CREATING CULTURE CHANGE: A STUDY OF HOW EVIDENCE IS MOVED INTO
PRACTICE FOR IMPLEMENTATION OF A PUBLIC POLICY INITIATIVE IN
ONTARIO

by

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A thesis submitted in conformity with the requirements
for the degree of Doctor of Philosophy
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Doctor of Philosophy, 2014
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Abstract

The Ontario government, in an effort to close the gap between what we know (scientific inquiry) and what we do (public policy and practice) has, since 2009, supported implementation of the enhanced 18-month well-baby visit (18-month EWBV), in primary care practices throughout the province. Informed by the evidence, the 18-month EWBV represents innovation, an opportunity to expand the current, universal, 18-month check-up to a provision of care that supports standardized assessment at 18 months of age for each child in Ontario.

This thesis begins in the author’s experience, as a Program Consultant (Nursing), whose work it is to coordinate the development and implementation of provincial child development programs. As seen through the case of the 18-month EWBV, the study and its research are about knowledge work. Defined as a process that sees the creation of new knowledge during the transfer of knowledge in the context of the application of knowledge to clinical decision-making (Quinlan, 2009), the study is one of empirical inquiry. Understood that knowledge alone is insufficient to change practice, the study takes seriously the social and organizational processes of work and relations, often coordinated by documents (text) that shape the everyday experience of health professionals as they “invite or reject innovation” (Kontos & Poland, 2009) that the 18-month EWBV represents.

Using insights from institutional ethnography (IE) (D. Smith, 1987, 1999, 2005, 2006) as its method of inquiry, the study used experience as data and documents (text) as data. In its
discovery, the study offers interview and document (text) analysis and maps knowledge work as those processes of work and relationship for the cause and effect of people’s activities, made visible for how things happen as they do, in real life settings, for action that is coordinated, linked in relationship through documents (text), language, ways of speaking, and discourse, to organize experience (Turner, 2003, 2008; Webster, 2009).

In its conclusion, the study moves beyond appreciation of knowledge translation (KT) as a set of individual processes and moves towards a new way of looking to understand and learn of the forces and processes of work and relation that shape change in the local context.
Acknowledgements

A circle of trust holds us in a space where we can
make our own discernments, in our own way and time,
in the encouraging and challenging presence of other people.
(Palmer, 2004, p. 27)

In honouring and acknowledging my “circle of trust” special thanks and appreciation is
first extended to the health professionals, administrators, and office staff, the focus of this study
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am blessed always to be in your company. You have accompanied me on this journey with
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- Dr. Leslie Rourke (lead author): Rourke Baby Record© - Evidence-based infant/child health maintenance guide, English/French 2011, Ontario version, Guide IV;
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The need to address significant inequalities in opportunity, beginning in the earliest years of life, is both a fundamental moral responsibility and a critical investment in our nation’s social and economic future. Thus, the time has come to close the gap between what we know (from systematic scientific inquiry across a broad range of disciplines) and what we do (through both public policy and private sector policies and practices) to promote the healthy development of all young children. (National Scientific Council on the Developing Child, 2007, p. 2)
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List of Acronyms

18-month EWBV: Enhanced 18-Month Well-baby Visit

AAP: American Academy of Pediatrics

CIHR: Canadian Institutes of Health Research

CPS: Canadian Paediatric Society

EDI: Early Development Instrument

FHT: Family Health Team

ICES: Institute for Clinical Evaluative Sciences

IE: Institutional Ethnography

KT: Knowledge translation

MCYS: Ministry of Children and Youth Services

MOHLTC: Ministry of Health and Long-Term Care

OCHN: Ontario Children’s Health Network

OCFP: Ontario College of Family Physicians

OMA: Ontario Medical Association

PHU: Public Health Unit
Dedication

For all that it has been this study, its work, and the journey, is dedicated to …

To my parents, in particular Madelaine Joan Riches (1926 – 2001) whose belief that “she will because she can” has set the course for a daughter’s determination and dedication to a path of lifelong learning. You are with me always.

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Keith, as my strongest support, we are, forever and always.

And to Wendy and Gail, you are both missed deeply.
Preface

Your research is autobiographical in that some aspect of yourself is mirrored in the work that you choose to pursue. Figuring out where your interests lie leads you to a greater understanding of your core values and beliefs. (Glesne, 1999, p. 198)

This is a study beyond the academic of understanding knowledge translation (KT) and evidence informed medicine, with focus on the professional, as in the everyday lived experience of health professionals supporting child health and well-being, and begun in the personal, in my role as mother, experienced nurse, committed reflective practitioner, and, since its inception, as program consultant, with direct involvement in the implementation of the 18-month EWBV, the public policy initiative that supports this inquiry. My approach to this study has been one of qualitative inquiry that continues an approach that began in graduate master’s study. It is a place of inquiry where I feel at home, allowing me, the researcher and author of this study, to go, as Sandelowski and Barroso (2002) suggest, to a place beyond the “tables and figures that provide much of the appeal in quantitative research” (p. 77) to a “tableaux of experience and figures of speech that communicates the tensions, paradoxes and contradictions of inquiry” (p. 77). It is as van Manen (1988) describes, my opportunity, as researcher and reflective practitioner, to share and understand the “tales of the field” conveying methodological rigor, but also methodological flexibility, achieving intimacy but also ability to maintain distance from, subjects and data; and, fidelity to the tenets of objective inquiry, …feeling for the persons and events observed; want[ing] reports to be as true as science is commonly held to be, and yet as evocative as art is supposed to be. (Sandelowski & Barroso, 2002, pp. 77-78)

Those tales take form, developed in thesis writing, study discovery, and in sidebar personal journal entries, a record of my direct experience and thoughts for this research journey. They initiate in the chapter to follow, titled Nurse as Ethnographer, where the study, and my pursuit of wanting to know more, begins.
CHAPTER ONE: NURSE AS ETHNOGRAPHER

In committing myself to investigation, I am taking up something like a piece of the fabric and examining it to make plain, as far as I am able, just how the warp and weft have been laid down and the pile knotted into them. I start work with a piece of the weave, wherever it may be, whatever has caught my attention, and try to explicate the way in which it is put together, to explicate them as definite and identifiable practices. (D. Smith, 1999, pp. 9-10)

This study and its research are about the social organization of knowledge. It is a study of the process of knowledge work that sees the creation of new knowledge during the transfer of knowledge, in the context of the application of knowledge to clinical decision-making (Quinlan, 2009). The study, as seen through the case of the 18-month EWBV, is one of empirical inquiry. Informed by the evidence, the 18-month EWBV represents innovation. The visit brings opportunity to expand the current, universal, 18-month check-up to a provision of care that includes, a more extensive discussion with parents on healthy child development, a more in-depth review and evaluation of a child’s current stage of development using standardized assessment tools, the provision of information to assist parents ability to connect with community programs and services that support healthy child development and early learning, and, when needed, the provision of referrals to specialized community services for those children identified with potential issues, needs and risks (Ministry of Children and Youth Services [MCYS], 2006).

Begun in the experience of the health professional delivering well baby care at the 18-month visit, the inquiry takes very seriously the nature of activities and how they are organized, and of relations often “crystalized in [documents] text” (Campbell & Gregor, 2008, p. 57). In so

1 With acknowledgement to George Smith and Susan Marie Turner from whose work I have taken inspiration for the title of this section; Smith in his seminal article, Political activist as ethnographer (G.W. Smith, 1990) and Turner in her OISE/UT, unpublished dissertation, Municipal Planning, Land Development and Environmental Intervention: An Institutional Ethnography (2003), where she wrote of her experience, activist as ethnographer.
doing, the research provides not so much a study of health professionals delivering well-baby care at 18-months but rather an exploration, to understand, as a social phenomenon, the organizational processes of work and relations that shape the clinician’s everyday experience as he/she invites or rejects innovation that is the 18-month EWBV, complements or inhibits the activities required for its success, and sustains or alters adherence to entrenched practices (Kontos & Poland, 2009). In its discovery, the study offers interview and document (text) analysis and maps knowledge work as those processes of work and relationship for the cause and effect of people’s activities, made visible for how things happen as they do, in real life settings, for action that is coordinated, linked in relationship through documents (text), language, ways of speaking, and discourse, to organize experience (Turner, 2003, 2008; Webster, 2009).

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**Personal Journal Entry - September 2011**

**Bob Miller Bookstore, Toronto**

A favourite visit but yet an unlikely place to decide the path for my travels.

I had great conversation with a dear friend yesterday ... a glass of wine, homemade soup, and a great visit ... as always, she is that “friend to my mind, she gather me, the pieces that I am” (Morrison, 1987, pp. 272-273). She was attentive as I talked of excitement for what this research could be. She shared, its ethnography, its language, it’s an ability to tell someone’s story, its listening and making meaning.

... And so here I am, standing, reading and getting excited. For a wall of books, for a topic called institutional ethnography. I find myself on the floor, cross-legged, absorbed in the words, and their world of possibilities, Institutional ethnography is committed to exploration and discovery. It takes for granted that the social happens and is happening and that we can know it much the same way as it is known among those who are right in there doing it (D. Smith, 2006, p. 1).

This is it, my choice ... Now I must be patient, have strength for the work ahead, and begin one step at a time ...
In undertaking doctoral work and this study, I bring a curiosity of many years for all that is child health and early intervention. Linked to my professional role as a public servant, a participant observer of sorts, with direct connection to the policy, development, and implementation work of the 18-month EWBV, I knew of the experience of moving evidence into policy for implementation of the visit in primary care practices in Ontario, the literature on knowledge translation (KT); (Graham et al., 2006). And, like many, I had heard the anecdotal stories of bringing change to practice. I knew that knowledge alone was not enough to change practice (Dopson, FitzGerald, Ferlie, Gabbay, & Locock, 2002; Kontos & Poland, 2009), but what were the forces that influenced and shaped the nuances of local processes, and in knowing of those processes, how could they be made better? And so, like Diamond (1992), I wanted to know, wondering of the how; how do things happen as they do, “what did things look like from the inside, what kind of rules operated” (p. 3) for bringing shift in people’s thinking; for enhancing skills and expanding practice? (Canadian Paediatric Society [CPS], Canadian Academy of Child and Adolescent Psychiatry, 2012, p. 535). More specifically, how does knowledge work for the enhanced visit become “defined and get reproduced day in and day out” (Diamond, 1992, p. 5); how is new knowledge created as a way of being or not?

With a focus for study in hand, I was challenged in areas of method. Initially drawn to narrative, then to case study, and classic ethnography for an approach to inquiry it was in IE as method that I found fit. Its requirement for one “to see herself as a knower located in the everyday world and finding meaning there, in contrast to reliance on library research and the application of theories” (D. Smith, 2006, p. 11), proved interesting, different, and appealing. IE as a method of inquiry adopts a “materialistic approach” (Sevigny, 2012, p. 4) to social research, combining “ethnomethodology with insights from the feminist practice of consciousness-raising”
(D. Smith, 2006, p. 16). It is understood as an “emergent mode of inquiry, always subject to revision and improvisation required by new applications” (p. 16). Its study, I came to understand, is not to explain people’s behaviours but rather to discover how local practices and experiences are tied into extended social relations or chains of action, many of which are mediated by documentary forms of knowledge (DeVault & McCoy, 2006). I took up the ways of IE, learning a practice of research that required me to look differently to understand, a tool that allowed for the merging of research to practice (Wright, 2003), a way of learning that encourages the researcher to “unravel your own and other people’s experiences, to discover how they are put together” (Campbell & Gregor, 2008, p. 17), to explore everyday life and not to theorize it. My work though had just begun. The days and weeks that followed were filled with thoughtful reflection for the tireless work of the forming, reforming, and positioning of questions to guide the inquiry. They ultimately found home under the arch of the question: What can we learn about the movement from evidence to practice in the implementation of Ontario’s 18-month EWBV? That question and those that followed (abbreviated here for ease of reading and as tempt for the discovery that follows) for how knowledge (child health evidence) is moved to practice, how health professionals are organized to embrace new ways and processes of care, the role of documents (text) to organize practice, and contributions of IE towards understanding innovation guided and formed this study and its research.

In the days, weeks, and months that followed it was, as Crispin (2009) best describes, a process, initially, as one of “stumbling around.” Begun in discussion with trusted friends, my process of coming to understand matured to a never-ending journey of quiet, thoughtful reading on all things IE. New titles, now familiar: The Everyday World as Problematic, Writing the Social, Institutional Ethnography: A Sociology for People, and Institutional Ethnography as
Practice (D. Smith, 1987, 1999, 2005, 2006) found prime space on my bookshelf. Book pages became worn, weathered, marked, and highlighted as my understanding grew. Then in workshops led by Dorothy Smith, pioneering force of IE as a method for inquiry, and Susan Turner, her student and now colleague, I entered a new phase of learning. What was found in reading became alive in the language and conversation of the method; of institution, not as a particular organization but as a coordination and intersection of work processes taking place in multiple sites; of social organization and social relations as action that is coordinated and linked; ruling relations as a form of making invisible work, visible; knowledge creation as social, rather than an individual process; the role of documents (text) as those coordinators, visible traces of institutionalized relations and work processes; problematic as a beginning point to understand the need for study; discourse as discussion for framing the language and speech that coordinates people’s activities; data collection in the traditions of IE, as interviewing for understanding experience, document (text) gathering for understanding how work is activated and experience coordinated; and mapping as a form of analysis to understand actual experience of relation and process (D. Smith, 1987, 1999, 2005, 2006).

In adopting the role of institutional ethnographer as my own, I worked, over a several year period, collecting and analyzing documents (text) that guided implementation of the 18-month EWBV provincially. With ethics approval secured (Appendix A), my research took on new ways. I conducted interviews with information-rich stakeholders and key informants, each selected for their expertise in leading education initiatives in support of provincial implementation of the 18-month EWBV and for their role as front line staff and professionals, members of a government-sponsored community of practice identified as a family health team (FHT), responsible, in part, for delivering well-baby care at 18 months. Conducting research on
the front-line was amazing, a gift, for energizing thinking, challenging previously held ways of considering, and for my understanding of how. Using a structure of open-ended inquiry, with the purpose to learn “how things work” (DeVault & McCoy, 2006; D. Smith, 2006; D. Smith, personal communication, June 2012), I focused on the work of moving evidence to practice, asking each participant of their lived experience of knowledge work, of the “visible institutional hooks and traces” (D. Smith, 2006, p. 111) that guided their experience for moving evidence to practice for the enhanced visit. In conversation, as someone mentioned a document (text) used in the work of the visit, I would ask for a copy or access to the document (text) and then purposefully focus discussion on its use; what did the professional/worker do with it? How was it used? What was its origin? In these ways I built, as D. Smith (2006) describes, an “accumulating understanding of how work processes were textually linked across sites and levels of administration” (p. 29). I paid heed and became as a listening board as stakeholders and informants spoke of their activities, both visible and invisible, the social action that took place in their particular setting, the relations of power and authority from both policy and governance (macro forces) and for those in local practice (micro processes). In interviewing, I listened to the language, for a genre of speech and a discourse of child development that was new. On all fronts in the interview process I remained challenged, and feel that my challenges were met. I monitored myself closely as I listened and cautioned myself repeatedly so as to not be tempted “to plug in the missing pieces from one’s own knowledge” (Campbell & Gregor, 2008, p. 77), to get only “a clear account of how things go together to make up what the informant might consider standard practice without his omitting anything he takes for granted” (p. 77). I sought clarification for understanding. I practiced active listening. I found that knowledge acquired in the interview process became cumulative, each interview building on the next. It was, as
Diamond (1992) suggests, the work of developing a “collective story” (p. 6) shared with me, as the ethnographer, by the health professionals and staff that I came to know. It was an experience that left me exhilarated and wanting for more.

Though never an evaluation of individual clinicians or family health teams (FHTs), in the course of the research, I heard of and witnessed many things. Passion, frustration, tenacity, indifference, as well as commitment and courage as health professionals and staff developed understanding, enhanced skills, and/or challenged policy and governance were the stories of the day. I came to understand; through language used and discussion heard, of the ways work was organized (Turner, 2003). In the gathering of documents (text) I understood their central role as coordinators, organizers, and mediators of the widespread and interconnected relations of policy and governance that set delivery of well-baby care in local practice and also produced, in their interpretation, its inconsistencies. In the study’s analysis I developed maps of understanding, crafted, woven from the threads gathered (Diamond, 1992) of conversations with participants interviewed and documents (text) collected, to show the “work of documents (text) active and bringing into relation a complex of textual and speech practices as institutional, as relatively enduring forms of social organization” (Turner, 2003, p. 5). Such analysis brought discovery and meaning to a complexity of organized linked relations that rule delivery of the movement of evidence to practice for the enhanced visit.

Not to be forgotten was an additional element of contribution to the study, that of reflection and reflexive inquiry. For me reflection is a life force, an integral part of my daily and professional life. At each juncture in my doctoral work, in the study’s conversation, and with the undertaking of the research, I have wondered of questions and possibilities. In dialogue with study participants and opportunities following our meetings, I reflected, taking time to step
back, review how I was doing, what kind of impact was I having, deliberating on further questions to use in discussion, identifying those “ah-ha” moments that had come from the work. I assembled field notes, those tools of “record” of field activities (Hays & Singh, 2012, p. 423). Such notes captured “subjective aspects of data collection, including assumptions, impressions, attitudes and ideas” (p. 423). Those notes and scribbles, expanded and revised following and before discussion with my participants, provided me with patterns of practice, identification of themes, an ability to record my scrutiny and description of observations, use of actual words that people shared to describe and emphasize. They are an archive of discovery that has enriched this study. I also took note, with surprise even, of how my questions prompted reflection on the part of my interview participants. Some took notes as we spoke; others verbalized acknowledgement of discussion that had framed new ways of thinking for them. It was reflection and reflexive inquiry in action for the researcher and her participants.

To complement the voice of my participants and to add dimension to the study, I actively wrote notes, weekly and sometimes daily, of the personal journey that the research and the study was. The journal provides an additional reflexive dimension and insight, a biography of sorts, of this research journey and how my insights as the researcher have been woven into the “epistemological fabric of the interpretations” (Kilbourn, 2001, p. 2). Journal notes are found throughout this thesis, included for the background, context, and insight to a specific conversation or event that they may offer.

The foundation for this institutional ethnographic study is set as I begin in discussion that locates myself, nurse as ethnographer, within a process of research and study. The chapter sections to follow build on this foundation, continuing next in a description of the “case” of the 18-month EWBV. Such description and the evidence that prompted its development set the
stage for the overview of the study itself. And so, in the fashion that D. Smith (1999) describes,
and in the way that this section began, I move forward in this thesis for this next chapter and the
chapters that follow, “working as with a piece of the weave, examining to make it plain” (pp. 9 –
10), and in so doing, creating, as Denzin (2004) writes, “authentic understanding” (p. 507).
No longer are well-baby visits limited to immunization and early identification of variance or abnormality. Increasingly, the primary care role is to proactively recognize and help enhance the unique assets of all children and their families. For these interventions to be effective, the literature supports using a physician-prompt health supervision guide, having found that clinical judgment alone is not enough. (R. Williams, Clinton, CPS, Early Years Task Force, 2011, p. 647)
CHAPTER TWO: THE CASE OF THE ENHANCED 18-MONTH WELL-BABY VISIT

Background And Overview

The Role of Primary Care in the Early Years

Primary care health professionals are central to the support of child development, particularly for children who are not of school age (Halfon et al., 2004; Regalado & Halfon, 2001). Shonkoff and Phillips (2002), Halfon and Inkelas (2003), R. Williams et al. (2010) speak more specifically to the role of primary care providers, understanding these health professionals as well positioned to improve child health and developmental outcomes through care opportunities because of their connection and influence with families in the early years. In discussion of the health system and its role in early years and the influence of primary care, To et al. (2004) see it as one of the most “universally utilized resources for preschool children” (p. 258). They suggest that the health system, including family physicians, community pediatricians, nurse practitioners, and other primary health care providers, are in a unique position through well-baby visits that incorporate early identification and intervention programming (p. 258). R. Williams et al. (2010) see the importance of the roles as one to help “improve the odds for positive childhood development outcomes by virtue of their continuing contact with their patients and families over time” (p. 23). Often such practitioners are the only professionals in contact with the child between birth and 5 years of age, have an accepted role of authority (Rydz et al., 2005), and have insight into the child’s environment and thus can interpret the child’s development and health in the context of the family and the social environment (Dworkin & Glascoe, 1997).
Family Health Teams in Ontario

Family medicine is an art, informed by science.  
(Dr. David Price, Chair, Department of Family Medicine, McMaster University  
Chief, Hamilton Health Sciences, 2013)

In a policy paper, authored by Ontario’s Ministry of Health and Long-Term Care  
(MOHLTC) (2005), the solution identified for Ontario for the growing recognition that  
population health needs are diverse and complex and thus best met by teams of health  
professionals was the development of FHTs. Defined as an approach to primary care that brings  
together various health care providers to coordinate the highest possible quality of care for  
patients, family health teams consist of doctors, nurses, nurse practitioners, and other health  
professionals who work collaboratively (MOHLTC, 2005). The government created FHTs as  
governing structures with responsibilities to provide a core set of comprehensive primary health  
care services to their enrolled patients. The agreement between the MOHLTC and the FHT sets  
out requirements for service delivery, reporting, and compensations (MOHLTC, 2005, p. 3). In  
providing background to the role of teams in developing care the ministry shares:

While professional practice is guided by each provider’s regulated scope of  
practice, it is recognized that the working relationship among the members of the  
team will also take into account the expertise, preferences and skill set of  
individual providers. No two teams will function exactly alike. Each, over time  
will develop its own character, working relationships and culture. (p. 3)

In discussions of developing a knowledge base for family practice, Strange, Miller, and  
McWhinney (2001) speak to six basic reasons why new knowledge is needed for family practice.  
As outlined, they share:

1. A discipline needs a coherent and evolving body of knowledge in order to exist;  
2. To teach new generations, our tacit knowledge must be made explicit;  
3. Information is needed to improve patient care in ways that optimize the valued roles  
and life course of individuals, families, and communities;  
4. The current knowledge base and conceptualization of information needs are  
incomplete (Nutting & Strange, 2000);  
5. There are new challenges for which we need answers; and
6. Knowledge is needed to achieve a healthy sustainability of the health care system, within the context of society’s other system and needs. (pp. 288-290)

The authors see the power of developing a knowledge base as that of creating a culture of learning and inquiry that develops the knowledge base and enhances the healing power of the broad, integrative, relationship-centred primary care discipline of family medicine.

The Opportunity at 18 Months

Timely and periodic assessment of children in the early years has opportunity to provide additional influences across a system of care and support. New science and emerging evidence suggests strong correlation for early childhood as a predictor of lifelong health (National Scientific Council on the Developing Child, 2007). It is in the evidence and understanding of the early years and their psychological foundations that there is opportunity to “improve outcomes for children for the betterment of society” (p. 4). The age of 18 months is a key stage in healthy child development. In the past families have routinely brought their children to primary care providers at 18 months to be assessed for height and weight and routine concerns as well as for immunization. Building on the evidence of the importance of the early years, an expansion of current well-baby care towards a more systematic approach includes opportunity to

- Address parental concerns;
- Monitor physical growth and development;
- Assess parent-child interactions and family health;
- Counsel about development, behaviour, safety, literacy, nutrition and community resources;
- Provide immunization and other preventative care; and
- Identify risks and problems for action. (OCHN & OCFP, 2005, p. 7; R. Williams et al., 2010, p. 24)

The bringing of new knowledge and evidence on the importance of the early years for creating opportunity for more extensive discussion with parents about enhancing healthy child development, a more in-depth review and evaluation of the child’s current stage of development,
and information and referrals that will help parents connect with community programs and services is a tipping point for practitioners in supporting evidence-based population health science, child development as a social determinant of health\textsuperscript{2} and the provision of care grounded in the medicine of social paediatrics.\textsuperscript{3}

The Enhanced 18-Month Well Baby Visit

Health professionals, policymakers, and the public now recognize the lifelong impacts of children’s early life experiences and the need to provide appropriate services so that they may ultimately reach their potential. But even as the rates of preventable health, behavioural, and developmental problems increase, studies document that many children are not receiving the services – including anticipatory guidance, developmental screening, and appropriate interventions - that they need. (Halfon, Stanley, & DuPlessis, 2010, p. 1)

The scientific evidence is clear. Early childhood counts. The impact of early childhood experiences and environments are measured both in young children and throughout the lifespan. Yet not all Canadian children are doing well, despite living in a country with one of the highest standards of living in the world. (Hertzman, Clinton, & Lynk, 2011, p. 655)

In late fall of 2004, a vision for young children and their families living in the province of Ontario was announced. Proposed as \textit{Best Start}, it was promoted as a plan “designed to support parents in their efforts to raise healthy children and help them achieve their potential” (Ministry of Children and Youth Services [MCYS], 2004; Ontario Children’s Health Network [OCHN] & Ontario College of Family Physicians [OCFP], 2005, p. vi). With studies suggesting that health professionals are well positioned to improve child health and developmental outcomes

(American Academy of Pediatrics Committee on Children with Disabilities [AAP], 2001;

\textsuperscript{2} The concept of healthy child development as a determinant of health is one that honours the importance of early child development and its foundational role in setting and influencing life trajectories. (Mikkonen & Raphael, 2010)

\textsuperscript{3} Social paediatrics, as defined by the European Society of Social Paediatrics and Child Health (ESSOP), is a global, holistic, and multidisciplinary approach to child health; it considers the health of the child within the context of their society, environment, school, and family, integrating the physical, mental, and social dimensions of child health and development as well as care, prevention, and promotion of health and quality of life (Spencer et al., 2005, p. 106).
Dworkin & Glascoe, 1997; Halfon & Inkelas, 2003; Rydz, Shevell, Manjner, & Oskour, 2005) the Best Start vision called for the creation of an Expert Panel on the 18-Month Well Baby Visit. Evidence for change and new ways of supporting young children was strong. In Ontario, Early Development Instrument (EDI) results indicate almost 30% of Ontario non-special-needs students score below the 10th percentile on at least one readiness to learn domain (i.e., physical health and well-being, social competence, emotional maturity, language, cognitive development or communication skills, and general knowledge) and 14% of children are low on at least two readiness to learn domains (Offord Centre for Child Studies, 2010). Reports from the United States of America indicate, “nearly half of parents have concerns about their young child’s behaviour (48%), concerns related to developing speech (45%), and emerging social development (42%)” (Halfon, Olson, & Inkelas, 2002), that between 12% and 16% of children have developmental or behavioural disorders (Boyle, Decoufle, Yeargin-Allsoop, 1994), and of those children, about 70% with developmental problems at kindergarten entry could have been identified earlier but had not been (Glascoe, 2000). In addition to reports on the status of the developmental health and well-being of young children, the 18-month EWBV as a public policy initiative was informed by a critical body of evidence drawn from fields of neuroscience, molecular biology, and genomics. Research that crossed disciplines (public health, epidemiology, developmental psychology, sociology, anthropology, economics, medicine, and education) also informed. All pointed to clear evidence that early child development is a critical period of development with long reaches into later childhood, later adolescence, and adult life (Bertrand, 2001; Centre on the Developing Child, 2010; Hertzman, 2000; McCain & Mustard, 1999; Shonkoff & Phillips, 2002; Shore, 1997). As well, contributions from the world of finance on the value and importance of investing in young children (Cunha, Heckman, Lochner, &
Masterov, 2005; Ellwood, 2001; Heckman, 2007; Knudsen, Heckman, Cameron, & Shonkoff, 2006; Schweinhart et al., 2005; Shonkoff & Phillips, 2002) in its role as a powerful equalizer and a key tool for economic and social stability (McCain, Mustard & McCuaig, 2011) served to inform.

And so, with a mandate set for the development of a report that would provide the basis for a provincial strategy to support standardized assessment at 18 months of age for each child in Ontario (MCYS, 2005), the panel, under the joint leadership of the OCHN and the OCFP was convened. The panel’s report, delivered in 2005 and accepted by government, provided advice, recommendations and implementation strategies that have set policy in the province since 2009 for the “involvement of primary care providers in a more systematic way in promoting and monitoring healthy child development, focusing on the 18-month well-baby visit” (OCHN & OCFP, 2005, p. vi; MCYS, 2006).

In identifying the opportunity to enhance development for all Ontario’s children (OCHN & OCFP, 2005, p. 1) through an 18-month visit, the panel saw the visit as an opportunity to reach young children at a critical point in their development. By being one of the “last regularly scheduled visits coupled to immunization, and potentially the last time children are seen before school entry” (R. Williams, Clinton, Price, & Novak, 2010, p. 24) and for its access to the children—upwards of 96% of children under the age of 2 seen by a primary care provider (Institute for Clinical Evaluative Sciences [ICES], 2002/04) - the visit represented a coming together of both need and opportunity. With its accompanying recommendations, implementation strategies, tools, and resources, the Report of the Expert Panel on the 18 Month Well Baby Visit became an important document (text) for moving evidence to practice so that all
children would have an opportunity for a good start in life (OCHN & OCFP, 2005; Williams, et al., 2010).

In its program design, the enhanced visit (Figure 1) represents a movement beyond the use of clinical judgment alone (CPS, 2011, p. 647) in the delivery of 18-month well-baby care to the introduction of an evidence-informed, standardized approach, to support the “creation of culture focused on enhancing developmental health and well-being of children to improve outcomes (MCYS, 2006; OCHN & OCFP, 2005) as part of primary care practice in the early years. Knowledge (child health evidence), information, resources, and evidence-informed guidelines and tools guide and structure the visit and are key to its delivery.

**Figure 1. Program Design – 18-month EWBV.**

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**Program Design**

**Development and Design**

- **Province**
  - Responsible for the design, funding and overall management of the Enhanced 18 Month Well-Baby Visit.
  - Completed by a health professional in collaboration with parents, the initiative is based on:
    1. Use of standardized tools
    2. Discussion with parents to provide information and make referrals as needed
    3. Measurement and evaluation component

**Supporting Delivery**

- **Education/Information (MCYS)**
  - Academic and physician detailing including an electronic format that provides a platform for providing education and its information on the initiative and tools to health professionals and families to support service delivery.

**Enhanced 18 Month Well-Baby Visit**

- **Health Professionals**
  - Responsible for delivering the visit in accordance with the direction provided by the province.

**Tools to Support Delivery of the Visit**

- NDDS™, Pictorial NDDS, e-NDDS
- RBR, e-RBR
- 18 month clinical report; PBSG module
- Early Child Development and Parenting Resource System (ECDPRS) pathway

**Families and Children**

- Key partner in overall process by completing the Nipissing District Development Screen.

**Data Collection**

- Funded Physician Remuneration Fee Code (MOHLTC)

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**Figure 1.** Program design for the 18-month EWBV. Rectangles on the left denote responsibilities for the design, funding and overall management of the 18-month EWBV. Rectangles on the right denote activities that support delivery of the enhanced visit and those...
responsible for delivering the visit in accordance with the direction provided by the province. Adapted from “The Enhanced 18-Month Well-Baby Visit” Ministry of Children and Youth Services, (2006b, p. 6).

In concluding this section, the chapter information to follow will be provided as background and overview of the study that is the account of this thesis. The chapter begins in narrative: a description of the 18-month visit in Ontario as it is currently being delivered. The use of such description serves to orient the reader to the study’s intent; how it is that the visit is organized. The next chapter sections continue with presentation of understanding for the need for study, description of the study’s setting, and context for the study. In its conclusion is a sharing of the significance and potential benefits of the study as well as a brief glossary of words and terms to assist with the reader’s orientation to the inquiry and understanding of the discussion.
If we keep doing what we have been doing we are going to keep getting what we have been getting. Concerns about the gap between science and practice are longstanding. There is need for new approaches to supplement the existing approaches of research to practice models and the evolving community centred models for bridging this gap. (Wandersman, Duffy, & Flaspohler, 2008, p. 171)
CHAPTER THREE: THE STUDY

Background

The impetus for strengthening health research systems and linking research to action was given support with the release of a World Health Organization (2004) report titled, World Report on Knowledge for Better Health (p. 131). Its release summoned an international call for “reaffirming the view that the generation and application of high-quality knowledge is vital to a high-performance health system and socioeconomic development of any given country” (p. 131).

Yet despite the call, the challenge remains for how knowledge is best moved “off the shelf” and into the “messy” realities of clinical practice (Kontos, & Poland, 2009). Efforts to move evidence into practice can be fraught with tension, including strain for the realities of day-to-day busy practice, stresses often found in professionals working together, challenges for clinician understanding of the relevance and meaning of the innovation, the social context of the clinic setting, including the power and authority processes present that promote or inhibit the uptake of new ways (Gravel, Légaré, & Graham, 2006; Rycroft-Malone, Harvey, Seers, Kitson, McCormack, & Titchen, 2004). All can serve to seriously undermine even the best of efforts for change. And then, there are the possible tensions ascribed from forces outside of local practice, those forces of policy and governance that may be interpreted as dictate: government initiatives and mandates challenging autonomous practice with definitions of care, requirements for elements of service and medical recording.

Following is description of the study and its research. It begins in personal narrative that describes the 18-month visit as it is currently delivered in Ontario. Continuing, it provides orientation to the study focus and direction for understanding knowledge work. The chapter extends with description of IE’s fundamental appreciation that “human existence is essentially
social” (Townsend, Langille, & Ripley, 2003, p. 19), by way of introducing knowledge work for the 18-month EWBV as a series of processes of social organization and relations, documents (text) as tools of knowledge work, and language, speech genre, and discourse as ways for knowledge work. It culminates in an overview of terminology to assist with orientation to the investigation and understanding of the study and its discussion.

The 18-Month Well-Baby Visit In Ontario

It is the start of another busy day in one of Ontario’s many community health practices. A mother has come with her 18-month old son for his regular well-baby care visit. He is due for a complete examination including diagnostics of weight and measurement, his immunization needle, and instructions provided to the parent regarding his health care following immunization. The visit is short and the record will show that he is well within the norms that have been plotted in the growth chart and despite some viral infections he is growing well.

Across the province, in another practice setting, the well-baby visit is being delivered somewhat differently. A young father and his 18-month old daughter sit with a nurse as the father completes the developmental checklist that was provided to him, as part of his child’s enhanced 18-month well-baby visit. He reviews the checklist and makes note of a number of skills that his daughter can successfully complete and puzzles over issues that may be of concern and some that he had not thought of. He thinks about how his daughter communicates, how she lets him know what she wants, she gestures but he wonders about her words. He reflects on how he helps her to walk but wonders what he can do to help her walk by herself. The visit continues as the physician discusses with him about the importance of this busy time in his child’s life, asks how he is doing, how is his family doing, and then listens to his concerns for his child’s development. Using a point of care tool the physician, then asks some additional questions, building on the issues and needs that the father has expressed about his daughter’s communication and motor skills as well as exploring other areas of development key for this child’s age. Continuing his evaluation the doctor shares additional information, provided to the physician by the public health nurse who has been linked to the practice from the local public health unit. The information on parenting and community programs that support early learning and child development has proved helpful for the patients in the practice and for the physician delivering such care. The doctor encourages a referral to a specialized community services to provide additional support for the child’s language

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4 With acknowledgement to Janet Rankin and Marie Campbell, who in their groundbreaking study Managing to nurse: Inside Canada’s health care reform (2006), offered inspiration for using personal narrative as a tool of description in the sharing the problematic of this inquiry.
concerns that both the father and physician have identified. He counsels on the importance of literacy in this child’s life and shares a book for the child to have as her own. The immunization is administered and the nurse provides contacts for the referral to the community speech and language program along with some practical and parenting suggestions for activities to promote the child’s overall development and to address the language concerns specifically. (Personal narrative, June 2012)

In an “evolving order of change” (Quinlan, 2009), this is how well-baby care, at 18 months, is delivered in Ontario.

Orienting Study Focus and Direction: The Problematic

Underlying anyone’s everyday life experience, something invisible is happening to generate a particular set of circumstances. It is that “something” that is of research interest. (Campbell & Gregor, 2008, p. 7)

A problematic is a territory to be discovered, not a question that is concluded in its answer. (D. Smith, 2005, p. 41)

The study researches the routineness of well-baby care at 18 months. It seeks to understand, through exploration, those processes and relations of knowledge work that shape practice, inviting or rejecting innovation, complementing or inhibiting the activities required for success, sustaining or altering adherence to entrenched practices (Kontos & Poland, 2009).

Since 2009, with introduction of the 18-month EWBV as an expanded scope of practice, new knowledge (child health evidence), information, resources, and evidence-informed tools have been available in efforts towards shifting the structure and process for the delivery of well-baby care at the 18-month visit. Seen as an initiative to improve child health and well-being, the question arises for me, how are practitioners experiencing that change? The puzzle for me to understand and explore was how do health professionals integrate new knowledge and shift the structure and conversation of well-baby care at 18-months in practice? What are the forces at play that shape this to happen, or not? In experience, in stories shared from the field, of
practitioners and parents experiencing the enhanced visit, or not, I understood there to be a
tension, a disjuncture (D. Smith, 2005, 2006), a contested area being experienced between
“policy and actuality ” (Ng, Stooke, Regan, Hibbert, Schryer, Phelan, & Lingard, 2012, p. 1), for
those involved in how to accomplish a provision of clinical care as the competent, somewhat
autonomous professionals that health care clinicians are and how to make changes in practice
that the new science, research, and evidence suggested and new program policy required.

The study I undertook was designed to explore how knowledge work for health
professionals (leadership and family health teams in partnership) involved in 18-month well-
baby care is socially organized and how the forces, guided by documents (text) that are so
fundamental to the enhanced visit, shape and form uptake and implementation of the 18-month
EWBV. I did not focus on people’s different perspectives on the enhanced visit, although I
noted them. I focused on the work itself, the “how” of evidence-informed policy, organized in
documents (text) in finding its way to practice. Beyond theory, I set forth inquiry to explore
everyday life. In so doing, I made the following knowledge claims that support the need for
study. First, that the movement of evidence to practice is “a complex process, in dynamic
tension” (Green, 2004, p. ii) with “established patterns of care” (Grol & Grimshaw, 2003, p.
1225). Second, that in identifying, to make visible, the relations that shape individual
experience, those “processes and forces” (Bawoy, Burton, Arnett-Ferguson, & Fox, 1991, p.
282) of policy and governance (macroforces); to local practices, in and across (microprocesses);
(Wright, 2003, p. 247), provide insight for understanding how knowledge work is done. Third, I
put forth the notion that IE is best suited as a method of inquiry, making accessible
understanding of actual and embodied professional knowledge work processes, their social
organization and relation, as mediated by documents (text) for the implementation of the 18-
month EWBV. In doing so the research study uses IE a its method of inquiry and justifies its use for research, by asking how IE makes accessible understanding of actual and embodied professional knowledge work activities and what insights, reorganizations, and refinements to current practice for the enhanced visit may be generated using IE.

**Knowledge Work as an Institution**

*Knowledge work as processes of social organization and relations.* Moving knowledge to practice is more than an “activity that simply attaches research to a local worksite” (Mykykhalovskiy & Weir, 2004, p. 1059), and if applied in this way seriously makes the mistake of overlooking the profound differences between settings and resources as well as the established routines and cultural practices that influence and shape care (Fervers, et al., 2006). Beyond the narrow treatment of knowledge creation, translation, and utilization as individual cognitive processes (Schultze, 2000, pp. 3 – 41) it is important to understand the moving from evidence to practice as a social phenomenon. One that sees knowledge as a social undertaking, to be seen as a coordinated and linked activity

> a collective form of work carried out during formal meetings and informal interactions among team members; involving three knowledge processes: the creation of new knowledge during the transfer of knowledge, the sharing of knowledge between team members, in the context of the application of formal and practice-based knowledge to a particular clinical decision. (Quinlan, 2009, p. 627)

In understanding *knowledge work* for its organization and relations is to appreciate those “visible and invisible institutional hooks and traces” (D. Smith, 2006, p. 111) that makes work happen asking:

> What is the work that informants are describing or alluding to? What does it involve for them? How is their work connected with the work of other people? What particular skills or knowledge seems to be required? What does it feel like to do this work? What are the troubles or successes that arise for people doing this work? What evokes the work? How is the work articulated to institutional work processes and the institutional order? (p. 111)
Documents (text) as tools of knowledge work. In many areas of health professional practice, knowledge is managed, transferred, and applied to clinical decision-making through the creation of codified knowledge (Grol & Grimshaw, 2003; Quinlan, 2009; Straus, Tetroe, & Graham, 2009) and shared as knowledge translation tools (Straus, et al., 2009). Such tools take many forms and formats. Practice guidelines, protocols, patient decision aids (p. 35), as well as web-based and other emerging technologies are all to be considered as the tools of knowledge work. For purposes of this study, as discussed previously they act in knowledge work as the “visible traces of institutionalized social relations” (Quinlan, 2009, p. 628). It is the activation of documents (text) that is fundamental to people’s work (Campbell & Gregor, 2008; D. Smith, 2006; Turner, 2008). Be it policy developers designing programs, education organizations supporting program implementation and/or health professionals shifting to new structures and ways of practice, it is document (text) that invites a process that anchors us into our local reality (Campbell & Gregor, 2008).

Documents (text) for the 18-month EWBV. The following key documents (text), identified for the purposes of research study as primary and secondary, bring knowledge (child health evidence), information, resources, and tools for use at the 18-month EWBV to practice. Central to the study and its research is the Report of the Expert Panel on the 18 Month Well Baby Visit. (OCHN & OCFP, 2005). The report, titled Getting it Right at 18Months … Making it Right for a Lifetime, is the backbone of the 18-month initiative and is central to the activation of knowledge work for the enhanced visit.

