work on absorptive capacity and adaptive leadership. There are no clear answers at this time for these common challenges.

11. *How do change management models fit with KT?*

Similar to quality improvement models, change management models often focus on the process piece of implementation, whereas KT focuses on the evidence piece. These are different but complementary approaches to implementing practice changes.

12. *Have you heard of the term "deliverology"? How does KT implementation relate to this new field of "deliverology"?*

Deliverology is a new way we can think about deliverables and performance measurement. Deliverology and KT are compatible in that well done implementation projects think through process and outcome evaluations by measuring implementation quality and outcomes in a systematic way. Measuring outcomes and implementation quality relate to Deliveraology.

We are just learning about Deliverology and need to continue to systematically think through how Deliverology and KT relate.

13. *Does your course address coding, example TDF, how to make information useful to the end-user?*

We spend a lot of time thinking about mapping barriers to TDF, selecting strategies that directly relate to the barriers/facilitators, and tailoring these strategies to the local audience. We don't spend as much time on plain language and tailoring messages to specifically address one audience over another (i.e., writing for a policy maker vs. writing for a researcher).