

PERSONAL VIEW

Building bridges with decision-makers: rules for rural and remote health researchers

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Submitted: 24 February 2006; Resubmitted: 9 July 2006; Published: 4 August 2006

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Rural and Remote Health 6: 567. (Online), 2006

Available from: <http://rrh.deakin.edu.au>

A B S T R A C T

Context: Until recently, rural and remote health researchers have undertaken predominantly investigator-driven research. In Canada and elsewhere, major health research funding agencies have begun to expect researchers to incorporate into funding proposals, a well-developed plan for sharing research findings with decision-makers, those who can incorporate relevant findings into clinical practice, programs and services.

Issue: The research arising from the interests of investigators, although frequently relevant to communities, too often has resulted in data extraction that parallels resource extraction from resource-based rural or remote communities. Such research can result in non-usable findings, and in the non-use of research findings by decision-makers.

Lessons learned: In order that useful and usable knowledge is created, bridges need to be built between researchers and decision-makers. Six 'rules for researchers' are proposed to help build bridges with decision-makers: Rule 1. Engage the right decision-makers; Rule 2. Determine what's in it for you and for them; Rule 3. Develop a sustained relationship; Rule 4. Live in their world once in a while; Rule 5. Think of doing research differently; Rule 6. Build integrative research infrastructures.

Key words: diffusion of innovation, knowledge exchange, knowledge translation, research methodology, research partnerships.



Context

The way in which many rural and remote health researchers in Canada are conducting research is undergoing a sea change. Until quite recently, rural and remote health researchers most commonly undertook investigator-driven research. That is, they identified interesting problems, made the argument for their importance, and set about investigating them. Researchers engaged those individuals or communities that were necessary to gather various kinds of qualitative or quantitative information, and forwarded the results to participants or communities 'upon request'. Seldom were ongoing relationships developed between researchers and the communities they studied. Increasingly, however, communities and research funding agencies are expecting researchers to engage strategically with those who are the subjects of research and/or those who are likely to use research results.

In response to rising public expectations that research findings will be translated into health benefits, funding agencies are rapidly evolving 'in terms of their approaches to and means of increasing the uptake and dissemination of the results of the research they fund'¹. In Canada, three national research funding agencies, the Canadian Institutes of Health Research, the Canadian Health Services Research Foundation (CHSRF), and now, the Social Sciences and Humanities Research Council, have begun more strongly to favour research that actively involves those who may use the research – in roles that go far beyond just receiving and using what researchers produce²⁻³. Partnered research has been explicitly identified as the way to undertake Aboriginal health research in Canada⁴. Similar efforts are underway in other countries. For example, in the US, the National Institutes of Health, as part of the 'Roadmap' initiative, are funding new Clinical and Translational Science Awards, which are designed to foster interaction among various kinds of researchers, clinicians, networks, industry, and professional societies in order to engender new professional interactions, programs, and research projects.

In many ways, the requirement to engage more directly with communities in conducting and translating the results of research works well for rural and remote health researchers. The long history of agricultural extension and farmer action research⁵ gives rural health researchers a base that others do not have. Many rural health researchers already routinely work with communities, and some have built up substantial networks of people with whom they regularly engage. Others are just beginning, and still others are reluctant to go there. One of the latter is a colleague, who said, 'You go make the connections – I'm going to apply only to those funders that don't make me have partners – they're too confining. They take too much time'. This unnamed colleague is now finding that in order to do research and receive appropriate funding, there is no getting away from working with decision-makers.

Issue

Opportunities to address the real needs of rural peoples have driven the ideas, inspirations and passions in rural health researchers' studies of rural health services and health determinants. In addressing the needs, however, rural health researchers have been subjected too often to well-founded critiques. One is that researchers have been guilty of data extraction. That is, researchers enter a community or communities, gather data, and leave. We do not leave the community with an increased capacity to engage in research or with a better understanding about their situation and how they might effect change. Although the research findings may benefit the community in the long run – the really long run – the immediate beneficiaries are ourselves as researchers, our students, our careers, as well as other researchers who read academic journals. The researchers' action of data extraction parallels the resource extraction that many resource-dependent communities feel happen in their economic and social lives. The second critique that researchers frequently hear from rural practitioners and community members is that our findings are nice, but not quite usable. Researchers seldom present findings to those we study in understandable terms or formats. We also



seldom answer the communities' 'so what?' question very well. A related criticism is that practitioners who are the subjects of research are sometimes blind-sided by research results that only partially capture important complexities of practice, sometimes to the point of distortion. The third critique is heard from researchers. Why does it take so long for our important findings to be used by those who can make a difference in rural and remote community health, safety and rural health services access and provision? These three critiques, of data extraction, of producing non-usable findings, and of non-use of research findings, are prompting the drive to find new ways of doing research, and to build bridges with those who use the results of research – decision-makers.

