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From 'multicultural health' to 'knowledge translation'—rethinking strategies to promote language access within a risk management framework

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ABSTRACT

Introduction. There is compelling international evidence on the negative impacts of language barriers and reliance on untrained interpreters on health and healthcare. However, response to this evidence has been slow and uneven, and gains made over the years risk being eroded. This 'knowledge to action' gap is, however, not unique to the issue of language access.

Methods. In one large Canadian health authority, a four stage knowledge translation (KT) strategy (getting the issue on the agenda; informing the response; guiding implementation; and changing provider practice) was developed to promote evidence-informed action to address language barriers. This multi-faceted strategy incorporated the principles of partnership with knowledge users, maintaining a focus on the evidence, phased introduction of evidence, synthesising evidence in context, and working within the conceptual framework of decision-makers. This approach reflected a shift from a 'multicultural health' to a 'risk management' approach in communicating with decision-makers, and integration of the issue of language access with already identified organisational priorities.

Results. This collaborative strategy resulted in health system adoption of a unique evidence-informed model of trained health interpreter services, even though initiated during difficult economic times.

Conclusion. Focused use of 'knowledge to action' strategies has the potential to promote evidence-informed action in provision of interpreter services.

KEYWORDS

Language barriers, evidence-informed services, knowledge translation, knowledge to action, organisational change, health interpreters.

1. Introduction

In both North America and Europe the increasing diversity of national populations is accompanied by growing attention to issues of equitable treatment and access. On both sides of the Atlantic, researchers are focusing on disparities related to health status, service access, prescribed treatment and health outcomes of minority populations. Addressing language barriers is

the one strategy for improving organisational cultural competence that has both theoretical and empirical evidence linking it to improved health outcomes (Brach & Fraser 2000). However, in spite of this evidence, response to addressing language barriers has been slow and uneven, and in many areas important gains made over the years risk being lost.

This paper will present a case study of a multifaceted knowledge translation (KT) strategy to promote evidence-informed action to address language barriers within a large Canadian urban health authority, the Winnipeg Regional Health Authority (WRHA) in the province of Manitoba. Although initiated during difficult economic times, these strategies have, to date, been effective in building consensus on a model for trained health interpreter services, and gaining funding to develop, implement and operate this new service.

2. The evidence on language barriers

The risks of language barriers and use of services of untrained interpreters to both the health of individuals, and to the health system itself, have been well documented. There is consistent and compelling international research, documented in several systematic and general reviews (Bowen, 2001; Flores 2005; Jacobs et al. 2006; Karliner et al. 2005), highlighting the impacts of language barriers on participation in health promotion and prevention activities; delayed presentation for care in non-urgent situations; barriers to initial access for most non-urgent health services; avoidance of needed care; increased risks of misdiagnosis; poorer patient understanding of and adherence to prescribed treatment; lower patient satisfaction; lower quality of care; increased risk of experiencing adverse events; poorer management of chronic disease; and poorer health outcomes. It is not only the individual client that is at risk: there is increasing evidence of the risks to health providers and organisations. Language barriers commonly result in failure to obtain informed consent; to appropriately assess and prescribe treatment (increasing risk of failing to meet care standards); and to protect client (patient) confidentiality. They are associated with lower provider satisfaction, impaired learning experiences for medical students and residents, and failure of organisations to learn from medical errors. There is also growing evidence on the often hidden costs of failing to appropriately address language barriers: increased use of high intensity services and decreased use of primary care services; costs related to misdiagnosis and repeat visits; and costs of longer lengths of stay and more intensive use of resources in some settings. These risks are not avoided through reliance on ad hoc interpreters or family members. Transcript analysis research has revealed the frequency of potential clinical consequences of misinterpretation by untrained interpreters. In fact, there is some evidence that working with untrained

interpreters may be more dangerous than having no interpreter at all—as it leads to the ‘illusion’ that accurate communication is actually taking place.

3. The gap between research and practice

If the evidence on risks is so compelling, why then has there been so little action? This gap between current evidence and action is not unique to the issue of language access, but a major challenge facing healthcare systems in all countries: there is a significant gap between what we know and what we do in either healthcare practice or health system management (Browman et al. 2003). Recognition of this ‘knowledge to action gap’ has resulted in focused interest in developing effective ‘knowledge translation (KT) strategies’ (Graham et al. 2006), including requirements for researchers to include a KT plan in their funding proposals, and dedicated funds for KT research. At the same time, there are increasing demands that both clinicians and managers use ‘evidence’ in practice, planning and priority setting; leading to a growing literature on both ‘evidence-based practice’ and ‘evidence-informed management’.