18-Month EWBV primary documents (text):
1. Getting it Right at 18 Months ... Making it Right at 18 Years and Beyond (MCYS, 2005). Proposal that saw the development of a report to government to provide the basis for a provincial strategy to support standardized developmental assessment at 18 months of age for each child in Ontario.
2. *Getting it Right at 18 Months ... Making it Right for a Lifetime - The Report of the Expert Panel on the 18-Month Well Baby Visit* (OCHN & OCFP, 2005). The document includes reference to several associated documents, including:

a) New fee code assessment (Ministry of Health and Long-Term Care (MOHLTC), 2013);

b) Standardized tools: *NDDS®; Rourke Baby Record© - Ontario (RBR© - Ontario*; and

c) *Early Child Development Parenting Resource System pathway/18-month visit flow chart* (MCYS, 2006; OCHN & OCFP, 2005)

1. [www.18monthvisit.ca](http://www.18monthvisit.ca)

2. *Final Report to the OCFP for the Evidence to Support the 18 Month Well-Baby Visit* (Guidelines Advisory Committee, 2005; OCHN & OCFP, 2005);

3. Ontario’s enhanced 18-month well-baby visit: Information for physicians & other health professionals. (R. Williams et al., 2010);

4. Getting it right at 18 months: In support of an enhanced well-baby visit. (R. Williams et al., 2011);


6. MCYS, *Ontario’s Enhanced 18-month Well-baby Visit: Information for Physicians & Other Health Professionals* (Professional brochure, 2011a); and


### 18-Month EWBV supporting documents (text):

- MCYS, *Best Start Implementation and Planning Guidelines* (MCYS, 2004);

- MCYS Building on the Foundation – Moving Forward: *Addendum to the Implementation Planning Guidelines for Best Start Networks – System Integration* (MCYS, 2006a);


**Language, speech genre and discourse as ways for knowledge work.**

Distinctive forms of language involving terminology, syntactic conventions, styles of speaking and writing, concert people’s activities as people draw on and activate them. (Turner, 2003, p. 81)

Be it words, the way of speaking or writing, a discussion framed within the world of early years meaning, all are tools for bringing people together in a way of knowing, for “getting things done” (D. Smith, 2006, p. 118). For this study and in the current world of understanding the importance of the early years, it is the utterance of language, speech and discourse of, “epigenetics,” “the brain,” “population health,” “developmental assessment,” “social
determinants of health,” “developmental trajectories,” “collaborative discussion,” “standardized tools,” “early identification,” “intervention,” “child development,” and “life-long health and well-being” that brings change to structures and processes in the delivery of well-baby care as science is put into clinical action (CPS, Canadian Academy of Child and Adolescent Psychiatry, 2012). It is as D. Smith (2006) shares, a “phenomenon of interface – partly in and constituent of individual consciousness, but also shared” (p. 118). It is the notion of “language as coordinating individual subjectivities and, of discourse [streams of talk or text] as a regulator of the coordinating languages” that will be attended to in this study. With the written message, found in documents (text) the same for all to read, the reality of how meaning is taken up and put into different courses of action—is dependent, as D. Smith (2005) shares, framed in analogy, “on where the driver is going and what her or his options are” (p. 82). She continues, helping to make accessible the concept of language’s role and its application in the organization for how things happen as they do, by sharing:

Each driver can take into account that others have read and what she or he has read. Each coordinates her or his own driving decisions with the message, all the while remaining responsive to the ongoing traffic around her or him and taking the local traffic pressure, including what she or he can see ahead, into account in deciding how to interpret it. We count on the messages being read by other drivers as we are reading them. This how a significant symbol is defined: a speaker speaks, and both hearer and speaker respond to what has been said as meaning the same thing: the utterance means the same to both. (pp. 82 – 83)

**Definitions**

Following is a brief overview of terminology to assist with readers’ orientation to the investigation and understanding of the study and its discussion. The list is provided as a roadmap to assist with integration of the inquiry’s discussion, expansion of the text, and conceptualizations of the ideas presented in the inquiry (Eisner, 1991).
Terms and Words of Child Development

*Child outcome(s):* describe the knowledge and skills that children should acquire. They define the range of knowledge and skills that children should master. They can also extend beyond knowledge and skills, describing habits and attitudes and dispositions that are expected to develop based on early years experiences. (Bordrova, Leong, & Shore, 2004, p. 2)

*Developmental surveillance:* a flexible, continuous process whereby knowledgeable professionals perform skilled observations of children during the provision of health care. The components of developmental surveillance include eliciting and attending to parental concerns, obtaining a relevant developmental history, making accurate and informative observations of children, and sharing opinions and concerns with other relevant professionals. (Dworkin & Glascoe, 1997)

*Early intervention:* Interventions that provide resources, programs and services to young children and their families aimed at supporting child, parent and family functioning. (Centre on the Developing Child, 2007)

*Population health:* an approach to health that aims to improve the health of an entire population, and views healthy child development as growing out of universal supports for all children and their families rather than an exclusive focus on programs targeted to at-risk groups or clinical interventions. The population health perspective aims to reduce health inequalities among population groups and considers the importance of social determinants of health. (Hertzman, 1998, pp. 14-19)

*Social determinants of health:* primary factors that shape health including, income and income distribution, education, unemployment and job security, employment and working conditions, early childhood development, food insecurity, housing, social exclusion, social safety network, health services, aboriginal status, gender, race, and disability. (Mikkonen & Raphael, 2010, p. 3)

Terms and Words of Knowledge

*Diffusion:* the process by which an innovation is communicated through certain channels over time among members of a social system. (Rogers, 1995, p. 5)

*Implementation:* The execution of the adoption decision, that is, the innovation or the research is put into practice. (as cited in Alberta Health Services – Alberta Mental Health Board, 2009, p. 6)

*Knowledge transfer:* the transfer of good ideas, research results, and skills between universities, other research organizations, business, and wider community to enable innovative new products and services to be developed (as cited in Alberta Health Services – Alberta Mental Health Board, 2009, p. 5).

*Knowledge translation:* in relation to health care. “A dynamic and iterative process that includes synthesis, dissemination, exchange and ethically sound application of knowledge to improve the
health of Canadians, provide more effective health services and products and strengthen the health care system”. (Canadian Institutes of Health Research, 2005)

*Research utilization:* process by which specific research-based knowledge (science) is implemented in practice. (Estabrooks, Wallin, & Milner, 2003, p. 3)

**Terms and Words of Health Care**

*Collaboration:* a recognized relationship among different sectors or groups, which is formed to take action on an issue in a way, that is more effective or sustainable than might be achieved by the public health sector acting alone. (Public Health Agency of Canada, 2007, p. 9)

*Partnership:* collaborations between individuals, groups, organizations, governments, or sectors for the purpose of joint action to achieve a common goal. (Public Health Agency of Canada, 2007, p. 12)

*Primary health care:* incorporates personal care with health promotion, the prevention of illness and community development. The philosophy of primary health care includes the interconnecting principles of equity, access, empowerment, community self-determination, and inter-sectoral collaboration. It encompasses an understanding of the social, economic, cultural and political determinants of health. (ICES Atlas, 2006, p. xiii)

*Primary Care:* clinically focused, considered a sub-component of the broader primary health care system. Primary care is considered to be health care provided by a medical professional that is a patient’s first point of entry into the health system. (Martin & Sturmberg, 2005, p. 106)

*Primary care practitioners:* general practitioners, family physicians, community paediatricians, nurse practitioners, nurses and other allied health professionals whose goal is to assess, treat and monitor the healthcare needs of patients. (Martin & Sturmberg, 2005, p. 106)

*Public Health:* an organized activity of society to promote, protect and improve, and when necessary, restore the health of individuals, specified groups, or the entire population. (Public Health Agency of Canada, 2007, p. 13)
CHAPTER FOUR: READING AND APPRAISING THE LITERATURE

A review of the literature sets the proposed research in context, frames it within what has already been done, and provides a rationale for the current investigation. (Hays & Singh, 2012, p. 115)

The following review offers a multifaceted, comprehensive, but not exhaustive exploration of the literature pertinent to how knowledge is translated in health care. It begins with an overview of studies of professional knowledge and their understanding for how knowledge is realized. This serves as a way of framing the importance of study. It moves on to a critical review of studies of knowledge translation. This provides an appreciation of the various approaches and theories used in understanding how knowledge is brought to action and sustained in its use. Ultimately the review offers examination of studies of communities of practice. This section examines communities of practice and their role in the dissemination of knowledge. The review drawn from primary quantitative and qualitative studies, systematic reviews, and the grey literature (e.g. discussion documents, research reports, and government documents) considers what is currently known about knowledge and how it is most effectively managed to bring evidence into action for knowledge work processes.

Following the review, the chapter, in its conclusion, focuses on my role as institutional ethnographer in appraising the literature to identify its gaps. That process allowed me to “position my focus of study” (Campbell & Gregor, 2008, p. 51), leading to the development of the inquiry’s overarching question and subquestions (Campbell & Gregor, 2008, p. 51). The chapter concludes with identification of the key research questions that lead investigation.

Studies of Professional Knowledge

There are those who choose the swampy lowlands. They deliberately involve themselves in messy but crucially important problems and, when asked to
describe their methods of inquiry, they speak of experience, trial and error, intuition, and muddling through.

Other professionals opt for the high ground. Hungry for technical rigor, devoted to an image of solid professional competence, or fearful of entering a world in which they feel they do not know what they are doing, they choose to confine themselves to a narrow technical practice. (Schön, 1983, p. 43)

The literature is rich with understanding and meaning making of professional knowledge. Appreciation for its complexities (Eraut, 1994) is captured in the following definition that Dickson (2007) provides. She writes of professional knowledge as being “dynamic, intellectual, personal, developmental, research informed and achieved in synthesis; the success of definition lying in the breadth of these categories rather than in the enumeration of unwieldy lists of competencies” (p. 1).

Knowledge can be defined as data, raw material that still needs to be processed; as information, that interpreted and contextualized data that reveals meaning; and as knowledge, a social process, the result of perceiving, learning and reasoning of the information. In realizing knowledge as a social construct, Denis and Lehoux (2009) suggest that this happens when “it contributes to increasing individuals’ problem solving capacities, when it increases their sense of self-control over their working contexts and day-to-day practices” (p. 219). Scardamalia and Bereiter (2006), speak of knowledge in terms of the infinite. They see knowledge building as a process, one that is never ending, focused on knowledge creation and innovation, shifting from treating students [individuals] as learners and inquirers to treating them as members of a knowledge building community. Inherent in their appreciation that individuals are capable of building knowledge, the authors suggest that the following key themes identify membership into a knowledge building community

- Knowledge advancement as community rather than an individual achievement;
• Knowledge advancement as idea improvement rather than as progress toward true or warranted belief;
• Knowledge of in contrast to knowledge about;
• Discourse as collaborative problem solving rather than as argumentation;
• Constructive use of authoritative information; and
• Understanding as an emergent (p. 100).

The literature is rich in contrasts of just how such knowledge is realized. Schön (1983), in his seminal writing, *The Reflective Practitioner*, argues that “technical rationality” is of limited use in educating professionals (p. 8). He saw reflective practitioners as holding “a variety of interpretations, some traditional, some contradictory, in their minds before selecting some and rejecting others in order to solve a specific problem” (p. 28). Eraut (1994) describes four modes of knowing: *replicative* for routine decisions; *applicatory* which uses technical knowledge to produce a prescription for action; *interpretative* which is a mix of technical knowledge, experience, and personal insight/ability; and *associative* which often exists in the profession’s guiding metaphors (pp. 47 – 50). He also shares how “acquisition of professional knowledge is highly dependent on its context for use” (p. 33). In contrast, Elbaz (1991) summarized knowledge categories as *positivist, interpretive, critical, cognitive, practical, biographical, contextual, and knowledge of subject* (pp. 1 – 19).

**Clinical Judgment/Tacit or Embodied Knowing/Explicit Codified Knowing**

Understanding professional knowledge as it is embedded in the health sciences is a broad and often conflicted discussion of opposite viewpoints: clinical judgment alone or practice grounded in evidence. It is the latter that sees the role of *explicit knowledge* as codified knowledge, easily transferable, mainly through written documentation. In opposition, often as support to clinical judgment alone, is *tacit knowledge*, knowledge based on experiential learning, learned from social interaction and stored in our heads, not on paper. And so at the heart of the debate of professional knowledge is the role of clinical autonomy, often determined as the
defining characteristic of professional power, status, and prestige (Freidson, 1970), against
evidence-based/evidence-informed practice; the acceptance of “mechanisms of external ‘decision
summarizes best the literature for issues related to changing physicians’ behaviour in the
discussion of moving from evidence to practice by sharing:

In effect, the application of evidence-based medicine provides an illustration of
the new tensions between preservation of traditional privileges for the profession
as a collective (guided by the controlling actions of the elite) and the clinical
discretion exercised by individual practitioners. (p. 1772)

Clinical judgment.

The necessity of a deliberate control of policies by the method of intelligence,
and intelligence which is not the faculty of intellect honoured in text-books and
neglected elsewhere, but which is the sum-total of impulses, habits, emotions,
records, and discoveries which forecast what is desirable and undesirable in
future possibilities, and which contrive ingeniously in behalf of an imagined
good. (Dewey, 1957, p. 9)

As Karthikeyan and Pais (2010) write,

The term clinical judgment conjures up visions of the archetypal clinician
endowed with infinite wisdom and breathtaking clairvoyance. In popular
conception, clinical judgment seems to be more about the clinician than about
judgment. (p. 623)

Harsh in its assessment, Phaneuf (2008) sees clinical judgment as a complexity of
processes. Dallaire and Dallaire (2008) rationalize clinical judgment as one that “enables the
individual to recognize the aspects of a given situation, to foresee possible interventions to
stabilize the condition of a patient” (p. 279). Others see clinical judgment as the critical
decisions made on the basis of scientific observations but with the added skill provided by long
experience of similar cases (Stedman, 2011).

Tacit or embodied knowing. Implicit in understanding professional knowledge is
awareness of tacit and embodied knowing. First introduced as a concept by Polyani (1958) in his
treatise, Personal Knowledge, wherein “we can know more that we can tell” (Polyani, 1967, p. 4), tacit knowledge or embodied knowing is knowledge possessed only by an individual. It is knowledge that is difficult to communicate to others through words or symbols but gained through observation, imitation, and practice (Leonard & Sensiper, 1998). Such knowledge is often characteristic of a person considered to be the expert. In the role he or she “acts, makes judgments, doing so without explicitly reflecting on the principles or rules involved, without having theory of his or her work; he or she performs skilfully without deliberation or focused attention” (Schmidt & Hunter, 1993, pp. 8 – 9). Nonaka and Takeuchi (1995) speak of the role of discussion as an important tool for the “articulation of taken-for-granted, tacit knowledge” (p. 626), and though “difficult to express, it (tacit knowledge) is precisely in its conversion into explicit knowledge through articulation that new knowledge is created” (p. 626). Integrating such knowing as a component of clinical judgment sees a final understanding for this review of clinical judgment as “the sum total of all cognitive processes involved in clinical decision making” (Karthikeyan & Pais, 2010, p. 623).

**Explicit codified knowledge as evidence-based/evidence-informed.** Polyani (1967), as described above, is one of many who have made the authoritative distinction, between tacit and explicit or codified forms of knowledge. The literature speaks of “codified knowledge in health care organizations as knowledge that is embedded in formal and visible codes and well-circumscribed technologies” (Straus et al., 2009, p. 220), and found in health care organizations in “clinical practice guidelines, quality indicators, performance management systems, information systems, and electronic patient records” (p. 220). The authors go on to suggest that

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Knowledge as codification refers to knowledge that is embedded informal and visible codes and well-circumscribed technologies. Codified knowledge in health care organizations includes clinical practice guidelines, quality indicators, performance management systems, information systems, and electronic patient records (Denis & Lehoux, 2009, p. 220).
current research on clinical governance “underscores the importance of codified knowledge for improving organizational and clinical performance (Starey, 2003; Scally & Donaldson, 1998), and is often “associated with a search for increased accountability and the need to open the black box of resource use” (p. 220).

Referenced in the literature is an evolving distinction of the terms of explicit knowledge as evidence based or evidence informed. Drawn from the positivist approach to clinical practice, evidence-based practice and programs are approaches to prevention or treatment that are validated by some form of documented scientific evidence. This includes findings established through controlled clinical studies, or other methods of establishing evidence. Evidence based programs use a defined curriculum or set of services that, when implemented with fidelity as a whole, has been validated by some form of scientific evidence (Children’s Bureau, 2011, p. 16).

In contrast, evidence-informed practice uses the best available research and practice knowledge to guide program design and implementation. This informed practice allows for innovation while incorporating the lessons learned form the existing research literature. (Children’s Bureau, 2011, p. 16)

Current and comprehensive definitions of evidence-informed practice view it as a “process” (A. Rubin & Bellamy, 2012, p. 7), whereby practitioners “integrate the best research evidence available with their practice expertise and with client attributes, values, preferences and circumstances” (p. 7). A more comprehensive approach of evidence-informed practice should, as Nevo and Slonim-Nevo (2011) suggest, “be understood as excluding non-scientific prejudices and superstitions, but also as leaving ample room for clinical experience as well as the constructivist and imaginative judgments of practitioners and clients who are in constant interaction and dialogue with one another” (p. 1176).
Karthikeyan and Pais (2010) speak to evidence-based medicine as being “around since the time of the first clinicians” but “what has changed is the nature of “evidence itself” (p. 624). Claridge and Fabian (2005) share a timeline of the history and development of evidence-based medicine that begins long ago. They record:

Ancient era evidence-based medicine consists of ancient historical or anecdotal accounts of what may be loosely termed evidence-based medicine. This was followed by the development of the renaissance era of evidence-based medicine, which began roughly during the seventeenth century. During these years personal journals were kept and textbooks began to become more prominent. This was followed by the 1900s; during an era we term the transitional era of evidence-based medicine (1900 – 1970s). Knowledge during this era could be shared more easily in textbooks and eventually peer-reviewed journals. Finally, during the 1970s we enter the modern era of evidence-based medicine where technology had had a large role in the advancement of evidence-based medicine. (p. 547)

It was only in the 1980s that the term “evidence-based medicine” was truly coined. Credit to McMaster Medical School (Ontario, Canada) is provided for the term, with their description of the approach to practicing medicine in which the clinician is aware of the evidence in support of his or her clinical practice and the strength of that evidence (Elliott & Moyer, 2001, p. 14) for clinical decision-making. Sackett, Rosenberg, Gray, Haynes, and Richardson (1996) define evidence-based medicine as the “conscientious, explicit and judicious use of current best evidence in making decisions about the care of individuals, emphasizing the need to integrate the individual physician’s expertise, judgment and proficiency with the best evidence available” (p. 71). They cite an essential component in the decision-making process as the “ability of the clinician to comprehend the nature and strength of evidence and appropriate application of it to individual patients in his or her care” (p. 72). Elliott and Moyer (2001) and R. Williams et al. (2011), the latter citing work of the Guidelines Advisory Committee (2006), continue in understanding of evidence for use in practice with an offering of caution. From Elliott and
Moyer (2001), those clinicians who do not seek the recent evidence relevant to their practice face the risk of rapidly becoming out of date, to the potential detriment of their patients. From R. Williams et al. (2011), that the use of clinical judgment alone is not enough if interventions are to be effective.

**Paediatric explicit codified knowledge as evidence-based/evidence-informed.**

Limited in the past by the “availability of evidence for children” (K. Williams, Scheinberg, Moyer, & Mells, 2003, p. 142), and still early in its evolution, Elliott and Moyer (2001) share that work has continued since 2000 for paediatric topics that bring evidence into practice to be included in paediatric journals. They cite the work of Dr. Virginia Moyer, in instituting “a bimonthly section entitled ‘Abstracts from the Literature’ for inclusion into the prestigious Journal of Pediatrics”, and describe it as providing “summaries of recent, high quality, clinical studies in paediatrics, accompanied by expert commentary” (p. 16). Also shared is the hope of future opportunities “for creating a register of valid and clinically applicable paediatric literature” (p. 16). Suggested as important steps for the profile of EBM in paediatric practice, the literature in the domain of paediatric care suggests that development and access to important paediatric research, evidence, and information must be developed further and will be aided by the introduction of evidence-based/evidence-informed medicine as a component of medical school curricula (p. 16). The need is further emphasized in the writing of Sanders et al. (2005) who share that “many community-based programs that aim to improve child health, are neither evidence based (i.e., proven efficacious by controlled trial) or successful (i.e., proven efficacious by regional or national dissemination)” (p. 1142).

The literature, in understanding evidence as a pillar for providing sound clinical decision-making in the provision of best care for the paediatric patient and their families, acknowledges a
number of issues that impact on the application of evidence to children and their families and in
the implementation of evidence into practice (K. Williams et al., 2003, p. 143). These include:

- time for accessing evidence for every clinical interaction, the lag-time between
evidence generation, publication and application, ability to find information in
predigested and accessible forms, and, in the discussion of implementation, the
access, or not, to “guidelines to health professional who are seeing the children
with the problems addressed by the guidelines. (p. 143)

As well, the authors have noted, a further challenge is the “lag-time between the
availability of evidence and the necessary changes to the structure of a health care system to
allow appropriate action to be directed to the new or modified activity” (p. 143).

**Tools for Mobilizing Explicit Codified Knowledge**

Formalized tools such as audits, clinical practice guidelines, and protocols are identified
as important in the mobilizing of knowledge to practice (Armstrong, 2002). Brower’s, Stacey,
and O’Connor (2009) understand clinical practice guidelines in their ability to “translate
evidence into clinical practice recommendations to assist in decisions by patients and providers”
(p. 35), as well as having the “capacity to impact quality of care and systems performance
quality” (p. 35). In contrast, patient decision aids, they share:

- translate evidence to inform patients about their options, helping patients clarify the value
they place on the benefits and harms of these options, and subsequently guide them in the
process of decision making; improving patient participation in decision-making,
knowledge of options, and agreement between patient values and subsequent care
decisions. (p. 35)

Such tools are used as “adjuncts to practitioner counseling” (p. 39), differing from
educational materials by not only providing option information but also by tailoring it, in part, to
the patient’s profile (p. 39).

All tools, both professional and patient, “should facilitate high-quality practice informed
by evidence, enable appropriate resource allocation, and advance research by identifying
research gaps and areas in which additional research will not advance knowledge further” (p. 36).

**Studies Of Knowledge Translation**

Health care systems are faced with the challenge of improving the quality of care and decreasing the risk of adverse events. Globally, health systems fail to optimally use evidence, resulting in inefficiencies and reduced quantity and quality of life. The science and practice of knowledge translation\(^6\) (KT) can answer these challenges. The finding that providing evidence from clinical research is necessary but not sufficient for providing optimal care delivery has created interest in KT, which we define as the methods for closing the knowledge-to-action gaps. (Straus et al., 2009, p. 3)

There is significant interest in how knowledge is managed, how evidence is brought to practice and applied, the “science and the practice of the process” (Straus et al., 2009, p. 7). Understood, through an abundance of terms, to describe a process for moving evidence to practice,\(^7\) significant thought and discussion has been dedicated to approaches and strategies to “coordinate the knowledge processes of creation, transfer, and application” (Quinlan, 2009, p. 626). Drawing on a variety of models and theories for how knowledge is put into action (e.g., planned action theories, cognitive psychology, theories of change, educational theories, organizational theories, and quality improvement) (Straus et al., 2009); the literature, in its description of such models and theories, provides understanding of the rationale and processes involved as efforts towards innovation and change are advanced. Bennett and Jessant (2011)

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\(^6\) As defined by Straus et al. (2009), KT is a dynamic and iterative process that includes the synthesis, dissemination, exchange, and ethically sound application of knowledge to improve health, provide more effective health services and products, and strengthen the health care system.

\(^7\) In the United Kingdom and Europe, the terms *implementation science* and *research utilization* are commonly used in this context. In the United States, the terms *dissemination* and *diffusion*, *research use*, *knowledge translation*, and *uptake* are often used. Canada commonly uses the terms *knowledge transfer* and *exchange*. (Straus et al., 2009, p. 3)
describe how there can be only four reasons for the “know-do” gap. People with the ability and authority to use good information to design their action either:

- **Don’t know** – that the information exists, or what action to take, or
- **Don’t understand** – the information, what it means, why it is important, or
- **Don’t care** – see the information as irrelevant, not beneficial to their agenda, or
- **Don’t agree** – think the information is misguided or false. (p. 1)

Added to these reasons may be an additional one; **not allowed** – that people with the ability and authority to use good information to design their action may not be able to because of the context or circumstances in which they work. Rycroft-Malone (2004) share how contextual factors can play an important role in facilitating or inhibiting the research implementation process (p. 299). Factors include influences of culture, leadership, and evaluation (McCormack, Kitson, Harvey, Rycroft-Malone, Titchen, & Seers, 2002).

The concept of “knowledge as capabilities” holds that “organizations will excel in knowledge translation if they manage the tension between the autonomy of a decentralized structure and the need to stimulate professionals to improve their performance” (Donabedian, 1988a, 1988b; Institute of Medicine, 2001). Knowledge, understood as a process, is best seen as “the role of scientific evidence in spreading clinical-administrative innovations” (Denis & Lehoux, 2009, p. 218). It is, as many in the literature suggest, “the search for appropriate strategies and techniques to co-ordinate the knowledge processes of creation, transfer and application” (Davenport & Prusak, 1998; Nonaka & Takeuchi, 1995; Quinlan, 2009; Szulanski, 2003).
Gabbay and LeMay (2004) write of the need for successful implementation of research and evidence into clinical practice requiring “an understanding of the processes of collective ‘sense making’ by which knowledge, both explicit and tacit and from whatever sources, is negotiated, constructed, and internalized in routine practice” (p. 329).

**Approaches for Understanding Knowledge Translation**

The literature is replete with many perspectives and models for understanding how evidence is moved into practice. Be it frameworks or models directed by efforts of “push”, of “pull”, “exchange”, or “integration” (Lavis, Lomas, Hamid, & Sewankambo, 2000), all attest to the desire to improve ability to inform and influence, to bring knowledge closer to practice. Generally, each sees knowledge as described in the Pyramid of Knowledge (Lomas, 1993; WHO, 2004), with its foundation as that of basic science, theoretical and methodological innovations. Moving upward it builds to single studies, articles, and reports, then to systematic reviews of research, and then actionable messages” (p. 5). Knowledge translation in its broadest concept then is the talk of “focusing our efforts to link research to action at the apex of the knowledge pyramid while continuing to build a solid base for the pyramid (p. 5). It is the mobilizing of those actionable messages that are the approaches for linking research to action.

The following models identified by Sudsawad (2007) either provide guidance for knowledge translation planning by encouraging the participation of both researchers and users throughout the knowledge translation process or provide focus on bridging research gaps. Each of the models provides an effective framework for knowledge translation inclusive of the environmental organizational view, but also the micro perspective of an individual (Davis, 2005). Each finds prominence in the current literature and are described in the following sections.
Canadian Institutes of Health Research (CIHR) Model of Knowledge Translation.
The CIHR Model of Knowledge Translation is “a global KT model, based on a research cycle, that could be used as a conceptual guide for the overall KT process” (Sudsawad, 2007). The model identifies six opportunities within the research process for knowledge exchange, including defining research questions and methodologies; conducting research; publishing research findings in plain language and accessible formats; placing research findings into the context of other knowledge and socio-cultural norms; making decisions and taking action informed by research findings; and influencing subsequent rounds of research based on the impacts of knowledge use (CIHR, 2005).

Understanding User Context Framework. Five domains, each with a set of questions, make up the framework: the user group, the issue, the research, the knowledge translation relationship, and dissemination strategies. The framework offers a comprehensive approach to guide the interaction of knowledge creators and knowledge users for the implementation of existing knowledge (Sudsawad, 2007).

Ottawa Model of Research Use. The model focuses on information (innovation) that is ready to be shared. It includes six primary elements: evidence-based innovation; potential adopters; the practice environment; implementation of interventions; adoption of the innovation; and outcomes resulting from implementation, monitoring, and evaluation (Sudsawad, 2007).

Knowledge-to-Action Framework. The knowledge-to-action cycle uses the language of “action” rather than “practice” because it includes a wider range of uses of knowledge (Graham et al., 2006, p. 14). The knowledge to action process (Figure 2) begins with the concept of knowledge creation, where knowledge moves through a funnel of inquiry and synthesis to become tools or products. The action cycle represents the activities that lead to implementation
or application of the knowledge (Graham, et al., 2006, p. 20). The additional component of the knowledge-to-action process includes planned-action theories, which incorporate, deliberate activities to facilitate change. Feedback exists among all phases and between both the knowledge creation and the action cycles.

**Figure 2. The Knowledge – To – Action Framework**

![Diagram of the Knowledge – To – Action Framework](image)

The conceptual framework provides an approach that builds on the commonalities found in an assessment of planned-action theories. A knowledge creation process has been added to the planned-action models and labeled as the knowledge – to – action cycle. The CIHR, Canada’s federal health research funding agency, has adopted the cycle as the accepted model for promoting the application of research and as a framework for the KT process (Straus et al., 2009, pp. 5 – 6). Reprinted with permission from Knowledge Translation in Health Care: Moving from Evidence to Practice. Edited by S. Straus, J. Tetroe, and I. Graham. Copyright 2009 Blackwell Publishing, ISBN: 978-1-4051 -8106-8.
Promoting Action on Research Implementation in Health Services Framework.

This framework focuses on implementing research for evidence-based practice, attending to the characteristics of the elements of evidence (research, clinical experience, and patient experience, local data/information), context (culture, leadership, and evaluation), and facilitation (purpose, role, and skills/attributes). The elements are located on a continuum from low to high, with elements located higher on the continuum more likely to have success of implementation (Rycroft-Malone et al., 2004).

Framework for Knowledge Transfer.

For each situation of knowledge transfer under consideration, five questions are posed:

1. What should be transferred to decision makers (the message)?
2. To whom should research knowledge be transferred (the target audience)?
3. By whom should research knowledge be transferred (the messenger)?
4. How should research knowledge be transferred (the KT process and support system)?
5. With what effect should research knowledge be transferred (evaluation)?
   (Lavis, Robertson, Woodside, McLeod, & Abelson, 2003, p. 222)

Coordinated Implementation Model. From the literature related to diffusion and dissemination of information the model was proposed as a coordinated implementation plan that includes the distillation of research evidence, adoption by a credible disseminating body, and the competing factors in the overall practice environment (Lomas, 1993, p. 445). Coordination is also needed among external audiences including patients, clinical policymakers, community groups, administrators, and public policymakers.

Stetler Model of Research Utilization. For use by individual practitioners as a procedural and conceptual guide for the application of research in practice (Sudsawad, 2007), the model has five phases: preparation, validation, comparative evaluation/decision making,
translation/application, and evaluation. The model also implements a set of applicability criteria: substantiating evidence, current practice, fit, and feasibility (Stetler, 2001).

**Theories of Knowledge Translation**

To provide current theoretical and framework understanding for how the research to practice gap can be supported, I draw heavily from the work and words of Straus et al. (2009) in providing content for the following review. The discussions that follow of planned action theories, cognitive psychology theories of change, educational theories, organizational theory, and quality improvement, are summarized, following discussion, in Table 1 shed light on the complexities and challenges that are the starting point for navigating the use of evidence in policy and practice (Bowen & Zwi, 2005).

**Planned action theories.** “A planned action theory can focus implementation efforts and provide all stakeholders with a common script or understanding of the action plan (Graham, Tetroe, & Knowledge Translation Theories Group, 2009, p. 185). The authors continue,

> Conceptual models of implementing change are essentially models or theories of change. Change theories fall into two basic kinds: classical and planned (Rimmer & Johnson, 1998). Classical theories of change (sometimes referred to as descriptive or normative theories) are passive; they explain or describe how change occurs. (p. 185)

Examples such as Rogers’s diffusion theory (Rogers, 1995) and Kuhn’s conceptualization of scientific revolutions (Kuhn, 1970) are cited by the authors as theories that “describe change but were not specifically designed to cause or guide change in practice” (Graham et al., 2009, p. 185). They continue in citing other theories, such as Lomas’s Coordinated Implementation Model (Lomas, 1993) as ways of “thinking about or researching knowledge translation” (p. 185).
Planned change theory sets a different trajectory of understanding. Such theory represents a set of logically interrelated concepts that explain, in a systematic way, the means by which planned change occurs, that predict how various forces in an environment will react in specified change situations, and that help planners or change agents control variables that increase or decrease the likelihood of the occurrence of change (Tiffany, 1994, pp. 60-62; Tiffany, Cheatham, Doornbos, Loudermilk, & Momadi, 1994, pp. 54-59).

Citing the work of Rimmer and Johnson Lutjens (1998), Graham et al. (2009) share how planned change theories are also referred to as prescriptive theories with those who use planned change theories “working with individuals, but their objective is to alter ways of doing things in social systems” (p. 186). In completing their focused search and rigorous evaluation of 31 planned action theories current in the literature, the authors identified that “planned action theories generally outline the following steps to deliberately engineer change” (p. 193). These include:

1. Identify a problem that needs addressing;
   a. Identify the need for change;
   b. Identify change agents (i.e., necessary participants to bring about the change);
   c. Identify target audience; and
   d. Link to appropriate individuals or groups with vested interests in the project.
2. Review the evidence or literature;
3. Adapt the evidence and/or develop the innovation;
4. Assess barriers to using the knowledge;
5. Select and tailor interventions to promote the use of the knowledge;
6. Implement the innovation;
7. Develop a plan to evaluate use of knowledge;
   a. Pilot test; and
   b. Evaluate the process to determine whether and how the innovation is used.
8. Evaluate the outcomes or impact of the innovation;
9. Maintain change. Sustain ongoing knowledge use;
10. Disseminate results of the implementation process. (p. 193)

In concluding, Graham et al. (2009) offer advice to researchers interested in using planned action theory as a mode for understanding. They counsel,
In choosing a planned action theory to guide implementation efforts, we advise careful review of the component elements and how they have been coded into action categories and determine which theory is the best fit for the context and culture in which individuals are working. (p. 192)

**Cognitive psychology theories of change.** Hutchinson and Estabrooks (2009a) share how “cognitive psychology theories related to motivation, action, stages of change, and decision making have been influential in the field of knowledge translation” (p. 196) and how such theories can be “useful for identifying cognitions that are amenable to change and providing a theory-based rationale for and guiding development of strategies to increase the adoption of relevant research evidence by health professionals” (p. 203).

In a discussion of *theories related to motivation* (Hutchinson & Estabrooks, 2009a, p. 197), the authors share that “according to motivational theories, behaviour is determined and, therefore predicted by motivation” (p. 197).

For *theories related to action* there is a “focus on predictors of behaviour in individuals who are motivated to change” (Hutchinson & Estabrooks, 2009a, p. 198). Two theories are described, the theory of implementation intentions (Gollwitzer, 1999) and the operant conditioning theory (Blackman, 1974).

The theory of implementation intentions proposes that intentions to engage in behaviour are distinct from the intentions of achieving a certain goal. Specifically, implementation intentions related to the logistics surrounding when, where, and how the behaviour will be carried out to achieve a goal. Hence, when certain conditions are met the individual is mentally committed to specific behaviour to accomplish particular intentions. The process of planning for a change is premised to increase the likelihood of an individual actually adopting the behaviour, (Walker et al. 2003). According to this approach, interventions designed to facilitate planning and preparation may help promote the adoption of specific behaviour. (p. 199)
In description of the operant conditioning theory, proposed is that positive feedback, such as reward or incentive in response to certain behaviour, is likely to encourage behaviour repetition. Such repetition over time may result in behaviour becoming part of routine practice. On the other hand, negative feedback, such as a reprimand or financial disincentive, is likely to discourage the behaviour. Interventions may be targeted to either encourage or discourage certain behaviour. (p. 199)

*Theories related to stages of change* (Prochaska & Velicer, 1997), according to Hutchinson and Estabrooks (2009a) after extensive review of the literature, provide limited support for behaviours to support the moving from evidence to practice for health professionals. They share,

Stage of change was not a predictor of behaviour when applied in the study of health professionals’ use of clinical practice guidelines (S. Cohen, Halvorson, & Gosselink, 2003). However, in the general population stages of change were useful for detecting barriers to certain behaviour, matching interventions, and predicting outcomes (Weinstein, Lyon, Sandman, & Cutie, 1998). (p. 200)

Cognitive continuum theory (Hammond, 1981) is cited as representative of *theories related to decision making*. Such theory understands “the mode of cognition used in decision making [as] exist[ing] on a continuum, with analysis and intuition at opposite poles” (Hutchinson, & Estabrooks, 2009a, p. 200).

In summary, to all cognitive psychology theories of change shared in this section, “for explaining as well as predicting behaviour change” (p. 201), is helpful understanding from the work of Michie et al. (2005) of the “key theoretical constructs embedded in psychological theories” (Hutchinson & Estabrooks, 2009a, p. 201). These include:

1. Knowledge, skills;
2. Social/professional role and identity (self-standards);
3. Beliefs about capabilities (self-efficacy);
4. Beliefs about consequences (anticipated outcomes/attitudes);
5. Motivation and goals (intention);
6. Memory, attention, and decision processes;
7. Environmental context and resources (environmental constraints);
8. Social influences (norms);
9. Emotion;
10. Behavioural regulation; and
11. Nature of the behaviours. (p. 201)

In addition, a “validated series of domain-specific interview questions were generated to assess behaviour change” (p. 201). As well, “an instrument map to map each theoretical domain to techniques that can be employed to promote behaviour change within the respective domain (Francis, Michie, Johnston, Hardeman & Eccles, 2005)” (p. 201) was developed. In concluding, Hutchinson and Estabrooks (2009a) suggest that such a framework is “designed to help researchers and health professionals diagnose and explain failed attempts to move knowledge to action and guide the design of interventions to promote successful knowledge translation” (p. 202).

Though my study takes an approach that begins in people’s experience and not in theory, an awareness of theory is important. In application to my research, rather than building theory, I, as researcher, am seeking to discover how the different categories of theory work in concert with related institutional processes, those forces and processes that coordinate and intersect to regulate activities in local sites (D. Smith, 2006). Such understanding of theory to the uptake and implementation of knowledge continues.

**Educational theories.**

Theory-informed educational interventions can be used to facilitate research use when they are tailored to individual learning styles and needs, matched to the skills of the learner, relevant to practice, problem-and-goal oriented, and when they enable the integration of new knowledge with existing knowledge and experience. They should be delivered in a cooperative and respectful atmosphere, using teaching approaches designed to accomplish learning objectives, to allow active involvement and self-directed learning, and to address key learning domains. (Hutchinson & Estabrooks, 2009b, p. 212)
In planning for educational interventions as evidence is moved to practice, Hutchinson and Estabrooks (2009b) continue that there are a number of educational theories and principles to guide the development of educational interventions. Citing the work of Laidley & Braddock (2000), Stuart, Tondora, & Hodge (2004), and Mann (2004) Hutchinson and Estabrooks (2009b) share how targeted at the individual level such theories and principles can be used to inform “the development of interventions to move knowledge to action” (p. 206). Mindful in moving forward with interventions is awareness and understanding of learning domains (i.e., cognitive, affective, and psychomotor [Krathwohl, Bloom & Masia, 1969; Stuart et al., 2004]). Learning domains are fundamental to health professionals’ knowledge, skill development, and ability to deliver high-quality health care (Hutchinson & Estabrooks, 2009b, p. 207). In addition, learning styles to “engage the learner and maximize learning outcomes, should be considered when designing educational interventions” (p. 206), suggest Hutchinson and Estabrooks (2009b). As well, they continue, “an understanding of motivators to behaviour change is important when designing interventions to promote learning” (p. 207). Described as either intrinsic or extrinsic\(^8\) (Grol, Wensing, Hulscher & Eccles, 2005), intrinsic sources of motivation, such as “the desire for professional competence, are considered to provide a more powerful impetus for behaviour change than external sources” (pp. 207 – 208). In conclusion, learning theories from the following approaches: behaviourist, cognitivist, constructionist, humanist, and social learning (Merriam & Caffarella, 1999) help to “inform the choice of educational interventions” (Hutchinson & Estabrooks, 2009, p. 208).

\(^8\) Intrinsic motivation comes from within individuals and is related, for example, to their personal interest in acquiring new knowledge or to their desire to advance or contribute service to the community. Extrinsic sources of motivation for learning include conditions such as employment requirements, career advancement requirements, or a directive from a higher authority (Hutchinson & Estabrooks, 2009b, pp. 207 – 208).
**Organizational theory.** Denis and Lehoux (2009) see “organizational perspective as useful for understanding the factors and processes that can impede or facilitate the use of research-based evidence to enhance decisions and practices” (p. 222). Through the lens of “three knowledge concepts: capability, process and codification (p. 222) they see each concept embodying different strategies for promoting the use of knowledge or research-based evidence in health care organizations and systems” (p. 222).