Lessons learned

Developing research approaches that engage with decision-makers in meaningful ways is neither easy nor simple. Lessons learned from 10 years' experience with partnered research has led to the creation of rules of how to successfully build bridges and work with decision-makers in rural and remote health research. A recently published book of rules for entrepreneurs⁶ was in part, an inspiration for the following 'rules for researchers':

Rule 1: engage the right decision-makers

The term, decision-makers, comes from health services research⁷. It generally means those who are in the position to make decisions on the use of research findings. In health services that usually means policy-makers and health service managers. It can also mean clinicians and members of particular lay or patient communities, non-governmental agencies, health industries, and the public at large. The Canadian Health Services Research Foundation has led change in Canada and elsewhere in articulating the field, and in providing resources to both decision-makers and to researchers about learning how to work differently⁷⁻⁹.

It is important to identify decision-makers with whom you can work over time, and who can help move your research and the use of its findings forward in appropriate ways, while meeting their own agendas for action. In 1999, colleagues and I were funded by the CHSRF for the national study, the Nature of Nursing Practice in Rural and Remote Canada¹⁰. A requirement of funding was the substantial involvement of a principal decision-maker. As we were putting the grant together, it became apparent that we needed not only the right person but also a person in the right position. In the national study, it was complex. We would be accessing nurses through each of the provincial nurses' associations, and our findings would be used for health human resource planning by provincial health ministries, provincial nurses' associations, regional health authorities, unions, as well as national associations, and the federal government departments - Health Canada and Health Resources and Development Canada. We sought advice from a senior national nursing policy-maker, who told us that instead of seeking a person from a national organization or federal department, we should seek the current head of the Federal Provincial Territorial Advisory Committee on Health Human Resources. We did, and it was the right thing to do. With this person's help, and the help of 23 key nurses at various policy-making, planning, and professional association levels nationally and in all provinces and territories, and our advisory team, we were able to make sure our research design was workable and our findings were reported in relation to current policy and practice issues.

In health services research it is perhaps easier to tell who are the decision-makers. In other fields within rural health research, it may be less easy. In a recent encounter with the Chief, Canadian Centre for Climate Modelling and Analysis, I asked who were the decision-makers for his own research on modeling climate change. He said that the question is the topic of continued debate in his office, but ultimately the decision-makers for his research are policy-makers, in Canada and internationally. He went on to say that a second key group of research-users are other scientists who need his research to do theirs on the impacts of climate change, and on methods for mitigating climate change (F Zwiers, pers.



comm., 2005). In his work, and in much of rural health research, scientists from other disciplines will be the end users, as much or more so than community members, farmers, health practitioners, engineers and planners. Like this climatologist, rural health researchers may find themselves working with scientists from other disciplines, and with policy-makers and the public, helping them to use the research in order to re-frame the problems with which they are dealing. Identifying the decision-makers for particular research projects has implications for who is involved, how they are involved, and how communication flows.

Rule 2: determine what's in it for you and for them

What's in it for researchers to build bridges with decision-makers are two things, obtaining funding and greater uptake of research findings. What's in it for decision-makers is more responsive research, as well as relevant approaches or answers to problems they need to solve. As funding agencies increasingly require meaningful knowledge translation in the criteria for grants, what it means to translate knowledge is expanding. Always, it means more than just presenting a paper or publishing in a research journal. Without the involvement of decision-makers in determining how knowledge arising from a study might best be used, meaningful knowledge translation is impossible.

A by-product of engaging in meaningful knowledge translation is learning how to ask the research question from the decision-makers' point of view. Concomitantly, decision-makers learn how to ask researchable questions. In our work within the national rural and remote nursing study, the researchers addressed in the first instance, the 'what' question, such as, 'What is the supply and distribution of registered nurses in rural and small town Canada?'¹¹ While finding that information to be useful, decision-makers were more interested in 'how' questions, such as 'How can we address practically, the shortage of nurses in rural communities?' Our study advisory team has created opportunities in each province and territory, and nationally, for us to present our findings in policy and planning

workshops and meetings that use the answers to the 'what' questions to begin to think of ways of addressing the 'how' questions. This dialogue with decision-makers has resulted in immediate research uptake. Subsequent projects, such as one on rural-focused nursing education and another on the development of a rural lens for practice, are not only considering what knowledge might be generated. They are also including consideration of what reconfigurations of work places and work processes are needed in order to appropriately take up research-generated knowledge⁹.

Rule 3: develop a sustained relationship

Creating a sustained relationship characterized by trust and respect is the most important thing that researchers can do with decision-makers. Over the past 10 years, a solid working relationship has developed among faculty involved in rural health research at the University of Northern British Columbia, and practitioners and managers within Northern Health, the regional health authority. By working together on a series of research projects of concern to practitioners and health service managers, as well as involving those same managers and practitioners in decision-making around faculty appointments and undergraduate and graduate curriculum, a considerable base of trust has been established.