In spite of these initiatives, KT efforts to date have had modest impact (Grimshaw et al. 2004) leading to an intensity of interest in determining ‘what works’ in KT (Strauss et al. 2009). There is an emerging body of research in this area: simple, linear conceptions of how knowledge is ‘transferred’ have been largely abandoned. Research has identified interaction between researchers and users as a critical factor in research uptake (Innvaer et al., 2002; Bowen et al., 2005). This understanding has resulted in evolution of KT theory and a major focus on promoting research partnerships between users and researchers. An important development in the evolving understanding of what works in KT has been the differentiation between *end of grant* (the conventional approach to KT, focusing on dissemination) and *integrated* KT (Graham et al., 2006) that recognises that new forms of research are needed (Van de Ven & Johnson 2006; Nowotny et al. 2003). Also referred to as ‘Mode 2’ research, collaborative research, action-oriented research or co-production of knowledge (Graham et al. 2009), *integrated KT* requires meaningful and early engagement of users in all stages of the research process—from determining priorities and the research question, to interpretation of findings.

Nonetheless, there has been very little research exploring what KT strategies are effective in promoting action on knowledge related to issues of cultural diversity. We do know, however, that there are additional knowledge translation challenges in areas that are considered ‘soft’ science (Hanney et al. 2003), and that evidence related to underserved populations tends to be ‘marginalised’ in health system planning (Bowen et al. 2006). In order to

begin to address this gap in the research, a two-phase 'Knowledge to Action' research project (funded by the Canadian Institutes of Health Research—CIHR) was undertaken to determine what KT strategies were effective in moving evidence of concern to culturally diverse groups into health care planning and decision making.

4. Case example: language barriers in the Winnipeg regional health authority

The initial focus of this research was exploration of strategies for promoting evidence-informed action to address language barriers within the Winnipeg Regional Health Authority (WRHA), a large Canadian urban health authority responsible not only for health care planning and delivery within the Winnipeg region, but also for specialised and tertiary care for the entire province of Manitoba, areas of northwest Ontario and the territory of Nunavut.

Within the Canadian cultural and legislative context, four 'language constituencies' are recognised. Official language (English, French) speakers may face language barriers in areas of the country where they are a minority (e.g. Anglophones in Quebec, Francophones in Manitoba). The other constituencies are speakers of Aboriginal languages, of immigrant languages, and those using visual (sign) languages. Each of these language constituencies has different language 'rights' and is served by different government departments. At the time this initiative began in 2004, services for all these communities in the Winnipeg health region were separate and uncoordinated. Because French is an official language in Canada, the WRHA had a commitment to offer direct services in French, and a centre of responsibility for French language services. In addition, a successful challenge under the disabilities provision of the Canadian Charter of Rights and Freedoms (*Eldridge vs. British Columbia*, 1997) had led to well developed interpreter services for American Sign Language. There were also long established interpreter services provided by staff of the WRHA Aboriginal Health Services program to speakers of First Nations languages, and through a separate organisation (Kivalliq Inuit Services) for speakers of Inuktitut. Even where services were available, however, standards were not consistent, and services were often not used when needed. There were no trained health interpreter services for immigrant languages, nor were such services planned.

Growing concern among service providers related to the absence of trained interpreter services led to the engagement in 2004 of a researcher (SB) to undertake an initial review of the literature and an assessment of needs in the region. This was followed by establishment of a collaborative, steering

committee for the project, and implementation of a multi-phased knowledge translation strategy. In 2005, WRHA Senior management approved an evidence-informed model for trained interpreter services and provided funding to support this activity. Unique characteristics of this model included:

- Coordination of centralised access to services for all four language constituencies;
- Trained interpreters who provide 'neutral' rather than support/brokering roles;
- Centralised point of access—one phone number, accessible 24 hours a day, 365 days a year—for health interpretation across the health region;
- Availability of interpreters for both in-person and remote interpretation;
- Development and delivery of a customised in-house training program;
- Selection of a remote interpreter service provider, on the basis of standards of training and quality control, as back-up to the face-to-face service;
- Adoption of organisational policy (Interpreter Services—Language Access, 2009), and Code of Ethics and Standards of Practice for Health Interpreters (2007) based on best current evidence;
- Provision of interpreter services not only in acute care settings, but across the continuum of care—from health promotion and prevention to tertiary care.