**Quality improvement.** Sales, Lurie, Moscovice, and Goes (1995) report on the similarities between quality improvement and knowledge translation (p. 225), sharing how the “overlap between quality improvement and knowledge translation is embedded in the desire to increase the degree to which health services are consistent with current professional knowledge” (p. 225). Both processes have intent to improve care but may be approached in different ways. Quality improvement has greater focus on efforts to address problems or issues that are perceived as affecting the degree to which health services “increase the likelihood of desired health outcomes” or are perceived as inefficient, harmful, or violating other precepts of high quality care, including safety, effectiveness, patient-centeredness, timeliness, efficiency and equity. All of these may be part of desired health outcomes but may not relate to whether professional knowledge and practice are current and effective. (Institute of Medicine, 2001)
Table 1

**Theories of Knowledge to Action (Change)**

<table>
<thead>
<tr>
<th>Author/ Sources</th>
<th>Theory</th>
<th>Theory statement</th>
<th>Elements</th>
<th>Understanding</th>
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<tbody>
<tr>
<td>Rogers, 1995; Kuhn, 1970; Lomas, 1993</td>
<td><strong>Planned Action Theory</strong></td>
<td>A set of logically interrelated concepts that explain in a systematic way the means by which planned change occurs, that predict how various forces in an environment will react in specified change situations, and that help planners or change agents control variables that increase or decrease the likelihood of the occurrence of change.</td>
<td>1. Identify a problem; 2. Review the evidence/literature; 3. Adapt the evidence and/or develop innovation; 4. Assess barriers to using the knowledge; 5. Select and tailor interventions to promote the use of knowledge; 6. Implement the innovation; 7. Develop a plan to evaluate use of knowledge; 8. Evaluate outcomes or impact; 9. Maintain change; 10. Disseminate results.</td>
<td>• Conceptual models of implementing knowledge are essentially model or theories of change. • Can focus implementation efforts and provide all stakeholders with a common script or understanding of the action plan.</td>
</tr>
<tr>
<td>Bandura, 1977, 1982; Azjen, 1991</td>
<td><strong>Cognitive Psychology Theory - Motivation</strong></td>
<td>Behaviour is determined by incentives and expectations related to outcomes. Intentions to engage in and perceived control over the behaviour are also predictors.</td>
<td>1. Informed by situation, 2. Action - Outcomes 3. Perceived self-efficacy (performance accomplishments, vicarious experience, verbal persuasion, physiological feedback).</td>
<td></td>
</tr>
<tr>
<td>Gollwitzer, 1999; Blackman, 1974; Cader, Campbell &amp; Watson (2005).</td>
<td><strong>Cognitive Psychology Theory - Action</strong></td>
<td>1. <strong>Theory of Implementation Intentions</strong> – intentions to engage in behaviour are distinct from the intentions of achieving a certain goal.</td>
<td>Interventions designed to facilitate planning and preparation may help promote the adaptation of specific behaviour.</td>
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<td>Author/ Sources</td>
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<tr>
<td>Prochaska &amp; Velicer, 1997</td>
<td>Cognitive Psychology Theory - Stages of Change</td>
<td>In the transtheoretical model of change there are five phases through which an individual progresses over time.</td>
<td>Five stages: 1. Precontemplation; 2. Contemplation; 3. Preparation; 4. Action; 5. Maintenance.</td>
<td>Interventions may be targeted to either encourage or discourage certain behaviour.</td>
</tr>
<tr>
<td>Prochaska</td>
<td>Cognitive Psychology Theory - Stages of Change</td>
<td>The mode of cognition used in decision-making exists on a continuum, with analysis and intuition at opposite poles (Hutchinson &amp; Estabrooks, 2009a, p. 200).</td>
<td>Six modes of health care decision making on the cognition and task characteristics continuum: 1. Scientific experiment; 2. Controlled trial; 3. Quasi-experiment; 4. System-aided judgment; 5. Peer-aided judgment; and 6. Intuitive judgment.</td>
<td>The point on the continuum adopted is dependent on: • Characteristics of the decision at hand; • Decision task structure (e.g., greater task structure, higher level of analysis). Task characteristics determined by: • Complexity of the available information; • Degree of uncertainty associated with the content area; • Presentation of information; • Time available to make the decision; • Format of the information;</td>
</tr>
<tr>
<td>Author/ Sources</td>
<td>Theory</td>
<td>Theory statement</td>
<td>Elements</td>
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<td>Stuart, Tondora &amp; Hodge, 2004; Krathwohl, Bloom &amp; Masia, 1969 Grol, Bosch, Hulscher, Eccles &amp; Wensing 2007; Lewis &amp; Bolden, 1989 Collins, 2004 Bandura, 1977</td>
<td><strong>Educational Theories</strong> (behaviour, cognitive, constructivist, humanist, and social learning)</td>
<td><strong>Behaviour</strong> – the context in which individuals work influences their behaviour. <strong>Cognitive</strong> – a study of the processes used to acquire, interpret, store, and use information to formulate awareness, understanding, and meaning. <strong>Constructivist</strong> – learning is based on experience from which meaning and understanding are constructed. <strong>Humanist</strong> – learning is a function of growth; humans have control over their future, will actively work toward improvement, and have unlimited potential. <strong>Social learning</strong> – learning can result from observations of others’ behaviour and the consequences of their actions</td>
<td>• Learning domains of cognition, affect, and psychomotor; • Learning styles (activist, reflective, theoretical, pragmatic); • Motivators to behaviour change (intrinsic/extrinsic).</td>
<td>Learning theories help to inform the choice of educational interventions.</td>
</tr>
<tr>
<td>Greenhalgh, Robert, Bate, Kyriakidou, Macfarlane &amp; Peacock, 2004; Cummings, 2003; Lane, &amp; Lubatkin, 1998; Champagne, Lemieux-Charles, &amp; McGuire, 2004; Mitton, Adair,</td>
<td><strong>Organizational Theory</strong></td>
<td>Knowledge as capability; knowledge as process; and knowledge as codification.</td>
<td>Knowledge as capability underlines the potential of organizational structures and resources to support people in their attempts to use knowledge. Knowledge as process … emphasizes flexibility in knowledge use and the need to contextualize knowledge to adapt to local settings and</td>
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<tr>
<td>Author/ Sources</td>
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<td>Theory statement</td>
<td>Elements</td>
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<td>McKenzie, Patten, &amp; Waye Perry, 2007</td>
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<td></td>
<td>Knowledge as codification focuses on the potential of sophisticated information systems to govern health care organizations, (Denis &amp; Lehoux, 2009, p. 223).</td>
</tr>
<tr>
<td>Waddell, Lavis, Abelson, Lomas, Sheperd, Bird-Grayson et al., 2005; Dopson, 2007</td>
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<td>Polyan, 1966; Starey, 2003; Scally &amp; Donaldson, 1998</td>
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<td>Walsh, McDonald, Shojania, Sundaram, Nayak, Lewis, et al, 2006; Shojania, Ranji, McDonald, Grimshaw, Sundaram, Rushakoff et al, 2006; Shonaia &amp; Grimshaw, 2005; Øvretveit, 1998; Øvretveit &amp; Gustafson, 2002; Buchanan, Fitzgerald, Ketley, Gollop, Jones, Lamont et al, 2005</td>
<td><strong>Quality Improvement (QI)</strong></td>
<td>The desire to increase the degree to which health services are consistent with current professional knowledge.</td>
<td>Local in nature, often do not generalize, geared toward dealing with immediate problems, with real patients, in real time.</td>
<td>There is an increasing merger between QI and KT.</td>
</tr>
</tbody>
</table>
Implementing Knowledge to Action

Change in any form can be fraught with challenge, including the health sector (Golden, 2006). Change such as that brought to practice as new research, evidence, and information suffers, I would suggest, no less. Drucker (1993) shares that “healthcare organizations are the most complex form of human organization we have ever attempted to manage” (p. 10). Golden speaks of four stages of change (Golden, 2006) that identify a need to determine a desired end state, assess readiness for change, broaden support, and involve the need to reinforce and sustain the change (p. 12). In bringing evidence-informed knowledge and information to practice is the “need to know not only about the current best evidence concerning the medical problems we manage but also the evidence concerning ways to improve the quality of the care we provide (Haynes, 2001). Transformational change, to close the evidence-to-practice gap, is a complex process of stages that see movement from research to practice-altering outcomes (Lang, Wyer, & Brian, 2007, p. 355).

Barriers and facilitators to using knowledge. The literature provides rich discussion for the barriers and facilitators to adapting knowledge to local practice within the health disciplines. Issues of time, reliance on colleagues for up-to-date information, time since graduation (K. Williams et al., 2003; Kianifar, Akhondian, Najafi-Sani & Sadeghi, 2010; Sackett, Rosenberg, Gray, Haynes & Richardson, 1996) are but some of the factors that impact knowledge use. Best learning and enhanced physician performance are seen, the literature suggests, by those who learn and apply summaries and practice protocols developed by their colleagues and which are informed by the evidence (Davis, Thomson, Oxman, & Haynes, 1995).

Rycroft-Malone et al. (2004) propose “successful implementation [of innovation] is dependent upon the nature of the evidence being used, the quality of context, and, the type of facilitation required to enable the change process” (p. 913). Makic, VonRueden, Rauen and
Chadwick (2011) cite the importance of moving away from “habits of tradition” guiding care and having “clinical practice based on evidence whenever possible” (p. 58). They go on to identify the challenge of “getting the evidence in the right hands and encouraging and empowering the clinicians” (p. 58). Lemelinn, Hogg, and Baskerville (2001) cite the Canadian Task Force on Preventative Health Care in their role in establishing “guidelines for the delivery of preventative care that are supported by clinical evidence as effective”. They go on to share how “changing physicians” long-held patterns of behaviour and the environments in which they work is complex and difficult” (p. 757). Barriers and facilitators to using knowledge are summarized in Table 2.

Table 2

**Barriers and Facilitators to Using Knowledge**

<table>
<thead>
<tr>
<th>Author/Sources</th>
<th>Barriers</th>
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<tbody>
<tr>
<td>Caplan, 1979</td>
<td>• Lack of infrastructure to conduct or use research;</td>
</tr>
<tr>
<td>Tsui et al., 2006</td>
<td>• Lack of access to information;</td>
</tr>
<tr>
<td>Canadian Health Services Research Foundation, 1999</td>
<td>• Too much information to process;</td>
</tr>
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<td></td>
<td>• Little power to modify practices within the organization;</td>
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<td></td>
<td>• Contradicts practice experiences;</td>
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<td></td>
<td>• Research language difficult to understand;</td>
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<td></td>
<td>• Organizations have a limited capacity to participate in the research process;</td>
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<td></td>
<td>• Lack the experience or background needed to lead them in the research process or change process;</td>
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<td></td>
<td>• Given the scarce funding available, different or competing priorities make it difficult to collaborate with other organizations or to identify research priorities for the research community;</td>
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<td></td>
<td>• Environments not receptive to change;</td>
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<tr>
<td></td>
<td>• The instability of funding and programming makes it difficult to build long-term relationships with</td>
</tr>
<tr>
<td>Author/Sources</td>
<td>Facilitators</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Barwick et al., 2005</td>
<td>• Early and ongoing involvement that increases understanding and respect, builds trust and sharing of knowledge;</td>
</tr>
<tr>
<td>Pyra, 2003</td>
<td>• Frequent face-to-face interactions allowing for dialogue, trust-building, and sharing of knowledge;</td>
</tr>
<tr>
<td>Tsui et al., 2003</td>
<td>• Incentives;</td>
</tr>
<tr>
<td>Provincial Centre of Excellence for Child and Youth</td>
<td>• Adequate time;</td>
</tr>
<tr>
<td>Mental Health, 2006</td>
<td>• Build capacity to enhance efforts to uptake and use research and practice innovations;</td>
</tr>
<tr>
<td></td>
<td>• Clarify roles and expectations;</td>
</tr>
<tr>
<td></td>
<td>• Use active, effective, and multifaceted dissemination strategies (e.g., educational outreach visits, interactive continuing education, social marketing, personal involvement, use of opinion leaders; and</td>
</tr>
<tr>
<td></td>
<td>• Knowledge brokers/facilitators whose role is to serve as an interface or link between research/policy/practice.</td>
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</tbody>
</table>

**Knowledge to action interventions.** The literature is rich with insight into intervention strategies designed to improve preventative care performance (Oxman, Thomson, Davis, & Haynes, 1995; Wensing & Grol, 1994). Lemelin et al. (2001) summarize the following findings and results from their appraisal of systematic reviews. They write,

Programs that address physician knowledge alone, such as traditional continuing medical education and dissemination of guidelines are insufficient to change practice behaviour (Tamblyn & Battista, 1993; Davis, Thompson, Oxman & Haynes, 1995; Grimshaw & Russell, 1993; Strange, Kelly, Chao, Zyzanski, Shank & Jaeen (1992). In addition, single interventions are less likely to result in significant improvement of practice behaviour than interventions using two or more strategies in an intensive combined intervention (Davis, Thompson, Oxman & Haynes, 1995; Lomas & Haynes, 1988; Oxman, Thompson, Davis & Haynes, 1995; Wensing & Grol, 1994; Hulscher, Wensing, Grol, Weeijden & vanWeel, 1999). … Single interventions such as educational materials, reminder systems, and audit and feedback had modest or negligible practical effects when used alone (Oxman, Thompson, Davis & Haynes, 1995). However, combined intervention
strategies resulted in significant changes in physician behaviour and health outcomes (Davis, Thompson, Oxman & Haynes, 1995; Oxman, Thompson, Davis & Haynes, 1995). … Multifaceted interventions were effective. (pp. 757 – 758)

Table 3 provides a summary of three main frameworks found in the literature for identifying knowledge to action interventions. Each framework identified includes questions or guidelines that can be used to enhance knowledge translation interventions and identify tools that might be most effective in practice.
### Table 3

**Knowledge to Action Interventions**

<table>
<thead>
<tr>
<th>Authors/Sources</th>
<th>Framework</th>
<th>KT TOOLS</th>
</tr>
</thead>
</table>
| **Lavis, Robertson, Woodside, Mcleod & Abelson, 2003** | 1. What message do you want to transfer?  
2. To whom should the message be delivered?  
3. By whom should the message be delivered?  
4. How should the message be delivered?  
5. With what effect? | • Virtual libraries/encyclopedias;  
• Electronic newsletters, bulletins, listserv, reminders;  
• Discussion forums;  
• Social marketing/media relations/opinion leaders;  
• Tailored messaging/products(manuals, clinical guidelines);  
• Knowledge brokers/research exchange officers;  
• Roundtables;  
• Networks;  
• Briefs/Reports/Summaries;  
• Media Advisories;  
• Conferences/Workshops/Presentations/Symposiums;  
• Meetings;  
• Websites;  
• Training Sessions; and  
• Journals. |
| **Jacobson, Butterill & Goering, 2003** | Five domains:  
1. The user group;  
2. The issue;  
3. The research;  
4. The researcher - user relationship;  
5. The dissemination strategies. | |
| **Contandriopoulos, 2012** | 1. Why? The nature of the problem to be addressed.  
3. To whom? The context being addressed.  
Sustaining knowledge\textsuperscript{9}. Davies and Edwards (2009) identify key learning points\textsuperscript{10} for understanding how knowledge is supported over the long term. They highlight the importance of sustaining knowledge and the role of research in policy, programs, and practice to improve the health of populations, build stronger health care systems, and to better inform government policies (p. 165). In addition, the literature identifies eight key factors that need consideration in the development of a sustainability action plan. These include:

1. Relevance of the topic;
2. Benefits;
3. Attitudes;
4. Networks;
5. Leadership;
6. Policy articulation and integration;
7. Financial – what funding is required to implement, sustain, and scale up knowledge; and
8. Political – who are the stakeholders and what power or support might be leveraged? Who will initiate scaling up processes? (Buchanan, Fitzgerald, Ketley, 2007; Davies et al., 2006; Ketley, 2007; Lomas, 1993; Maher et al., 2007; Nolan, Schall, Erb, & Nolan, 2005)

Studies of Communities of Practice

A community of practice is a group of people who share a common concern, a set of problems, or interest in a topic and who come together to fulfill both individual and group goals usually focused on improving professional practice (Wenger, 1998). Primary care clinicians work in “communities of practice” where information from a wide range of sources is combined

\textsuperscript{9}Sustainability, as a “complex construct” (Davies & Edwards, 2009, p. 170) is “the degree to which an innovation continues to be used after initial efforts to secure adoption is completed” (Rogers, 1995, p. 429) or when new ways of working and improved outcomes become the norm (Maher, Gustafson, & Evans, 2007)

\textsuperscript{10}Key learning points: sustained knowledge use refers to the continued implementation of innovations over time and depends on the ability of workers and organizations to adapt to change; tension exists between the routinization of one innovation and the receptiveness to subsequent innovations; there is limited research about sustainability; key factors found to influence sustainability include the relevance of the issue, attitudes of stakeholders, leadership, financial supports, and political climate; sustainability planning is recommended early in the knowledge-to-action cycle, when interventions are being designed; and addressing sustainability requires planning for “scaling up” knowledge use. (p. 165)
to inform their practice (Gabbay & LeMay, 2004, p. 334). Wenger (1998) understands that communities of practice provide a basis for thinking about knowledge use within a network. Thinking is framed around three components: identity, problem sharing, and artifact development. He shares,

Because of their organic and contextual nature, communities of practice link social dynamics and learning holding the potential to translate and appropriate knowledge processes within and across organizations, constrained or enabled by governance structures and normative frames embedded in organizational or social settings. (p. 72)

As well, the notion of communities of practice can be taken forward to assume practice within the broader community context. The AAP (2001) in a statement of policy encouraged “evidence-based community pediatrics to serve as a bridge from bedside to neighborhood” (p. 1142), a platform that can work towards “innovative programs to improve child health “ (p. 1142).

Communities of Practice and Knowledge Dissemination

Knowledge is viscous and does not readily flow across professional boundaries. (Dopson et al., 2002, p. 43)

Glasgow and Chambers (2011) share that “scientific evidence has generally not translated rapidly or consistently into policy and practice (Glasgow, Lichtenstein & Marcus, 2003; Greenhalgh, Robert, Bate, Kryriakidou, Macfarlane, & Peacock, 2004). Fixsen et al. (2010) speak of the field “coming to understand more fully that the ‘to’ in ‘science to service’ represents implementation: that is, ‘science implemented in practice’” (p. 435).

Strange et al. (2001) share how family practice organizations that espouse a goal of improving the health of the population have a responsibility to develop the people, attitudes,

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11 Knowledge dissemination is recognized as comprising of three conceptually distinct types of knowledge translation activity. These include diffusion, dissemination, and implementation (Lomas, 1993).
skills, or infrastructure that will advance a culture of inquiry. Graham et al. (2006) see the role of knowledge dissemination as one of “the promulgation of knowledge products to increase stakeholders’ awareness of them or the specific and discrete strategies used to promulgate knowledge products” (p. 17).

In a discussion of approaches to the dissemination of knowledge, the literature identifies knowledge brokers\(^{12}\) or knowledge mobilization intermediaries (Cooper, 2010) and networks\(^{13}\) as two important strategies for “moving knowledge to action”. In addition, Bero et al., 1998, Davis et al., 1995; Graham, et al. (2006), Grimshaw et al., 2006; Oxman et al., 1995) all identify that when planning for and implementing interventions and when promoting awareness and implementation of knowledge that change is more likely to occur with more planned and focused interventions. Graham et al. (2006) continues to account that

> barriers and potential adopters may be related to knowledge, attitudes, skills, habits, or the like. Interactive educational interventions and outreach visits can be useful for addressing these types of barriers. When the barriers are related more to the organization of service delivery, introducing reminder systems, changing staffing levels, purchasing equipment, or altering the remuneration process may be useful strategies. (p. 21)

In making integrated knowledge translation processes work effectively cites the following as key,

---

\(^{12}\) The rationale for knowledge brokers is the need to provide an intermediary who can facilitate collaborations between researchers and research users and find research evidence to shape decisions, assess this evidence, interpret and adapt it to circumstances, and identify emerging management and policy issues that research can help solve (Canadian Health Services Research Foundation, 2003).

\(^{13}\) Networks, including communities of practice, knowledge networks, and soft networks are potentially effective mechanisms for knowledge dissemination and application because their principal purpose is to connect people who might not otherwise have an opportunity to interact, enable dialogue, stimulate learning, and capture and diffuse knowledge. (Birdsell & Matthias, 2003; Cambridge & Suter, 2005; Gagon, 2009; Wenger, McDermott & Synder, 2002)
• A process to develop a shared perspective, common language, and common understanding about the health problem/issue that the team will focus on
• A plan for collaboration with explicit description of roles and responsibilities and a commitment to regularly assess its effectiveness
• A plan for the inclusion of team members who are collaborative
• A strategy for ensuring that trusting relationships among team members are maintained and conflicts are resolved appropriately when they arise. (Gagnon, 2009, p. 237)

Using the Literature/Finding Gaps in Understanding

Through the qualitative lens of inquiry the literature review limits and identifies the research problem and the expectations of findings, informs the researcher about what has been done, provides possible research designs and methods, identifies research gaps, provides a backdrop for interpreting research results. It also supports the natural part of qualitative inquiry of understanding and integrating “unanticipated results” as part of analysis with identified themes. (Hays & Singh, 2012, p. 115)

Qualitative research assumes that reality is constructed, multidimensional, and ever-changing; there is no such thing as a single, immutable reality waiting to be observed and measured. (Merriam, 1995, p. 54)

A review of the literature suggests that there is an abundance of information to guide the implementation of knowledge into practice but that research was often “empirically thin and pitched at high levels of abstraction” (Mykhalovskiy & Weir, 2004, p. 1061). In its reading I did not find an abundance of literature that provided insights for the organization and relation of the processes for uptake and implementation of knowledge, the cause and effect of interactions, empirical understanding for the how of happenings that result from forces directed to individuals as they come to know and interact with new knowledge, or not, and clear identification and understanding of the lived experience of a shift in practice or embracing new ways. Realizing the gap, I moved my reading to previous studies that had employed IE as method. In their reading, I found satisfaction for moving ahead. It was a place of research stance where one “maintains the research interest in the social organization of the topic” (Kontos & Poland, 2009,
p. 51), and directs empirical inquiry to a description that “takes into account the actuality of texts, talk and coordination of complex work processes of those engaged” (Turner, 2003, p. 70).

What the literature, both institutional ethnographic and mainstream, identified and confirmed for me was several things; the need to explore and understand the “missing voice” (Hays & Singh, 2012, p. 115) of everyday experience, and a need to have available in the literature research that provided an exploration, to understand empirically, the “connected [events and actions] in actual practices, the material social world, and an ontology of the social as the coordination of people’s activities in sequences of action that connect their local practices in multiple settings into the organization of governing institutions” (Webster, 2009, p. 72).

My review of the literature, and understanding its gaps, focused my study to move “beyond the positivist discourse of evidence-based medicine and implementation that assumes that research produces knowledge that is neutral and can be translated” (Webster, 2009, p. ii), to one of discovery to understand those sequences of action, mediated in documents (text) that invite or reject policy and programming founded in the evidence.

**Research Questions Derived from the Literature**

Starting in a place that is “largely unexplored in the literature” (Biller-Andorno, Lie, ter Meulen, 2002, p. 261), my empirical study, grounded in institutional ethnographic research, provides close examination of the organization and relations of knowledge work for the 18-month EWBV. The following overarching research question and subsequent subquestions were developed, derived from a review and appraisal of the literature.

**Research Question:** What can we learn about the movement of evidence to practice in the implementation of Ontario’s 18-month EWBV?
More specifically, in wanting to support understanding and orderly inquiry, the following subquestions were identified:

1. How is it that knowledge (child health evidence), information, resources, and tools for use at the 18-month EWBV are moved into this new way of practice?
2. How are multidisciplinary family health teams organized to support the enhanced visit?
3. How do documents for evidence-informed practice organize, mediate, and guide clinical practice for implementation of the visit?
4. How does IE make accessible understanding of actual and embodied professional knowledge work activities, mediated by written communication and documents for the implementation of the visit?
5. What insights, reorganizations, and refinements to current practice for the visit might be generated using IE?
IE’s modest proposal is to work from what people are doing or what they can tell us about what they and others do to find out how the forms of coordinating their activities ‘produce’ institutional processes, as they actually work. (D. Smith, 2005, p.60)

IE offers the capacity to look at the everyday world and figure out and “map” how things happen as they do. We explore how relations between people establish the world, and how we know it and live in it. (Campbell & Gregor, 2008, p. 16)

It’s that looking up and into as a process of investigation, of progressive discovering, and assembling what you’ve got as a base from which to move to investigating further and more widely that’s the key to IE. (D. Smith, 2006, p. 5)
CHAPTER FIVE: INSTITUTIONAL ETHNOGRAPHY AS METHOD OF INQUIRY

This chapter provides an overview and “orienting discussion” (Mykhalovskiy & McCoy, 2002, p. 18) of key concepts and insights provided by IE as the method used in this study’s inquiry.

Institutional, understood not as a particular organization but as “coordinated and intersecting work processes taking place in multiple sites” (D. Smith, 2006, p. 17) and ethnography as highlighting the importance of research methods that can “discover and explore everyday activities and their positioning within extended sequences of action” (D. Smith, 2005, p. 18) sets formative understanding of IE as method.

IE provides an approach for empirical investigation that begins in the everyday. It provides understanding of “people’s activities within their day-to-day troubles, and discovers how these troubles are put together” (Rankin, 2004, p. 4). Simply put, IE provides a window to

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**Personal Journal Entry - March 2012**

“There is no ‘one way’ to conduct an institutional ethnographic investigation; rather there is an analytic project that can be realized in diverse ways” (D. Smith, 2006, p. 20).

These concepts and their learning are difficult. I am challenged but not deterred. I am reading, always reading. My books are dog-eared and highlighted with all colours of the rainbow.

... To understand is hard. Once understood, action is easy (Sun Yat Sen, 1866-1925).

Accessible adj [often foll. by to] 1 that can readily be reached, entered, or used. 2 [of a building] posing no obstacles to handicapped people. 3 [of a person] readily available. 4 easy to understand or appreciate (Bisset & Barber (eds.), 2000, p. 5).

To be accessible, I can ask nothing more of this research and its work.

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14 D. Smith (2006) uses the following example in describing institution, shared here because of its implication for understanding the work of this study. She writes, “When health care is considered as an institution, what comes into view is a vast nexus of coordinated work processes and course of action – in sites as diverse as hospitals, homes, doctors’ offices, community clinics, elementary schools, workplaces, pharmacies, pharmaceutical companies, advertising agencies, insurance companies, government ministries and departments, mass media, medical and nursing schools. Obviously, institutions cannot be studied and mapped out in their totality, and such is not the objective. Rather, the aim of the institutional ethnographer is to explore particular corners or stands within a specific institutional complex, in ways that make visible their points of connection with other sites and courses of action” (p. 17).
understanding, for how a world is put together, through the work activities and actions of the actors (p. 4).

In the chapter sections to follow are presentation and interpretation of the key conceptual tools for “thinking and investigating” (Campbell & Gregor, 2008, p. 27) of the everyday experience. Under section headings of “Understanding Social Organization and Social Relations,” “Entering the Study of an Institutional World,” “Data Collection for Investigating an Institutional World,” and “Mapping Work Processes as an Analytic Approach” IE’s language for terms and techniques are described. I will conclude with a brief description of knowledge work as institution. The intent is that such description sets the stage for the chapters that follow as the research and study unfold.

**Understanding Social Organization and Social Relations**

For institutional ethnography, the social as the focus of study is to be located in how people’s activities or practices are coordinated. Individuals are there; they are in their bodies; they are active; and what they’re doing is coordinated with the doings of others. That is the four-part package that is foundational to the institutional ethnographic project. Coordination isn’t isolated as a phenomenon that can be differentiated from people’s activities; it is not reified as “social structure” nor as “rules”; it is not conceived to be a specialized form of action in itself. For institutional ethnography, the social, as the focus of sociological inquiry, is specified as people’s activities as they are coordinated with those of others. The focus of the research is never the individual, but the individual does not disappear; indeed, she or he is an essential presence. Her or his doings, however, are to be taken up relationally. (D. Smith, 2005, p. 59)

To situate IE is to understand its approach as an “explicit ontology of the social (shared with phenomenologists, ethnomethodologists, and symbolic interactionists)” (McCoy, 1999, p. 25). Similar to phenomenology, whose purpose is to discover and describe the meaning or essence of participants’ lived experience, or knowledge as it appears to consciousness (Hays & Singh, 2012, p. 50), to ethnomethodology, which focuses study on informant’s perspectives of social order, assessments, and explanation (p. 61), to symbolic interaction in which the
interactions between individual and context are seen to create knowledge and truth (p. 54), IE has as its focus, not on studying people or explaining people’s behaviour but in understanding extended chains of action (social relations), mediated by documentary forms of knowledge, that shape people’s lives and circumstances (Denzin & Lincoln, 2013; Grahame, 1998; Walby, 2006).

Our way of being in the world, is “invariably social” (Campbell & Gregor, 2008; D. Smith, 1987, 1999, 2005, 2006), identified in people’s “activities and through the ongoing and purposeful concerting and coordinating of those activities” (Campbell & Gregor, 2008, p. 27). It is in understanding social organization, how work at the local setting is organized outside of that setting, that D. Smith (1987, 1999, 2005, 2006) describes and others have written,

Social life is not chaotic but is instead organized to happen as it does. What Smith calls the social relations of everyday life actually organizes what goes on. People’s own decisions and actions and how they are coordinated with outside events are part of social relations. It is the interplay of social relations, of people’s ordinary activities being concerted and coordinated purposefully that constitutes “social organization”. (Campbell & Gregor, 2008, p. 27)

Insights from IE facilitate understanding of the “socially-organized character of everyday life to explore its puzzles; how things are put together so that they happen as they do” (Campbell & Gregor, 2008, p. 29), in order to effect a specific order of experience. Quinlan (2009) furthers understanding in her suggestion that social organization presents an understanding of the “sum of experiences of everyday practice embedded in an institutional order, while simultaneously bringing into focus relations that are not particular to, but coordinate the experiences” (p. 629).

Never a study of the individual alone, IE is a study of “her or his doings, taken up relationally” (D. Smith, 2005, p. 59).

It is through the concept of “concerted action” (Campbell & Gregor, 2008, p. 30), simply understood as coordination, “where-in action is combined together, jointly arranged or planned” (Bisset & Barber, 2000, p. 194) that social relations are best understood. D. Smith (1987, 1999,
2005, 2006) proposes that social relations are actual practices and activities through which people’s lives are socially organized. Clearly shared it is that something is actually connecting what happens here to what happens there, social relations are not done to people, nor do they just happen to people. Rather, people actively constitute social relations. People participate in social relations, often unknowingly, as they act competently and knowledgeably to concert and coordinate their own actions with professional standards or organizational rules. (Campbell & Gregor, 2008, p. 31)

Exploring Organization

Methodologically, Quinlan (2009) accounts, “IE proceeds inductively, moving from the particular experience to the general analysis of social relations” (p. 629). It is in looking for the connections of the complex practices that are the social relations that the ethnographer is not looking for “agreement among different informants but for the intersections and complementarities of their different accounts in the relations that coordinate their work” (D. Smith, 2005, p. 63). It is in these connections that comes possibilities in analysis of exploration of how things are done both in the visible and the invisible.

The relations that rule.

The concept of ruling relations (D. Smith 1987, 1999) doesn’t refer to modes of domination but to a new and distinctive mode of organizing society … The ruling relations are forms of consciousness and organization that are objectified in the sense that they are constituted externally to particular people and places. (Smith, 2005, p. 13)

D. Smith’s term relations of ruling is to be interpreted, as Holstein and Gubrium (2013) suggest, as that “dominant form of coordination” (p. 274), that “socially organized exercise of power that shapes people’s action and their lives” (Campbell & Gregor, 2008, p. 32). D. Smith (1990) describes them as “those forms that we know as bureaucracy, administration, management, professional organization and the media. They also include the complex of discourses, scientific, technical, and cultural that intersect, interpenetrate and coordinate the
multiple sites” (p. 6). It is in those relations that comes direction, power, governance, and “forms of consciousness” (Quinlan, 2009, p. 629) that provide authority to the process. Helping to organize, by creating connections across relations, ruling relations originate external to the people, place, and things that they influence over.

In asking, “how is this done?” the role of documents (text), as “visible traces of institutionalized social relations” (Quinlan, 2009, p. 629), is key. To be described more fully in later sections of the chapter, “documents (text) based forms of knowledge exhibit an influence of coordination and power that helps to organize and describe the connection across sites, that is governance and large scale coordination” (Holstein & Gubrium, 2013, p. 274).

**Entering the Study of an Institutional World**

Multiple terms set the course for beginning research that uses insights from IE. “Begun in experience,” “establishing a standpoint,” “problematising” as a tool to orient and direct inquiry, coordinating “language and discourse,” and understanding “documents (text)” for their role as they coordinate and mediate activity will be described in this chapter, followed by a brief description of IE’s methods of data collection used for investigating an institutional world. In its conclusion, the chapter will describe IE’s use of “mapping” as an analytical approach, visual appreciation of the knowledge gained in discovery of the complex relations and processes as they are represented and organized across sites.

**Beginning in Experience**

DeVault (2008) discusses the importance in IE of having “an anchor group, or touchstone whose perspectives and experiences provides a standpoint” (p. 5); “the sum of experiences of everyday practice embedded in an institutional order” (Quinlan, 2009, p. 629). In its commitment to discovering “how things are actually put together”, “how it works” (D. Smith,
2006, p. 1), IE does not begin in theory but in people's experience (p. 2). And from this beginning, in the everyday life of the subject under investigation, the work of the researcher in undertaking IE is one of branching out and exploring the processes occurring within the larger institutional context, always keeping in mind “the effect of institutional actions on the anchor group” (DeVault, 2008, p. 5).

Establishing a Standpoint

Standpoint is a term used by an institutional ethnographer to explicitly note the place from which she looks, acknowledging that her inquiry is situated vis-à-vis other knowers and ways of knowing. (Campbell & Manicom, 1995, p. 7)

In undertaking study, the ethnographer’s standpoint may be defined by her or his own experience or by what she or he has learned by talking with others (D. Smith, 2005, p. 38). Specific to the establishment of standpoint and understanding from where people are coming is awareness that in the social organization of the event or experience for study there may be different ways of knowing, for how a practice, an event, a way is represented and how it is actually happening. This differing in realities is for IE called disjuncture, an issue of two differing forms of reality (D. Smith, 1987, 1999, 2005, 2006).

Problematizing as Orientation and Direction for Where Study Begins

Identifying a problematic in IE requires the researcher to notice and name the relations in the research setting into which she is stepping. (Campbell & Gregor, 2008, p. 46)

Problematic is a technical term used in IE, not unlike the range of technical terms used in other analytic approaches such as constant comparison, triangulation, variable (Campbell & Gregor, 2008, p. 47), to identify the place in which the study inquiry begins. In planning for a topic of study, drawing inspiration from the world in which you, the researcher live, the problematic, the place for inquiry to begin (p. 47) is to discover a puzzle, a situation that needs to
be understood or solved. It is the problematic, the need to learn more about the situation that someone in that world is living in, knowing it from the inside, that identifies how the researcher will take up the inquiry, from which standpoint will be taken—will I look from this person’s point of view or from another’s?

**Coordinating Action Through Language, Ways of Speaking and Discourse**

The phenomenon of language is integral to the investigation of the social. (D. Smith, 2005, p. 70)

Each separate utterance is individual, of course, but each sphere in which language is used develops its own relatively stable type of these utterances. These we may call speech genre. Each sphere of activity contains an entire repertoire of speech genres that differentiate and grow as particular spheres develop and become more complex. (Bakhtin, 1986, p. 60)

The speaker’s or writer’s part in the dialogue is that of finding in discourse the resources she or he needs; the part of discourse is to make the speaking/writing of intention possible. (D. Smith, 2005, p. 127)

Language as a coordinator of action is a key concept of institutional ethnographic inquiry. It is language, either as spoken or as text, that D. Smith (2005) suggests is the “medium in which thoughts, ideologies, and so on are lifted out of the regions of people’s heads and into the social, understood as the coordinating of people’s doings” (p. 94). Language creates new dimensions of organization in the social process. D. Smith (2005) describes how people “introduce into the social act an utterance, a conventionalized sound or script to which both speaker and hearer respond in the same way” (p. 82). That utterance, sound or script, is language, be it a word or way of speaking that provides the beginning of social organization for a topic, process or a way. Language, for those involved in the process, coordinates “her or his own decision with the message, all the while remaining responsive to what is occurring around, taking into account particulars of a situation and deciding how to interpret it” (p. 82). Awareness of language, heard
or read, its interpretation and subsequent meaning, is critical for understanding how people represent themselves in their experience.

In learning a language one has capacity to learn a way of being and doing. D. Smith (1999) writes, “models of meaning are grounded in the experience of language” (p. 141). Citing the work of Bakhtin (1895–1975) and his study of the philosophy of language, IE sees language as having the ability “to project organization into ongoing sequences of people’s activity and brings them into an active coordination with the activities of others” (D. Smith, 1999, p. 142). It has as an understanding the capacity of language to organize work, the “selecting, ordering, and assembling operations” (p. 142), and its ability to bring such organization across settings.

In language for coordinating action begins a “cumulative process of coming to know and do; first language, then the development of a way of speaking (speech genre), then discourse as a field of relations of talk, text and activity” (D. Smith, 2006, p. 44). Described further, from the individual word (spoken or written), language over time and within social relations becomes speech and a way of speaking. Located in social organization, speech genres, the moving towards a “talk of the institution” allows for

the source of the familiar feeling you have when you are new to a socially organized setting not a problem of strictly knowing the language but rather of how to insert properly made sentences into local sequences of action (including, of course, talk and writing). (D. Smith, 1999, p. 144)

And ultimately growing from a speech genre comes discourse: the designation of a “kind of large-scale conversation in and through texts (Foucault, 1981 as cited in D. Smith, 2006, p. 44) and that IE continues understanding as “a field of relations that includes not only texts and

15 According to Bakhtin, speech genres, the ways in which people speak (e.g., use of terminology, styles of speech), carry and regenerate the social organization of groups, large-scale organizations, discourse, and all forms of social life in which people are concerting their activities in some specialized way. (Turner, 2003, pp. 80 – 82)
their intertextual conversation but the activities of people in actual sites who produce them and use them” (D. Smith, 2006, p. 44). For IE, discourse is central to the coordinating of the work that people do in “bringing into being every day the institutional complexes embedded in the ruling relations” (D. Smith, 2005, p. 111).

**Documents (Text) as a Connecting Link in Relations**

Texts appear in people’s talk because they are an integral part of what people do and know. (Campbell & Gregor, 2008, p. 79)

Texts perform at that key juncture between the local settings of people’s everyday world and the ruling relations. They come before us as something to read, watch, or listen to. (D. Smith, 2005, p. 101)

Texts are part of the taken for granted routine work that is done in creating a new program, through which the program is developed and, these texts provide the coordinative basis to direct others in the way that they go about doing their work (such as, approving or rejecting the program as expressed in documentary form). In general, texts are taken to be a part of the phenomenon rather than simply being the means of conveying information about the phenomenon. (Muller, 1989, p. 274)

Be it policy documents, archival data, legislation, assessment tools, brochures, web-based technologies, guidelines, reports, memos, emails, or other formats, all, through the lens of IE, are considered as documents (text). All have an ability to communicate. Understood broadly, more than sources of information, they, from an institutional ethnographic approach, carry the “determinations of many of our actions” (Campbell & Gregor, 2008, p. 32), functioning as a tool(s) to make the invisible connections of relation work (p. 32).

G. W. Smith, Mykhalovskiy, & Weatherbee (2006) speak of the origins of the “organizational significance of texts and documents “as beginning with Max Weber (1978) and his “early twentieth-century studies of bureaucratic forms of authority” (p. 171). The organization of information into document (text) form allows us, as Soergel (2004) suggests, “to collect and record it, retrieve it, evaluate and select it, understand it, process and analyze it, apply
it, and rearrange and reuse it” (p. 1). Documents (text) as used in policy directives, legislation, research evidence, instructions, guides, web technologies, and assorted directives provide the institutional organizational memory of work that is anticipated and/or to be done. In essence, documents (text) provide the source of “formal organization” (D. Smith, 2006, p. 170) for the undertaking of tasks.

**Activating Documents (Text) to Coordinate Work**

Text-based forms of knowledge and discursive practices are central to large-scale organization and relations of ruling. Textual processes in institutional relations are like a central nervous system running through and coordinating different sites. To find out how things work and how they happen the way they do, a researcher needs to find the texts and text-based knowledge forms in operation. Reading a text is a special kind of conversation in which the reader plays both parts. She or he “activates” the text (McCoy, 1995) – though probably never quite as its maker intended – and at the same time, she or he is responding to it or taking it up in some way. Its activation by a reader inserts the text’s message into the local setting and the sequence of action into which it is read. (Smith, 2005, p. 105)

Institutions exist in that strange magical realm in which social relations based on texts transform the local particularities of people, place, and time into standardized, generalized, and, especially, translocal forms of coordinating people’s activities. Texts perform at that key juncture between the local settings of people’s everyday worlds and the ruling relations. They come before us as something to read, watch, or listen to. (D. Smith, 2005, p. 101)

Within IE, documents (text) represent “people’s doings,” the way in which documents (text) are able to “enter into and coordinate people’s doings,” coordinate their work. IE focuses understanding of documents (text) and how they do their work around three principles:

1. Texts are constituents of social relations, are mediated by subjects, and, concert social relations;
2. Texts are part of the taken for granted routine work that is done in creating a new program, through which the program is developed “put it in a report” so that someone else can read it; and
3. Those texts provide the coordinative basis to direct others in the way that they go about doing their work (such as, approving or rejecting the program as expressed in documentary form). In general, texts are taken to be part of the
phenomenon rather than simply being the means of conveying information about the phenomenon. (D. Smith, 1987, p. 3 – 7)

Prior (2003) understands text as “documents in action recruited into alliances of interests so as to develop and underpin particular visions of the world and the things and events within the world” (p.102). Smith writes of how

reading a text is a special kind of conversation in which the reader plays both parts. She or he “activates” the text (McCoy, 1995) –and at the same time, she or he is responding to it or taking it up in some way. Its activation by a reader inserts the text’s message into the local setting and sequence of action into which it is read. The concept of text-reader conversation brings the text into action in the readers who activate it. It is text that anchors activity in the local actualities in which people are at work. (D. Smith, 2005, p. 105)

This “activation” of text from the static to the active (McCoy, 1995), as well as use of discourse, drawn from language and a way of speaking, is key to institutional ethnographic inquiry and for its analysis. Turner (2003) summarizes well these key concepts and insights for how work is coordinated. She writes:

- The active (text) organizes institutional processes and relations that govern and regulate the society that we produce and live;
- We are constantly engaged in textually mediated forms of action and thus in ruling relations;
- The operation of texts is pervasive, relatively unnoticed in people’s behaviour; and
- Text mediated social organization is observable as people’s actual practices. (Turner, 2003, p. 91)

**Data Collection for Investigating an Institutional World**

This research does not study people as such. Instead it studies activities and how they are organized, and relations often crystallized in texts. (Campbell & Gregor, 2008, p. 57)
**Experience as Data**

Techniques for data collection in institutional ethnographic study vary, just as they can do with other methods of inquiry. Common to institutional ethnographic research is data collection undertaken in interview, focus groups, participant observation, shadowing, and researchers’ reflection on their own experience (DeVault & McCoy, 2006). Understood in IE as “experts in their own field” (Deveau, 2008, p. 14), interview participants serve as rich resources of information for a *problematic* under investigation. Their stories collected in a way to discover “the nature of connections” (p. 15) between people and then transcribed as narratives for understanding of the relations that rule their work, is both challenging and informative.