The relationships are personal and flexible. An individual for whom I was a mentor is now a key decision-maker partner. She now mentors me in how to make my way through health service planning. Her advice in developing a relationship is for researchers to listen, to dialogue with decision-makers, to set aside assumptions about what a decision-maker is, or the kind of person they might be. Meet with them face-to-face. Communicate regularly. 'Assume they are hungry for information but too busy to actually digest this same information independently -- but don't make them feel stupid in the process' (C Ulrich, pers. comm., 2005).

The most recent studies of research uptake among policy makers show that trust in the interpreter of the research is key to its uptake¹². When decision-makers know and trust you as a researcher and your assessment of research *vis-a-vis*



their needs, your own research will be better received. And where there is trust and dialogue, researchers and decision-makers can be much more productive in creating the knowledge agenda together¹³.

Rule 4: live in their world once in a while

It would behoove all researchers to live in our decision-makers' worlds once in a while, so we can understand what they read, how they think, what decisions they routinely make, and what kinds of information they need to make them. Just before the Co-Principal Investigators (Co PIs) on the national rural and remote nursing study wrote the final report, I met with the Chief Nursing Officers of the six health authorities in British Columbia. I shared the results of the study in a presentation that the researchers had organized according to the advice of our advisory team around the themes of access to care, quality of care and sustainability of care. These themes had been identified as the key issues that policy makers were struggling with in health human resource planning and health service delivery. The British Columbia nurse leaders said that the information was fine and the organization into the three themes was appropriate, but the information in the form as presented from the researchers' perspective, was not usable. They asked me what we researchers would like to see as an outcome of the uptake of the research in 5 years time. The question stumped me and the other Co-PIs. It was a great struggle. In seeking to address that question while keeping true to the data, led to presenting our findings in ways that they became immediately usable (M. MacLeod, oral presentation, Truro, NS, Canada, 31 May 2005)¹⁴. Being in the decision-makers' world, and understanding how they needed information, turned our heads around.

Rule 5: think of doing research differently

In a study that is currently underway with public health nurses (PHNs) and high priority families (MacLeod ML, Browne AJ, Cerny, L, Moules NJ, Doane GA, Greenwood M et al., pers data, 2006) public health nurses on the team continually prompt the university-based researchers to think

differently about how research might be done. By involving staff PHNs in almost all the meetings the university investigators have, re-thought many aspects of the research creation and implementation. One aspect was to reconsider who may be researchers. Instead of training PhD students in family nursing from a southern university as interviewers, five PHNs in rural communities across northern BC were trained. The in-depth qualitative interview data they collected from families in sensitive situations reflected the PHNs' strengths in working with high priority families, as well as some limitations of their research experience. Importantly, however, research and researcher capacity has been built. This experience, for at least two PHNs, has renewed their interest in their jobs, and has given them new insights about how they can better work with families. Two others have elected to enroll in graduate studies. The process has helped to increase research awareness and interest among public health nurses across the northern part of the province.

Rule 6: build integrative research infrastructures

Too often the researcher-decision-maker links are dependent on the interests and skills of individual researchers and decision-makers. In northern British Columbia, where resources are limited, we need more synergy of effort. There is little depth of research resources in the Health Authority, and the university is research-intensive but small. We are now developing a process and an inclusive infrastructure to better support researchers and decision-makers at various levels and places in the Health Authority and its collaborating agencies¹⁵. This research infrastructure is designed to enable ideas to be generated and captured, so that they can be turned into research proposals, as well as processes for knowledge synthesis, knowledge exchange and research-based practice. The goal is to be both systematic and opportunistic in our research development.



Conclusion

In conclusion, rural and remote health researchers need to address the three issues of data resource extraction, of producing non-usable findings, and of non-use of research findings. The six proposed rules for researchers will help to build bridges with decision-makers. To recap:

- ◆ Rule 1. Engage the right decision-makers
- ◆ Rule 2. Determine what's in it for you and for them
- ◆ Rule 3. Develop a sustained relationship
- ◆ Rule 4. Live in their world once in a while
- ◆ Rule 5. Think of doing your research differently
- ◆ Rule 6. Build integrative research infrastructures

It is instructive to conclude with the words of a decision-maker, Cathy Ulrich, Vice President Clinical Services in BC's Northern Health Authority:

We need to assume decision-makers come to the table with legitimate and important things to say - just from a different perspective. The exciting part is in exploring these perspectives and finding the moments where there is intersection between the experiences and questions of decision-makers and the research interests and answers of the researchers. I am not sure there needs to be complete synergy or even understanding of each other's perspective ... we just need to listen long enough to find the intersections...

Acknowledgements

This material was first presented to the Canadian Centre for Health and Safety in Agriculture, 17 October 2005 in Quebec, QC, Canada. Thanks to Cathy Ulrich, Northern Health, and Dr Judith Kulig of the University of Lethbridge for their helpful comments.

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