While services for all languages constituencies were to be coordinated under the same umbrella, and training made available to interpreters from all language constituencies, the focus of the LAIS was on immigrant languages.

In June 2007, the first cohort of trained interpreters was employed and the service began phased implementation. As of December 2009, four training sessions had been delivered, and over 60 interpreters (speaking 32 non-Aboriginal languages) had successfully completed the training program and were employed as casual WRHA staff.

WRHA Language Access interpreter services are currently available free of charge to over 100 WRHA and WRHA-funded facilities, sites and programs, WRHA funded dental services, CancerCare Manitoba, and to local fee-for-service physicians. The latter is a leading development: in other Canadian

provinces failure to fund interpreter services for fee-for-service physicians is a major barrier to equitable and cost effective care for individuals who speak English as an additional language (Hoen et al. 2006). These services are also available on a cost-recovery basis to non health-related sites, programs, and services, e.g. social services, justice, education.

In addition to financial support from the health authority, funding for training development, interpreter training facilitation and ongoing coordination has been secured from the Manitoba Department of Labour and Immigration, an active participant in a Regional Language Access Committee (RLAC). In 2009, additional funding was obtained from the Manitoba Department of Health and Healthy Living.

5. What worked?

This initiative was effective while more established services have been losing ground. It is useful to explore strategies identified by participants as effective, and highlight principles (since used in other regional activities) found to be effective in promoting action.

5.1 Partnership is essential

Consistent with KT theory indicating the importance of meaningful involvement of those who are intended users of research findings, the first step was to establish a collaborative committee to guide activities. In addition to the researcher, there was representation from various service areas within the WRHA and from service providers/advocates for language services with each of the language constituencies. This committee reported directly to Chief Operating Office and Vice President, Community Health Services, which ensured direct connection to the senior executive decision-making body.

Those promoting language access services often work in close collaboration with affected language communities. However partnerships within the health system (or other systems that are the target of change) may not be so well developed. A principle of integrated KT is involvement of *intended users* of any research or evaluation in these activities if use of findings is to be promoted. This activity included as partners both those who understood the issues, and those who would be required to be 'on board' with any recommendations going forward—those currently involved in service delivery with the affected language communities, and those who understood organisational needs and perspectives and could facilitate organisational action. The RLAC created a climate where different perspectives and areas of expertise (research, clinical care, management, community interpreting)

were respected and valued. This setting promoted 'leverage' of the diverse expertise of participants to achieve greater understanding and creativity (Van de Ven & Johnson 2006).

The same principle is currently being applied as phased implementation of the service is undertaken, with establishment of facility or program-based steering committees. Preliminary data confirms that a key factor in appropriate uptake of the service is the meaningful participation of managers and staff at the front line. The Manager of the WRHA interpreter services has noted positive impacts on interpreter service use when direct service providers and managers promote the use of the service among their colleagues.

5.2 Clarify the KT Challenge: Focus the KT Activity

The first strategic question addressed by the RLAC was to determine the focus of KT efforts. It was quickly agreed that because the issue of language barriers was not even 'on the agenda' of decision-makers, the first task was to communicate effectively the evidence on these risks in a way that led to a decision that something must be done to address them. All initial strategies were, therefore, directed to the Senior Executive of the organisation—the 'audience' who were hoped to be the 'intended users' of any research or communication activities. When the activities proved to be successful in bringing understanding "that we have a problem and something needs to be done," the next step was to use evidence to *inform the response* to this identified problem. This is critical activity as—often within healthcare—while evidence may be used to identify a problem, the same strength of evidence is not necessarily used to frame the most appropriate solution (Bowen & Struthers, 2009).

Once the model was accepted, the focus of evidence use was on the challenges of *informing implementation*. Since it would be impossible to meet all needs the day the service was launched, what should the priorities be (in terms of health conditions, and languages)? And finally, evidence is now being used to *promote provider behaviour change*.