**Dealing with perceived power differential: Researcher and participant.**

Prior to sharing information on the purpose of the study, what your role will be as a participant and the risks and benefits of taking part, it is important for me to declare an additional relationship that I have with the study focus. In addition to my doctoral studies I am also employed as a Program Consultant (Nursing) with the Ministry of Children and Youth Services (MCYS) with ministry responsibility for oversight of education/information and tools to support delivery of the Enhanced 18-month Well-Baby Visit (18-month EWBV) in Ontario. The Ministry of Health and Long-Term Care (MOHLTC), a sister ministry of MCYS, is responsible for funding the visit through its fee code system. As the study’s principal investigator I will conduct all activities associated with the research project independent of my work role, on my own time and with faculty supervision. The research that I am undertaking has been classified as minimal risk student research in accordance with the Social Sciences, Humanities & Education Research Ethics Board, University of Toronto. (Novak, 2012, p. 9)

As an instrument of the research, in my role as researcher, actual or perceived power differentials in undertaking the research must be addressed (Hays & Singh, 2012). Clear identification of myself, including my role and intention to potential participants was critical, and efforts for exercising a sensitivity to boundaries, understanding of the vulnerabilities, and need for privacy for individuals was upheld through all aspects of the research process.
Employed as a Ministry of Children and Youth Services (MCYS) Program Consultant with responsibilities that include oversight for the provincial implementation of the 18-month EWBV and other early years programs delivered in PHUs in the province, I conducted the research study, independent of my work role, on my own time and with the supervision of Dr. Charles Pascal, as thesis advisor. My standing and purpose of the research were conveyed to all research participants both prior to and as part of the research process. At all times it was with understanding that participants could withdraw from the study, at any time, with no consequences, beyond a certain point. That point was identified in information and consent documents, with participants as coming following the interview process and if withdrawal from the study had not been requested, then the right to withdrawal ended once data was in the process of analysis.

In advance of conducting this research, I had corresponded with the office of the MCYS Ethics Advisor and had approval to move forward with the proposed study and the study’s method of inquiry and study design.

Documents (Text) as Data

Texts as they are read, taken up, talked about in a setting are the organizing constituents of relations, according to IE. (Turner, 2003, p. 86)

Complementary to the notion of experience as data, and seen as an important data collection technique in IE, is the gathering of key documents (text) that have a role within the problematic to be explored. It is in documents (text) that comes discovery of the “textual requirements of the organization” (Muller, 1989, p. 274), bringing further insight for documents (text) in the role that they play as part of the experience or phenomenon under study (p. 274).

To use documents (text) as a source of data is to follow activity that begins with the identification of those documents (text) that play an authoritative and present role in the work
process under investigation. Following is to understand that documents (text) are not to be analyzed by themselves but always to be considered in relation to talk and action that is coordinated by the words and information contained in their reading. Turner (2003) writes of how by observing talk and text in action and asking about and reflecting on how people including ourselves engaged in work processes, take them up and produce our own actions, we can see and display how individuals oriented too and relying on texts, produce their individual action in the terms of stable coordinative processes. (p. 85)

**Mapping Work Processes As An Analytical Approach**

Mapping text to text, site to site and local speech practices, I show the extensive coordinative work of standardized texts and institutional local practices of speaking in connected sites that bring diverse actions into a text realm to count as a single step as if one moment or act. The mapping can show how the organization of key ‘steps’ – particularly notification, consideration and decision, and consultation – actually takes place in its routine and materials detail and how what individuals do becomes institutional action. It makes visible the organization of a distinct field of action as a ‘functional complex’ of governing with its peculiar work processes and embedded standard texts and forms of speaking and coordinating them. It makes visible how opposing views are invited and are integrated as ‘concern’ that are ‘resolved through conditions’ so that the process goes on. (Turner, 2003, p. 6 – 7)

Turner (2006) describes how “mapping actual sequences of work and texts extends ethnography from people’s experiences and accounts of their experience into the work processes of institutions and institutional action” (p. 139). Her seminal work of mapping as an analytical approach in IE offers, as D. Smith (2006) shares, “an ability to track the macro institutional practices that organize those local settings” (p. 29), those “complex extended relations [shown for] how individual activities in multiple sites are coordinated and produced as acts of institutions” (Turner, 2006, p. 143). It does not produce, as Turner (2006) shares,

A chart of organizational structure, a map of job descriptions, workflow analysis, or diagram of a social network. Rather, the analytical procedure results in an
account of the day-to-day text based work and local discourse practices that produce and shape the dynamic ongoing activities of an institution. (p. 139)

As a tool of analysis, mapping is a guide “to locate and trace the points of connection among individuals working in different parts of institutional complexes of activity” (D. Smith, 2006, p. 18). Turner (2008) has crafted questions to set the work – text – work sequence that is the activation of documents (text); (text in action). Questions include,

1. What is the entry work setting?
2. What is the work/action getting done?
3. What is the key text used in the work?
5. Who gets the text next? How do they get it and use it? To whom does it go next; and

Also identified for mapping organizational work processes are insights and questions for texts that come into play in people’s work that operate in their routine work knowledge and activities, specific unfamiliar or problematic language used in text’s sections, text formats, how is text/language linked to use in other texts (e.g. behind the scene texts – manual, legislation, models being followed, budget), how are wordings in a text changed in their move from one setting to next, and who exactly does what exactly in a sequence of work-text-work action? What are the consequences? (Turner, 2008, p. 1)

Processing interchanges. Pence (1996) writes of “the notion of a ‘processing interchange’, as a characteristic work organization” (p. 171), as that point in social organization where “text enters and is processed. Text may then be passed on as modified or checked, or a new text built from the resources of the original is produced and passed on” (p. 171). DeVault and McCoy (2006) understands processing interchanges as points where work processes intersect (p. 30). It is these points where work processes intersect that provide, when mapped, opportunities for a “fuller shared understanding of organizational action” (Campbell, 2001, p. 31)
Summary

In the course of this study and in planning for its research I have found that IE opens thinking and discussion for new insight. It makes possible for “people to understand the apparently inexplicable organization of their own and other people’s everyday lives focusing research attention on puzzles emerging in everyday life, as actual people experience them” (Campbell & Gregor, 2008, p. 7). Importantly, IE is a good and comfortable fit for myself as a committed reflective practitioner who has been using narrative writing as a tool of choice for my journey, both personally and in my role as a researcher. This chapter has attempted to make the theory and method of IE usable and meaningful. In so doing, it provides foundation for the next chapters of this thesis, where details of the research undertaken, designed to explore the social organization of the institutional world of “knowledge work” as health professionals experience the 18-month visit, is described.
Relationships are at the heart of qualitative inquiry. As you engage in qualitative research, you will build relationships with participants and your research team. You will also build a relationship with your research topic itself. As with any relationship, this relationship can vary in time, focus, energy, and outcomes. (Hays & Singh, 2012, p. vii)

People are complex and should be studied by watching them, joining in, talking, and reading what they write. (Mays & Pope, 1995, p. 45)
CHAPTER SIX: METHODS FOR DISCOVERY

This chapter is a description of the empirical design used in this study’s research. It begins initially with discussion of qualitative inquiry and methodological trustworthiness and continues with a conceptual framework developed to guide inquiry. Continuing, it outlines the strategies and approaches used to respond to the key research questions. In its conclusion it enters the reader into the institutional world of knowledge work through a discussion of the methods used for the research study.

Ensuring Methodological Trustworthiness

All research must have “truth value”, “applicability”, “consistency”, and “neutrality” in order to be considered worthwhile, the nature of knowledge within the rationalistic (or quantitative) paradigm is different from the knowledge in naturalistic (qualitative) paradigm. Consequently, each paradigm requires paradigm-specific criteria for addressing “rigor” (the term most often used in the rationalistic paradigm) or “trustworthiness”, their parallel term for qualitative “rigour”. (Morse, Barrett, Mayan, Olson & Spiers, 2002, p. 15)

Qualitative researchers can move away from the language of positivist concerns with validity and reliability and embrace a more illuminative approach when offering evidence of goodness. (Tobin & Begley, 2004, p. 391)

In assessing “quality” in qualitative research, the pioneering work of Guba (1981) and Guba and Lincoln (1985) creates an opportunity to explore new ways of expressing validity, reliability, and generalizability outside the linguistic confines of a rationalistic paradigm (Tobin & Begley, 2004, p. 329). Identifying trustworthiness is a hallmark of qualitative research rigour, their seminal work continues, as a response to questions of “how can an inquirer persuade his or her audiences (including self) that the findings of an inquiry are worth paying attention to, worth taking account of” (p. 290). Truth – value, applicability, consistency, and neutrality are criteria used as standards to judge both qualitative and quantitative research. In comparing the research approaches, qualitative criteria are spoken of in terms of credibility, transferability,
dependability, and confirmability. Quantitatively they are considered as internal validity, external validity, reliability, and objectivity.

A variety of strategies support each of the criterion measures. Specific to qualitative inquiry are the established techniques of triangulation, use of disconfirming evidence, researcher reflexivity, investigator responsiveness during the research process, member checking “whereby data, analytic categories, interpretations, and conclusions are tested with members of those stakeholding groups from whom the data were originally collected” (Lincoln & Guba, 1985, p. 314), collaboration with the participants to build their view into the study, and the provision of thick, rich description to “capture the reader’s imagination by not only detailing the physical appearance of the participants, but also by capturing their emotions, feelings and experiences (Creswell & Miller, 2000). Summarized in Table 4, both the criteria and strategies used to establish trustworthiness in qualitative research (Krefting, 1991) demonstrate “integrity and competence” (Tobin & Begley, 2004, p. 390) for research rigour. Employing qualitative inquiry with such an approach helps to ensure that that inquiry is “beyond question, beyond challenge, and provides pragmatic scientific evidence that must be integrated into our developing knowledge base” (Merriam, 1995, p. 19).
Table 4

Criteria by Research Approach/Strategies to Establish Trustworthiness

<table>
<thead>
<tr>
<th>CRITERIA BY RESEARCH APPROACH</th>
<th>Qualitative approach</th>
<th>Quantitative approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Truth value</td>
<td>Credibility</td>
<td>Internal validity</td>
</tr>
<tr>
<td>Applicability</td>
<td>Transferability</td>
<td>External validity</td>
</tr>
<tr>
<td>Consistency</td>
<td>Dependability</td>
<td>Reliability</td>
</tr>
<tr>
<td>Neutrality</td>
<td>Confirmability</td>
<td>Objectivity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STRATEGIES TO ESTABLISH TRUSTWORTHINESS</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credibility</td>
<td></td>
</tr>
<tr>
<td>• Prolonged and varied field experience</td>
<td></td>
</tr>
<tr>
<td>• Time sampling</td>
<td></td>
</tr>
<tr>
<td>• Reflexivity (field journal)</td>
<td></td>
</tr>
<tr>
<td>• Triangulation</td>
<td></td>
</tr>
<tr>
<td>• Member checking</td>
<td></td>
</tr>
<tr>
<td>• Peer examination</td>
<td></td>
</tr>
<tr>
<td>• Interview technique</td>
<td></td>
</tr>
<tr>
<td>• Estimating authority of researcher</td>
<td></td>
</tr>
<tr>
<td>• Structural coherence</td>
<td></td>
</tr>
<tr>
<td>• Referential adequacy</td>
<td></td>
</tr>
<tr>
<td>Transferability</td>
<td></td>
</tr>
<tr>
<td>• Nominated sample</td>
<td></td>
</tr>
<tr>
<td>• Comparison of sample in demographic data</td>
<td></td>
</tr>
<tr>
<td>• Time sample</td>
<td></td>
</tr>
<tr>
<td>• Dense description</td>
<td></td>
</tr>
<tr>
<td>Dependability</td>
<td></td>
</tr>
<tr>
<td>• Dependability (audit)</td>
<td></td>
</tr>
<tr>
<td>• Dense description or research methods</td>
<td></td>
</tr>
<tr>
<td>• Stepwise replication</td>
<td></td>
</tr>
<tr>
<td>• Triangulation</td>
<td></td>
</tr>
<tr>
<td>• Peer examination</td>
<td></td>
</tr>
<tr>
<td>Confirmability</td>
<td></td>
</tr>
<tr>
<td>• Confirmability audit</td>
<td></td>
</tr>
<tr>
<td>• Triangulation</td>
<td></td>
</tr>
<tr>
<td>• Reflexivity</td>
<td></td>
</tr>
</tbody>
</table>

Conceptual Frame for Research Study

The process to create a conceptual frame for inquiry organized and set the course for study. In so doing, it helped identify for me both “what is known and what needs to be discovered about the topic to understand its social organization” (Campbell & Gregor, 2008, p. 51). The sequence used to set the course for my study involved three processes. First was my activity in identifying an experience that was close to me. Second was to identify some of the institutional processes (social relations) that were shaping that experience; and third was to
investigate those processes in order to describe analytically how they operate as the grounds of experience (DeVault & McCoy, 2006, p. 755). Table 5 provides an overview of the conceptual frame for my research study.

Table 5

**Conceptual Frame for Research Study**

<table>
<thead>
<tr>
<th>Focus of Study: Moving from Evidence to Practice for Implementation of the 18-Month EWBV</th>
</tr>
</thead>
<tbody>
<tr>
<td>What can we learn about the movement from evidence to practice in the implementation of Ontario’s 18-month EWBV?</td>
</tr>
<tr>
<td>How is it that knowledge (child health evidence), information, resources, and tools for use at the 18-month visit moved into practice?</td>
</tr>
<tr>
<td>How are multidisciplinary FHTs organized to support the visit?</td>
</tr>
<tr>
<td>How do documents (text) for evidence informed practice organize, mediate, and guide clinical practice for implementation of the visit?</td>
</tr>
</tbody>
</table>

Addressed myself to the issues through listening to health professionals speak of their experience, observing data on uptake and implementation (ICES; OMR articles; parent’s experience; community events), and accepting as true that knowledge work is social, organized and in relation.

**Tension** for those involved between how to accomplish their provision of clinical care as the competent, somewhat autonomous professionals that they are and how to make changes in their practice that the new science, research, and evidence suggest and new program policy requires.

**Disjuncture, contested area,** the definition of “good practice,” adoption or rejection of innovation and those factors that invite or reject innovation, complement or inhibit the activities required for success, and sustains or alter adherence to entrenched practices (Kontos & Poland, 2009).

“The continued use of clinical judgment alone vs adopting new structures and processes informed in evidence to create a culture focused on enhancing the developmental health and well-being of children beyond just a medical model of height, weight and immunization”

**REVIEW OF THE LITERATURE**

Review: Basis for analysis and critique. What is already known about the events of the kind proposed for study?

Appraisal: Positioning of self as the researcher in the phenomena and the setting. What in the focus of study is not found in the literature?

*Knowledge work* defined as the creation of new knowledge during the transfer of knowledge, in the context of the application of knowledge to clinical decision-making (Quinlan, 2009).

<table>
<thead>
<tr>
<th>KNOWLEDGE</th>
<th>KNOWLEDGE TRANSLATION</th>
<th>COMMUNITIES OF PRACTICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical judgment</td>
<td>Models and Frameworks</td>
<td>Inter-professional knowledge uptake</td>
</tr>
<tr>
<td>Explicit codified knowledge</td>
<td>Theories</td>
<td></td>
</tr>
</tbody>
</table>

**IE as Method**

Application of IE’s theory (social organization) and method (experience and documents [text]) as data.

**Analysis:** Interview, document (text) analysis and mapping as analytic for document (text) mediated work, and decision process for knowledge work.
From Research Question to Experience as Data and Documents (Text) as Data

Using IE as method, the following strategies and approaches were used to address the key research questions and explore the many ways of knowing.

1. **How is it that knowledge (child health evidence), information, resources, and tools for use at the 18-month EWBV are moved into this new way of practice?** Using experience and documents (text) as data, and interview, document (text) analysis, and mapping as an analytic, *knowledge work* for well-baby care at 18-months and the relations that shape its experience will be described. Probes for understanding the meaning and values of knowledge, roles of documents (text) used in *knowledge work* and examination of those factors that enable, detract, and sustain uptake of the enhanced visit were used to guide interview discussion with key stakeholders and informants serving as participants in the study.

2. **How are multidisciplinary family health teams organized to support the enhanced visit?** Key stakeholder and informant interview discussion explored how the everyday work of navigating complex and regulated processes (Ng et al., 2012) for *knowledge work* was done. Discussion focused on how practices were organized for the sharing of evidence-informed education, information on child health and tools to support the 18-month EWBV with/in the health care teams and with practitioners. As well, interview conversation brought to light the role that documents (text) played in organizing this new structure and/or shift in practice for the enhanced visit.

3. **How do documents for evidence-informed practice organize, mediate, and guide clinical practice for implementation of the visit?** The gathering of key documents (text) that guide implementation for *knowledge work* related to the 18-month EWBV is a
key activity of the research. Documents (text) were collected both at the provincial level and from local practice and included policy documents, regulatory texts, reporting texts, archival data, legislation, standardized tools, brochures, web-based technologies, and clinical guidelines. Document (text) identification was completed through the dialogue and connections made with stakeholder and key informants in understanding what guided their knowledge work in bringing innovation of the 18-month EWBV to practice.

4. **How does IE make accessible understanding of actual and embodied professional knowledge work activities, mediated by written communication and documents for the implementation of the visit?** Using IE’s commitment to exploration and discovery of real, lived experience, IE, as method, allows for “putting into words supplemented in some instances by diagrams or maps” (D. Smith, 2006, p. 1) the understanding of those relations that shape and organize the knowledge work for moving from evidence to practice. Beginning in practice, rather than theory, using IE to inquire allows a view to local nuances, exceptions, inequalities, and creative problem solving (Ng et al., 2012) occurring at the local level, influenced by the relations and forces that hold power over process.

5. **What insights, reorganizations, and refinements to current practice for the visit might be generated using IE?** Research study and mapping of real experience, document (text) to text, site to site, provides important discussion of the how and why of the relations that shape experience, how they interact, the causal mechanisms for linking how knowledge work happens as it does, and identifying those processes and ways for organizations that invite or reject the innovation.
Summarized in Table 6 are the key questions that guide this inquiry and the complementary questions, and probes used in the interview discussion with stakeholder and informant study participants.
### Table 6

**Research Questions Linked to Interview Questions for Discussion**

<table>
<thead>
<tr>
<th>Overarching Question: What can we learn about the movement from evidence to practice in the implementation of Ontario’s 18-month EWBV?</th>
<th>Key Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RQ1.</strong> How is it that knowledge (child health evidence), information, resources and tools for use at the 18-month EWBV are moved into this new way of practice?</td>
<td><strong>Research questions</strong></td>
</tr>
<tr>
<td>• How would you describe or interpret the term “knowledge transfer” (Probe understanding/interpretation of knowledge work definition)?</td>
<td></td>
</tr>
<tr>
<td>• Tell me about what you would like primary care practitioners who deliver the 18-month EWBV to know or be aware of (Probe progress and success outcome definition and measurement for the movement of evidence to practice for the visit).</td>
<td></td>
</tr>
<tr>
<td>• From your experience what are some of the methods that you have used to bring evidence into practice related to knowledge transfer for the 18-month EWBV (Probe roles of printed education materials, CME activities, conferences, small group interactive education, educational outreach, local opinion leaders, mass media, computerized decision support, multi-professional collaboration*, quality improvement, financial interventions, patient mediated interventions, combined interventions).</td>
<td></td>
</tr>
<tr>
<td>• What has been found to be effective? Most effective?</td>
<td></td>
</tr>
<tr>
<td>• Tell me about the challenges involved in working to support the bringing of evidence to practice to support knowledge transfer/provincial implementation of the 18-month EWBV.</td>
<td></td>
</tr>
<tr>
<td>• Tell me about the facilitators, or potential facilitators in bringing evidence to practice to support the implementation of the 18-month EWBV.</td>
<td></td>
</tr>
<tr>
<td><strong>RQ2.</strong> How are multidisciplinary family health teams organized to support the enhanced visit?</td>
<td><strong>Research questions</strong></td>
</tr>
<tr>
<td>How do you personally navigate practice, for the sharing of evidence-informed education, information on child health, and tools to support delivery of the 18-month EWBV, with/in the health care teams and with practitioners?</td>
<td></td>
</tr>
<tr>
<td>• Do you, and if so how do you, see clinicians/teams organized to support the 18-month EWBV?</td>
<td></td>
</tr>
<tr>
<td>• Do you, and if so how do you, see disciplines, across the teams, organized to support the 18-month EWBV?</td>
<td></td>
</tr>
<tr>
<td>• How do you see documents/18-month EWBV documents organize, mediate and guide clinical practice for implementation of the visit (Probe policy documents, regulatory texts, reporting texts, archival data, legislation, standardized tools, brochures, web-based technologies, and guidelines)?</td>
<td></td>
</tr>
</tbody>
</table>
### Overarching Question: What can we learn about the movement from evidence to practice in the implementation of Ontario’s 18-month EWBV?

<table>
<thead>
<tr>
<th>Key Stakeholders</th>
<th>Research questions</th>
<th>Interview questions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>o In your opinion/experience, is this documentation helpful to the process of supporting implementation of the visit?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Do you have examples of documents that your organization has created to support clinicians in their implementation of the 18-month EWBV?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o What considerations do you/did you take into account when creating documents to support delivery or implementation of the visit?</td>
</tr>
<tr>
<td></td>
<td>Tell me more about an especially memorable/critical experience supporting/working with clinicians for this work.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>What could primary care practitioners who deliver the 18-month EWBV, do to further facilitate (Organization’s) collaboration with them for uptake and delivery of the visit? What could (Organization) do to further facilitate collaboration with clinicians to support uptake and delivery of the 18-month EWBV?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>What if anything would you change in your practice of supporting clinicians in implementing the visit (Probe content/processes)?</td>
<td></td>
</tr>
</tbody>
</table>

### RQ3. How do documents for evidence informed practice organize, mediate and guide clinical practice for implementation of the visit?

- What directs/governs the way you work with primary care practitioners who deliver the 18-month EWBV?
- What documents related to the 18-month EWBV are you familiar with that support the movement of evidence to practice for the 18-month EWBV? Which documents do you use? (Probe policy documents, regulatory texts, reporting texts, archival data, legislation, standardized tools, brochures, web-based technologies, and guidelines).

### Key Informants

<table>
<thead>
<tr>
<th>Research Questions</th>
<th>Interview Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>RQ1. How is it that knowledge (child health evidence), information, resources and tools for use at the 18-month EWBV are moved into this new way of practice?</td>
<td>• How would you describe or interpret the term ‘knowledge transfer’ (Probe understanding/interpretation of knowledge work definition)?</td>
</tr>
<tr>
<td></td>
<td>• From your experience what are some of the methods that you have used to bring evidence into practice related to the 18-month EWBV (Probe roles of printed education materials, CME activities, conferences, small group interactive education, educational outreach, local opinion leaders, mass media, computerized decision support, multi-professional collaboration*, quality improvement, financial interventions, patient mediated interventions, combined interventions).</td>
</tr>
<tr>
<td></td>
<td>• What has found to be effective? Most effective?</td>
</tr>
</tbody>
</table>
**Overarching Question:** What can we learn about the movement from evidence to practice in the implementation of Ontario’s 18-month EWBV?

### Key Stakeholders

<table>
<thead>
<tr>
<th>Research questions</th>
<th>Interview questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tell me about the <strong>challenges</strong> involved in working to support the bringing of evidence to practice to support implementation of the 18-month EWBV.</td>
<td></td>
</tr>
<tr>
<td>Tell me about the <strong>facilitators, or potential facilitators</strong> in bringing evidence to practice to support the implementation of the 18-month EWBV.</td>
<td></td>
</tr>
</tbody>
</table>

**RQ2.** How are multidisciplinary family health teams organized to support the enhanced visit?

- How do you personally navigate practice, for the sharing of evidence-informed education, information on child health, and tools to support delivery of the 18-month EWBV, with/in the health care teams and with practitioners?
  - In your team, do you, and if so how do you, see clinicians/teams organized to support the 18-month EWBV?
  - Do you, and if so how do you, see disciplines, across the teams, organized to support the 18-month EWBV?
  - How do you see documents/18-month EWBV documents organize, mediate and guide clinical practice for implementation of the visit *(**Probe policy documents, regulatory texts, reporting texts, archival data, legislation, standardized tools, brochures, web-based technologies, and guidelines)**?*
  - In your opinion/experience, is this documentation helpful to the process of supporting implementation of the visit?
  - Do you have examples of documents that your practice has created to support your clinicians in their implementation of the 18-month EWBV?
  - What considerations do you/did you take into account when creating documents to support implementation of the visit?

Tell me more about an especially memorable/critical experience supporting/working with the 18-month EWBV.

**Would you change**, and if so **what would you change**, in the process/content for bringing child health evidence and the evidence that supports the 18-month EWBV to practice?

**RQ3.** How do documents for evidence informed practice organize, mediate and guide clinical practice for implementation of the visit?

- What directs/governs the way your primary care practitioners deliver the 18-month EWBV?
- What documents related to the 18-month EWBV are you familiar with that support the 18-month EWBV? Which documents do you use *(**Probe policy documents, regulatory texts, reporting texts, archival data, legislation, standardized tools, brochures, web-based technologies, and guidelines)**?*
Entering Into the Institution of Knowledge Work

Following is a description of the formal and informal procedures used in undertaking this research. Procedures begin with site selection and share how access was gained at each of the sites, including the permissions process and activities for participant sampling and recruitment. This section also details my activities as researcher for developing and maintaining relations in the field (L. Cohen, Manion & Morrison, 2000) and in creating an “interactive environment of trust and rapport” (Altheide & Johnson, 1994, p. 494) for my study participants. Continuing is discussion of how research data were generated for both experience as data and documents (text) as data. Methods of data analysis follow and complete this discussion.

Site Selection, Participant Recruitment and Sampling

Sites for Inquiry

Within purposeful sampling, you may decide to use a random or stratified technique. You may decide to use random purposeful sampling to increase the variation of cases within your study. Random purposeful sampling literally means randomly selecting from a purposeful sample. Although it does help to minimize any bias associated with hand-picking cases, random purposeful sampling does not guarantee that these were “random” cases, as in quantitative research”. (Hays & Singh, 2012, pp. 166 – 167)

Research sites participating in the study included a nationally recognized organization for child studies. The organization is actively involved in providing education activities to support provincial implementation of the 18-month EWBV in primary care practices in Ontario. In addition, FHT practices, where delivery of well-baby care at 18 months occurs, took part.

Selection of the FHT sites was completed as a randomized process. Using a Google Internet search (Family Health Teams in Ontario), a listing of Ontario family health teams was identified. Using the online list, a map of the province, and ICES data that compared primary care models in Ontario by demographics, case mix and emergency department use (Glazier,
Zagorski & Rayner, 2012) teams were selected by the researcher to be representative of geographic and demographic diversity in the province. As well, teams may or may not have had current or active association with the organization that provides education activities to support implementation of the 18-month EWBV.

FHT sites that provided consent to participate in the study identified as both academic teaching/training clinics and non-academic practices. Locations represented were rural, urban, and urban-rural in their nature and had a mix of academic and nonacademic affiliations. All provided broad-spectrum primary care (Bodenheimer, 2007, p. 11) services and programs. Several of the practices participated in government-sponsored quality improvement initiatives. All total, the FHTs participating provide care to approximately four hundred 18-month-old children.

Research Participants

Participants engaged in the research study were recruited from the two sites of inquiry identified in the preceding section. Organization leadership and FHT administrators played an invaluable role as “gatekeepers” (Hays & Singh, 2012, p. 178) to facilitate my accessing contact and maintaining relations with study participants. Their enthusiasm for the project allowed the number of my research participants involved in the study grow from seven to twelve. As well, the quality and commitment of each of my organization key stakeholders and family health team key informants met, as Morse (1995), describes, criteria that defined them as a “primary informant.” Such criteria include

having necessary knowledge, information and experience of the issue being researched, is capable of reflecting on that knowledge and experience, has time to be involved in the project, is willing to be involved in the project, and, indeed, can provide access to other informants. (p. 228)
Study participants from both sites were identified as key stakeholders (education leaders [EL]) and key informants (FHT participants). Key stakeholders interviewed had as their collective or shared history a legacy of providing education leadership and support for the implementation of the 18-month EWBV. The organization and its staff have championed outreach and academic detailing strategies to support the movement of evidence to practice and have overseen the development of web-based access to education, information, and tailor-made decision support tools. In doing so they have promoted uptake and championed the 18-month visit as an expanded scope of practice in primary care practices in Ontario.

Participating as key informants, FHT professionals included a family physician (FP), nurse practitioner (NP), family practice nurses (FPN), a family outreach nurse (FON), a health administrator (HA), and a business administrator (BA) responsible for data collection and management. In addition, at the request of a FHT, their public health unit partner was included. Information and consent to participate in the study templates were shared with these additional participants. Signatures for participation and study participation grew to include a public health nurse (PHN), a public health manager (PHM), and an epidemiologist (E).

Key informants represented a diversity of professional background (e.g., nursing, medicine, public health, business, data entry, epidemiology), authority and influence in practice (e.g., physician, nurse practitioner, nurse, business administrator), and experience in practice (e.g., novice < 1 year in practice, to experienced > 10 years). As well, research participants represented both genders.

Participants provided individual interview accounts and in the case of some sites where more than one individual wished to be interviewed, group interview accounts were spontaneously held. The latter provided opportunity for a similar-like gathering of individuals
and rich discussion for a range of perspectives and experiences (Lambert & Loiselle, 2008, p. 229). As the researcher, I drew from my extensive professional experience in conducting interviews and facilitating groups to complete this form of data collection. In the course of discovery no personal identifiable information from or about a research participant was extracted or collected. Data at all times remained confidential. Data collected across all sites were shared at the aggregate level, with representation identified generically by position.

A total of 12 research participants participated in the study (e.g., two education leaders, seven professionals from the FHT practice sites, and three public health unit staff who support community uptake of the visit in partnership with one of the FHTs). No research participants actively withdrew from the study and 12 research participants completed the study. A total of seven interview accounts (five individual interview accounts and two group interview accounts [three participants in Group A; four participants in Group B]) were completed with study participants. The interviews were held across multiple sites, beginning in January 2013 and were completed in April 2013.

In providing summary to this section, it is important to understand how knowledge being created from experience as data is truly meaningful. In institutional ethnographic study, and most qualitative research approaches, generalization of findings is not the goal of research study but rather benefit comes from the richness of experiential accounts (Sevigny, 2012) and in the ability “to discover actual connections” (Campbell & Gregor, 2008, p. 89). As researcher, I did not anticipate being able to recruit all members of the organization contacted or every FHT member, nor would it have been necessary based on prior qualitative research experience and institutional ethnographic literature (Ng et al., 2012; D. Smith, 2005). Rather, a rich understanding of the specific phenomena under study to generate potentially transferable and
meaningful knowledge was my goal (Charmaz, 2005; Ng et al., 2012; Ponterotto, 2005). Research rigour and trustworthiness for IE as an approach comes from placing trust in study participants knowledge of their own experience, tracing, and describing the social relations that extend beyond the boundaries of any one informant’s experiences (or even of all informant’s experiences), and knowing that informants’ understanding, talk, and activities, are never found in isolation but informed by relation, either as in local-to-local connection created through everyday practice where individuals connect or from participation and influence of a broader discourse (Campbell & Gregor, 2008). To offer credibility, this study used a strong triangulation of data methods including individual and group interview accounts and on-site document collection. As well, my professional role brought to the study an established authority of the researcher. To offer transferability, dependability, and confirmability, the study met criteria that included thick description, reflexivity, member checking, and a strong interview technique. A detailed and systematic approach to data analysis, described in later sections of this chapter, that included experience as data, documents (text) as data, and mapping as an analytic also contributes to knowing that knowledge being created is truly meaningful.

**Permissions, informed consent, privacy and confidentiality.**

Informed consent is an important ethical and legal concept that clearly identifies and outlines research activity and the rights and responsibilities of all parties involved. (Hays & Singh, 2012, p. 80)

Permissions and informed consent are viewed as a “cornerstone of research” (Hays & Singh, 2012, p. 80). In seeking and gaining consent for study participation the researcher describes “the purpose of the research study and provides information about the researcher, the extent of participation, limits of confidentiality, and any foreseeable risks and benefits of participation and non participation, and emphasizes the voluntariness of participation” (p. 80).
For purposes of my study, consent to participate was obtained first at the organizational and team level and then with interested participants identified by leadership at each of those sites. A letter of information and invitation, including a consent form for organization and FHT participation in the study, was sent by email to the organization director and to business administrators/chief executive officers for each of the family health teams selected (Appendices, B, C). With organization and team confirmation of interest in participating in the project confirmed, and consent provided, a letter of information and invitation, including informed consent, was provided to those individuals identified by their respective leadership for participation in the study (Appendices, D, E).

Participant vulnerability: possible risks and benefits. “Keeping individual participants from harm while engaging in the research process” is key” (Hays & Singh, 2012, p.79). In seeking consent to participate, we are, as Hays and Singh (2012) suggest, “as researchers, immersing ourselves in participants’ settings, invading their privacy, and potentially inducing reactions such as anxiety, stress, or sadness, asking much of their time and energy and analyzing data and presenting findings that have only been analyzed by a research team” (p. 79). And so, to that end, as part of sharing information for the study, as a component of introduction to the interview process, and in monitoring participant reaction during discussions, due diligence was provided in ensuring that no risk was experienced for participants in the study. At all times participation in the study was offered as voluntary. Any risk associated with feeling uncomfortable, embarrassed, or upset by participating in the project or as part of the interview process was mitigated by my declaration prior to the interview and contained within information packages shared with gatekeepers, stakeholders, and key informants that if for any reason they might choose not to participate or continue in the study, they could do so with no consequences.
Contact information was provided for both the researcher and for the Office of Research Ethics, University of Toronto for answers to questions on participation in the study, research, and the rights of participants. At no time were such vulnerabilities and/or requests expressed by participants.

In “giving back” (Hays & Singh, 2012, p. 80), benefits and contributions for participation in the study were shared with participants. Articulated within the initial information letter and as part of the interview process awareness was raised that:

In participating in this study you may benefit through increased understanding of the conditions and implications for moving emerging and new child health evidence and information into practice generally and the process specific to the 18-month EWBV. It is my hope that the results of this study will contribute to broader understanding of child development as a key determinant of health and the role that the community has in promoting and supporting children and their families in the early years and continued opportunities for awareness of the health dimensions of early years policy. An understanding of knowledge translation processes that begin in practice, beyond theory or policy, highlighting the nuances, exceptions and inequalities, and creative problem solving can help to further inform policy and improve practice. The study involves interviews and document collection analysis. Understanding from the interview conversation and document analysis will help, to enable understanding of what actually happens for the movement of evidence to practice in delivery of the 18-month EWBV. (Novak, 2012, p. 33)

Developing and maintaining relations in the field.

The issue here is that the data collection process is itself socially situated; it is neither a clean, antiseptic activity nor always a straightforward negotiation. (L. Cohen et al., 2000, p. 235)

As L. Cohen et al. (2000) describe, the development and maintenance of relations in the field that is the focus of research study is multipronged. It addresses both “interpersonal and practical issues” (p. 234). Such issues include building participants’ confidence in the researcher, developing rapport, trust, sensitivity, and discretion, handling people and issues, being attentive and empathizing, being discreet, and deciding how long to stay in site activities.
With an initial email out to both the organization and to selected FHT teams, an information letter on the project with an accompanying organization or team and included key informant consent form, gatekeepers\textsuperscript{16} for the study were identified. A process of rapport building/trust building for relationship development ensued. Through multiple emails and in some cases follow-up telephone conversations, aspects of Pitts’s (2007) model of participant–researcher relationships in fieldwork were enacted. I found myself in situations asking, “How can I help you feel comfortable participating in this research?” I saw patterns of self-in-relation-to-other, where I reflected on, “Who am I (as researcher) to you (as participant)?” I sought understanding, again in reflection, for patterns self-and-other-linking, where I asked self for understanding the researcher/participant bond, “Who are we to each other as knowledgeable persons?” I looked for patterns of interpersonal connection, where I challenged, “Where is the line between participating in research and friendship?” And in conclusion, I sought answers for patterns of partnership, for “How does our relationship enhance the research in which we are mutually invested?”

\textsuperscript{16} Gatekeepers are those people who hold access to your participants and/or site of study (Hays & Singh, 2012, p. 180).
Participants, serving as both stakeholders and informants, at organizational sites and in and across teams were provided at every occasion in the research process the opportunity to ask questions and be provided with clarification to any queries that may have arisen. Requests for information for the Research Ethics Board process were granted, unconditionally, scheduling changes for interview dates were handled with no questions asked, and interview times were negotiated for what was always deemed in the best interest of the participants.

The research process was at all times both exhilarating and humbling. The access and cooperation provided by all those who participated resonates still with me today in this writing. I was met with acceptance as the researcher, acknowledgement for the merits of the study, and generosity for continued support from all of those who participated.

**Personal Journal Entry - February 2013**

*Dusk, traveling home …*

I have stopped on the roadside, overwhelmed in the moment of what a first day of interviews has brought. I feel a shift in my thinking, from the ‘expert out there’ as a means to an end to an aha its up to me now. I use the expert knowledge that participants are providing me to write my own research, an “expert inside view”. It continues learning from what was learned from Master’s work so many years ago.

The light is dimming, the winter day is growing old, and the snow is crisp, the weather icy, and my drive home waits. But I know that I must honour this moment of understanding. I have completed a first set of interviews. The generosity and kindness of participants is overwhelming; the knowledge of the initiative, its impact, and its effect is humbling. I am caught between two worlds, my research and my professional life.

To the south, a flock of birds takes flight, out, over the lake; they are silent, focused and on course. They are no different than I. Their flight, as mine, continues destination unknown.
Data Generation

Experience as Data: Key Stakeholder\(^{17}\) Key Informant\(^{18}\) Interviews

Listen to the person tell her story. Pay attention to the sequencing. Then ask yourself; can you tell exactly how she gets from one point to another? If not, ask questions, clarify so that you can. (DeVault & McCoy, 2006, p. 28)

Interviews, the art of “hearing data” (A. Rubin & Rubin, 2012), for the purpose of this study and for institutional ethnographic study generally, serve purpose not for understanding “individual experience” (DeVault & McCoy, 2006) as with other qualitative approaches but are designed for understanding the “investigation of organizational and institutional processes (p. 15).” D. Smith (2005) speaks to interview not revealing subjective states but to locate and trace the points of connection among individuals working in different parts of institutional complexes of activity” (p. 18). For purposes of the study, my goal was to “elicit talk that will not only illuminate a particular circumstance but also point toward next steps in an ongoing, cumulative inquiry” into processes that begin from the experiences of health professionals providing well-baby care at 18 months as part of an expanded scope of practice but are shaped by “macroinstitutional policies and practices that organize those local settings” (D. Smith, 2006, p. 29). Questions serving as probes were shaped as “open-ended inquiry, oriented to sequences of interconnected activities, with the purpose to learn “how things work” (DeVault & McCoy, 2006; D. Smith in conversation, 2012). Shared in the study’s Information Letter and the Consent to Participate Form, and formalized as part of the interview process, was the researcher’s intent to engage in a process of

\(^{17}\) Stakeholders are described as people or groups who have an investment—or stake—in the findings of your study (Stoecker, 2005 as cited in Hays & Singh, 2012, p. 181)

\(^{18}\) Key informants include people who serve as important contacts for the study and who often provide important information that may shape the study. Seen as distinct from gatekeepers and stakeholders (Hays & Singh, 2012, p. 181).
open-ended inquiry, oriented to conversational interviews, not as an evaluation of individual clinicians or family health teams, but rather to support an understanding of work processes for the creation of new knowledge during the transfer of knowledge, in the context of the application of knowledge to clinical decision-making. (Novak, 2012; Quinlan, 2009)

Each interview provided opportunity not just for the asking of questions but also for participants to collaborate in the development of an account of how knowledge work for the enhanced visit had come to practice. They also allowed for myself, as the researcher, to initiate, as Mykhalovskiy (2006) describes, “analytic thinking, like an analytic rehearsal; checking for understanding as it develops; offering it up to the informant for confirmation or correction” (p. 23). Each encounter with participants, across sites, allowed me as researcher to understand how efforts/activities for the movement of evidence to practice were coordinated, to learn about a particular piece of the extended relational chain, to check in on the developing picture of the coordinative process, and to become aware of additional questions that needed attention (D. Smith, 2006, p. 23).

Many times the interview process became the co-investigation it was supposed to be, a listening and probing towards connections, “a fully reflexive process in which both the participant and the interviewer construct knowledge together” (D. Smith, 2006, p. 24). I observed notes being taken by participants as the interview process evolved. I heard reflective comments on efforts that could be better directed for increased effectiveness and awareness within practitioner communities. I was encouraged and proud when discussion goodbyes were completed with “this has been good conversation, good questions being asked, you have made me think.” I was heartened when a front-line practitioner expressed how she now found clarity for her role. In speaking out loud and sharing with me all that she was responsible for and managed, she shared; “Now I can tell the Board. Now I can share in a way all the work that I do,
that will be helpful.” Conversations with study participants helped to inform, recognize future work opportunities, and validate work that had previously gone unrecognized, labeled now and no longer invisible.

All interview sessions were audiotaped for ease of review of the conversations. Recorded interview data was transcribed professionally, verbatim, in order to capture all that transpired in individual and group encounters. Time, experience, and skill were determinants for why I did not transcribe the interviews myself. With transcription completed I reviewed original audiotapes against the transcript for accuracy, identification of “who said what”, and other pertinent information (e.g., participant language, sighs, voice inflections, utterances), making note of such detail on the transcript. I then reduced the data, chunking it into themes and clusters of themes for the important issues and topics that best and frequently spoke to the research questions represented in interview questions. In addition, field notes taken prior, during, and after the interview process to support the taped conversation helped, as supplemental evidence (Hays & Singh, 2012, p. 228), to create an accurate and thorough written record of my activities at the site and in the field. Captured as notes scribbled on scraps of paper on the drive home from the interview site, or as observations, comments, and thoughts gathered in spiral-bound binders that became constant companions on my research journey, all represented accumulated thought and thinking, “preserving the presence of the subject” (D. Smith, 2006, p. 53). I wrote a lot. The field notes were both reflective, recording subjective aspects of data collection such as assumptions, impressions, attitudes and ideas (Bogdan & Biklen, 2003) as well as my thoughts, feelings, and reflections regarding the setting, site and study participants. I chronicled participants’ reactions and interactions with me, thoughts about what or who might be missing from the setting, and always thinking and planning for new questions and ideas that could be
asked. They provided space for me to reflect on the conversations that I was hearing, the experiences I was participating in.

**Interview discussion development.**

Although there should be a relationship between research and interview questions, interview questions tend to be more contextual and specific than research questions. And their development requires creativity and insight, rather than mechanical translation of the research questions into an interview guide. (Glesne, 1999, p. 70)

The data you get are only as good as the questions you ask. (Glesne, 1999, p. 75)

In my efforts and desire to “talk with people”, my interviewing and interview discussion development was planned as an opportunity of open-ended inquiry, “oriented to sequences of inter-connected activities” (D. Smith, 2006, p. 23). My goal was to learn “how things work” (p. 23). An interview guide, including questions to guide conversation, was developed (Appendix F). Themed to support the understanding of the social phenomenon of *knowledge work*, questions and probes for the exploration of the practitioners’ practice, knowledge transfer, documents, and practice organization were included. The questions developed act as “aide memoire” for conversations to explore the linkages between the front-line and the ruling discourses and relations. Questions generally focused, as Patton (1990) describes, on background/demographics, experience/behaviour questions, opinion/value questions, knowledge questions, feeling questions, and sensory questions. Revised and revised again, they were as if pilot-tested with my first set of interviews and then confirmed as additional sites participated. Questions were shaped and ordered in specifics, within the context of the past and the present, and one created for thinking of future possibilities (Glesne, 1999, pp. 72 – 73). All were designed to promote rapport and maximize discussion. Probes and follow-up questions were used to clarify and add completeness to a response. Though the process of drafting and redrafting
interview questions required time, thought, and effort on my part, I feel strongly that my research benefited. Discussion initiated by questions flowed in some case, effortlessly; creating stream of thought and language that in reflection had followed the order of how questions and probes had been prepared but without their purposeful asking. In some cases, interviews that were scheduled originally for only an hour at times became social encounters extending much longer at the insistence of the participants. Interested and engaged participants were recorded on several occasions as commenting on how questions posed had made them think differently and with unimagined resonance.

**Documents (Text) as Data**

Your understanding of the phenomenon in question grows as you make use of the documents and artifacts that are part of people’s lives. (Glesne, 1999, p. 59; Merriam, 1988)

The texts that researchers see being used by informants during field observations are often central to everything that happens. Therefore to understand the setting and to explicate the problematic arising in it, texts are a very useful ethnographic data source. (Campbell & Gregor, 2008, p. 79)

In moving evidence to practice in the context of the 18-month EWBV, documents (text) are set to organize the formation and functioning of the visit for the knowledge work to occur. It is written, “the production and circulation of printed text is a requirement of practice in medicine prepared in evidence” (Mykhalovskiy & Weir, 2004, p. 1059). And so, significant to the research was the role of documents (text) for their representation and development of organizational knowledge; active constituents of social relations (D. Smith, 2006, pp. 65 – 66). Documents (text) as features of discursive organization that relate people purposively to each other, and to events, organizations and resources (D. Smith, 2005, 2006; Turner, 2003) were gathered, actively recruited, and generously provided by research participants. The documents (text) provided, in all formats, provided form, content and direction representing essential
aspects of institutional action (D. Smith, 2005, 2006; Turner, 2003). They were as Glaser and Strauss (1967) suggest, as important to study as observations and interviews (p. 163).

Document collection at the government policy/program oversight level and from the organization responsible for provincial education and support for implementation of the 18-month EWBV in practices in Ontario served as an entry point for text as data generation. All documents and documentation collected at this stage and from materials provided by study sites were considered public and were found in the public domain. No documents (text) or documentation of a confidential nature were used in the study. Documents identified through stakeholder and informant interviews were also gathered for study. That collection was gathered by attending to the connections that informants revealed through the interview process, with participants asked to produce or indicate documents for me to review as they were identified in discussion. As a follow-up, some sites mailed materials in addition to those that they had shared, feeling that on reflection of the interview conversation these additional documents would further support the discussion.

Documents (text) collected included public policy documents (MCYS, Ministry of Health and Long-Term Care [MOHLTC], regulatory texts, reporting texts, archival data, legislation (Schedule of Benefits for Physician Services under the Health Insurance Act), standardized tools suggested for use at the visit (Nipissing District Developmental Screen® - 2011 and Rourke Baby Record Evidence Informed Guide © - Ontario 2011), brochures, web-based technologies, local protocols and documents, and guidelines (Appendices, G, H, I).

Data Analysis

The use of IE as method allows the organizing role of documents (text), language, and the tacit elements of integrating work to be revealed (D. Smith, 2006; Ng et al., 2012; Turner in
conversation, 2012). IE has as its analytic goal “to make visible the ways the institutional order creates the conditions of individual experience” (DeVault & McCoy, 2006, p. 109). My goal in analysis was for discovery, for how knowledge work for clinical practice was “institutionally coordinated not to focus on how an individual does her or his work but on how that work was shaped” (Crispin, 2009, p. 50), not just by other people and processes in the practice but by forces found in the community, in organizational leadership, whose mandate was to lead activities for building new knowledge and in structures and processes that developed policy and governance for the introduction of the new knowledge to the local context.

Interview and key document analysis was undertaken, culminating in a map that served as a reference guide for tracking and diagramming organizational work (Turner, 2008) for the movement of evidence into practice. The map recreated study interview dialogue and documents data identified by participants as part of their 18-month EWBV work processes. Such mapping represented actual sequences of work, day-to-day document-based work and local discourse practices that produced and shaped the dynamic ongoing activities of the social phenomenon (Turner as cited in D. Smith, 2006): how child health evidence is integrated into primary care paediatric practice. The data were used to discover what “actually happens to participants in a research setting and what triggers those particular actions or events” (Campbell & Gregor, 2008, p. 70).

Interview Analysis

Grouping chunks of transcript, sometimes pages in length, by theme or topic. For others the grouping is done rather simply, something like the indexing for a book (D. Smith, personal communication 2012), sticking closely to topics of talk and references to institutional sites and processes. (DeVault & McCoy, 2006, pp. 38 – 39)

This component of data analysis invokes the use of experience as data, as new knowledge
and its language coordinate action. Language as a coordinator of experience, and action is a key concept of institutional ethnographic inquiry. It is language, D. Smith (2005) suggests, that is the “medium in which thoughts, ideologies, and so on are lifted out of the regions of people’s heads and into the social, understood as the coordinating of people’s doings” (p. 94). Language creates a new dimension of organization in the social process. D. Smith (2005) further identifies how people “introduce into the social act an utterance, a conventionalized sound or script to which both speaker and hearer respond in the same way” (p. 82). That utterance, sound, or script is language; be it a word or speech it is the beginning of social organization. From that process, Smith goes on to share, each “coordinates her or his own decision with the message, all the while remaining responsive to what is occurring around, taking into account particulars of a situation and deciding how to interpret it” (p. 82). Awareness of language, its interpretation, and subsequent meaning, to those who hear or read, is critical for understanding how people, in the case of my inquiry, health professionals, represent themselves in their practice.

Document (Text) Analysis

Analysis of gathered documents (text) was done through the lens of asking, what is accomplished by the texts that are being used?; what are the external causes and effects of people’s activities?; what social relations are reflected in the everyday activities? And how do those social relations play a part in generalizing institutional processes? (Campbell & Gregor, 2008).

Mapping as Analytic

Mapping actual sequences of work and texts extends ethnography from people’s experience and accounts of their experience into the work processes of institutions and institutional action. It does not produce, for example, a chart of organizational structure, map job descriptions, workflow analysis, or diagram of a social network. Rather, the analytical procedure results in an account of the day-
to-day text based work and local discourse practices that produce and shape the dynamic ongoing activities of an institution. (Turner, 2006, p. 139)

In actually determining “the life conditions” (Campbell & Gregor, 2008, p. 17) of work processes and how texts “operate in decision-making” (p. 17), the mapping of institutions and their processes, as work – text – work action, has an important role in understanding how “governing and policy work” (Turner, 2006, p. 140) provides ability to “track the work people do with texts that is generally understood to put ‘policy’ into action and that produces what happens as ‘routine’” (p. 140). Elements used to support the process for descriptive mapping include,

- Documents (text) that comes into play in people’s work that operate in their routine work knowledge and activities;
- Specific language used in the documents (text) to focus language and discourse;
- Documents (text) linked with other text (e.g., behind-the-scene documents (text) – manuals, legislation);
- Wording in documents (text) that is changed in their move from one setting to next; and
- Sequences of text – talk – action with their resulting consequences. (Turner, 2008)
Getting to an account that explicates the social relations of the setting is what an institutional ethnographic account is about. This kind of analysis uses what informants know and what they are observed doing for the analytic purpose of identifying, tracing and describing the social relations that extend beyond the boundaries of any one informant’s experiences (or even of all informants’ experiences).

Translocal and discursively organized relations permeate informants’ understandings, talk and activities. An IE must therefore include research into those elements of social organization that connect the local setting and local experiences to sites outside the experiential setting.

Analysis in IE is directed to explication that builds back into the analytic account what the researcher discovers about the working of such translocal ruling practices. These are some of the important theoretical and ontological differences that distinguish analysis of data in IE. (Campbell & Gregor, 2008, p. 90)
CHAPTER SEVEN: PRESENTING DISCOVERY AND ANALYSIS

Of analysis: It’s never instances; its always processes and coordination. It’s all these little hooks. To make sense of it, you have to understand not just the speech of the moment, but what it’s hooked into. (DeVault & McCoy, 2006, p. 40)

In this chapter I return to the problematic of the study: How is knowledge work organized and relations shaped for the acquisition of new knowledge for the 18-month enhanced visit; an examination of those processes that invite or reject innovation, complement or inhibit the activities required for success, and sustain or alter adherence to entrenched practices (Kontos & Poland, 2009). This chapter shares discovery of what are the relations and processes, mediated in documents (text), which shape knowledge work for new ways of practice. It is an account of the “data collected on people conducting their lives” (Campbell & Gregor, 2008, p. 84) and the reality of that life as new knowledge is created during the transfer of knowledge for its application to clinical decision-making. The presentation of research results and analysis in this chapter is organized around the initial three research questions posed for study, with the two remaining questions on the role of ethnography and its insights more ably handled in Chapter Eight. Current analysis looks at experience as data in relation to language, knowledge work as it is institutionally coordinated, and in the coordination of those relations. Also for analysis are documents (text) as data. Guiding analysis are the following questions, informed by Campbell and Gregor (2008) but adapted for this study

- What are the external causes and effects of people’s activities?
- What does this tell us about how this setting or event happens as it does?
- What social relations are reflected in the everyday activities? And how do those social relations play a part in generalizing institutional processes of knowledge work?
- What is accomplished by the documents (text) that are being used?
**Experience as Data: How Knowledge Moves Into Practice / How FHTs are Organized**

*Knowledge work* required for implementation and uptake of the enhanced visit is tied into institutional relations of policy, governance, and local contexts that are rich with nuance, inequalities, power and authority processes, and creative solution making. To receive compensation for the visit, specific requirements must be met, new knowledge, concepts, and language learned, new norms of collaborative discussion, unaccustomed processes, and structures established, and, in some cases, unexpected partnerships and collaborative processes put into place. Both success and tension exist in the messiness and creativity that is *knowledge work* and its inherent innovation. Ruling relations that shape the work, guided in language and discourse, mediated by documents (text) are expressed in many ways.

Discussion and dialogue with education leaders as stakeholders and FHT and public health (PH) professionals as key informants produced rich discovery of those processes of language and relation that shapes *knowledge work*. The interview accounts, captured in Table 7 and Table 8 are representative of other quotes not used. Chosen for their accurate representation of what transpired as part of an individual or group interview account, they represent a “mutually reinforcing network of social understandings” (Geertz, 1983, p. 156) and shared meanings that “constitute a particular version of reality shared within the group” (Smart, 1998, p. 115).

Discovery is captured, identified by themes arising from the data that struck me as interesting, relevant, and important. They account for an appreciation of knowledge as social more than information alone, as needing to be relevant to create meaning, the importance of customized messaging with shared goals, objectives, and outcomes to make connection, knowledge in relation to a diversity of stakeholders (e.g., health professionals, office staff, parents), and the role of reflection as an influence. In addition *knowledge work* in the context of the application of
knowledge to clinical decision-making brought discovery for the role of social organization and relations for “spreading the word” and invoking collaborative effort, influences of power and authority processes, and for the discussion of leadership as an influence.

Following, is discussion related to initial research questions posed,

1. How is it that knowledge (child health evidence), information, resources, and tools for use at the 18-month EWBV are moved into this new way of practice; and
2. How are multidisciplinary family health teams organized to support the enhanced visit.

First, are discovery, interview accounts, and analysis for research question #1 (Table 7). The data informs understanding for the first step in knowledge work, the “creation of new knowledge during the transfer of knowledge”. Second, are discovery, interview accounts, and analysis for research question #2 (Table 8). Discovery here continues to inform knowledge work for the processes found in the “context of the application of knowledge to clinical decision making”. In discussion, stakeholders and key informants share insights on the application of knowledge in light of local nuances, inequalities, and creative problem-solving.
Table 7
Experience as Data
Research Question 1: How is it that knowledge (child health evidence), information, resources, and tools for use at the 18-month EWBV are moved into this new way of practice?

<table>
<thead>
<tr>
<th>Discovery with themes arising from the data.</th>
<th>Participant</th>
<th>Interview Account</th>
<th>Analysis</th>
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<tbody>
<tr>
<td>The acquisition of knowledge is social, more than information alone.</td>
<td>EL</td>
<td>… We need to have them understand a model of early childhood development that is tied to brain development … that has implications for the life of the organism … a mental model of “I wonder how this child’s brain is developing because it is going to have radical implications for the rest of this person’s life.”.</td>
<td>In analyzing for cause and effect one sees that although change is more likely where the evidence is seen as strong, it is not in itself sufficient (Dopson et al., 2002). Knowledge is to be considered as a process, one that needs to be accessible, understood, and valued by the practitioner or community of practice. At times it can be emotional, threatening, and misunderstood. Knowledge is part of an active process with multiple influences presenting pressures (e.g., EL: “we need always to be humble … this is a small part of what they do on a daily basis … and some paediatricians are doing this without support that FHTs get …”)</td>
</tr>
<tr>
<td>FON</td>
<td>… We had put that report out of how poor our kids are doing … oh my god it was an eye opener … we did it as quality improvement … well statistics are a great eye opener, there was a lot of information that surprised us, we had no idea … we have to improve. That was the bottom line here. We have to do better and that better has to start in the beginning … and that information … really got all the doctors on-board. That was a good opening for all of them.</td>
<td></td>
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<tr>
<td>FPN</td>
<td>… The docs didn’t think about that, it was the old wait and see … That it’s all right, old Johnny’s slow, and he has got sisters and poo poo. It was really poo poed. Now we are making them talk about it, and do it, and the tick sheet on the RBR was a little invasive at first because it has all kinds of social things that they are not used to having to ask</td>
<td></td>
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<tr>
<td>PHM</td>
<td>… I think we did start to move thinking forward, and the understanding about the enhanced well-baby visit, and the importance of it, and</td>
<td></td>
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In appreciating the social relations and the
<table>
<thead>
<tr>
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<th>Participant</th>
<th>Interview Account</th>
<th>Analysis</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>FON</td>
<td>eventually we were able to get a physician/paediatrician to work on our 18-month committee … and she has been, well you know what they say, the rolling stone gathers no moss, things really seem to be gaining much greater momentum … the earlier work was a part of it.</td>
<td>What are the external causes and effects of people’s activities? What does this tell us about how this setting or event happens as it does? What social relations are reflected in the everyday activities? And how do those social relations play a part in generalizing institutional processes of knowledge work? What is accomplished by the documents (text) that are being used?</td>
</tr>
<tr>
<td></td>
<td>FPN</td>
<td>… We go to the conferences, the retreat was very helpful, we meet with the office staff for “tips and tricks,” the physician advisor is very strong on this and she will send notes out to the docs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EL</td>
<td>… It is learning, we are all learning. I am better about it now. I was uncomfortable; the docs were uncomfortable about it at first. They didn’t know how to do it, but I see change in it. First some of the docs, they would say, you come and do it … so they would actually stay in with me … I think it is a learning curve, that everybody has had to do … the residents are much better about this than we are. But the docs have had that level of speaking about all of it.</td>
<td>generalizing effect of those relations that are at play for knowledge work one sees opportunity for the end users of knowledge actively and reactively gaining knowledge, innovation happening, when there is a critical mass of people who adopted the new ways, as if a ‘tipping point’ that enabled processes to improve (e.g., it is learning, we are all learning).</td>
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<td></td>
<td>EL</td>
<td>So I think when you have powerful evidence and can present it in an accessible way … that you are not overwhelming them with the evidence about early child development, about language acquisition, about reading to kids… this is what motivates them about the evidence … don’t tell me about the esoteric stuff that I can’t do anything about … tell me something that I can do with my patients now … [and we say] well here we have got these tools for you to use, and it is a conversation starter, and if you talk about literacy, reading and some of the programs that communities are using, then that is also a motivator. … This is a win-win</td>
<td>Documents (text) make possible the same set of words, numbers or images (D. Smith, 2001, p. 160) for everyone to see. Be it a report, notes, tools for use at the visit [RBR; NDDS; fee code] all set the language for knowledge work. The new language/new knowledge needs to be understood and adapted by all so as to create new ways of speaking and an introduction of discourse that is different than one shared previously (e.g., . For the 18-month EWBV it is language of epigenetics, developmental trajectories, brain development, skill acquisition for the discourse of child development and well-being, population health and school readiness). The language though needs to be accessible, meaningful (e.g., don’t tell me about the esoteric stuff that I can’t do anything about … tell me something I can do</td>
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<td></td>
<td>EL</td>
<td>I have no idea eighteen months could do all of this stuff ‘… physicians</td>
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<td>Discovery with themes arising from the data</td>
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<td></td>
<td>PH</td>
<td>hearing parents talk about how their child develops, motivates them ... You need to continually booster physicians ... we have a process in place, we have a second and a third presentation ...</td>
<td>What are the external causes and effects of people’s activities? What does this tell us about how this setting or event happens as it does? What social relations are reflected in the everyday activities? And how do those social relations play a part in generalizing institutional processes of knowledge work? What is accomplished by the documents (text) that are being used?</td>
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<td></td>
<td>FP</td>
<td>… Like when I am using the RBR in the office, I plod through the questions, partly it’s time, partly it’s so that you are hitting the higher payoff or at least perception of a higher payoff, and some are comfort things … I don’t ask enough about abuse and things like that you know … we mention safety but we don’t grill them about it …</td>
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<td></td>
<td>EL</td>
<td>… One of the things I have learned over this period of time is that there are different approaches that docs take to this, and there are different relationships in primary care practices between docs and nurses. There are the docs who want, okay tell me what I have to do, give me the flow chart and I can do a well-baby visit in three minutes, so there is that, you know there is that checklist mentality, you know, been there, done that, off you go … in some ways we have to find the way, do you know what it is, it is finding the way to encourage more reflection on their part, because that is what the other group of docs … talking about the whole office is engaged in the enhanced 18 month well-baby visit … so there isn’t any three-minute visit</td>
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<td>FON/BA</td>
<td>… They said they are not “doing all that” just to make our stats look good. It makes more work for them … so I just have to niggle more. It makes me sad …</td>
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<td></td>
<td>FP</td>
<td>… External pressure I suppose … in talking with our partners it was just a</td>
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EL: Education Leadership; FON: Family Outreach Nurse; HA: Health Administrator; PHN: Public Health Nurse; PHM: Public Health Manager; FPN: Family Practice Nurse; FP: Family Physician; NP: Nurse Practitioner; E: Epidemiologist; BA: Business Administrator (Data)
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<th>Discovery with themes arising from the data.</th>
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<th>Interview Account</th>
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<td></td>
<td>FON</td>
<td>good idea, we were pressured and encouraged … and then the government stuff came along, “oh here is a fee code to do this because we think it is important” … you kind of pick and choose which buttons you are going to hit, and you don’t necessarily hit all the buttons … you try to hit the highest payoff ones to some extent … &lt;br&gt;… All of this has made us so much more aware and quicker to address things, and now we are noticing things much sooner than we really would have … and better … and we are asking … and we are knowing now … and we are learning to address things quicker. To pick up things, and to talk with parents more about it … I was uncomfortable, the docs. were uncomfortable about it at first. They didn’t know how to do it, but I see such a change in it. First some of the docs. they would say, you come and do it … so they would actually stay in with me, and it is just because I know these families …</td>
<td>What are the external causes and effects of people’s activities? What does this tell us about how this setting or event happens as it does? What social relations are reflected in the everyday activities? And how do those social relations play a part in generalizing institutional processes of knowledge work? What is accomplished by the documents (text) that are being used?</td>
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<td>Knowledge must be relevant to create meaning</td>
<td>EL</td>
<td>… In the training of physicians … in family medicine, its that the majority of kids are going to be okay, that you don’t want to alarm a family … So well-baby visit, even just by its name implies, oh well, we are just checking to make sure that they are well, … the emphasis has been on immunization… only rarely that something goes off track …that mentality has defined the road to them, … so we need to say there is new evidence now since you were in medical school, that is informing us, that health is developing, that you are building health here, that the weighing, measuring and immunizing is capturing some parameters, but there is a whole other system going on. &lt;br&gt;… Physicians have commented on how powerful the epigenetic story is for them, thinking about this [well-baby care] in a different light. … so the</td>
<td>In understanding the need to have relevancy for the acquisition of new knowledge one can see the causes and effects; clinical experience past and/or present is a motivator or deterrent to ‘knowledge work’ (e.g., professional training, need identified in practice). Acknowledging experience involves understanding that evidence may or may not be more accessible to different professions in different ways. Those relations that allow disciplines to work along side each other in non-threatening ways is supportive of the new knowledge and knowledge work. Surprisingly knowledge does</td>
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<td>Discovery with themes arising from the data.</td>
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<td>epigenetic, the long term, the building of health that is being done … this is a paradigm shift. … They don’t necessarily get a lot of training on typical child development. They don’t get a lot of training on that … development issues kind of scare them. You know even pediatricians tell us over and over again; behaviour, and development were the worst parts of preparing for their exam … so they are not as comfortable in their practice, with these kinds of things, as they are for skin rashes, and the more obvious the “I can see this. I can measure this.” … I think people sometimes don’t ask the questions because they don’t know what to do with the response … difficult health information, breaking bad news … these are very sensitive domains that are challenging … there needs to be guidance … you may not get straight answers. You many encounter resistance. I think people are people … a bit afraid and intimidated by this domain. [The brain] is more complicated than other organs. There are a lot of unknowns about how it actually functions and develops … you have to learn quite a bit of hypothesis and theories that aren’t necessarily proven, “but this is how we think it happens” … the complexity of the human brain and some of these concepts like neuroplasticity and epigenetics, they are not simple … sometimes people want to think about simpler things. But to have meaning and motivation [for the visit] they do need to keep thinking, “what is happening in terms of brain development”. What is happening in terms of language development, behaviour, emotional [development], attachment?</td>
<td>What are the external causes and effects of people’s activities? What does this tell us about how this setting or event happens as it does? What social relations are reflected in the everyday activities? And how do those social relations play a part in generalizing institutional processes of knowledge work? What is accomplished by the documents (text) that are being used? not always find its way to practice after initial qualifications are granted, ongoing education is not always a standard of practice or deemed as relevant.</td>
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<td>What are the external causes and effects of people's activities? What does this tell us about how this setting or event happens as it does? What social relations are reflected in the everyday activities? And how do those social relations play a part in generalizing institutional processes of knowledge work? What is accomplished by the documents (text) that are being used?</td>
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<td>Customized messaging with shared goals, objective and outcomes</td>
<td>FPN</td>
<td>What we did, we put up the stats of what we were doing … FPN#1 is on board. FPN#2 is on board, but not everybody was on board. So it was just a good way of just summarizing where are we? Where we are going, and then we were able to use our stats … that was a good tool …</td>
<td>Again, with cause that allows for shared goals, objectives and outcomes for innovation there is effect of a greater likelihood for creating success through a ‘spreading the word’ approach. Note again the power of language found in documents (text) for evoking change (e.g., we presented to the board; use of EMR system, check the charts, package preparation)</td>
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<td>PHM/PHN</td>
<td>… We have also presented to the board of the family health team, who are comprised of physicians … so you know sort of closing the feedback loop, you know this is the number of children we are identifying, this is what we are finding, this is what parents are saying about the service … we looked into using the electronic medical record (EMR) system … we tried, there is a lot we tried.</td>
<td>Common vision, set in relationship, permits continued evaluation and asking of ‘did this work’. With common vision there is also opportunity for assistance across the team with help in overcoming obstacles.</td>
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<td>FP</td>
<td>…. Like it has evolved and it is now so much better.</td>
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<td>BA/FON</td>
<td>… Each month we do a query, check referrals … we check the charts and go back to discuss with the docs making sure that they have signed off … the office staff do a monthly roster of the 18-month kids … I prepare the packages and check in with the office and then the nurses do the NDDS and the RBR is on the EMR. We go back and check the referrals and check in with the docs to see how it has gone.</td>
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<td>Knowledge in relation to a diversity of stakeholders</td>
<td>EL</td>
<td>[Parents] they love this; they love getting the permission to talk about their child’s development and the concerns, in this kind of way. … I have only heard one physician talk about the joy and pleasure of</td>
<td>Social relations set across disciplines and sectors as well as with patients are motivators for innovation or not (e.g., Our parents love it; I have seen parents block it). Patient preference</td>
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<td>What are the external causes and effects of people's activities? What does this tell us about how this setting or event happens as it does? What social relations are reflected in the everyday activities? And how do those social relations play a part in generalizing institutional processes of knowledge work? What is accomplished by the documents (text) that are being used?</td>
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<td>FP</td>
<td>seeing the parents’ delight of what the child is able to do … I would love for the physician’s engagement to be around, you know observe people … look how much, when you have this conversation, parents get a chance to talk about how wonderful their kids are, rather than, do you know what I mean? … I would love that, because it in itself brings about a different dialogue about what is right with my child and how they are thriving, compared to what is wrong with them and what do I have to do … … Our parents love it. We spend longer time with them and we have a conversation. … I have seen parents who block it … they get defensive if there are any issues … they don’t want to send their kid to speech therapy …</td>
<td>and experience past and/or present, and shared with their practitioner, can be a motivator or deterrent to knowledge work.</td>
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<td></td>
<td>FON</td>
<td></td>
<td>The patient is a consumer of sorts and influential in the ease with which practitioners engage in or are motivated to continue with innovative practice.</td>
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<td>FON/NP/FPN</td>
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<td>Relationship with self, reflection in groups is motivation. As the interviews progressed the importance and power of reflection for the knowledge work being undertaken was an additional discovery. In somewhat unguarded moments, some, not all participants, left discussion to muse on their own discoveries and used such reflection as motivation for new efforts, new strategies to enable change. Critical reflection for aspects of the culture and context of practice were shared. Such reflections for the most part created elements of excitement both for the individual and for others in conversation. All provided</td>
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<td>Discovery with themes arising from the data.</td>
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<td>FON</td>
<td>really good idea … something we can put on our desks, each desk … what would be really good if we had a mouse pad, mouse pads with some of those sites … even just a little sheet of paper to hand out … the other thing … we have just installed an overhead TV in our waiting room … we could use that for messages … I just brought back this information … I am thinking now of all the ways that I can use it … that is brilliant … I could adapt it for us …</td>
<td>What are the external causes and effects of people’s activities? What does this tell us about how this setting or event happens as it does? What social relations are reflected in the everyday activities? And how do those social relations play a part in generalizing institutional processes of knowledge work? What is accomplished by the documents (text) that are being used?</td>
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<td>FPN/FON</td>
<td>… And maybe that is why the HU isn’t active in the 18-month … like we were saying, it hasn’t taken off yet … maybe that is what it is Nancy. Maybe they don’t, they don’t have a lead. Maybe that is what it is … Maybe that is why.</td>
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<td></td>
<td>EL</td>
<td>…. In some way we have to find the way to encourage more reflection on their part … The other thing I would like to do, now that we have done the conversations about the child … In my mind, I want to do the conversations with the parents … like birth control … with depression … with socioeconomic stuff … with violence in the home … this is just me but I want to get more into the mum. I do … both parents because when you think about it …</td>
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<td>… We do not ask enough about relational health, I hope that once we get people starting to ask about development and encouraging parents to be more engaged in their child’s development, rather than asking “should I put salt on the carrots” we can get them excited about “what my baby just did” to think … from an attachment perspective, from an anxiety perspective … For physicians to wonder … when the baby gets the needle. What opportunity for additional aspects of innovation to occur. Note the infusion of language of think/thought that is infused in the discovery linked with the theme of role of reflection. In using such language reflection is demonstrated as a process of active and engaged thinking that aids deep learning and supports independent thought (Hinett, 2002).</td>
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<td>Where social relations do not exist innovation is met with resistance or slow (e.g., they don’t have a lead, the HU is not active with the18-month).</td>
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<td>Discovery with themes arising from the data.</td>
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<td>happens? Does the mom cuddle in or just what happens? … Them saying, all my patients do that, and then the next time when they looked oh my god, once I started looking, it is not happening … So being curious about the child, being focused on the child’s experience …</td>
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**Analysis**

What are the external causes and effects of people’s activities? What does this tell us about how this setting or event happens as it does? What social relations are reflected in the everyday activities? And how do those social relations play a part in generalizing institutional processes of *knowledge work*? What is accomplished by the documents (text) that are being used?
Table 8
Experience as Data

Research Question 2: How are multidisciplinary family health teams organized to support the enhanced visit?

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<th>Discovery</th>
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<th>Interview account</th>
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<tr>
<td>Social Organization</td>
<td>PHM/PHN/E</td>
<td>… We worked on the PowerPoint together and there were slides in there right back to the Expert Panel. Here is where we are, here is how you know things have changed over time, here is where you can make a difference, and here is why these early years are so critical, here is the fee code, here are the tools that are recommended for the visit, here is what the visit entails, educating them about the resources in the community … that is huge. I think sharing among the family health teams has really evolved over time too, and that is helping to move along the importance of the visit</td>
<td>What are the external causes and effects of people’s activities? What does this tell us about how this setting or event happens as it does? What social relations are reflected in the everyday activities? And how do those social relations play a part in generalizing institutional processes of knowledge work? What is accomplished by the documents (text) that are being used?</td>
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<td>1. Receptive context supporting good relationships, collaborative effort between and within groups; and 2. Supportive culture with clear goals for the change; access to information and opportunities for sharing information.</td>
<td>FON</td>
<td>The visit promotes literacy … five books in the home, and their literacy level, okay I can’t remember the percentage, but five books in a home means their literacy level goes up. The visit has made for some great partnerships … We have the book lady from the “** **” committee … It has made such a beautiful expansion. We are collecting books … my backseat is full of books … we have a box of books in the reception area – “bring a book or take a book” we say. They are now going to start dispensing them at the local food bank.</td>
<td>In understanding cause and effect, social relations and the role of documents (text) for the context of the application of knowledge one appreciates that social organization is complex, multi-dimensional and far-reaching in the roles and responsibilities that partners and others play for work processes to occur. An ability to define culture in terms of prevailing values and beliefs, level of concern for the issue, if the knowledge or innovation can be applied to a large patient population, and relationship with others provides motivation for uptake of innovative practice (Gabbay &amp; LeMay, 2004).</td>
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<td>HA</td>
<td>… We are a publicly funded agency. Part of our mission is our partnership training ability. The HU is offering something that is</td>
<td>Medical behaviour is shaped as much by experience and peer comparison as by scientific evidence shared, Dopson et al., (2002). Interview accounts suggest that local experiences are shaped often haphazardly, sometimes from the local needs of the community but often from the experience of past relationship. With a favourable history between professions and across groups those relationships provide traction with positive results for change. Access to opportunities to share information and ideas within the local</td>
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<tr>
<td>PHN/E</td>
<td>seen as a monstrous benefit to a patient … so it wasn’t a big leap for them to buy into the notion of what is right for the patient, but the partnership with the HU was probably the bigger obstacle … so in the back of my head was let me help you understand how this partnership can benefit the patient … it is great for the agency and by the way I used to work at a health unit … I can tell you they are pretty harmless … so maybe that was my whole you know coming at him (lead FP) with lots of you know just say yes … yeah and he is a guy to take a chance</td>
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<td>FPN</td>
<td>… Our role is more to support the data collection piece, and really sharing resources, and kind of keeping them [family health team] in the loop you know, sending information about anything new that came along … sort of being a resource and a support. Letting parents know about the visit …</td>
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<td>FP</td>
<td>Many, many [offices] are really good systems … like there is really good team work … everyone has to have their role … we are all committed to quality and we know that there is good reason that this is being implemented and that this is based on good evidence.</td>
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<td>… It works quite well … referrals for, you know, tots and paediatric stuff is clunky … You know, we have sort of weekly lectures at the hospital, on just behavioural pointers and things like that for toddlers, and one of our slides at the end had all these different agencies that can help you out, right, which is wonderful, except there should be like one access point for that stuff, right. If you identify, okay there is trouble with behaviour context are the social relations that support and sustain innovation. One can surmise that if relationships have been weak in the past, dialogue for change may be at a disadvantage. Analysis would also suggest that if the collaborative efforts are not streamlined the processes may impede rather than facilitate innovation. Where professional, roles and responsibilities and boundaries have been clearly defined and acknowledged, appropriate and transparent decision processes available, power and authority processes acknowledged, receptiveness to change identified, appropriate resources (e.g., human, financial) available, alignment with key practice and patient issues identified, a synergy is created that promotes innovation.</td>
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Where resistance to innovation is identified, a review of those key processing interchanges (DeVault & McCoy, 2006; Pence (1996), is helpful in identifying where efforts to break down barriers must be initiated. Such efforts need to be accompanied by a strong sharing of the vision, goals, objectives, and outcomes for the innovation that is proposed.
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<tr>
<td>FON</td>
<td>particularly, because that is the most common thing to cause troubles, as opposed to something concrete, like okay you broke your leg and you need to see an orthopedic surgeon, or you know you have got troubles or for the most folks in the pediatric primary care issues tend to be behavioural now-a-days, you know, so it is nice to have one access point, you know as opposed to, well you can send them to the Centre, or you can send them to the Healthy Babies, the health unit, or you can send them to some you know pre-school teacher sort of thing, you know. So there are about three or four access points. It is like, well I don’t know, which one do I pick, and where do I send them. This is the issue and then they can kind of triage it and direct it to where it is supposed to go.</td>
<td>What are the external causes and effects of people’s activities? What does this tell us about how this setting or event happens as it does? What social relations are reflected in the everyday activities? And how do those social relations play a part in generalizing institutional processes of knowledge work? What is accomplished by the documents (text) that are being used?</td>
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<td>PHM/PHN</td>
<td>…It is all about building relationship … showing them [family health team] how they are improving … I niggle … you may have missed this or that …</td>
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<td>… We talk about what the components are in the 18-month EWBV … you know we think that the physicians understand it, but inevitably when we go, there are questions and they learn new things, like the Nipissing has changed. I think we told them, but you know things get lost over time, and new physicians come along, and things like that … so I think what we are hoping is that we will get a system in place where we can gather data from all of the family health teams about who they are seeing, what the visit entails, how many kids are identified, how many kids are referred, are they actually doing the visit in the way that it was intended to be done … and so now we are working on a survey</td>
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<tr>
<td>FON</td>
<td>of the family health teams to sort of find out what are they doing, and would they be interested in sort of a county sort of surveillance.</td>
<td>What are the external causes and effects of people’s activities? What does this tell us about how this setting or event happens as it does? What social relations are reflected in the everyday activities? And how do those social relations play a part in generalizing institutional processes of knowledge work? What is accomplished by the documents (text) that are being used?</td>
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<td>PHM</td>
<td>… I have learned so much from this whole visit, and I am continuously learning with every single client that I have. Every family is different on what their values and beliefs and what they do, and so I am learning all the time, but it is incredible, and the more research that is coming out to validate how important this program is, and the feedback that I get from the parents, it is really validating for myself as a nurse to know that I am making a difference for those parents.</td>
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<tr>
<td>FON</td>
<td>… What happened was the family health teams were coming into being and we played a role in actually facilitating the application for one of those teams. … We sat around a table with the lead physician and a consultant working with them, there was money available and they didn’t know what to do with it, and so we said, well we would be willing to work with you on an early child development initiative.</td>
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</tr>
<tr>
<td>NP</td>
<td>So isn’t that good news, and it is one step further, and moved into real partnership with the literacy group in town … more book collecting, and more books in the offices, and it is such good stuff … we have just made it really good. We are going to make a difference.</td>
<td>Power and authority processes can invite or reject innovation, facilitate or burden team/working together processes for change.</td>
<td></td>
</tr>
<tr>
<td>NP</td>
<td>… I have a huge issue … the NPs do 18 month visits … the doctors are being paid for the work that the nurses are doing … this is not fair … so many nurses are doing the visit … Why does</td>
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<tr>
<td>BA: (Data)</td>
<td>Power and authority processes can invite or reject innovation, facilitate or burden team/working together processes for change.</td>
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<tr>
<td>Discovery</td>
<td>Participant</td>
<td>Interview account</td>
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<td></td>
<td>FON</td>
<td>the government keep bonusing doctors for stuff the doctors shouldn’t be doing … <strong>Or don’t do</strong> … No, they don’t need to do this. This is nursing work. We can all do this really well … And we do … Why are we lining pockets. This is why the health care system is broke … Yea. … Because we keep bonusing doctors for nursing work, and I could go on … Sorry … It is not necessary … Nurses will do this work. This is screening of healthy babies … don’t code them … its free money for something you did. I mean that was in the Drummond report, right. Do you remember reading that part in the Drummond report? Why is Ontario paying doctors for the nurses who gave the immunizations? Why are we just having the nurses give them? … I don’t expect a bonus code to do it. Right. I expect that is part of what I have to do. I don’t need another $5.00, $10.00, $15.00. Just pay me a decent salary, and let me do my job. … I don’t want to start getting into that nickel and diming like the way that they do. We have said for years, why do they nickel and dime the family physicians. Why don’t they just pay them properly, and quit all this fighting with the OMA for every little service, whether it is … a basket … Why don’t they just pay them the decent salary they deserve, and they will keep doctors in family medicine. Pay them well, and be done with it. Why do they play such games with them right, and then the OMA has to fight, well if you want us to do the special visits, you have to pay us more. You have to pay us extra. We are just saying, we don’t want to get into that fight.</td>
<td>Power relations are expressed in different ways, in specialized knowledge, in better pay for performance, management and worker relations, and the continuance of long held traditions across sectors and disciplines.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I have one site that says, … “we are not doing all of that” just to give you data … it makes more work for me. … Not to worry I</td>
<td></td>
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<tr>
<td>Discovery</td>
<td>Participant</td>
<td>Interview account</td>
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<tr>
<td></td>
<td></td>
<td>will just keep having conversations ... do it in a fun way, stay on their tails ... be gentle and persuasive.</td>
<td>What are the external causes and effects of people’s activities? What does this tell us about how this setting or event happens as it does? What social relations are reflected in the everyday activities? And how do those social relations play a part in generalizing institutional processes of knowledge work? What is accomplished by the documents (text) that are being used?</td>
</tr>
<tr>
<td>FP</td>
<td></td>
<td>... Nurses certainly are more than capable of running a program ... So we initially we had a nurse practitioner running the tots program when we started, and like it was fine, but you know, we didn’t have any troubles with that program, but you kind of get this feeling that they should be doing more autonomous kind of work ... and part of our hope with the NP stuff was that rather than doing program related kind of things, they could actually see a bunch of the volume stuff that kind of bogs us down, right, and that never turned out successfully ... we tried for years and it just didn’t work. ... So we have given up ... we do have an NP who works part time for us, who like sees all kinds of issues, and is incredibly efficient, but we have had a bunch of them, they come, and they are gone, and it never really kind of clicked ... Well the nurse stuff has just clicked. ... The nurse has ample qualifications to do that ... she can’t do the physical exam part ... the criteria part... which is fine. We like that, because that gives us the chance to have a little “last kick of the can” and tie up the loose ends, and reinforce things and stuff. So that actually works out well for us, because it keeps our hand in and helps us reinforce whatever the nurse said and did ...</td>
<td></td>
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<tr>
<td>HA</td>
<td></td>
<td>... So we probably have after five years of involving you know, the NP, outside RNs back to an internal NP for a bit, an RN and then back to our own RN, the perfect model.</td>
<td>Our FP likes process, He likes evaluations, He likes statistics ...</td>
</tr>
</tbody>
</table>

ED: Education Leadership; FON: Family Outreach Nurse; HA: Health Administrator; PHN: Public Health Nurse; PHM: Public Health Manager; FPN: Family Practice Nurse; FP: Family Physician; NP: Nurse Practitioner; E: Epidemiologist; BA: Business Administrator (Data)
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<tr>
<th>Discovery</th>
<th>Interview account</th>
<th>Analysis</th>
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<tbody>
<tr>
<td>Leadership</td>
<td>So basically there was no way you could say no, because there wasn’t really anything that was substantial to object to.</td>
<td>The role of leadership is a complexity of relations, both visible and those not seen. Where leadership is supported, its effects can transform. Where leadership is ambivalent or hostile it can stop innovation in its track. Clear leadership at both the education leadership, organizational level, and in local practice has been identified in support of the 18-month EWBV.</td>
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<tr>
<td>PHM</td>
<td>… So they had a physician lead, a wonderful champion for this initiative … we worked with him on a “research day” that we coordinate for the area … we have promoted the 18-month model all over … he was an amazing champion.</td>
<td>Leadership can take many forms, that of expert and/or one who is a peer. The expert is often one in higher authority, able to respond to academic debate and explain the evidence (Dopson et. al., 2002). Peer leaders are often found within the practice setting, have applied the innovation, and who can provide colleagues with confidence and/or support (p. 44). Each as a leader has influence, to be positive, to be hostile, maybe to share an enthusiasm that goes too far, or come with an ambivalent or hidden agenda, as well, some are cynical about what they are doing but do it successfully nonetheless (p. 44).</td>
</tr>
<tr>
<td>FP</td>
<td>… And then we have the nurse who leads the program … she is the crown jewel. Oh my god. There is nobody better to do this job in this country than that woman.</td>
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<tr>
<td>FON</td>
<td>… If it wasn’t for her leadership … Can you get that baby? Can you call that mom and get that baby back? Can you make sure this mom gets this package? … Like we all need that …</td>
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<tr>
<td>FPN</td>
<td>… And sometimes we don’t tick off the Nipissing correctly … there is somebody that really has to help you through with things … there has to be someone in charge and overseeing …. Pull the secretary from this practice [exclamation of trouble] …. Like this is such a fine tuned show … just ticking away more beautifully than any clinic I have ever seen.</td>
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</tr>
<tr>
<td>NP</td>
<td>… and we have offices that just say “no” or others where you need to follow-up with each visit to make sure that everything has been signed off … you can’t sign for the doctor so you just have to keep going back.</td>
<td></td>
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<tr>
<td>BA (data)</td>
<td>We check the referrals every month … and where there are no</td>
<td>Leaders as described above, could be identified as knowledge brokers. The role of knowledge broker is an important concept for consideration. In their roles, of education leadership and/or</td>
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### Discovery

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<th>Participant</th>
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| **HA**      | results we go back … trying to understand what was input to the EMR or what was just skipped. If we want to meet targets and change the way it has been we just have to keep doing it …  
… we had a manual partially developed, we formed the committee, and the FP agreed to serve on it, and he would have read all the materials thoroughly … at that time, we had 60 physicians and probably were birthing 200 babies a year, and so there was 200 eligible, or actual candidates for the 18 month screening, and like everything in the FHT, we don’t have a physician adopter, it is not going to go anywhere.  
… I have only seen it as an enhanced visit, that is the way I was taught, even throughout school … it was the enhanced visit … I was trained by an incredible nurse and that is who I strive to be because of the way she, the visits she did were so incredible … she was just so very compassionate and empathetic … she was particular with her wording … we are here to educate and provide support in whatever needs or questions that there might be ….  
… If she was not there providing the packages. If someone wasn’t reminding us. If someone was not showing us our improvement … she presents the visit … but then she follows up.  
… That is what people need. Even if you are in the middle of a busy day and we act like we are resisting or rude … just because you are going full tilt. We need it. We need somebody | **Analysis** | What are the external causes and effects of people’s activities? What does this tell us about how this setting or event happens as it does?  
What social relations are reflected in the everyday activities? And how do those social relations play a part in generalizing institutional processes of knowledge work? What is accomplished by the documents (text) that are being used?  
peer champion, each plays a role in accelerating the transformation of knowledge into action. The role includes work in connecting people to share and exchange knowledge; understanding both ‘worlds’ to accelerate knowledge into use; working on overcoming barriers; communicating with stakeholders/users; and helping in the connection and exchanging knowledge. (Canadian Health Services Research Foundation, 1999; Straus et al., 2009)  
Leaders play an important role in coaching and supervision helping to ensure that there is fidelity to innovative practice. They problem solve and identify mechanisms for program sustainability (e.g., we are here to educate and provide support in whatever needs or questions that there might be; she is careful with her wording). |
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<tr>
<td>FON</td>
<td>reminding us all the time … There is a new template. There is a 2011 version. There are packages. … We are on the QI team too … That gave me extra oomph on this FHT to really make this work, and really, really support us, otherwise you are just kind of another program you are trying to run by yourself, but this has given a lot of support, and it goes to the board. So the board knows we are doing it.</td>
<td>What are the external causes and effects of people’s activities? What does this tell us about how this setting or event happens as it does? What social relations are reflected in the everyday activities? And how do those social relations play a part in generalizing institutional processes of knowledge work? What is accomplished by the documents (text) that are being used?</td>
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Documents (Text) as Data: How Documents Organize, Mediate, and Guide Clinical Practice

Texts are part of the taken for granted routine work that is done in creating a new program, through which the program is developed and, these texts provide the coordinative basis to direct others in the way that they go about doing their work (such as, approving or rejecting the program as expressed in documentary form). In general, texts are taken to be a part of the phenomenon rather than simply being the means of conveying information about the phenomenon. (Muller, 1989, p. 274)

Texts are read and interpreted across time and space. Different readers will have different interpretations of any given text, but the text remains constant. The constancy of texts provides for standardization of people’s actions that are integral to institutions. (Quinlan, 2009, p. 629)

The following section provides discovery and analysis relevant to question 3 of research study,

3. How do documents for evidence-informed practice organize, mediate, and guide clinical practice for implementation of the visit?