Phases of KT Strategy	Focus of KT efforts	Types of evidence used	Outputs	Desired Outcomes
Getting the issue on the planning agenda	Senior Executive and Board (policy)	Research literature on impacts of language barriers, and reliance on untrained interpreters, knowledge translation Demographic trends and projections Results of local community consultation and research activities Documented case examples Organisational strategic priorities and activities	Report: <i>Language Barriers within the WRHA: Issues and Implications</i> (2004)	Senior management recognition of risks related to language barriers and commitment to take evidence-informed action to address them
Informing the response	Senior Executive	Research literature ("best practice" related to interpreter services, modes of interpretation, interpreter roles, training needs, etc) Experience of regionalised services in other jurisdictions Standards of Practice, Codes of Ethics from established programs Demographic data and projections	Report: <i>Development of a coordinated response to addressing language barriers within the WRHA</i> (2005)	Senior management adoption of evidence-informed model

Informing implementation	Senior Executive, program and facility management	Research literature (priority health areas, organisational change, knowledge translation) Knowledge of organisational structure, program readiness Local assessment of KT needs and strategies Results of project Implementation Evaluation	Initial implementation plan Communication plan <i>"Interpreting" Knowledge into Action Phase 1 Findings Report (2007)</i> <i>Implementation Evaluation Report for WRHA Language Access Interpreter Services. (2009)</i>	Effective implementation responding to community and health priorities Minimisation of barriers that could risk continued implementation
Changing provider practice	Health care providers, managers, Policy Committee	Organisational change literature, evidence on effective and failed strategies to promote clinical and management change Local assessment of KT needs and strategies Results of project Implementation Evaluation	Language Access Resource Kit	Appropriate use of interpreter services by healthcare providers

Table 1: Summary of targeted KT activity and evidence sources

5.3 Start with, and stay focused on, the evidence

The starting point for each activity was the available evidence on the topic. Evidence was defined to include not only peer-reviewed research, but also evidence related to settlement patterns and demographic trends; needs and preferences of local communities; the experience of established health interpreter services in other Canadian jurisdictions; the organisational change literature; and organisational evidence (such as organisational strategic priorities). The evidence used at each KT stage is summarised in Table 1. It can be noted that ongoing research and evaluation activities contributed to the base of evidence for subsequent stages. For example, a

comprehensive assessment of the understanding of regional managers of the issues around language access and barriers to implementation of a trained health interpreter service was undertaken to inform implementation planning (Gibbens & Bowen 2007). Another critical component was findings of an implementation evaluation: findings informed and redirected the continuing implementation of this complex service; and strategies were developed to promote changes in provider practice (Gibbens & Bowen 2009).

5.3.1 Synthesise the evidence in context

This broader definition of evidence allowed the research to be *synthesised in context*, with the result that it was more meaningful—and useful—to decision-makers. For example, population patterns and projections for the province have important implications not just for future need, but also for the model of interpreter services most appropriate for a low population density province. Similarly, we found a need to synthesise local evidence with the research literature—local examples alone were viewed as ‘anecdotal’; however, the international research evidence was not convincing unless its relevance to the local context could be demonstrated. This need was addressed by integrating local, recent case examples into the research review.

<i>ACADEMIC LITERATURE</i>	<i>LOCAL CASE EXAMPLE</i>
<p>Language barriers affect the health and well-being of other family members. Relatives or friends may be forced to miss work (and often lose pay) to provide interpreter services. They often report stress related to the responsibilities of interpretation when they know their English language ability is limited (AMSSA, 2000). Mistranslation may result in tension between family members. Winnipeg school administrators report ongoing problems with children missing school to provide interpretation for their parents (Bowen, 2004).</p>	<p><i>Winnipeg: A woman went into labour at 30 weeks resulting in the stillbirth of twins. The circumstances of the birth were traumatic, as one of the twins started to emerge while the mother was at home using the toilet. The family had been in Canada less than a year, and the woman spoke no English. An 18 year old relative was used for most interpretation. However, at the time of discharge, the social worker attempted to use the woman's 8 year old son as an interpreter, until it became apparent that not only was he not capable of interpreting, but that he was also in distress, and needed support and comfort.</i></p>

Table 2: Example of integration of research and local case example

This 'focus on evidence in context' also proved to be an essential strategy for building consensus among diverse language constituencies. Findings from both the literature review and local community consultations indicated that the risks of failing to adequately address language barriers, and key elements of community preference for service, were similar for Aboriginal, Deaf, Francophone, and immigrant communities. This facilitated development of a response that could be supported by all constituencies. Evaluation of KT strategies (Bowen & Gibbens 2009) also found that RLAC committee members identified this continued focus on the evidence as supporting development of quality services—it allowed them to effectively 'resist' pressures to compromise on issues that would jeopardise service quality.