Documents (Text) For Knowledge Work

Following the approach of IE, that understands documents (text) as constituents of institutionalized social relation (D. Smith, 2005, 2006), this section describes documents (text) for knowledge work as data. Seen in their role to display work processes, make apparent the people who are involved, and how they are working (Campbell & Gregor, 2008, p. 99), documents (text) that inform text-mediated knowledge and work processes for primary health care (Appendix H) and documents (text) that inform text-mediated knowledge work processes for primary care implementation and delivery of the 18-month EWBV (Appendix I) are shared. Facsimiles of some of the documents (text) used for implementation and delivery of the 18-month EWBV are included (Appendix J). Also included are broad, nonidentifying descriptions of documents (text) gathered during interview discussion that are used in local practice by health professionals and parents alike for enhanced visit implementation.
The documents (text) of 18-month EWBV policy and governance. The report of the Expert Panel on the 18 Month Well Baby Visit (OCHN & OCFP, 2005) a seminal document for the enhanced visit contained reference to an number of other key documents (text) for use at the enhanced visit. These include, in part, standardized tools for use at the visit, reference to a clinical practice guideline of best practice for the visit, mention of the Physician Services Agreement (MOHLTC, 2013) that provides physician remuneration incentive for the visit, community referral pathways, and an algorithm for the flow of the visit. Others documents (text), such as the Best Start Implementation and Planning Guidelines and the accompanying document (text) Building on the Foundation – Moving Forward: Addendum to the Implementation Planning Guidelines for Best Start Networks – System Integration are important as context to the Expert Panel Report on the 18-month visit but will not receive additional treatment here, beyond their description included in Appendix H.

The Expert Panel Report, Getting it right at 18 Months ... Making it Right for a Lifetime (OCHN & OCFP, 2005) represents an expanded scope of practice and transformative change for the delivery of well-baby care. Summarizing the science and research that provides evidence on the importance of the early years the Expert Panel’s report shares,

Our children are our future. The skills they need to achieve their full potential in life begin to form in the first months and years of life. Brain development in the first three years will affect learning, behaviour and health throughout life. Healthy child development is one of the key determinants of health. (OCHN & OCFP, 2005, p. i)

Continuing, it describes desired outcomes for the 18-month EWBV as

- The creation of a culture focused on enhancing the developmental health and well-being of children. Where every child in Ontario receives an enhanced 18 month well baby visit, which would include:
- A developmental review and evaluation by parents and primary care providers, using the Nipissing District Developmental Screen (NDDS) and the Rourke Baby Record;
• A discussion between parents and primary care providers about healthy child development and behaviour;
• Information about parenting and other community programs that promote healthy child development and early learning;
• When needed, timely referrals to specialized services; and
• A measurement and evaluation component that tells us how our children are doing and that our programs are working. (OCHN & OCFP, 2005, p. i)

The report further sets the agenda for transformative change in the delivery of care at 18 months, with subsequent effect on people’s activities, by outlining a “Plan To Action” (OCHN/OCFP, 2005, p. ii) agenda for government and a “Summary Of Strategies To Achieve The Outcome” (p. iii). Such strategies have far-reaching impact. In its plan to set a movement that would bring a strengthened, enhanced system of early identification and intervention for young children, structural change to well-baby care as it is delivered at the 18-month visit, including a new remuneration scheme for physicians, provision of information, education, and tools to support primary care providers in their collaborative discussion with parents and providers on the importance of the early years, building of effective partnerships among parents, primary care providers and community services and programs, develop outcome measures for the visit and data collection systems to aid in the description of the developmental health status of 18-month-old children, the document (text) of the panel’s report reflects the bringing of new evidence to clinical practice.

Important to the discussion of this influential document (text) is awareness of the groundbreaking and innovative additional documents (text) that were included and developed purposed from its discussion. It is these documents (text) that are the report’s legacy in their bringing of evidence and best practice to clinical care. Documents (text) include the Rourke
Baby Record; Guide IV (Ontario)\textsuperscript{19}, the NDDS,\textsuperscript{20} the clinical practice guideline\textsuperscript{21} for primary care providers for an enhanced 18-month well-baby visit, the Early Child Development and Parenting Resource System,\textsuperscript{22} 18-month flow sheet,\textsuperscript{23} and incentives to compensate/remunerate primary care providers for providing the 18-month EWBV.\textsuperscript{24}

The documents (text) of 18-month EWBV education leadership. Documents created at this level by the centre that provided leadership and education to primary care practices for implementation of the visit serve as companion documents (text) to the documents (text) of policy and governance described above. Documents of 18-month EWBV leadership include the

\textsuperscript{19} \url{www.rourkebabyrecord.ca} An evidence-based guide for health professionals in the delivery of the 18-month EWBV.
\textsuperscript{20} \url{www.ndds.ca} A parent-completed developmental milestone checklist designed to assist parents, health care, and child care professionals with a convenient and easy-to-use method of recording the developmental progress of infants and children within certain age groupings.
\textsuperscript{21} Funding provided to the Ontario College of Family Physicians in 2005 enabled work with the Guidelines Advisory Committee (GAC), a joint initiative of the Ministry of Health and Long-Term Care (MOHLTC) and the Ontario Medical Association that provided an opportunity for development of a clinical practice guideline for primary care providers for an enhanced 18-month well-baby visit. It was the mandate of the GAC at that time to promote evidence-based health care and the consistent use of best available clinical practice guidelines. Identified at the time was that when developing a guideline, the GAC conducts an in-depth, rigorous review of existing clinical practice and current evidence and makes recommendations about the best approach (OCHN & OCFP, 2005, p. 15).
\textsuperscript{22} Designed to provide information regarding services available in communities, the templates illustrate the organization of local early child development and parenting resources across a community, region or district so that young children are offered the opportunity for healthy development and the best start in life. The Ontario template is located on the back of Guide IV of the RBR 2011 (Ontario) and provides health care professionals with a reminder of the services available in their communities and regions (OCHN & OCFP, 2005; MCYS, 2006b).
\textsuperscript{23} The 18-month visit flow sheet included in the community template helps to ensure that the visit is delivered in a standardized and consistent way in each community (MCYS, 2006b). The flow sheet sets the route that most families will take and identifies the critical points where information provided by parents or identified by providers may require more discussion or a referral to services (OCHN & OCFP, 2005; MCYS, 2006b).
\textsuperscript{24} The Schedule of Benefits/Physician Services Agreement (MOHLTC 2013) outlines the fee code assessment for the enhanced visit. It provides general descriptions of the definition/required elements of service for the 18-month EWBV as well as medical record requirements.
18 month web-portal, www.18monthvisit.ca and a widely used PowerPoint presentation titled, *Promoting Healthy Child Development with Ontario’s Enhanced 18-Month Well-Baby Visit* (McMaster University). All documents, technology enabled and otherwise, attempt to formalize, develop awareness, and bring shape to visit education and outreach, helping to reinforce with primary care providers the importance of healthy child development (OCHN & OCFP, 2005, p. 19).

The documents (text) of 18-month EWBV protocols in local practice. The documents (text) gathered to represent visit implementation in local practice include an array of presentation and evaluation materials, protocols, general visit information, description of health professional roles and responsibilities for the visit, service descriptions, data management practices, and parent information resources. Described at the aggregate level because of their use of practice site identifying information, each coordinates the work of the visit with the team at the site, bowing to community nuance and creative problem solving to effect change. Information flyers grab attention with headlines of “What are benefits at this visit? (WAIT & SEE = WAIT AND PAY!!!)”; physician packages have been developed; flush with early years information, facts, and resources to support positive trajectories for development. As well, data reports speak of Grade 3 Education Quality and Accountability Office (EQAO) and EDI results, of successful 18-month visits and those of families who were hard to reach. Community specific local policy papers have also been developed for future work and thoughts that will close the gap between children that do well and those who do poorly.

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25 www.18monthvisit.ca Online education and information strategy enables the easy dissemination of practice tools, evidence-based e-learning, curriculum and online community support infrastructure for professionals as well as information for parents.

26 Used as a tool in professional development and educational activities to provide an overview of the 18-month EWBV.
From one practice site there are materials that actively support the visit: practitioner guidelines for providing anticipatory guidance, a “questions to ask parents” guide, along with documents (text) on “guidelines for teaching,” and a document for identifying “red flags” for concern. When areas of developmental concern are identified, local protocols have been developed. They draw on the currency provided by policy documents (text) and encourage “community based referrals” to programs and services identified as both universal and targeted. Locally created documents include an 18-month developmental milestones reference chart, a “useful websites” list of local and national resources as well as [www.18monthvisit.ca](http://www.18monthvisit.ca), flyer notices distributed to health professionals that identifies that “clinical judgment alone is not enough to identify all vulnerable children” and with accompanying direction provided to “refer, and recommend and avoid wait and see”.

Each document (text) developed for use by a health professional or for parent information is text and language (talk) that shares how the visit happens as it does and of the social relations reflected in the everyday activities of 18-month care, and how these social relations play a part in generalizing institutional processes (Campbell & Gregor, 2008) of knowledge work for the 18-month EWBV.

**Activating Documents (Text) For Knowledge Work**

A fundamental aspect of people’s work is ‘activating’ texts, which involves anchoring the text in the local realities. (D. Smith, 2002, p. 105)

Quinlan (2009) writes of how knowledge work is activated through the coordination of documents (text) (p. 633). She continues, “teams activate the mandating texts by anchoring them in the teams’ local conditions; in doing so, the texts co-ordinate the knowledge work performed across teams” (pp. 633 – 634). In so doing they, for purposes of the 18-month EWBV, provide vehicle for the creation of new knowledge.
Summarized from the preceding identification of documents (text) identified for use in *knowledge work*, Figure 3 serves as a platform for interview accounts for how *knowledge work* for the 18-month EWBV is done through the activation of authority documents (text) from the forces of those identified as policy and governance to those identified for processes of local protocol and practice.

**Figure 3. Knowledge Work: Activating An Expert Panel Report on the 18-Month Well-Baby Visit**

The activation of documents (text) is a key component of *knowledge work* for the 18-month EWBV. Documents (text) include regulatory texts, policy documents, and tools for use at the visit.

Education leadership is the “spokesperson for the text” (Quinlan, 2009, p. 634). They are the agents responsible for bringing standardized care to the 18-month visit, promoting knowledge (child health evidence), information, resources, and tools for use at the visit, documented in authority documents (text) of policy and governance for the new way of practice. The activation of documents (text) “opens up the communicative space for the team to reflect on
its practice patterns and the role of the team members in the formation of those patterns” (Quinlan, 2009, p. 634). FHTs in local practice settings are the end-users of the documents (text) of policy and governance, translating those texts into local protocols and policies. Knowledge work for the enhanced visit is organized, mediated, and guided by documents (text) in the role that they play in organizing language, speech and discourse on child health, development, and life course trajectories of well-being.

Summarized in Table 9, the following are accounts of how authority documents (text) such as the Expert Panel Report on the 18-month Well-Baby Visit and documents (text) of local protocols and practice organize, mediate and guide clinical practice for implementation of the 18-month EWBV. Interview accounts are rich with sharing of processing interchanges. Those points are characteristic of work organization (Pence, 1996, p. 171) where “work processes intersect for a fuller shared understanding of organizational action” (Campbell, 2001, p. 31).
Table 9  
**Documents (Text) as Data**

**Research Question 3:** How do documents for evidence-informed practice organize, mediate, and guide clinical practice for implementation of the visit?

<table>
<thead>
<tr>
<th>Authority documents (text)</th>
<th>Participant</th>
<th>Interview accounts</th>
<th>Analysis</th>
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<tbody>
<tr>
<td><strong>Expert Panel Report on the 18-month Well Baby Visit which includes:</strong></td>
<td>EL</td>
<td>… I think the fee code has been an enabler … I don’t think the dollar amount is significant [but] it gives the message, this is important work, this is important enough for there to be a special fee code for it, and important enough, for example in a family health team to be able to have two time slots put towards it … but the fact that this is, has been classified as different.</td>
<td>Prior (2003), in his conceptualization of “documents in action,” suggests text as aiming to “knit documents into people’s activities” (p.102). He suggests how in organizational settings “documents can be recruited into alliances of interests so as to develop and underpin particular visions of the world and the things and events within the world” (p.102). Watson (1992) understand text from the reader’s perspective, as one of the reader being in conversation with the words and language of the text, taking and making meaning from what is written and maybe from what is intended. The activation of text (McCoy, 1995) inserts the “text’s message into the local setting and the sequence of action into which it is read” (Smith, 2005, p. 105). This is the text-reader conversation that moves text from the static to the active. Education leaders for the 18-month EWBV are spokespeople for the report of the expert panel on the 18-month visit. Report recommendations and strategies for implementation have been endorsed and supported through channels of government policy and governance. The document mandates specific behaviours and conducts for the visit. It explicitly speaks to all</td>
</tr>
<tr>
<td>• Physician Services Agreement fee code assessment</td>
<td>FON</td>
<td>… The web portal, that is a great website, I have that bookmarked, you can go into that portal and you can access a Canadian Paediatric Society handout</td>
<td></td>
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<tr>
<td>• Clinical Practice Guideline (GAC)</td>
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<tr>
<td>• <a href="https://www.18monthvisit.ca">www.18monthvisit.ca</a></td>
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<tr>
<td>• Early Child Development and Parenting Resource System Pathway</td>
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<tr>
<td>• RBR</td>
<td>EL</td>
<td>… We have lots of hits and downloads of Rourke and the Nipissing from more nurses and physicians …</td>
<td></td>
</tr>
<tr>
<td>• NDDS</td>
<td>FP</td>
<td>… We have a template on our EMR … you open it up and it has the RBR in the template … we have a summary sheet that is at the top that is scanned … that kind of guides you to well was there anything found … sets the stage for what to address.</td>
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</table>
Documents (Text) to Organize, Mediate, and Guide Clinical Practice For Implementation of the Visit
Activating an Expert Panel Report; Activating Local Protocols and Practices
EL: Education Leadership; FON: Family Outreach Nurse; HA: Health Administrator; PHN: Public Health Nurse; PHM: Public Health Manager; FPN: Family Practice Nurse; FP: Family Physician; NP: Nurse Practitioner; E: Epidemiologist; BA: Business Administrator (Data)

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<tr>
<td></td>
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<td>of the elements for the visit, opportunities for the visit and the challenges that practitioners may face in implementing the strategy.</td>
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*Local Protocols and Practices*

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<th>In examining knowledge work one sees that the work is shaped by institutional forces that reach back into new knowledge gleamed from evidence and information and move forward, directed by documents (text) to guide payment for services, tools for use at the visit, knowledge and skill development and organization and access to community resources. In short documents (text) mediate, regulate, and authorize people’s activity. (D. Smith, 2001, p. 159).</th>
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<tr>
<td>HA</td>
<td>… We had a manual partially developed, we formed the committee, and the FP agreed to serve on it, and he would have read all the materials thoroughly.</td>
<td>In supporting knowledge work teams ascribe to the document and the supporting texts that it has created. Recommendations maybe/are challenged (e.g., wait times; remuneration for physicians with no change to NP compensation). The document opens up the discussion as to who has responsibilities across teams and across services in the community for the visit – new knowledge continues to be created as role definitions are negotiated and clarified.</td>
<td></td>
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<tr>
<td>PHM/PHN</td>
<td>… We had a Paediatric Day, we have a healthy child development committee, an integration committee, a literacy committee.</td>
<td>By way of activation of the text the team was able to critically reflect on the larger set of institutional relations. New knowledge is made explicit through the formation of new practices and procedures. New knowledge is created</td>
<td></td>
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<tr>
<td>FPN</td>
<td>… We developed some protocols or guidelines around the different bits and pieces, like how to implement the NDDS, what is involved in the RBR, and then a very big piece on data collection for the visit … and created a letter of agreement.</td>
<td>In supporting knowledge work teams ascribe to the document and the supporting texts that it has created. Recommendations maybe/are challenged (e.g., wait times; remuneration for physicians with no change to NP compensation). The document opens up the discussion as to who has responsibilities across teams and across services in the community for the visit – new knowledge continues to be created as role definitions are negotiated and clarified.</td>
<td></td>
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<tr>
<td>PHM/PHN</td>
<td>… We didn’t really model the conversation, we developed the Parent Self-Identified Concern Summary to help with the dialogue with parents because we felt that was important … we talked a lot, there was a lot of interaction, you know working together.</td>
<td>In supporting knowledge work teams ascribe to the document and the supporting texts that it has created. Recommendations maybe/are challenged (e.g., wait times; remuneration for physicians with no change to NP compensation). The document opens up the discussion as to who has responsibilities across teams and across services in the community for the visit – new knowledge continues to be created as role definitions are negotiated and clarified.</td>
<td></td>
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<tr>
<td>FON</td>
<td>… Everybody went out of there shaking their head … we had that report of how poor our kids are doing. Oh my god it was eye opening for me. Yea I have it here. You can have this whole package too.</td>
<td>In supporting knowledge work teams ascribe to the document and the supporting texts that it has created. Recommendations maybe/are challenged (e.g., wait times; remuneration for physicians with no change to NP compensation). The document opens up the discussion as to who has responsibilities across teams and across services in the community for the visit – new knowledge continues to be created as role definitions are negotiated and clarified.</td>
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<tr>
<td>FPN</td>
<td>… And we know speech and language is the big no, right on the Nipissing, like the little guy I just saw this morning. He has four words, and he is 20 months old.</td>
<td>In supporting knowledge work teams ascribe to the document and the supporting texts that it has created. Recommendations maybe/are challenged (e.g., wait times; remuneration for physicians with no change to NP compensation). The document opens up the discussion as to who has responsibilities across teams and across services in the community for the visit – new knowledge continues to be created as role definitions are negotiated and clarified.</td>
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Documents (Text) to Organize, Mediate, and Guide Clinical Practice For Implementation of the Visit

Activating an Expert Panel Report; Activating Local Protocols and Practices

EL: Education Leadership; FON: Family Outreach Nurse; HA: Health Administrator; PHN: Public Health Nurse; PHM: Public Health Manager; FPN: Family Practice Nurse; FP: Family Physician; NP: Nurse Practitioner; E: Epidemiologist; BA: Business Administrator (Data)

<table>
<thead>
<tr>
<th>Authority documents (text)</th>
<th>Participant</th>
<th>Interview accounts</th>
<th>Analysis</th>
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<tr>
<td>Four words, but nobody has ever accessed anything, or done anything, so I had to go really gentle and said, let’s start with a hearing test. This is always my first line, because they like that. It is covered with OHIP. Let’s make sure there is nothing. I always kind of start with that, and then come back and let’s see where we are at, but four words is really bad numbers for his age … and I think that care provider wasn’t going to do anything. … We didn’t have any kind of roadmap or game plan … as you develop over the years you kind of feel your way through what works and what doesn’t work So for us, being kind of multisite, scattered through town, and a couple out in other places and such, having an EMR that we are all on the same database has been a huge benefit. So that is the thing. If someone has a question, so the nurse during the program, or any program, they have got a question about something, they send me a flag. I can respond to it you know within minutes, and we do that for a lot of our programs. Someone is in for blood pressure stuff, and oh it is up, well I just, so okay, yea it is persistently up, here I will fax him this medication. Can you do the explaining? Yea, so the patient knows that I am in the background pulling some strings here, but I don’t have to be doing all that face to face. So we are in a virtual group office, even if we are physically in a, you know multiple, discrete site. So that has been handy.</td>
<td>FP</td>
<td>… At that time there was an NP on board with delivering 18-month EWBV … so we put together a document … and it had in it you know the throughout the process of the team’s collective reflection on its local conditions and potential ways of coordinating the delivery of well-baby care. Documents (text) provide the possibility to trace sequences of action (D. Smith, 2001, p. 160) that are the knowledge work. In their material forms, words, images or sounds are replicable, that is anyone else from anywhere else can read, see hear and reflect on the same words, images, or sounds as any other person engaged with the same text. They have the ability and power as Turner (2003) describes to “orient the researcher to the actual practices of people in work settings. They provide the basis for observation and descriptive analysis of people’s practices as they produce the social organization within which individual experience and institutional acts happen (p. 223).</td>
<td>PHM</td>
</tr>
</tbody>
</table>
Documents (Text) to Organize, Mediate, and Guide Clinical Practice For Implementation of the Visit  
Activating an Expert Panel Report; Activating Local Protocols and Practices  
EL: Education Leadership; FON: Family Outreach Nurse; HA: Health Administrator; PHN: Public Health Nurse; PHM: Public Health Manager;  
FPN: Family Practice Nurse; FP: Family Physician; NP: Nurse Practitioner; E: Epidemiologist; BA: Business Administrator (Data)

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<td>recommended tools, and all that kind of thing … you know the overview, the importance of the visit and all of that. She had been a public health nurse, so we knew her, and that was very helpful to the process, so we worked with her to develop what the visit would look like.</td>
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**Mapping Knowledge Work Processes**

I open up moments and sequences of action … I point out in the verbal text what I want the reader to look at in the figure, what I analyze and want you to see. (Turner, 2003, p. 155)

The mapping I did reveals not just a cluster of linear text-based work processes. Rather, it shows the work of documents (text) actively coordinating and bringing into relation a complex of textual and speech practices as institutional, that is, as relatively enduring forms of social organization. (Turner, 2003, p. 5)

In its conclusion, the social organization of knowledge work is mapped, as summary of analysis. The activity makes visible the complex of document (text) based work processes (social relations) which people actively put together as they orient to and talk about documents (text) in diverse ways and in different settings (Turner, 2003, p. 45). I begin mapping activity with the elements, previously described on p. 127 of this thesis, to support the process for descriptive mapping in mind. They provide a frame supporting visualization of “*talk, documents (text), action*” that initiates in the social organization of knowledge moving from evidence to policy, continues in the social organization of knowledge moving from policy to practice for the 18-month EWBV, and completes itself in maps generated for understanding knowledge work process for creating culture change in local practice. The key to “making institution visible,” as Turner (2003) describes, is the “making visible the operation of particular replicated texts that connect the setting of the reading, speaking and writing to the organizing complex of texts that coordinates the multiple sites of individual’s work” (p. 156). In the case of the 18-month EWBV, as previously written, the institution is knowledge work and the mapping that I have created provides “an account of the day-to-day [document] text based work and local discourse” (Turner, 2006, p. 139). It represents the “text-based work processes that are observable, available to experience”(p. 151), identifying the coordinated complex of institutional sequences of work and texts into which nurses, family physicians, nurse practitioners, and others make visible the invitation to practice or rejection of innovation that is the enhanced visit. Mapping
for this study makes discovery, for appreciation of how documents (text) coordinate work of organizational action, how invisible work of leadership finds influence, the location of processing interchanges, where work processes intersect (DeVault & McCoy, 2006) and document (text) and language/speech/discourse (talk) enters and is processed (Pence, 1996), and where barriers to innovation are found. Mapping as an analytic for this study charts,

1. The work an individual reader does to activate documents (text) of knowledge, research, evidence, information, resources, and tools in order to orient to the institutional processes that brought evidence to policy (Figure 4); and

2. The coordination of work, across government, organizations, and local practice, as “talk, documents (text) and action” move from policy to practice for the implementation of the 18-month WBV (Figure 5).

In continuing my development of maps, I formed, typographically, the sequences of activity, “talk, document (text), action” that accomplish in local practice settings,

3. The coordination of work in local teams, representing multiple individual practice sites linked by “talk, documents (text)” to affect “action” (invite or reject, complement or inhibit the activities required for success, and sustain or alter adherence to entrenched practices (Kontos & Poland, 2009) across settings (Figure 6a, Figure 6b, Figure 7).

To facilitate reading of the maps in these figures I have used SmartArt circle and arrow processes, with text boxes of rounded rectangles and oval callouts, supplemented with arrows to show lines and connections. Further description for understanding follows.

• Circle arrow processes represent “hooked into sequences of action implicating and coordinating multiple local sites where others are active” (D. Smith, 1999, p. 7);
• Shaded callouts represent the development and use of language, speech, and discourse that create “meaning, authoritative ways of knowing” (Campbell & Gregor, 2008, p. 91), or language that is carried out in the “organization of the social” (Turner, 2006, p. 151) of knowledge work;

• Shaded rectangular boxes represent document (text) embedded within sequences of activity that organize, mediate, and guide implementation of knowledge work for the 18-month EWBV;

• Shaded circles indicate the activity performed as people take up and do something with text. These are the moments when different parties are at work with the documents (text); (Turner, 2003, p. 167); and

• Solid thin and thick arrow lines indicate a direct connection or influence of activity.

Building on description provided above, following is summary analysis of the study’s five maps prepared for tracking and diagramming organizational knowledge work processes. Each section begins with a visual map, followed by discussion that identifies the entry or starting point for the map’s journey, what work /action is getting done, the documents (text) that guide work, words or phrases dominant in the discourse or captured from the language used in the document (text) that is linked to language used in other text across sites. Traced is how the pieces of talk, text, and action work together, marking how wordings in a text change in their move from one setting to another, showing who is doing what in the work process sequence and what are the consequences (Turner, 2008). Also illustrated, as part of discovery, is “fine detail that brings into view places where the original purposes of work process is being undermined or subverted to another (implicit) purpose (Ng, et al. 2013, p. 5),
“What people are doing and experiencing in a local given site is hooked into sequences of action implicating and coordinating multiple local sites where others are active” (D. Smith, 1999, p. 7).
Figure 4. Map 1 activity begins in the document (text), of an 18-month proposal, *Getting it Right at 18 Months ... Making it Right at 18 Years and Beyond* (MCYS, 2004). Informed by the early years evidence on brain development, and understanding of influences that impact on optimal child development trajectories, this document (text) rallied a group of experts to come together as a panel. The panel, whose “knowledge and expertise in primary care, child health, public health, children’s services, and research” (OCHN & OCFP, 2005, p. vi) was used to inform the development of an authoritative document (text) known as *The Report of the Expert Panel on the 18 Month Visit: Getting it Right at 18 Months ... Making it Right for a Lifetime* (OCHN & OCFP, 2005). The panel’s report provided the basis for a provincial strategy to support developmental assessment at 18 months of age for each child in Ontario.

As evidence moves to policy, important to note is how both the language and text of proposal and report documents set direction for the work to be accomplished, and the knowledge to be translated, to bring innovation and shift to clinical practice for the 18-month visit. Both documents link language of research, information, and evidence to language of government policy and vision supportive of parents in their efforts to raise children to achieve their full potential. Text married the talk of the benefits of investing in young children to the discourse of healthy child development and life-long health and well-being. Scientific and clinical appreciation of developmental assessment became description and language of developmental review and evaluation. Words of collaborative discussion between parent and provider and processes to support discussion on healthy child development and risk identification were found in the evidence of early identification and early intervention. In its submission to government the panel provided
a comprehensive and definitive document (text) of report and recommendations for policy and program development for the 18-month EWBV.

Mapped in Figure 1 as the third circle arrow process, the expert panel’s report was reviewed across three government ministries (MCYS, MOHLTC, Ministry of Health Promotion [MHP]) as next steps in an institutional work process. The report’s recommendations were responded to in the creation of an Implementation Advisory Committee and Working Group. As policy and program implementation took form through this process, wording in the panel report set forth a complexity of work-text-work-action processes that were the mandates of these two groups. Tasked to work collaboratively together to implement an 18-month EWBV, it is in their complexity of talk, text, and action that new documents (text) and dialogue are established (e.g., new fee code assessment, strengthening of standardized tools, community referral pathway template, and strategies for primary care education).

Mapped for the social organization of knowledge, moving from evidence to policy, Figure 4. Map 1, and the activity that it represents, is a first foundational step in a sequence of organization that set discussion and knowledge work for the process now known as the 18-month EWBV. The extended relations where experience happens, is as Turner (2003) suggests “dialogically organized and begun in text” (p. 160).
Figure 5. Map 2: Social Organization of Knowledge Moving from Policy to Practice for the 18-month EWBV

- **Ministry Policy and Governance**
  - Ontario's 18-month EWBV

- **Talk**
  - “Bringing evidence to practice, to create a culture focused on enhancing the developmental health and well-being of children”

- **Documents (text)**
  - 18-month PBSG module; www.18-month.ca; standardized tools; community pathways
  - CPS Position Paper (2011)
  - OPHS Family Health (2009)
  - NDDS/RBR/Resources Referral Pathway Parent Information

- **Documents (text)**
  - Early Years Study (1999)
  - Early Development Instrument (EDI)

- **Talk**
  - Experience-based brain development; Windows of Opportunity; Environment as Influence; Development
  - “Clinical judgment alone is not enough”
  - “Early ID and intervention”

- **LOCAL PRACTICE SITES**
  - [Family Health Teams]

- **Talk**
  - Importance of the early years
  - “School readiness”

- **CENTRE OF EDUCATION**
  - Supporting Primary Care Practice for Uptake and Implementation of the 18-month EWBV

- **Talk**
  - “School readiness”

- **Talk**
  - “Clinical judgment alone is not enough”

- **Talk**
  - “Early ID and intervention”
Figure 5. Map 2 continues the work processes of previously discussed activity (Figure 4. Map 1). Map 2 has as its entry, or start, the forces and processes of ministry policy and governance grounded in the authoritative text of the expert panel report on the 18-month visit. Behind-the-scenes documents, text of evidence and information (e.g., Early Development Instrument (EDI), Early Years Study [1999]), and dialogue of school readiness frame context for 18-month EWBV policy and program development across government. Spheres of activity, initiated in government, transfer to the organization identified as the 18-month EWBV’s centre of education and support to primary care practice for uptake and implementation of the visit. Mapping shows this as a public process. One of extended relations that see knowledge founded in talk and documents (text) from provincial government ministries in concert with the talk and documents (text) developed by the centre of education in support of the visit. Centre of education document (text) development and support includes web-based education, practice based small group education modules for health professional use, presentation materials that highlight the importance of the early years and the role of the 18-month EWBV in supporting child development and well-being. Additional text presentation materials focus on the standardized tools for use at the visit, legislation for the visit’s new fee code assessment, and direction, found in text, for the development of community referral pathways, designed to illustrate the organization of local early child development and parenting resources across a community, region or district.

As knowledge moves from policy to practice, mapping at this stage, offers a view of authoritative text linking and concerting work processes, as well as coordinating sequences of action that are occurring in more than one work setting by a multitude of individuals. In so doing, language, speech, and discourse evolves as it moves from one setting to another. The language of child health evidence reconfigures to clinical judgment alone is not enough. The
provision of referrals to specialized community services for those children identified with potential issues, needs, and risk becomes conversation of care and support for child development and intervention. As one study participant shared, the 18-month EWBV in the local practice site context alters from policy to a quality of care within our family practice. As education leadership work with documents (text) in their support to local practice, local practice sites continue their work-text-work action in the creation of new text that informs and organizes their process.

Map 2 completes the work sequence of policy into practice and attempts “to make visible the sphere of relations in which key texts operate to pull in certain individuals to do certain kinds of work with texts to standardize the activities” (Turner, 2003, p. 163). It serves as a window into those rarely visible forces and relations that organize to influence at the local site. In so doing it sets a platform for knowledge moving directly into practice where if not understood “can create situations often as mystifying as they are frustrating” (Ng, et al., 2013, p. 5) for uptake and implementation of knowledge.
Figure 6a. Map 3: Social Organization of Knowledge Moving into Practice (Practice Sites 1–5; Accepting Innovation Represented by the 18-month EWBV)
Family Outreach Nurse
meeting resistance with administrative staff/family physicians

We have offices that just say “no” or others where you need to follow-up with each visit to make sure that everything has been signed off … you can’t sign for the doctor so you just have to keep going back.

… They said they are not “doing all that” just to make our stats look good. It makes more work for them … so I just have to niggle more. It makes me sad …

Practice site partial and total reistance to 18-month EW BV related to:
- Level of concern for the issue;
- Change includes a shift of work; and
- Practitioner’s experiential knowledge.

Figure 6b. Map 4: Social Organization of Knowledge Moving into Practice (Practice Sites 6 – 7; Partial and Total Resistance to Innovation Represented by the 18-month EW BV)
Discussion for Figure 6a. Map 3 and Figure 6b. Map 4 follows. Presented together, the maps represent 18-month well-baby care, delivered in multiple practice sites, across a FHT where knowledge work for innovation is both accepted and resisted.

Figure 6a. Map 3 brings into view innovation across practice sites 1 – 5. Centrally organized by the expert panel’s report, community processes and relations (e.g., Early Years Planning Table and the 18-month EWBV Planning Committee) are the starting point for the map. Planning activity, undertaken to promote uptake of the enhanced visit, is linked to language used in documents (text) of government guidelines for Best Start (MCYS, 2006a). Directing community-planning tables to work together, cross programs and cross sectors, for benefit of young families and their children they offer an example of a dominant form of coordination that shapes action. Mapping again identifies documents (text) of influence for the enhanced visit (e.g., the standardized tools for use at the 18-month EWBV [NDDS, RBR, community referral pathway, new fee assessment code]) but also highlights new documents (text) that have been created at the local practice site, “over time, often in steps or stages, and used for a variety of purposes and in sequences of action, in more than one work setting” (D. Smith, 2006 as cited in Ng, et al., 2013, p. 5). Such documents (text) have been created, linked to language used in the authoritative text of the panel report, of other government policy papers, in language found in the standardized tools for use at the visit, and from generic pathway templates created to support communities in development of their own resources.

For understanding of “who does what exactly in a sequence of work-text-work action and what are the consequences” (Turner, 2008), mapping traces the influence of action generated by the centre of education leadership as they share information on the visit and the evidence that supports such innovation with health professionals in the local practice setting. Also seen is the identification, development, and nurturing, through relation, of a FHT peer
champion for the 18-month EWBV at the practice site. The office administrative staff and family outreach nurse work, linked to the early years planning table, the local 18-month committee process, and supported by the centre of education leadership, come together to model the visit, support, encourage, and influence clinicians as they work towards integration of the 18-month EWBV in practice. In its conclusion, mapping reveals how the visit has served as a catalyst extending relations for collaborative effort between the FHT practice and community programming as represented by the Ontario Early Years Centre. In summary, Figure 6a brings into view the lived experience of an institutional world of knowledge work described in Chapter Five. As a consequence innovation is embraced for the delivery of care at 18-months, evidence is moved into practice, and a “culture focused on enhancing the developmental health and well-being of children” (OCHN & OCFP, 2005, p. i) is created.

Figure 6b. Map 4 identifies partial and total resistance to innovation across practice sites 6 – 7. It is representative of the same FHT activity described in Figure 6a. Map 3 but brings into view “points where the original purpose of a work process is being undermined or subverted to another (implicit) purpose” (Ng, et al., 2013, p. 5). Mapping for these sites identifies the significant breakdown in linkages for acquiring new knowledge (child health evidence), information, and resources. Expressions of resistance for uptake of the visit, come in a practice site’s talk of the 18-month EWBV as “extra work”, work “for the sake of data collection alone”.

Mapping makes apparent lost links in work-text-work action for the processing of new knowledge. There is no uptake of documents (text), both authoritative or those created at the local level to guide, inform, or coordinate activity, no access to peer champion influence and support, and no possibility for discussion to promote the need identified in community data and the science that supports innovation. The activity mapped demonstrates how “policy follows a plan that does not always relate to all local conditions, needs, and plans” (Campbell & Gregor,
Located in actual experience, mapping out a real situation, Figure 6b. Map 4, by investigating the work-text-work processes and asking what starts and completes the work sequence, provides opportunity for anyone wanting to intervene and make change to take action and do so.
Figure 7. Map 5: Social Organization of Knowledge Moving into Practice (Practice Sites 8–9; Accepting Innovation Represented by the 18-month EWBV in Collaboration)

**Talk**
To improve developmental health outcomes of preschool children by implementing a consistent approach to monitoring child health

**Early Years Planning Table**

**Documents (text)**
Report of the Expert Panel on the 18-month Visit; OCFP Improving the Odds (2007) NDDS/RBR; Community Referral Pathway

**Public Health Unit**
[Peer champions]
[Public health nurse; PHU Nurse Manager; Epidemiologist]

**Talk**
“Working in partnership”

**Family Health Teams**
Family physician; Family Practice Nurse; Health Administrator - (Peer champion)

**Local Practice Sites**
18-Month EWBV Community Clinic
+ Medical appt for physical exam

**Documents (text)**
Parent satisfaction survey; Referral summary sheet (Parent self-identified)

**Documents (text)**
EMR – Data collection/PHU Data collection and analysis

**Talk**
Booking the 18-EWBV at the 15-month visit

**Documents (text)**
Parent Letter

**Documents (text)**
Parent satisfaction survey; Referral summary sheet (Parent self-identified)
Figure 7. Map 5 represents a work process sequence for knowledge work that is innovation brought to practice through collaborative process. The map displays the location and connection of work-text-work across the partnership. Again, beginning and guided by a single text, the authoritative document (text) of the expert panel report on the 18-month visit, the text is taken up by the local early years planning table. Supportive documents (text) also influence. For these practice sites partnership is the language and discourse that guides innovation and serves to influence the model adopted for 18-month EWBV. Numerous, locally developed, documents (text) guide and inform the partnership and uptake of the enhanced visit. Be they protocols, parent satisfaction surveys, referral summary sheets, data tracking templates, all have been created through the sourcing and linking of language found in other 18-month documents (text). Authoritative texts informed public health staff who initially did work to raise awareness of the visit within the FHT. FHT clinic staff continued work based on documents (text) that were shared. Work-text-work activity, talk created from those work processes, availability of legislative text that identified enhanced forms of payment for the visit, and parent evaluation, in the form of document (text), helped to ensure, for these practice sites, knowledge work as a quality of care implemented in relationship.

Summary of Mapping Knowledge Work Processes

IE departs from other analytic approaches that are speculative in nature by having the researcher find and map the material connections showing the actual social organization of everyday events (Campbell & Gregor, 2008, p. 107). The five maps illustrated and discussed in this section provide a visual for processes that are coordinated and come together identified as knowledge work. They tell us of those processing interchange points, described in Chapter 5, and found in all of the study’s mapping activity with the exception of Figure 6b. Map 4, for those points in social organization where document (text) enters and is processed (Pence, 1996).
Mapping as an analytic provides a fuller understanding of organizational action (Campbell & Gregor, 2008) for how knowledge work was embraced, or not, in real practice. Maps, described here, offer insights into the text, talk, and activity that “organizes and regulates local work sequences of action” (Turner, 2003, p. 191) wherein the institution of knowledge work is able to exist. Mapping made visual the big picture of forces and processes of how evidence moves to policy and to program for the 18-month EWBV. It showed how forces and process bring people together whose work is connected, or who want to connect their work. It illustrated the work conditions where problems/gaps exist. For all it helped to make visible complex work processes in a comprehensible way (Turner, 2008).

As conclusion, mapping charts the degree to which processes and authoritative text influence and contribute to study participant’s understanding and uptake of change. They also reveal the influences and impacts of coordinating processes that come together to concert work and decision processes, the role of secondary documents (text) that have impact and guide, and the influence of early years planning tables as work settings of authority. Where resistance to innovation is met mapping as an analytic showed what the issue might be, where the work process has broken down, and how their “doings in a process, a sequence of action” (Turner, 2008) could be changed. Maps also helped identify, those invisible but important work processes that often go unnoticed (e.g., the influence of a peer champion to support practice shift, those processes and dynamics of partnership that influence change, barriers to access that results in resistance). In so doing mapping for this study brought advantage and focus to the organizational work of bringing new knowledge to practice.
In the degree in which an active conception of knowledge prevails change becomes significant of new possibilities and ends to be attained; it becomes prophetic of a better future. Change is associated with progress rather than with lapse and fall. Since changes are going on anyway, the great thing is to learn enough about them so that we are able to lay hold of them and turn them in the direction of our desires. (Dewey, 1957, p. 116)
CHAPTER EIGHT: SUMMARY, CONTRIBUTIONS, AND FUTURE WORK

As the thesis concludes, this chapter initiates with a summary of the research and contributions of the ethnography. The latter provides analysis for the two final research questions originally posed. In addition, the chapter presents study limitations, significance and potential benefits of the study, and recommendations for future research.

Summary and Contributions of the Ethnography

Summary of the Research

The 18-month EW BV is a complex strategy, a representation of work processes, embedded with language, speech, and discourse, that focuses relations guided, mediated, and organized by documents (text) that hold authority to coordinate. In Ontario the 18-month EW BV has had extensive work for its design, development, and implementation. The work has proceeded in partnership within government and across Best Start and early years planning tables. For primary care providers, it has meant change, in either the shifting or creation of new structures and processes for the provision of well-baby care at 18 months or in conscious choice not to accept such innovation.

Drawing from study discovery, interview accounts, and analysis presented in Chapter Seven, the study has confirmed that knowledge alone is not enough to effect change and that knowledge is social. Interview accounts with education leaders and FHT practitioners shared different approaches to acquiring new knowledge, different relationships within practice that facilitate or impede innovation. Voiced were the discomforts of learning, of a checklist mentality that may guide practice, the need for reflection to motivate change, and challenges sometimes inherent in the roles assumed by physician, nurses and nurse practitioners in the visit’s delivery. More specifically, health professionals, across disciplines, spoke of how, beyond just information, uptake of the 18-month EW BV was a process of learning how to
communicate and dialogue in new ways, how all staff have a role in knowledge work, and paradigm shift the result of multiple processes, that of peer pressure, assistance received from colleagues, and encouragement provided both by parents and the community. Key to knowledge work was the presentation of evidence in an accessible way, not to overwhelm with information but to “tell me something I can do with my patients now”. Others saw knowledge acquired as part of formal social organization, through retreat and conference activity. While others found informal social organization and relationship, the hearing of visit tips and tricks in daily office interaction, as helpful. Still others benefited from collaborative practice (e.g., public health unit and FHT staff; FHT and Ontario Early Years Centre workers). In speaking of their experiences one public health unit partner shared,

We worked on the Power Point together and there were slides in there right back to the Expert Panel. Here is where we are, here is how you know things have changed over time, here is where you can make a difference, and here is why these early years are so critical, here is the fee code, here are the tools that are recommended for the visit, here is what the visit entails, educating them about the resources in the community … that is huge. I think sharing among family health teams has really evolved over time too, and that is helping to move along the importance of the visit. (Interview account, March 2013)

Found in these relationships was common vision and purpose to support optimal child outcomes. In addition, often cited was the role of inter-disciplinary support for visit uptake. Clinicians spoke of the value of nurses who modeled the language and way of the visit for physicians who may have been uncomfortable or new to the discussion of visit domains, such as child development, family violence, and safety. Study discovery also shared how community and practice data provided impetus and organization, beyond just the sharing of information to facilitate and sometimes to prevent a shift in practice.

Important to the research was how the ethnography rendered visible the processes of text – talk and action that guides knowledge work. In standard documents (text) and with new language, “learned and reproduced” (Turner, 2003, p. 221) context is set for knowledge work as
evidence is brought to practice. Language, speech, and discourse, as well as documents (text) are the tools of change, active in their role to coordinate “what we are doing with another or others” (Smith, 2005, p. 102). They are what D. Smith (2005) believes, and what Turner (2003) writes of capacity to “not only coordinate people but are what puts people into action” (p. 102). Examples of language, discourse, and documents (text) as tools of coordination for action that sees uptake of the 18-month EWBV are found throughout study interview accounts. The seminal role played by the document (text) expert panel report is often mentioned as the lightning rod that rallied efforts towards practice change. Where there was resistance to visit uptake the document (text) is not identified. In the development of community referral pathways we see examples of language and documents (text) that bring practitioners, across sectors, coordinated in action with consistent information about the services available in their communities and regions so that families could easily be linked to the right resources. The new fee code assessment contained in a physician services agreement represents a document (text) of legislation. Important as a funding tool for the visit, study participants saw it as both an instrument to coordinate action, provide impetus for visit uptake but also an instrument to highlight power and authority processes. Documents (text) for visit knowledge work played a role, one that is a far more significant and influential than the “inertia” (D. Smith, 2005) sometimes ascribed of text that “often is left to languish on some forgotten shelf, dismissed, forgotten, or at best referenced only on occasion” (Turner, 2003, p. 225).

The study, beyond identifying text as a powerful coordinator of action, has also shown the role of language, speech, and discourse in effecting action. Study participants spoke of new ways of discussion, of new language; neuroplasticity, epigenetics, population health, child development as more than measurement and immunization, well-being, the role of the young developing brain, and life-long health. Such new and shared language was seen as a powerful
tool that can convey the “subtleties of meaning and importance” (Ontario Federation of Indian Friendship Centres (OFIFC), 2013, p. 8), bring people together in common purpose and vision, and motivate or diminish appetite for innovation and change.

Dominant forms of coordination or ruling relations was important to the study and its research. The research shows how knowledge work starts with a document (text) reader conversation for knowledge. This knowledge is found in the evidence. The reader, a health professional more vested in the traditional, more conventional ways of providing well-baby care at 18 months, is drawn into the conversation of child development, influenced, and practice shaped, by the documents (text) and the talk of the Expert Panel Report on the 18-Month Well-Baby Visit. To follow is activity, socially organized, that is “hooked into sequences of action implicating and coordinating multiple local sites where others are active” (D. Smith, 1990, p. 93). Action, for innovation or rejection of the 18-month EWBV, is coordinated by documents (text) and talk (language, speech, discourse) that provide the organizing agent by which professionals enter into complexities of linked relation that are the terrain for knowledge work. It is a terrain that at the local level navigates and problem solves, or not, power and authority processes, leadership and styles that support or diminish change, partnership and relationship processes, understanding of a common vision, goals, and awareness of influences of clinical and patient experience to the development of new structure and processes. Outlined in Figure 8 is an overview of the dominant forms of coordination (ruling relations) that shape people’s actions; from forces of influence to processes of local practice.
Figure 8. Dominant Forms of Coordination That Shape Action

Expert Panel; Policy and Governance; Education Leaders:
- Changes that are occurring in the primary care system may provide the opportunity for primary care to play a stronger role in promoting healthy child development.
- The regular contact the primary care providers have with families throughout the early years provides an opportunity to engage parents in an ongoing discussion about child development, services available in the community, and to help identify any developmental problems or delays.
- Clinical judgment alone is not best practice.

Health Professionals:
- “How do we have the conversation”?
- We can make a difference
- Practice is busy; When to integrate additional information
- Wait times – primary care as part of the early years system
- Previous practice experience
- External barriers (Reminder systems electronic medical record [EMR] limitations)

Documents (text) – Language, Speech - Discourse
Work is regulated through devices such as rules, regulations, guidelines, officially authorized definitions, matrices, forms, protocols and directives that are standardized across particular jurisdictions and setting. These devices ensure that workers operating in different locations, agencies and timeframes are coordinated in their actions (D. Smith, 2005, p. 188).

... But documents have potential to cause conflict.

... The health professional invites or rejects innovation that is the 18-month EWBV, complements or inhibits the activities required for its success, and sustains or alters adherence to entrenched practices (Kontos & Poland, 2009).

Figure 8. Work for the 18-month EWBV is coordinated through devices such as regulations, guidelines, officially authorized definitions, forms, protocols, and directives that have become standardized across sites and work settings (Appendix J). These help to ensure that health professionals operating in different location, agencies, and time frames are coordinated in their actions (D. Smith, 2005, p. 188).
In concluding this summary, I return to the research study’s objective: to create an expanded view of the institution of knowledge work as a coordination of document (text) based work processes whose routines assemble a “functional governing complex” (D. Smith, 1999). These sequences of action, from forces of policy, governance, and education leadership to processes of local nuances, exceptions, inequalities, and creative problem solving (Ng et al., 2012) to affect the 18-month EWBV were completed in the study’s activity of mapping. The maps generated “show the actual standardized coordinated work processes whose textual products and concerted activities” (Turner, 2003, p. 225) produce for this research, understanding of the influences that invite or reject uptake of the visit, complement or inhibit the activities required for success, and sustain or alter adherence to entrenched practices (Kontos & Poland, 2009). The mapping shows the dominant forms of coordination that shape the organization of knowledge work, and the processing interchanges where documents (text) and talk guide action. Mapping reveals, beyond linear processes of traditional KT models and frameworks, those processes that are the seen and unseen work of the organization of knowledge for change. As an analytic it shows the active use of documents (text) by providers, how those documents (text) are activated in different settings and at different times, how documents (text) shape behaviour and language, speech, and discourse, how such documents (text) can concert diverse points of view and understanding.

Contributions of the Ethnography

Making accessible understanding of knowledge work. The following provides understanding of the contributions of this ethnography and provides analysis for the fourth research question of the study,

4. How does IE make accessible understanding of actual and embodied professional knowledge work activities, mediated by written communication and documents for the implementation of the visit?
IE is a sociology for the people (D. Smith, 2005). Sociology defined is the study of the development, structure, and functioning of human society, the study of social problems (Bisset & Barber, 2004, p. 993). IE serves as a frame of inquiry for how people do their work and how it is shaped. Viewing knowledge work through the lens of IE revealed the mix of conditions and events at all levels, those forces that shape processes, to create change. Knowledge work was represented as if in a chain of reaction that results in different outcomes depending on the “dynamic interplay of conditions and mechanisms over time and space” (Poland, Frohlich, & Cargo, 2008). For example where organizational leaders and peer champions interacted and community networks were created the result was an active and encouraged use of documents (text) that served to guide and maintain integrity of the visit’s intent. Where there was breakdown in major linkages (Practice sites 6 and 7) innovation was rejected. IE, in its method and as an analytic, showed why it worked, for whom, and in what circumstances, where it did not work, and for whom, and possibly for what reasons. It offered understanding, through analysis, of circumstances, factors, and/or conditions that acted and interacted to affect and influence practice so that innovation could happen. In its conclusion, it also offered the identification of strategies that could offer insights to refinements and reorganizations for the enhanced visit that could support knowledge work where it has been successful and possibly influence where meaningful change has yet to happen. The identification of influence in support of the visit at early years planning tables and through MOHLTC quality improvement initiatives are but some of the examples that come to mind. IE provided me as the researcher with opportunity to examine and question the structures, processes, and relations that shape knowledge work for the visits in ways that have not been done before. It offered opportunity, through interview participation, for those close to their knowledge work to reflect on their practice, reflect on the ways and means by which their practice was shaped and how they may
facilitate ongoing change. For me, it showed me where the work is, the contextual contingencies that are in play, beyond the more visible places identified in the individual processes of traditional knowledge translation frameworks and processes. In its method IE offered much, the opportunities for reflection, the identification of power and authority processes, the role of leadership and identification of leaders, often found in the most unsuspecting places, the invisible work that is so critical to the work more visible, and the commitment necessary to empower and sustain change. In knowing how the work is organized, the relations in place that shape what is to be accomplished offers “clearer view” (Crispin, 2009, p. 153) for how interventions can be better promoted and a program strengthened in order to have greater impact and better chance of sustainability. It is as DeVault and McCoy (2006) suggest, in their sharing of thoughts of the importance of IE, that even as the “research won’t bring solutions without the political work, the approach is meant to offer the kind of ‘map’ that could help those working politically to see what they are up against and where they might want to apply pressure” (p. 295).

**Insights, reorganizations, and refinements.** This section provides focus and analysis for the final research question of the study.

5. What insights, reorganizations, and refinements to current practice for the visit might be generated using IE?

*Knowledge work* for policy implementation is complex, socially organized, and shaped by the relations coordinated in documents (text) that guide its processes. Fundamental in its conclusion for this study of knowledge work set against the case of the 18-month EWBV, one may be wise to remember in some small way the writings of Machiavelli (1469 – 1527) as study conclusions are set. He wrote,

There is nothing more difficult to plan, more doubtful of success, nor more dangerous to manage than a new system. (Machiavelli, 1961)
Insights from study of social organization and relations that shape processes have provided much in the way of understanding knowledge work associated with the innovation of care at the 18-month visit. It has shed light on some of the issues that Pettigrew, Ferlie, and McKee (1992) identify when they suggest that building and sustaining a receptive context for change are extremely complex and dynamic processes and professional groups are well able to resist change.

The study has potential to strengthen KT research by putting a spotlight on the complexities of practice settings and inviting reflection on existing practices to identify strategies for change. Drawing from real lived experience, the study in its approach can inform KT processes by placing focus on the “institutional coordination of complex work processes” (Ng, et al., 2013, p. 9). That focus adds dimension to understanding of KT process, shining light on work processes, and the mapping of those processes, to understand the forces (policy and governance), processes (local practice and nuances of organizational culture), and organization and relations (cross communities, sectors, and disciplines) that rule. Understanding participants in the KT process, not as the topic or object of interest, but as “entry” into the social relations of the setting (Campbell, 1998, p. 57) provides additional meaning making to all those who seek to improve, innovate, or affect change as knowledge becomes action. As well, research such as mine, in identifying and tracing the organization of work processes and relation, can bring to light those invisible processes of KT activity, textually mediated that influence. Be it the role of a peer champion, who has keen interest and motivation to read, share information, and influence peers for the activity of knowledge work or the parent who takes up the documents (text) of a developmental checklist to better understand their child’s development, they are but some of the examples of the invisible work that influences change. Lastly, the research has potential to strengthen KT study in its discovery of the power and influence of reflective practice to motivate
and mark change. Simple prompt questions used with study participants (e.g., What could be done differently? What might you do better next time?) had unimagined capacity to generate new directions of thinking. One shared in reflection of how she thought “people sometimes don’t ask the questions because they don’t know what to do with the response … difficult health information, breaking bad news … these are very sensitive domains that are challenging … there needs to be guidance”. Another when prompted to consider her role spoke insightfully sharing, “I hadn’t thought of it like that until our conversation just now. The board has trouble understanding just what I do … I may explain things differently”. In summary, the role my study may have to influence KT research is best seen as in contributions made for understanding of work processes and their organization from the standpoint of the everyday experience, valuing the role of documents (text) to coordinate KT processes, putting spotlight and importance to those invisible processes of greatest influence that invite or reject innovation, and a valuing of the reflective process as integral to KT activity.

With institutional ethnographic research and analysis completed for the understanding of the social organization of knowledge work for innovative practice at the 18-month visit, the following recommendations for reorganizations and refinements to current practice are put forward for consideration. These include:

**For FHT professionals in the clinical setting:**

- Identify peer champions for the change process. Understand, value, and support the role of peer champions within the organization. Through a process of facilitation, “a technique by which one person makes things easier for others” (Rycroft-Malone, 2004, p. 300), change can occur. Facilitators can inspire, model, enable, and empower staff to change their practice and where resistance is encountered can work individually and with teams, adjusting their role and style (p. 300) to work towards improved uptake of new
knowledge. From a study participant the following example supports this claim. She shared, “The docs were uncomfortable at first. They didn’t know how to do it, but I see such a change in it. First some of the docs would say, you come and do it … so they would actually stay in with me”;

• Champion the visit with colleagues and other teams;

• Identify a clear coaching role for the peer champion:

• Listen closely to the voice of parents. They have the power to shape practice that is not often represented at levels of decision-making. Where parents feel engaged in collaborative discussion with their caregiver around the 18-month EWBV they are not only educating themselves about healthy child development but also supporting new and innovative ways that are better aligned with actual needs and interests. Study findings found that parent participation and contribution in and to the visit was motivation for continued innovation. Several study participants contributed, “Physicians hearing parents talk about how their child develops, motivates them”; “We developed the Parent Self-Identified Concern Summary to help with the dialogue with parents because we felt that was important … we talked a lot, there was a lot of interaction, you know working together”;

• Use of on-line mentor networks to support the creation of new knowledge. From interview conversation with participants the development of on-line mentor networks for family physician, paediatricians, and others in the field of early child development was proposed. One spoke of how the networks, “with a cadre of experts available to answer questions about early child development” would support practice and champion the importance of the early years;
• Understand, value, and support the role of reflection as a powerful motivator and facilitator for change. Build in and support practice opportunities for individual and group reflection to champion and/evaluate change and its processes. As previously discussed insights from study discovery on the role of reflection to support innovation can be seen as a “structure for learning” (Hinett, 2002, p. 4) to support knowledge acquisition and skill development;

• Understand roles and responsibilities, power, and authority processes for what they can do to support, facilitate or be a barrier to change;

• Celebrate and engage in cross-discipline, cross-sector collaborative efforts, team work and partnership;

• Embrace quality improvement initiatives for what they provide as vehicles for supporting and sustaining change processes. Quality improvement plans in primary care provides health care organizations with the opportunity to build knowledge, use evidence, and focuses on quality of care. Some FHT site participants spoke of how their involvement with quality improvement planning assisted them in understanding the enhanced visit but also on the quality of the visits that were conducted. A participant shared, “we are all committed to quality and we know that there is good reason that this is being implemented and that this is based on good evidence”;

• Engage in community of practice discussions to sustain and encourage new knowledge initiatives. Support the use of data as a driver for change;

• Understand local practice in relation to the community which the practice is serving (e.g., EDI results as a barometer of need in the community for which the practice is serving); and
• Support and reach beyond the child health conversation with parents to one of child/parent relationship, mental health, and family functioning. Some study participants saw the 18-month EWBV as a springboard for broader conversations to empower family health. They suggested, “now that we have done the conversations with the child … In my mind I want to do the conversations with the parents … like birth control … with depression … with socioeconomic stuff … with violence in the home … this is just me but I want to get more into the mum. I do … both parents because when you think about it”; “We do not ask about relational health, I hope that once we get people starting to ask about development and encouraging parents to be more engaged in their child’s development, rather than asking “should I put salt on the carrots” we can get them excited about “what my baby just did” to think … from an attachment perspective, from an anxiety perspective. For physicians to wonder … when the baby get the needle. What happens? Does the mom cuddle in or just what happens?”.

For **community-based early years program and service providers**:

• Ensure that there is broad representation of all program and service providers at early years tables, including primary care providers and parents who receive services. Help to ensure that all have a shared and common vision, goals, objectives, and outcomes for service; and

• Support population health initiatives. A population health perspective looks at health in broad terms. Linked closely with opportunities that happen in the early years of a child’s life there is important synergy created from the 18-month EWBV as a universal strategy to inform other population health initiatives (e.g., mental health and well-being, substance abuse prevention).
For provincial ministries and child-focused knowledge organizations tasked with policy and program development and implementation support:

- Support the development of community/provincial wide networks for information sharing, lessons learned, and best practices to support innovation;
- Champion an enhanced and broadened conversation of the importance of the early years, the opportunities for collaborative practice, and the importance of an integrated system of early years providers; and
- Understand the powers of language, document (text), and mapping to understand the social organization and relations for where innovation and change occur.

**Study Limitations**

All studies have limitations, and this study is no different. In understanding “how things happen as they do,” sample size, limited prior research on knowledge work using IE as a form of inquiry all pose limitations on this research and its study. As well, limitations of me as the researcher can impact on the study. These may include issues of access (e.g., people who did not respond or allow themselves to be interviewed, organizations [FHTs who were approached to participate but did not respond]), and/or documents, quality of the interview questions developed to lead discussion (e.g., were the questions far reaching enough to understand all of the work processes both visible and invisible), time for the study’s investigation, and professional bias related to my nursing background and with my previous and current role with the 18-month EWBV initiative. And finally, while I am strong on the use of narrative as methodology, I was new to IE as a method of inquiry.

Though the study cannot speak for all family health teams or all health professionals involved in moving evidence to practice for delivery of the visit, it does begin to portray the relations that shaped work for several family health teams and their practices during the period of the research study. It does represent how those relations were mapped to the larger ruling
systems and institutions that guided their *knowledge work*, exploring both the visible and the invisible work of the process (Crispin, 2009, p. 167) involved in the creation of new knowledge during the transfer of knowledge, in the context of the application of knowledge to clinical decision-making.

**Significance and Potential Benefits of The Study**

Despite the limitation identified in the section above I contend, that there is potentially significant benefit for this study. In its approach there is opportunity for “new avenues of exploration” (Mykhalovskiy & Weir, 2004, p. 1059). For study participants there is probability for increased understanding of the social, and cultural contexts, within which practice occurs, that invites or discourages innovation, generally and specific to the 18-month visit. For the early years community, there is prospect that the study’s discovery could further understanding of child development as a determinant of health, and of the roles and responsibilities that the community has in promoting and supporting knowledge, new evidence, information, tools and resources for all those involved in the care of young children and their families. For the scientific and the scholarly community, contributions, benefits and significance of the study could be multipronged. First, it is hoped that the study contributes to the literature and understanding of knowledge translation processes and evidence-informed medicine, beyond theory and the “narrow treatment” (Quinlan, 2009, p. 626) of *knowledge work* as individual components of processes identified through model and framework development. The study, by applying IE as its method, anticipates new insights that may assist understanding of the “(a) influences of both micro and macro contexts, (b) connection of issues across multiple sites, (c) ability of documents (text) to shape and control lives in unrecognized ways, and (d) provision of practical tools to foster change at the local level” (Wright, 2003, p. 247). As well, there may be insight and possibilities for rendering visible ways that relations intersect and are organized
within organizations (p. 247), in particular kinds of activities. In addition, it is hoped that as Mykhalovskiy and Weir (2004) suggest, it is study such as this, where “close examination of the local settings in which the texts and routines of evidence based medicine are produced and enacted” (p. 1062) that understanding is provided to help unsettle the medical communities ‘protocol equals restriction of medical autonomy’ discussion” (p. 1062). It is hoped that the research, as a qualitative study of human action, interaction, and relationship, will in concluding provide, as Mykhalovskiy and Weir suggest, “a more complex understanding of the knowledge mechanics of evidence based medicine and how they are implicated in contemporary relations of power in health care” (p. 1062).

It is for the reasons, proposed above, that this research discovery, not traditionally found in the literature, can provide significance and is of benefit.

**Recommendations for Future Research**

Recommendations for suggested future research are fivefold. First, that KT and implementation science must become more creative in its approaches to understanding innovation and change. Beyond the silos of individual cognitive processes there must be more research dedicated to understanding new ways to look to understand how research, policy, and practice come together in their social organization and for their relationships. KT initiatives that neglect discovery found, when “people’s expertise is tapped into, in the conduct of their everyday lives – their ‘work’ “ (Campbell, 1998, p. 57) are missing significant opportunity to understand how social relations and social organization influence to reject or invite change. Without such understanding one is limited to conjecture as to what are the forces and processes at play for the adoption of evidence and new information to practice. As such, there is risk of undermining initiative integrity, not understanding the true barriers and facilitators to meaningful
practice change, and missed opportunity for awareness and understanding of how and why interventions work or not.

Second, the power of reflection as an important influence for change needs research opportunity. For innovation to be embraced, change adopted, the nuances of local implementation are what matter, for this is where real change happens. End users of innovation must be allowed opportunity to understand the influences that surround them for adoption of innovation. Their ability to critically reflect on their roles and responsibilities and the complexities of practice setting has the potential to strengthen attempts at innovation. Well discussed in Chapter Seven and Chapter Eight of the thesis, this recommendation may be at the core of successful KT initiatives. Reflection should be seen as a tool of knowledge work. It has influence to engage potential adopters of change, monitor the change process for relevance and meaning, and provide insight and/or determine the merits, worth, or significance of future change processes.

Third, costly, but yet cost effective, I suggest, is implementation practice with research and evaluation that pays close attention to the local level, building infrastructure (networks and local champions/knowledge brokers) to be active for a “door-knocking” like approach when large-scale policy and/or program implementation is proposed.

My fourth recommendation is simply put. Their needs to be more activity within the research world dedicated to fuller understanding of the role of documents (text). Currently there is a minimal amount of study dedicated to such understanding, yet much time, effort, and activity assigned to their development and distribution. Questions that must be asked are broad but can provide important insight, Is what is written, read? Why? Why not? How is discourse fashioned from their writing? Do they coordinate action as they are meant to?
My last recommendation is for mapping as an analytic. Mapping is a tool that has a helpful role for understanding, application to a multitude of other areas of organization, projects, and processes under investigation. Mapping puts into vision the actual sequences of activity that produce or inhibit change, shows where catalyst for innovation occurs, processing interchanges exist, and identifies where barriers to innovation may loom. Knowledge of all can serve to strengthen and/or focus (or refocus) the direction of efforts directed to change.
The Woodcarver

Khing, the master carver, made a bell stand
Of precious wood. When it was finished,
All who saw it were astounded. They said it must be
The work of spirits.
The Prince of Lu said to the master carver:
“What is your secret?”

Khing replied: I am only a workman:
I have no secret. There is only this:
When I began to think about the work you commanded
I guarded my spirit, did not expend it
On trifles, that were not to the point.
I fasted in order to set
My heart at rest.

After three days of fasting,
I had forgotten gain and success.
After five days
I had forgotten praise or criticism.
After seven days
I had forgotten my body
With all its limbs.

By this time all thought of your Highness
And of the court had faded away.
All that might distract me from the work
Had vanished.
I was collected in the single thought
Of the bell stand.

Then I went to the forest
To see the trees in their own natural state.
When the right tree appeared before my eyes,
The bell stand also appeared in it, clearly, beyond doubt.
All I had to do was to put forth my hand
And begin.

“If I had not met this particular tree
There would have been
No bell stand at all.

“What happened?
My own collected thought
Encountered the hidden potential in the wood;
From this live encounter came the work
Which you ascribe to the spirits.”

EPILOGUE: RESEARCHER REFLECTIONS ON THE FINDINGS AND THE STUDY

Qualitative inquiry is a search that leads into others’ lives, your discipline, your practice, and yourself. Each step, no matter how small, contributes to understanding (Glesne, 1999, p. 199).

Unraveling the threads and telling the story of “how one’s knowing is organized – by whom and by what” (Campbell & Gregor, 2008, p. 15) has been the work of this thesis and its research discovery. Its mapping has allowed a window-in to see how things happen in the way that they do (p. 16).

With that work now complete and with suggestions for future work proposed, I feel, as Eliot (1943) shares in his epic poem on exploration, that “we shall not cease from exploration and at the end of all our exploring will be to arrive where we started and know the place for the first time.” For this study and for its research journey comes appreciation and awareness that in the process, there is product.

In concluding this study and this thesis I find myself reflecting on the findings, both as the researcher and the professional. The research has provided opportunity to expand my knowledge rather than “substituting the expert’s knowledge for my own” (D. Smith, 2005, p. 1). It has provided interesting learning for the social organization and social relations that shape work and knowledge, brought to light the value and necessity of organizational and peer champions, the power of reflection as a motivator and catalyst for innovation, the role that

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**Personal Journal Entry - August 2013**

There is potential to strengthen implementation research by addressing the complexities of the practice setting and engaging potential adopters to critically reflect on existing practices and strategies for change (Kontos & Poland, 2009).

The writing is now complete. I feel a weight lifted and a hope that what I have created satisfies others, as it pleases me. I have saved this final quote for what I knew this journal entry would be. It expresses the hopes that I have for this study and its inquiry and speaks to reflection. The latter is for me a value. It is key to all that we should do and be, I believe. It is what allows us to be in our personal lives and in our professional ways. To see its power with my study participants, as we shared conversation, is what will remain with me. What potential it had to excite, motivate, and galvanize. How do we spread the word and make it critical to all that we do. Another question, another study.
documents (text) play in organizing, mediating, and coordinating work, and how focus to their role must be emphasized, helping to ensure a common base for understanding as innovation and expectations are brought forward.

In daily life, both personal and professional, I now find myself thinking differently, looking always through the lens of relation, organization, language, and text for meaning making. I inquire through the lens of reflection that asks, what is to be known, what is being said, and how is the story being told, how are things happening as they do? And, what does the process look like, for all of the visible and invisible process that are at play?

In a recent interview, Michael Palin, actor, writer, and comedian in the tradition of Monty Python fame, shared his interest in all things that are discovery, exploration, and understanding. He mused for the need to be curious. He shared, “you’ve got to go, sniff, smell the earth, see it, look at it; feet-on-the-ground exploration; experience geography first-hand” (Barmak, 2013). I agree.

And so, as this study comes to its conclusion, with lessons learned and opportunities for future research proposed, I reflect, looking back to where I began, for both research and doctoral study. I draw inspiration and encouragement from Palin’s comments and take solace and comfort for what this journey and its work has been, from the description found in the Taoist tale, *The Woodcarver*, shared as lead to this section. I am proud of this work. I look forward to life’s next opportunity and see this research not as an ending, instead a pointing-of-the-way, for another question, another inquiry, and another journey of exploration and discovery.
References


health. Toronto, Canada: Children’s Mental Health Ontario.


*Knowledge translation in interprofessional education: A review of literature and resources*. Vancouver, Canada: University of British Columbia.


*Journal of the American Medical Association, 290*(23), 3136 – 3138.


research organizations more effectively transfer research knowledge to decision

multifaceted approach to changing family physician practice patterns and
improving preventative care. *Canadian Medical Association Journal, 164*(6),
757 – 763.

Management Review.*

The Royal College of General Practitioners, 39*, 187 – 199.


Logan, J., & Graham, I.D. (1988). Toward a comprehensive interdisciplinary model of


application of clinical practice recommendations: From “official” to “individual” clinical


Innovation and Improvement.

Mann, K. V. (2004). The role of educational theory in continuing education medical education:
Has it helped us? *Journal of Continuing Education for Health Professionals, 24*, S22 –
S30.


Ministry of Children and Youth Services. (2005). *Getting it right at 18 months ... making it right at 18 years and beyond*. Toronto, Canada.


APPENDIX A

ETHICS APPROVAL

UNIVERSITY OF TORONTO

Office of the Vice President, Research

PROTOCOL REFERENCE # 28343

December 20, 2012

Dr. Charles Pascal
OISE/UT, DEPT. OF THEORY & POLICY
STUDIES IN EDUC.
OISE/UT

Ms. Nancy Elizabeth Novak
OISE/UT, DEPT. OF THEORY & POLICY
STUDIES IN EDUC.
OISE/UT

Dear Dr. Pascal and Ms. Nancy Elizabeth Novak,

Re: Your research protocol entitled, "Creating culture change: A study of how evidence is moved into practice for implementation of a public policy initiative in Ontario"

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We are willing to advise you that the Social Sciences, Humanities, and Education Research Ethics B has granted approval to the above-named research protocol under the REB's delegated review process. Your protocol has been approved for a period of one year and ongoing research under this protocol must be renewed prior to the expiry date.

Any changes to the approved protocol or consent materials must be reviewed and approved through the amendment process prior to its implementation. Any adverse or unanticipated events in the research should be reported to the Office of Research Ethics as soon as possible.

Please ensure that you submit an Annual Renewal Form or a Study Completion Report 15 to 30 days prior to the expiry date of your current ethics approval. Note that annual renewals for studies cannot be accepted more than 30 days prior to the date of expiry.

If your research is funded by a third party, please contact the assigned Research Funding Officer in Research Services to ensure that your funds are released.

Best wishes for the successful completion of your research.

Yours sincerely,

Sarah Wakefield, Ph.D.
REB Chair

Dean Sharpe
REB Manager

OFFICE OF RESEARCH ETHICS
McMurrich Building, 12 Queen's Park Crescent West, 2nd Floor, Toronto, ON M5S 1S8 Canada
Tel: +1 416 946-3270 ● Fax: +1 416 946-3763 ● ethics.review@utoronto.ca ● http://www.research.utoronto.ca/for-researchers/administrators/ethics/
APPENDIX B

ORGANIZATION /FAMILY HEALTH TEAM INFORMATION LETTER

Creating Culture Change: A Study of How Evidence Is Moved Into Practice for Implementation of a Public Policy Initiative in Ontario

Date
Organization/Family Health Team contact information
Dear ***

My name is Nancy Novak. I am a registered nurse currently studying with the Ontario Institute for Studies in Education, University of Toronto (OISE/UT). For the successful completion of my doctoral studies, I am required to undertake a research study and report findings in the form of a thesis. I am writing today to invite you to participate in the study.

Prior to sharing information on the purpose of the study, what your role will be as a participant and the risks and benefits of taking part, it is important for me to declare an additional relationship that I have with the study focus. In addition to my doctoral studies I am also employed as a Program Consultant (Nursing) with the Ministry of Children and Youth Services (MCYS) with ministry responsibility for oversight of education/information and tools to support delivery of the Enhanced 18-month Well-Baby Visit (18-month EWBV) in Ontario. The 18-month EWBV is a public policy initiative, announced in 2009, is the focus of my research study. The Ministry of Health and Long-Term Care (MOHLTC), a sister ministry of MCYS, is responsible for funding the visit through its fee code system. As the study’s principal investigator I will conduct all activities associated with the research project independent of a work role, on my own time and with faculty supervision. The research that I am undertaking has been classified as minimal risk student research in accordance with the Social Sciences, Humanities & Education Research Ethics Board, University of Toronto.

The following information and consent form is to assist in your decision to take part in the study. The purpose of the study is to understand how knowledge (child-health evidence) information, resources and tools for use at the Enhanced 18-Month Well-Baby Visit (18-month EWBV), a public policy initiative in the delivery of well-baby care in Ontario, are moved into practice. For purposes of this study I have defined, supported by the literature, the movement of evidence into practices as knowledge work involving the following processes, the creation of new knowledge during the transfer of knowledge, in the context of the application of knowledge to clinical decision-making (Quinlan, 2009).

The project is not an evaluation of individual clinicians or family health teams but rather supports an understanding of work processes for delivery of the visit; how implementation of the enhanced visit is put together through the work activities and actions of the clinicians.

What current research tells us about knowledge translation in health care is more about the “effectiveness” of the process but does not consider the “dynamics” of moving evidence to practice. My hope, in pursuing this research is to gain understanding of the everyday work of health care professionals navigating complex and regulated processes (Ng et al., 2012) as
they implement a new model of well-baby care at the 18-month visit, in particular the
structures and processes that enable, detract and sustain uptake of the 18-month EWBV’s
mandate.

Your experiences will be an important contribution for informing such a process.

In participating in this study you may benefit through increased understanding of the
conditions and implications for moving emerging and new child health evidence and
information into practice generally and the process specific to the 18-month EWBV. It is my
hope that the results of this study will contribute to broader understanding of child
development as a key determinant of health and the role that the community has in promoting
and supporting children and their families in the early years and continued opportunities for
awareness of the health dimensions of early years policy. An understanding of knowledge
translation processes that begin in practice, beyond theory or policy, highlighting the
nuances, exceptions and inequalities, and creative problem solving can help to further inform
policy and improve practice.

The study involves interviews and document collection analysis. Understanding from
the interview conversation and document analysis will help, to enable understanding of
what actually happens for the movement of evidence to practice in delivery of the 18-month
EWBV.

Participants in the study will be health professionals supporting education activities for
implementation of the 18-month EWBV in primary care practices in Ontario and paediatric
clinical-based practitioners who deliver the 18-month EWBV.

Your organization/Family Health Team has been selected to participate in the study because
of its history of working in partnership with primary care practices for uptake of the 18-
month EWBV/role in delivering well-baby care in Ontario. Understanding of that work
would provide valuable contributions to the study’s findings.

Data for the study will be gathered through a process of open-ended inquiry, oriented to
conversational interviews and document analysis. Interviews with staff will be scheduled
individually for a time and place convenient for each participant. Each interview will take
approximately one hour. Families participating in the 18-month EWBV will not be
interviewed. Following the interview process documents identified as part of the process,
used to support the implementation of the enhanced visit and the bringing of child health
evidence to practice (e.g., policy documents, brochures, standardized tools, web based
technologies, guidelines, local protocols and policies) will be collected.

Interview and key document analysis will be undertaken, culminating in a map. The map
will recreate study interview dialogue and documents identified by participants as part of
their 18-month EWBV work processes. It will represent actual sequences of work, day-to-
day document-based work that shape, and produces the translation of knowledge into
practice.

The interview sessions with participants will be audiotaped so that both I, as the researcher,
and my participants can review our conversation. The audiotapes will not be used for any
other purpose. They will serve only as a record of our discussion so that in the writing of this research, the dialogue can be described as accurately as possible. All of the information obtained from the interviews and document analysis will be kept in the strictest of confidence by the researcher. No personal identifier will be noted or used at any time so that the participant’s identity cannot be traced. Please be assured that discussions will be confidential, names and titles of organizations and participants will be omitted from the final draft of my research submission, and any personal information that participants choose not to share will be edited out of the final draft of my dissertation.

I foresee no risk as a result of your participation in the study. However, if any concern arises from your participation, please contact the researcher, Nancy Novak, at 905-683-6697. You can also contact the Office of Research Ethics, University of Toronto, at 416-946-3273 for answers to questions about research and about the right of participants.

**Participation in the study is voluntary. You are free to decline to participate, to decline to answer any questions, to request revisions to transcripts and can withdraw from participation in the study at any time. There are no consequences to those participants who choose to withdraw from the study. All data remain confidential. Participation rates for the study will be included in the final report findings but with no identifying information included. Following the interview process, once you as a participant are in receipt of a copy of the interview transcript and withdrawal from the study has not been requested then the right to withdrawal ends once data are in the process of analysis.**

If you have any questions about the study, or wish to discuss your organization’s participation in the research please contact:

Nancy Novak, Researcher  
78 Humphrey Drive  
Ajax, ON L1S 4Z1  
(905)-683-6697  
nanceliz@rogers.com

Dr. Charles Pascal, Faculty  
Supervisor  
Department of Applied Psychology & Human Development  
OISE/UT  
Office 9 – 184  
252 Bloor Street West  
Toronto, ON M5S 1V6

Thank you for your consideration.

Sincerely,

Nancy E. Novak
APPENDIX C

ORGANIZATION /FAMILY HEALTH TEAM CONSENT FORM

Creating Culture Change: A Study of How Evidence Is Moved Into Practice for Implementation of a Public Policy Initiative in Ontario

On behalf of _____________________________________ (Organization/Family Health Team) I have read and understand the attached description of the study. I understand the additional relationship that the researcher has with the study focus and that the research is being conducted independent of the researcher’s work role. I understand that the ‘Organization’ Family Health Team (FHT) has the option to withdraw from the study at any time. I understand that all information will be treated as confidential and that no identifying information for the name of the organization/FHT, the name(s) of individual participants and/or staff will be used that could identify the information collected.

I understand that the purpose of the research is not to evaluate organization or FHT member(s) or their work, influence performance or interfere with the everyday responsibilities of the organization/FHT.