5.3.2 Phase the introduction of the evidence

In a situation of low awareness (as the issue of language barriers was in this organisation), and where a major initiative is needed, it is important to phase the introduction of evidence to support decision making. For example, it is not useful to present evidence on characteristics of a proposed model before the decision to take action has been made. It is also important to

position presentation of the evidence in such a way that it promotes a request for additional evidence related to the next stage of decision-making. To illustrate, in Phase 1 (getting the issue on the agenda) no recommendations were made regarding a proposed model—the recommendation was to *Develop a recommended model for addressing language access services for the Winnipeg region*—based on key principles identified in the first report (Bowen 2004). This resulted in a request for a second research activity focused on developing a model appropriate for the local context.

5.4 Work within the conceptual framework of knowledge users

This critical principle of knowledge translation was key to several of the strategies undertaken, and demonstrates the importance of partnership activities that included managers and staff who understood the culture, values and priorities of the organisation in general and of senior management in particular.

An important consideration in planning was that although there was sensitivity to issues related to Aboriginal health and French language services, there was very little organisational understanding of the risks of language barriers, and no internal organisational responsibility centre for immigrant/refugee issues. In spite of several leading cultural programs, issues related to cultural responsiveness were not seen as central to quality health care provision: they were considered ‘nice to have’ but not essential (Bowen, 2004). The challenge, therefore, was to align issues related to language barriers with issues that were of concern and priority to decision-makers. As outlined in Table 3, several activities illustrated this overarching ‘knowledge translation’ principle.

Principle	Examples in practice
Aligning with provincial or federal policy direction	Integrating provincial initiatives to increase immigration
Aligning with organisational strategic priorities or ongoing activities	Integrating evidence on risks of language barriers into regional “Integrated Risk Management Framework” (aligned with Accreditation Canada standards) Aligning communication with organisational strategic initiatives on Patient Safety
Positioning the issue around emerging incidents and organisational pressures	Linking need for trained health interpreters to recent complaints under the Personal Health Information Act

Identifying and using evidence to address concerns of decision-makers and staff	Developing conceptual business case argument based on the literature; collecting service cost data from other regional interpreter services to address decision-maker concerns about service costs
Presentation of response as a solution to an existing problem	Presenting trained health interpreter service as a strategy to address 43 of 154 regional organisational risks (e.g. confidentiality of patient information, ensuring informed consent, patient safety) Linking to existing knowledge of concerns regarding media coverage (Aboriginal community concerns, etc). Illustrate contribution of solution to organisational goals
Using language and concepts relevant to decision-makers	Frame discussion around concepts of 'risk management', 'patient safety', feasibility, 'cost implications', 'meeting organisational goals'

Table 3. Working within the Conceptual Framework of Knowledge Users

5.4.1 A risk management approach

A KT principle guiding initial activities, therefore, was to align with existing policy trajectories (Lavis, et al. 2002) and link with existing organisational activities. One key activity was the recent development of the regional Integrated Risk Management Framework, which was just being finalised and implemented across the region. This corporate activity, based on the standards of the then Canadian Council on Health Services Accreditation (now Accreditation Canada) and the regional insurer, had identified 154 corporate risks, organised in 12 categories (Table 4). Risk was defined as “anything that may compromise the achievement of the organisations objectives,” and risk management as a “process by which organisations identify, assess, control risks throughout the organisation.” Risk management was defined to consist of four components: risk identification; risk assessment, risk control, and evaluation of risk management activities. A risk management framework helped organise risk assessment and control activities under the headings of a) potential risk, b) impact, c) expected control, d) actual control, e) evidence and facts, f) control gap and g) recommendations. This organisational framework provided the opportunity to integrate the research on risks of language barriers into an existing organisational conceptual framework, and highlight both the often unrecognised risks of failure to appropriately address language barriers, and the gap between ‘best practice’ and current organisational behaviour.