I ______________________, agree on behalf of ______________________ (Organization /FHT) to have the Organization/FHT participate in the study.

Signature ____________________________________
Date  _______________________________________

Organization /FHT Contact Information

Address:
Telephone number:
Email address:
Creating Culture Change: A Study of How Evidence Is Moved Into Practice for Implementation of a Public Policy Initiative in Ontario

Applying for stakeholder/informant:

Site:
Organization/Team:

My name is Nancy Novak. I am a registered nurse currently studying with the Ontario Institute for Studies in Education, University of Toronto (OISE/UT). For the successful completion of my doctoral studies, I am required to undertake a research study and report findings in the form of a thesis. I am writing today to invite you to participate in the study.

Prior to sharing information on the purpose of the study, what your role will be as a participant and the risks and benefits of taking part, it is important for me to declare an additional relationship that I have with the study focus. In addition to my doctoral studies I am also employed as a Program Consultant (Nursing) with the Ministry of Children and Youth Services (MCYS) with ministry responsibility for oversight of education/information and tools to support delivery of the Enhanced 18-month Well-Baby Visit (18-month EWBV) in Ontario. The 18-month EWBV is a public policy initiative, announced in 2009, is the focus of my research study. The Ministry of Health and Long-Term Care (MOHLTC), a sister ministry of MCYS, is responsible for funding the visit through its fee code system. As the study’s principal investigator I will conduct all activities associated with the research project independent of a work role, on my own time and with faculty supervision. The research that I am undertaking has been classified as minimal risk student research in accordance with the Social Sciences, Humanities & Education Research Ethics Board, University of Toronto.

The following information and consent form is to assist in your decision to take part in the study.

The purpose of the study is to understand how knowledge (child health evidence), information, resources and tools for use at the Enhanced 18-Month Well-Baby Visit (18-month EWBV), a public policy initiative in the delivery of well-baby care in Ontario, are moved into practice. For purposes of this study I have defined, supported by the literature, the movement of evidence into practices as knowledge work involving the following processes, the creation of new knowledge during the transfer of knowledge, in the context of the application of knowledge to clinical decision-making (Quinlan, 2009).

The project is not an evaluation of individual clinicians or family health teams but rather supports an understanding of work processes for delivery of the visit; how implementation of the enhanced visit is put together through the work activities and actions of the clinicians.
What current research tells us about knowledge translation in health care is more about the ‘effectiveness’ of the process but does not consider the ‘dynamics’ of moving evidence to practice. My hope, in pursuing this research is to gain understanding of the everyday work of health care professionals navigating complex and regulated processes (Ng et al., 2012) as they implement a new model of well-baby care at the 18-month visit, in particular the structures and processes that enable, detract and sustain uptake of the 18-month EWBV’s mandate.

Your experiences will be an important contribution for informing such a process.

In participating in this study you may benefit through increased understanding of the conditions and implications for moving emerging and new child health evidence and information into practice generally and the process specific to the 18-month EWBV. It is my hope that the results of this study will contribute to broader understanding of child development as a key determinant of health and the role that the community has in promoting and supporting children and their families in the early years and continued opportunities for awareness of the health dimensions of early years policy.

An understanding of knowledge translation processes that begin in practice, beyond theory or policy, highlighting the nuances, exceptions and inequalities, and creative problem solving can help to further inform policy and improve practice.

The study involves interviews and document collection analysis. Understanding from the interview conversation and document analysis will help, to enable understanding of what actually happens for the movement of evidence to practice in delivery of the 18-month EWBV.

Participants in the study will be health professionals supporting education activities for implementation of the 18-month EWBV in primary care practices in Ontario and paediatric clinical-based practitioners who deliver the 18-month EWBV.

Your organization/Family Health Team has been selected to participate in the study because of its history of working in partnership with primary care practices for uptake of the 18-month EWBV/role in delivering well-baby care in Ontario. Understanding of that work would provide valuable contributions to the study’s findings.

Data for the study will be gathered through a process of open-ended inquiry, oriented to conversational interviews and document analysis. Interviews with staff will be scheduled individually for a time and place convenient for each participant. Each interview will take approximately one hour. Families participating in the 18-month EWBV will not be interviewed. Following the interview process documents identified as part of the process, used to support the implementation of the enhanced visit and the bringing of child health evidence to practice (e.g., policy documents, brochures, standardized tools, web based technologies, guidelines, local protocols and policies) will be collected.
Interview and key document analysis will be undertaken culminating in a map. The map will recreate study interview dialogue and documents identified by participants as part of their 18-month EWBV work processes. It will represent actual sequences of work, day-to-day document based work that shape and produce the translation of knowledge into practice.

The interview sessions with participants will be audio taped so that both I, as the researcher, and you as the participant can review our conversation. The audiotapes will not be used for any other purpose. They will serve only as a record of our discussion so that in the writing of this research, the dialogue can be described as accurately as possible. All of the information obtained from the interviews and document analysis will be kept in the strictest of confidence by the researcher. No personal identifier will be noted or used at any time so that the participant’s identity cannot be traced. Please be assured that discussions will be confidential, names and titles of organizations and participants will be omitted from the final draft of my research submission, and any personal information that participants choose not to share will be edited out of the final draft of my dissertation.

I foresee no risk as a result of your participation in the study. However, if any concern arises from your participation, please contact the researcher, Nancy Novak, at 905-683-6697. You can also contact the Office of Research Ethics, University of Toronto, at 416-946-3273 for answers to questions about research and about the right of participants.

Participation in the study is voluntary. You are free to decline to participate, to decline to answer any questions, to request revisions to transcripts and can withdraw from participation in the study at any time. There are no consequences to those participants who choose to withdraw from the study. All data remain confidential. Participation rates for the study will be included in the final report findings but with no identifying information included. Following the interview process, once you as a participant are in receipt of a copy of the interview transcript and withdrawal from the study has not been requested then the right to withdrawal ends once data are in the process of analysis.

If you have any questions about the study, or wish to discuss your organization’s participation in the research please contact:

Nancy Novak, Researcher
78 Humphrey Drive
Ajax, ON L1S 4Z1
(905)-683-6697
nanceliz@rogers.com

Dr. Charles Pascal, Faculty Supervisor
Department of Applied Psychology &
Human Development
OISE/UT
Office 9 – 184
252 Bloor Street West
Toronto, ON M5S 1V6

Thank you for your consideration.

Sincerely,

Nancy E. Novak
I have read the Information Letter/Consent Form relating to the above-titled project. I understand the additional relationship that the researcher has with the study focus and that the research is being conducted independent of the researcher’s work role. I understand the proposed research and my questions have been answered to my satisfaction.

I understand that I have the right to withdraw from the study at any time, that I may decline to answer any specific questions should I choose to do so, and that the information collected is for research purposes only. I understand that my responses and those of other individuals interviewed from the same location will not be disclosed to other members of the organization/team.

I consent to participate in this study.

___________________________
Printed Name of Participant

___________________________
Signature of Participant

___________________________
Date
APPENDIX F

INTERVIEW GUIDE/CONVERSATION GUIDE QUESTIONS

Creating Culture Change: A Study of How Evidence Is Moved Into Practice for Implementation of a Public Policy Initiative in Ontario

INTERVIEW GUIDE

Time of the Interview:

Date:

Site:

Place:

Interviewee (Title and Name):

Position of the Interviewee:

Other Topics Discussed:

Documents Obtained:

Post Interview Comments:

INTRODUCTION
Hello and welcome. My name is Nancy Novak and I am the researcher who will be conducting the interview today. Before we begin I will need you to read and sign this letter of consent to participate in this study. The letter provides some background information for the study and explains how your confidentiality will be maintained throughout the research process. Before signing I would like you to know that prior to our meeting today the ______________________ (Organization /Name of Family Health Team [FHT]) has provided me with a similar signed letter of consent acknowledging the organization’s participation in the study. The letter also explains how confidentiality will be protected both for the organization and for all participants in the study. As you prepare to sign the individual participant letter of consent you are welcome to review the letter of consent signed on behalf of your organization. Please let me know if you have any questions. If none, and with your signature to the individual participant’s letter of consent, I would like to begin taping our discussion – is that all right with you?
Confidentiality and processing of the information

- The interview should take about an hour. I will be taping the session because I do not want to miss any of your comments. In addition, I may take some notes during our conversation. Do you have any concerns with this process?

- Following the interview, you will have the opportunity to review the transcription or summary of your interview. For the duration of the study, all tapes, transcriptions and notes taken during the interview will be placed in a secure location and access will be restricted to only me, as the principal investigator for the project. Following the study the tapes and transcriptions will be destroyed. Study participants will be identified only by a pseudonym in any transcript and in the final draft of the thesis.

- This research is being conducted as part of my doctoral studies at the Ontario Institute for Studies in Education, University of Toronto (OISE/UT), under the direction of Dr. Charles Pascal as my faculty supervisor. Should either the institution or my supervisor require inspection of the research records, your confidentiality will be protected by the use of the pseudonym.

2. Background and the purpose of the interview

- The purpose of this study is to understand how knowledge (child health evidence), information, resources and tools for use at the Enhanced 18-Month Well-Baby Visit (18-month EWBV), a new public policy initiative in the delivery of well-baby care in Ontario, are moved into practice. For purposes of this study I have defined, supported by the literature, the movement of evidence into practice as knowledge work involving the following processes, the creation of new knowledge during the transfer of knowledge, in the context of the application of knowledge to clinical decision-making (Quinlan, 2009).

- The project is not an evaluation of individual clinicians or family health teams but rather supports an understanding of work processes for delivery of the visit; how implementation of the enhanced visit is put together through the work activities and actions of the clinicians.

- What current research tells us about knowledge translation in health care is more about the “effectiveness” of the process but does not consider the “dynamics” of moving evidence to practice. My hope in pursuing this research is to gain understanding of the everyday work of health care professionals navigating complex and regulated processes (Ng et al., 2012) as they move evidence to practice in implementing a new model of well-baby care at the 18-month visit, in particular the structures and processes that enable, detract, and sustain uptake of the 18-month EWBV’s mandate.

- Your experiences will be an important contribution for informing such a process. Thank you for making the time for us to discuss.
Credentials of the interviewer

- As mentioned I will be conducting this interview. I am currently a doctoral candidate in the Graduate Program at the OISE/UT. I am also a registered nurse, with my practice focused primarily in the field of public health nursing working in the area of early child development. Since 2006 I have worked within government, with the Ministry of Children and Youth Services (MCYS) as a Senior Policy Analyst and now as a Program Consultant. My role there has been, in part, to lead MCYS responsibilities for oversight of education/information and tools to support delivery of the 18-month EWBV.

- Information shared in connection with the study shall under no circumstances be used or disclosed for any other purposes than that for use with this research study. I further agree to be bound by the provisions outlined in Ethics Review Protocol Submission Form for Supervised and Sponsored Researchers, University of Toronto, Office of Research Ethics (2010).

Withdrawal from Participation

- Participation in the study is voluntary. You are free to decline to participate, to decline to answer any questions, to request revisions to transcripts and can withdraw from participation in the study at any time. There are no consequences to those participants who choose to withdraw from the study. All data remain confidential. Participation rates for the study will be included in the final report findings but with no identifying information included. Following the interview process, once you as a participant are in receipt of a copy of the interview transcript and withdrawal from the study has not been requested then the right to withdrawal ends once data are in the process of analysis.

Before we begin the interview, do you have any questions about anything I have just explained? Are you willing to participate in this interview?

Process

- The interview will take approximately one hour. Please feel free to ask questions at any time. Please be assured that you do not have to speak about anything you do not want to and you may end the interview at any time.

DISCUSSION GUIDE I

The following questions are meant as a guide with possibilities that participants may answer multiple questions in response to one question and may provide unsolicited information that is relevant to the research.

Questions to be addressed with Organization, key stakeholders responsible for education activities that support provincial implementation of the 18-month EWBV.

In your experience/as you understand:

1. Tell me about your work in relation to the Organization. (Probe roles and responsibilities).
2. Tell me about your experiences with the 18-month EWBV initiative. (*Probe roles and responsibilities*).

3. What was the initial mandate of the Organization with regards to 18-month EWBV activities? Has this mandate evolved? Why?

4. Tell me about the most effective or most helpful parts of 18-month EWBV activities.

**KNOWLEDGE TRANSFER**

5. How would you describe or interpret the term “knowledge transfer” (*Probe understanding/interpretation of knowledge work definition*)?

6. What do you think are the most important rationales for bringing evidence into practice related to the 18-month EWBV?

7. Tell me about what you would like primary care practitioners who deliver the 18-month EWBV to know or be aware of (*Probe progress and success outcome definition and measurement for the movement of evidence to practice for the visit*).

8. From your experience what are some of the methods that you have used to bring evidence into practice related to knowledge transfer for the 18-month EWBV (*Probe roles of printed education materials, CME activities, conferences, small group interactive education, educational outreach, local opinion leaders, mass media, computerized decision support, multi-professional collaboration*, quality improvement, financial interventions, patient mediated interventions, combined interventions).

9. What has been found to be effective? Most effective?

10. Tell me about the challenges involved in working to support the bringing of evidence to practice to support knowledge transfer/provincial implementation of the 18-month EWBV.

11. Tell me about the facilitators, or potential facilitators in bringing evidence to practice to support the implementation of the 18-month EWBV.

**DOCUMENTS**

12. What directs/governs the way you work with primary care practitioners who deliver the 18-month EWBV?

13. What documents related to the 18-month EWBV are you familiar with that support the movement of evidence to practice for the 18-month EWBV? Which documents do you use? (*Probe policy documents, regulatory texts, reporting texts, archival data, legislation, standardized tools, brochures, web-based technologies, and guidelines*).

**PRACTICE ORGANIZATION**

14. How do you personally navigate practice, for the sharing of evidence-informed education, information on child health, and tools to support delivery of the 18-month EWBV, with/in the health care teams and with practitioners?

   a. Do you, and if so how do you, see clinicians/teams organized to support the 18-month EWBV?

   b. Do you, and if so how do you, see disciplines, across the teams, organized to support the 18-month EWBV?

   c. How do you see documents/18-month EWBV documents organize, mediate and guide clinical practice for implementation of the visit (*Probe policy documents, regulatory texts, reporting texts, archival data, legislation, standardized tools, brochures, web-based technologies, and guidelines*)?
d. In your opinion/experience, is this documentation helpful to the process of supporting implementation of the visit?

e. Do you have examples of documents that your organization has created to support clinicians in their implementation of the 18-month EWBV?

f. What considerations do you/did you take into account when creating documents to support delivery or implementation of the visit.

15. Tell me more about an especially memorable/critical experience supporting/working with clinicians for this work.

16. What could primary care practitioners, who deliver the 18-month EWBV, do to further facilitate “Organization’s” collaboration with them for uptake and delivery of the visit? What could “Organization” do to further facilitate collaboration with clinicians to support uptake and delivery of the 18-month EWBV?

17. What if anything would you change in your practice of supporting clinicians in implementing the visit (Probe content/processes)?

CONCLUSION

18. What do you think about the child/parent experience in the 18-month EWBV visit?

19. Are there any other thoughts or insights on the experience of working with primary care paediatric clinicians as they integrate child health evidence for implementation of the 18-month EWBV that you would like to share?

In closing, I wondered if there was anything more that you would like to add. Is there a question that you think I should have asked but did not? Are there any documents or resources that you think would be helpful to have to further inform the study? If so where may I obtain a copy?

If nothing, thank you very much for your time and attention, both are very much appreciated. Would you like to receive a summary of the interview discussion and/or be informed of the study findings upon its conclusion?

Summary of the interview discussion:

Informed of the study findings upon its conclusion:

DISCUSSION GUIDE II

The following questions are meant as a guide with possibilities that participants may answer multiple questions in response to one question and may provide unsolicited information that is relevant to the research.

Questions to be addressed with FHT paediatric clinic-based informants responsible for implementation of the 18-month EWBV.

In your experience/as you understand:

1. Tell me about your practice in relation to the _______________ Family Health Team. (Probe roles and responsibilities).

2. Were you involved in the delivery of 18-month well-baby care prior to introduction of the enhanced visit?
a. If so, how? (e.g., assessments, program support, immunization, education, referral support)
b. In what capacity? (e.g. family practice nurse, nurse practitioner, family physician, community paediatrician)

4. What is your role in supporting implementation of the 18-month EWBV?
  a. How are you involved?
  b. How did you get involved?
  c. What motivates you to be involved?

5. Can you identify an aspect of your work activities related to the 18-month EWBV that you wish were different?

**KNOWLEDGE TRANSFER**

6. How would you describe or interpret the term “knowledge transfer” (Probe understanding/interpretation of knowledge work definition)?

7. Tell me about what you want primary care practitioners who deliver the 18-month EWBV in your practice to know or be aware of (Probe progress and success outcome definition and measurement for the movement of evidence to practice for the visit).

8. From your experience what are some of the methods that you have used to bring evidence into practice related to the 18-month EWBV (Probe roles of printed education materials, CME activities, conferences, small group interactive education, educational outreach, local opinion leaders, mass media, computerized decision support, multi-professional collaboration*, quality improvement, financial interventions, patient mediated interventions, combined interventions).

9. What has been found to be effective? Most effective?

10. Tell me about the challenges involved in working to support the bringing of evidence to practice to support implementation of the 18-month EWBV.

11. Tell me about the facilitators, or potential facilitators in bringing evidence to practice to support the implementation of the 18-month EWBV.

**DOCUMENTS**

12. What directs/governs the way your primary care practitioners deliver the 18-month EWBV?

13. What documents related to the 18-month EWBV are you familiar with that support the 18-month EWBV? Which documents do you use (Probe policy documents, regulatory texts, reporting texts, archival data, legislation, standardized tools, brochures, web-based technologies, and guidelines)?

**PRACTICE ORGANIZATION**

14. How do you personally navigate practice, for the sharing of evidence-informed education, information on child health, and tools to support delivery of the 18-month EWBV, with/in the health care teams and with practitioners?
   a. In your team, do you, and if so how do you, see clinicians/teams organized to support the 18-month EWBV?
   b. Do you, and if so how do you, see disciplines, across the teams, organized to support the 18-month EWBV?
   c. How do you see documents/18-month EWBV documents organize, mediate and guide clinical practice for implementation of the visit (Probe policy documents,
regulatory texts, reporting texts, archival data, legislation, standardized tools, brochures, web-based technologies, and guidelines)?

d. In your opinion/experience, is this documentation helpful to the process of supporting implementation of the visit?

e. Do you have examples of documents that your practice has created to support your clinicians in their implementation of the 18-month EWBV?

f. What considerations do you/did you take into account when creating documents to support implementation of the visit.

15. Tell me more about an especially memorable/critical experience supporting/working with the 18-month EWBV.

16. Would you change, and if so what would you change, in the process/content for bringing child health evidence and the evidence that supports the 18-month EWBV to practice/?

CONCLUSION

17. What do you think about the child/parent experience in the 18-month EWBV visit?

18. Are there any other thoughts or insights on the experience of your work as you integrate child health evidence for implementation of the 18-month EWBV?

In closing, I wondered if there was anything more that you would like to add. Is there a question that you think I should have asked but did not? Are there any documents or resources that you think would be helpful to have to further inform the study? If so where may I obtain a copy?

If nothing, thank you very much for your time and attention, both are very much appreciated. Would you like to receive a summary of the interview discussion and/or be informed of the study findings upon its conclusion?

Summary of the interview discussion:
Informed of the study findings upon its conclusion:
APPENDIX G

COPYRIGHT PERMISSION TO QUOTE/REPRINT
(Rourke Baby Record, Guide IV; NDDS – 2011 (18-month); Wiley)

----- Forwarded Message -----
From: "t@rourke@mun.ca" <t@rourke@mun.ca>
To: nanceliz@rogers.com
Sent: Wednesday, June 26, 2013 7:22:08 AM
Subject: RE: Nancy Novak - UT Copyright Permission

Hi Nancy,

As lead author of the Rourke Baby Record, I am delighted to give you permission to include the Rourke Baby Record, English 2011 - Ontario version, Guide IV as an appendix in your thesis.
All the best with your thesis and dissertation. Keep me in the loop re how it goes. I would also love to read the thesis when it is complete.

Best regards,
Leslie Rourke
Dr. Leslie Rourke, MD, CCFP, MChInSc: (FHi), FCFP, FRRMS
Associate Professor of Family Medicine
Faculty of Medicine, Memorial University of Newfoundland
Health Sciences Centre
St. John's, NL, Canada A1B 3V6
Telephone: 709 777 8541
Fax: 709 777 7913
Email: t@rourke@mun.ca
www.rourkebabyrecord.ca

----- End forwarding of message -----
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From: NDSS <nndss@ontera.net>  
To: nancellz@rogers.com  
Cc: janet.ndss@ontera.net; Marg Peterson <marg.peterson.nndss@gmail.com>; nndss@ontera.net; "Laferriere, Durlema" <durlema@benakidgibbs.ca>; Lynn Landry <landry@handslhm.ca>; Nicole Rochefort <nicole.rochfort@nympico.ca>; Nicole Foley@nndss.ca  
Sent: Wednesday, June 26, 2013 9:45:39 AM  
Subject: Nancy Novak - UT Copyright Permission  

Hello Nancy,

Your request was forwarded to the N마issing District Developmental Screen Intellectual Property Association (nndss IPA) for approval. They have approved your request to include the nndss 18-month checklist and activity sheet, English and French as an appendix in your Doctoral Thesis. The nndss IPA would like to request a copy of your dissertation, once complete, for their archives.

Sincerely,

Sue Campbell
Admin. Assistant
1 705-472-9211
1 1-888-582-0944
1 705-472-9588

P.O. Box 1493
North Bay, ON P1B 8K6

nndss.ca
nndss.ca
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www.facebook.com/nndss.ca
June 16, 2013

Re: Permission to Use Copyrighted Material in a Doctoral Thesis

Dear Canadian Permissions Requests:

I am a University of Toronto graduate student completing my Doctoral thesis entitled “Creating Culture Change: A Study of How Evidence Is Moved Into Practice for Implementation of a Public Policy Initiative in Ontario”. My thesis will be available via the U of T Libraries in digital format, for reference, study and/or copy for scholarly purposes. I will also be granting Library and Archives Canada and ProQuest/UMI a non-exclusive license to reproduce, loan, distribute, or sell single copies of my thesis by any means and in any form or format. These rights will in no way restrict republication of the material in any other form by you or by others authorized by you.

I would like permission to allow inclusion of the following material in my thesis:


Specifically:
1. Figure 1.1.1, The knowledge-to-action framework;
2. Content exceeding 200 words from Section 4 Theories and Models of Knowledge to Action (pages 185 – 226). Section content represents materials from,
   a. 4.1: Planned action theories;
   b. 4.2: Cognitive psychology theories of change;
   c. 4.3: Educational theories;
   d. 4.4: Organizational theory;
   e. 4.5: Quality improvement.

Please confirm in writing or by email that these arrangements meet with your approval.

Sincerely,

Nancy Elizabeth Novak
PhD Candidate
78 Humphrey Drive
Ajax, ON L1S 4Z1
nanceliz@rogers.com
Sent from my iPad

Begin forwarded message:

From: Permission Requests - UK <permissionsuk@wiley.com>
Date: 20 August, 2013 10:17:18 AM EDT
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Subject: FW: Permissions Request - Nancy Novak

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Thank you for your request.

Permission is granted for you to use the material requested for your thesis/dissertation subject to the usual acknowledgements and on the understanding that you will reapply for permission if you wish to distribute or publish your thesis/dissertation commercially.

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Emma Willcox
Permissions Assistant

WILEY

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To: Permissions - US
Subject: Permissions Request - Nancy Novak

Shik Safdar,

Thank you for taking my call this afternoon. I would appreciate your attention to my permissions request for content contained in the Wiley-Blackwell, BMJI Books publication *Knowledge translation in health care: Moving from evidence to practice*.
APPENDIX H

DOCUMENTS (TEXT) RESOURCES (PAPER AND ELECTRONIC) THAT INFORM TEXT-MEDIATED KNOWLEDGE AND WORK PROCESSES FOR PRIMARY HEALTH CARE

International
World Health Organization (WHO), (1978)
Declaration of Alma Ata
The Declaration of Alma Ata was adopted at the International Conference on Primary Health Care, Alma Ata, Kazakh Soviet Socialist Republic. It expresses the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world. It was the first international declaration underlining the importance of primary health care. It urged governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, nongovernmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference called on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of the Declaration. The Declaration has 10 points and is non-binding on member states.

World Report on Knowledge for Better Health: Strengthening Health Systems.
Through a review of global health research the document makes a diagnosis as to what strategies are needed to reduce global disparities in health through the strengthening of health systems. The report builds on previous reviews of global health research by the Commission on Health Research for Development (1990), the Ad Hoc Committee on Health Research Relating to Future Intervention Options (1996) and the International Conference on Health Research for Development (2000), as well as extensive consultations with key stakeholders. It argues that more health equity can be achieved only through better management of health research and increased investments in health systems research. It also advocates using research to strengthen human resources, health financing, information and delivery of health services. It proposes an action plan to meet these objectives that is based on strengthening and expanding existing initiatives and on identifying options and strategies for future actions.

WHO, (2005)
The Bangkok Charter for Health Promotion in a Globalized World.
The Bangkok Charter identifies actions, commitments and pledges required to address the determinants of health in a globalized world through health promotion.

WHO (2010)
Adelaide Statement on Health in All Policies.
The document introduces a strategic approach for government to take when setting policies to include social determinants of health for populations.
*Framework for Action on Interprofessional Education & Collaborative Practice.*
Prepared by the WHO Study group on Interprofessional Education and Collaborative Practice the framework highlights the current status of interprofessional practice around the world, identifies the mechanisms that shape successful collaborative teamwork and outlines a series of action items that policy-makers can apply within their local health system. The goal of the Framework is to provide strategies and ideas that will help policy-makers implement the elements of interprofessional education and collaborative practice in their own jurisdictions.

**National**
*A New Perspective on the Health of Canadians: A Working Document* (Lalonde Report)
The report proposed the concept of the "health field," identifying two main health-related objectives: the health care system; and prevention of health problems and promotion of good health. Four broad elements were identified: human biology, environment, lifestyle, and health care organization. The report is considered to have led to the development and evolution of health promotion and also the contribution of healthy communities and environments to health. (Minkler, 1989).

**Provincial (Ontario)**
Ministry of Children and Youth Services (2004)
*Best Start Implementation and Planning Guidelines*
Document to guide Ontario communities in the development of the Best Start vision. The guidelines served as a platform on which the broader determinants of healthy development could be addressed at the community level.

Ministry of Children and Youth Services (2006)
*Building on the Foundation – Moving Forward: Addendum to the Implementation Planning Guidelines for Best Start Networks – System Integration*
Accompanying document to the *Best Start Implementation and Planning Guidelines* with a focus on system integration at the community level.

Ministry of Health and Long-Term Care (2006).

Ministry of Health and Long-Term Care (2008)
*Ontario Public Health Standards (OPHS) (2008)*
The Standards establish requirements for fundamental public health programs and services, which include assessment and surveillance, health promotion and policy development, disease and injury prevention, and health protection. They outline the expectations for boards of health, which are responsible for providing public health programs and services that contribute to the physical, mental, and emotional health and well-being of all Ontarians. Boards of health are responsible for the assessment, planning, delivery, management, and evaluation of a variety of public health programs and services that address multiple health needs, as well as the contexts in which these needs occur.
APPENDIX I

DOCUMENTS (TEXT) RESOURCES (PAPER AND ELECTRONIC) THAT INFORM TEXT-MEDIATED KNOWLEDGE AND WORK PROCESSES FOR PRIMARY CARE IMPLEMENTATION AND DELIVERY OF ONTARIO’S 18-MONTH EWBV

Ministry of Children and Youth Services (2005)
*Getting it right at 18 months ... Making it right at 18 years and beyond*
A proposal to guide the development of a report to provide the basis for a provincial strategy to support standardized assessment at 18 months of age for each child in Ontario.

*Getting it right at 18 months ... making it right for a lifetime: Report of the expert panel on the 18 month well baby visit*
A report and recommendations for implementation of the 18-month EWBV in Ontario.

Ontario College of Family Physicians (OCFP, 2006)
*Final Report to the OCFP for the Evidence to Support the 18 Month Well-Baby Visit*
Facilitated by the Guidelines Advisory Committee (GAC) this document provides recommendations, developed by the GAC 18-Month Steering Committee for the enhanced 18-month visit.

Ministry of Children and Youth Services (2006 - 2011)
*The Enhanced 18-Month Well-Baby Visit*, PowerPoint presentation
Provides a description of the 18-month EWBV, an outline of the initiative and the components required to achieve delivery of the visit and an implementation status update on the initiative.

Offord Center for Child Studies (2009)
Enhanced 18-Month Well-Baby Visit [www.18monthvisit.ca](http://www.18monthvisit.ca)
A web portal providing an electronic platform for communicating with health care professionals and parents. The online education and information strategy enables the easy dissemination of practice tools, evidence-based e-learning, curriculum and online community support infrastructure for professionals as well as information for parents explaining the importance and expectations for their participation in the visit (MCYS, 2010).

Ontario Medical Review (2010)
*Ontario’s enhanced 18-month well-baby visit: Program overview, implications for physicians.*
Journal publication

Ministry of Children and Youth Services (2011)
*Ontario’s Enhanced 18-Month Well-Baby Visit: Information for Physicians & Other Health Professionals*. Professional brochure

Ministry of Children and Youth Services (2011)
*Your Child’s Enhanced 18-Month Well-Baby Visit*. Parent brochure
Nipissing District Developmental Screen® 2011  
www.ndds.ca  
A parent-completed developmental milestone checklist designed to assist parents, health care and 
child care professionals with a convenient and easy-to-use method of recording the 
developmental progress of infants and children within certain age groupings.

Rourke Baby Record© – Ontario 2011  
http://www.rourkebabyrecord.ca  
An evidence-based guide for health professionals in the delivery of the 18-month EWBV.

Canadian Paediatric Society (2011)  
Position Statement Early Childhood Development/Are We Doing Enough?/Status Report on Canadian Public Policy and Child Youth Health  
Documents in support of the 18-month EWBV as a health promotion strategy to support research into practice and an opportunity to assess and positively affect early child development and health and life outcomes.

Memo: Public Health Opportunities and the 18-month EWBV (2010)  
A memo to the field from Dr. R. C. Williams, Chair of the Expert Panel on the 18-month well-baby visit describing the 18-month EWBV and the opportunity and next steps for public health in support of the visit.

Foundation for Medical Practice Education (2011)  
18-month module  
Education based programming for small group (family physicians) based learning.

OCFP (2011)  
“Inside Out”: Number 85, Living Quality in Family Practice: The Enhanced 18-Month Well-Baby Visit  
Newsletter to family physicians identifying their role in providing quality of care in family practices.
APPENDIX J

SEQUENCE OF DOCUMENTS (TEXT) FOR IMPLEMENTATION OF THE 18-MONTH EWBV

Figure 1:  Getting it Right at 18 Months … Making it Right for a Lifetime: Report of the Expert Panel on the 18 Month Well Baby Visit

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Getting it Right at 18 Months …
Making it Right for a Lifetime

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Report of the Expert Panel on the 18 Month Well Baby Visit

September 2005
Figure 2: Final Report to the OCFP for the Evidence to Support the 18 Month Well Baby Visit

Final Report to the OCFP for the Evidence to Support the 18 Month Well Baby Visit

Recommendations developed by
The 18 Month Steering Committee
Facilitated by
The Guidelines Advisory Committee (GAC)

October 6th, 2006
Figure 3: ndds.ca (18-month Developmental Checklist/Activities for Your Child)
Figure 4: Rourke Baby Record – Ontario, Guide IV

Rourke Baby Record: Evidence-based Infant/Child Health Maintenance GUIDE IV: 18 mo - 5 yr

Ontario

DATE OF VISIT
18 months
3-5 years
6-8 years

GROWTH use VPTH growth charts

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Head circ.</th>
<th>Height</th>
<th>Weight</th>
<th>WC if prior BMI</th>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 cm</td>
<td>10 kg</td>
<td>38 cm</td>
<td>75 cm</td>
<td>15 kg</td>
<td></td>
<td>100 cm</td>
<td>25 kg</td>
</tr>
</tbody>
</table>

PARENT/RENEWAL CONCERNS

NUTRITION

1. Breastfeeding
2. Formula feeding
3. Solid foods introduction
4. Water intake
5. Nutritional concerns

EDUCATION AND ADVISORY

Injury Prevention

1. Car seat safety
2. Home safety
3. Childproofing
4. Injury prevention programs

Behavior

1. Parenting style
2. Discipline
3. Consistency

Family

1. Parental support
2. Family dynamics
3. Family structure

Other

1. Developmental delays
2. Speech and language delays
3. Behavioral concerns

DEVELOPMENT

1. Social development
2. Motor development
3. Communication skills
4. Cognitive development
5. Emotional development

PHYSICAL EXAMINATION

1. General appearance
2. Motor skills
3. Speech and language development
4. Hearing and vision
5. Dental health

PROBLEMS AND PLANS

INVESTIGATION/RADIATION

1. Recent vaccinations
2. Recent laboratory tests

Signature

Disclaimer: The Rourke Baby Record is a tool for the early identification of potential health problems in infants and young children. It is not a substitute for professional medical advice. The Rourke Baby Record is a copyrighted work and its use is governed by a license agreement. Unauthorized reproduction or distribution is prohibited. For more information, please visit www.rourkebabyrecord.ca.
Figure 5: Schedule of Benefits: Physician Services Under the Health Insurance Act (January 1, 2013), MOHLTC

Schedule of Benefits

Physician Services
Under the
Health Insurance Act
(January 1, 2013)

Ministry of Health and Long Term Care

Commentary:
The Schedule of Benefits Physician Services is a schedule under Regulation 552 of the Health Insurance Act, which is accessible from the Table of Contents, located at the beginning of the Schedule. Sections A, B, C, D, E, F, G, H, I, and the Numeric Index are relevant.
GENERAL PREAMBLE

ASSESSMENTS

WELL BABY CARE

Definition/Required elements of service:
Well baby care is a periodic assessment of a well newborn/infant during the first two years of life including complete examination with weight and measurements, and instructions to the parent(s) or patient’s representative regarding health care.

ENHANCED 18 MONTH WELL BABY VISIT

Definition/Required elements of service:
Enhanced 18 month well baby visit is the service rendered when a physician performs all of the following in respect of a child from 17-24 months of age:

a. Those services defined as “well baby care”;
b. An 18 month age-appropriate developmental screen; and
c. Review with the patient’s parent/guardian, legal representative or other caregiver of a brief standardized tool (completed by the patient’s parent/guardian, legal representative or other caregiver) that aids the identification of children at risk of a developmental disorder.

Medical record requirements:
This service is eligible for payment only when, in addition to the medical record requirements for well baby care, an 18 month age-appropriate developmental screen and concerns identified from the review of the brief standardized tool with the parent/guardian, legal representative or other caregiver are recorded in the patient’s permanent medical record.

[Commentary:
An example of an 18 month age-appropriate developmental screen would be that outlined in the Rourke’s Baby Record and an example of a brief standardized tool completed by the parent/guardian, legal representative or other caregiver that aids the identification of children at risk of a developmental disorder would be the Nipissing District Developmental Screen or similar parental questionnaire.]

PSYCHIATRIC ASSESSMENT UNDER THE Mental Health Act

Definition/Required elements of service:
A psychiatric assessment under the Mental Health Act (K620, K623, K624, and K629) includes such psychiatric history, inquiry, and examination of the patient, as is appropriate, to enable the physician to complete, and includes completing, the relevant forms and to notify the patient, family, patient representative and relevant authorities under the Mental Health Act, where appropriate.

GP30
January 1, 2013
Figure 6: Early Child Development and Parenting Resource System (Ontario)
Figure 7: Ontario Medical Review (2010)

Ontario’s Enhanced 18-Month Well-Baby Visit:  
Program overview, implications for physicians

by Robin C. Williams, MD, FRCP  
Jean Clinton, BMus, MD, FRCP  
David J. Price, BSc, MD, CCQ  
Nancy E. Nowak, RN, BSN, MEd

There has been significant “buzz” around an enhanced 18-month well-baby visit in Ontario over the past couple of years.

The 18-month visit is the last of a series of regularly scheduled primary care visits before school entry. Recognizing the importance of this visit, and the role that primary care plays in ensuring that all children meet their developmental potential, the Ontario Ministry of Children and Youth Services convened an Expert Panel on the 18-Month Well-Baby Visit to develop a report that would provide the basis for a provincial strategy to support standardized developmental review and evaluations at 18 months for each child in Ontario.

The panel's recommendations were based on evidence from multiple disciplines, which underscored the reality that the quality of the early years’ experience establishes trajectories of health and well-being for children. Published in 2005, the report from the expert panel entitled “Getting it Right at 18 Months: Making it Right for a Lifetime,” recommended shifting the focus of the universal 18-month visit from a well-baby check-up to a pivotal assessment of developmental health.

The recommendations included introducing a process using standardized tools in order to facilitate health professionals to have a broader discussion with parents on:

a. Child development
b. Parenting
c. Connecting to local community programs and services that promote healthy child development and early learning; and
d. Promotion of early literacy through book reading.

The visit also provides an opportunity to identify those children who will require referral to specialized services.

An underlying premise of the recommendations is that when there are collaborations among parents, primary care, community health and child development services, the outcomes for children will be improved. The full report is available online (http://www.children.gov.on.ca/htdocs/English/documents/topics/earlychildhood/getting_it_right18_months.pdf).

As part of an inter-ministerial collaboration, the recommendations were reviewed by the Ministry of Children and Youth Services, in partnership with the Ministry of Health and Long-Term Care and the Ministry of Health Promotion. The province responded to the recommendations and created an Implementation Advisory Committee and Working Group that developed strategies to support an enhanced 18-month well-baby visit in Ontario, based on the recommendations of the Expert Panel.

The following article outlines the purpose and nature of the Enhanced 18-Month Well-Baby Visit, key initiative components, and important implications for physicians. This article follows on previously published articles in the Ontario Medical Review that highlighted Ontario’s Best Start strategy, and the critical role of the primary care physician in child development.

The importance of well-baby visits

Family physicians, community pediatricians, nurse practitioners and other primary health care providers are in a unique position to improve the odds for positive childhood development outcomes by virtue of their ongoing contact with their patients and families over time.

These visits are opportunities for monitoring growth and development, for early identification of risk, and for referral to early intervention and treatment. Of equal importance is the opportunity to support parents, through anticipatory guidance, to enhance parenting skills that have been shown to
Figure 8: Ontario’s enhanced 18-month well-baby visit: Information for physicians & other health professionals (MCYS – Professional Brochure)
Introduction

Eighteen months is a milestone in a child’s development and a visit to a family physician or other health care provider at this time is important. Ontario has recognized the importance of the 18-month well-baby visit by funding a longer, more in-depth visit.

The overall goal of this new initiative is to better support the healthy development and well-being of Ontario’s children. What it means for you and your child is that you can have a more detailed discussion about your child with your family physician or other health care provider.

What can I expect at this visit?

When you go for your visit you and your health care provider will discuss your child’s development.

You will complete a checklist, such as the Ages & Stages Questionnaire®, which provides a snapshot of your child’s development and is a starting point for your discussion.

Alongside the checklist is information on typical child development, as well as activities to enhance development. It is available to you at the visit. You can also find it online at www.ontario.ca. It is a helpful parent tool that is free online to Ontario residents.

The enhanced 18-month well-baby visit is an opportunity for you to discuss your child’s development and address any questions you may have. For example, you may want to talk about your child’s motor or communication skills or behaviour concerns.

The visit also allows early identification of any concerns and a referral to specialized community services, if necessary, for your child.
Figure 10: Canadian Paediatric Society, *Position Statement* (2011)

**POSITION STATEMENT**

**Getting it right at 18 months: In support of an enhanced well-baby visit**

Robin Williams, Jean Clinton; Canadian Paediatric Society; Early Years Task Force

**The 18-month Well-Baby Visit**

Neuroscience has dramatically increased our understanding of the importance of the quality of early child development and its inextricable link to children’s behaviour, their capacity to learn and later health outcomes (1-4). This has increased attention on how the structure and process of well-baby visits can promote long-term health and well-being. There is tremendous potential for primary care providers to positively affect outcomes through regular contact with children and families in the early years. To fully realize this potential, paediatricians and family physicians must assess their current practice, updating where necessary with enhanced clinical practices and skills. Primary care providers — paediatricians, family physicians, and others — must also play a stronger role as advocates within the child health system.

No longer are well-baby visits limited to immunization and early identification of variance or abnormality. Increasingly, the primary care role is to proactively recognize and help enhance the unique assets of all children and their families. Primary care providers offer a wide variety of positive behaviours (such as breastfeeding, quality parenting, child management, injury prevention, and pro-literacy activities), using anticipatory guidance and connecting children and their families to their local community resources. For these interventions to be effective, the literature supports using a physician prompt health supervision guide, having found that clinical judgment alone is not enough (5).

Although primary care providers have an opportunity to work with families and children to enhance early childhood development at each well-baby visit, some jurisdictions have selected a pivotal visit as a starting point for universal, system-focused improvements. The 18-month encounter offers many opportunities: Not only is it seen as a crucial time in children’s development, but it is also a time when families face issues such as child care (especially centre-based care, which typically starts at this age), behaviour management, nutrition, and sleep. Screening for parental morbidities (mental health problems, abuse, substance misuse, physical illness) is an important task at all well-child visits, and particularly at this one.

The 18-month visit is often the final regularly scheduled visit (involving immunizations) with a primary care provider before school entry. Apart from illness-related visits, it may be the last time a child and family see their primary care provider until the child is four years of age or starts school. It is critical that families know how to promote healthy development during this important period of life and be alert to signs of difficulty, including problems with self-regulation, communication and language. They need to

Correspondence: Canadian Paediatric Society, 2105 St Laurent Boulevard, Ottawa, Ontario K1G 4J8. E-mail info@cps.ca

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