**Table 4. Corporate Risk Framework**

A literature and organisational review found evidence that 43 of the 154 organisational risks identified were affected by language barriers. Risks were not limited to direct risks to patients, but also identified in the categories of Corporate Governance, Operations and Business Support, Reputation and Public Image, Human Resource and Staff Relations, Information, Systems and Technology, Environment, Health and Safety, Policies, and Standards.

As indicated in the summary of risks above, another major opportunity for alignment was related to the organisation adopting patient safety as an organisational strategic priority. Of the 31 organisational risks in the category of Quality of Care and Patient Safety, 26 were found to be impacted by language barriers.

Participation by a range of organisational participants in planning also allowed for identification of emerging incidents and concerns related to language access. Identified issues included legal and privacy issues related to protection of client information and ensuring informed consent; and ongoing concerns (and media coverage) of issues related to Aboriginal community satisfaction with healthcare. Known incidents where patients had been at risk because of communication difficulties were integrated into the ongoing discussion.

Another critical strategy was the positioning of development of trained health

interpreter services as a “solution that would address issues already of concern to the organisation,” rather than as a ‘new program’ which was competing for funding with other important initiatives. It was stressed that effective communication was necessary if the organisation was to address risks and achieve its organisational goals. In so doing, the emphasis shifted from meeting individual needs, to addressing organisational risk.

And finally, the way these messages were communicated had to be consistent with the concepts and language relevant to decision-makers. Discussions with senior managers, therefore, were focused on ‘risk management,’ ‘patient safety,’ and ‘cost implications,’ not ‘multicultural health,’ or ‘cultural sensitivity.’ Messages for practitioners also needed to speak to their work reality. Key messages recommended for direct service providers positioned the new service as a tool to support them in their work; making it easier to access interpreter services (i.e. single access point) and enabling effective communication to support the provision of ‘high quality and safe care’ and ensure ‘informed consent’ (Gibbens & Bowen 2007).

5.5 Effective knowledge translation is more than education

The ‘*Interpreting’ Knowledge into Action Phase 1 Findings Report* (Gibbens & Bowen 2007) highlighted the need for a multi-faceted KT strategy if the new trained interpreter service was to be effectively implemented. This is most evident in the final KT Phase (*changing provider practice*) now underway. It is a major challenge to change long established practice patterns in a health region with a total staff of nearly 29,000, distributed among multiple professional disciplines, dozens of facilities and hundreds of services and programs. Research on effective strategies to change practice around working with trained, accredited interpreters is still emerging. However, it confirms that it is insufficient to simply convey information on how to access a service, or educate providers on the risks of language barriers. It has been established that even when trained professional health interpreter services are available, provider use of the service is often poor. While misperceptions about service availability and appropriate use can be addressed by education; simply providing information on availability of the service and risks of failing to address language barriers, has not proven to be sufficient. Time and convenience are major deterrents to appropriate use, requiring attention to both practice environments and to service design in order to minimise disincentives (Diamond et al., 2008). Structural drivers (which could include such factors as incentives, promoting rights to language service among clients, and policy and practice audits) are also needed (Hwang & Phillips, 2009). Partnership with those intended to act on the evidence is essential if effective KT strategies are to be developed. In our example, adoption of a regional policy requiring use of trained interpreter services, and

ongoing efforts to decrease wait times in requesting interpreter services were two of the strategies employed.

6. Discussion

In the past, many efforts to improve language access services have had limited success and, in some jurisdictions, hard won gains are being eroded. Analysis of this case study suggests important principles that can increase the likelihood of moving the evidence related to language barriers into action. Key principles include creating opportunities for meaningful and ongoing partnership with those in a position to act on the evidence; focusing and targeting KT activities based on the phase of the initiative; understanding and 'translating' evidence into the conceptual frameworks of decision-makers; and addressing process and structural barriers, not simply informational ones.

In this setting, both patient safety and risk management initiatives provided the opportunity to link the evidence with current concerns and therefore fit into the conceptual frameworks of decision-makers. This 'risk management' approach was central to the overall KT plan. However, it is highly unlikely that this strategy, used in isolation, would have been effective. Each of the other components also played a critical role.

It cannot be assumed that this 'risk management' approach should be the focus of KT interventions in other settings. This approach was selected because adoption of the organisational risk management framework was a current—and high profile—organisational activity that provided a vehicle for communication of new information in a way that would be relevant to decision-makers. In fact, now that the focus is on changing provider practice, there is much less emphasis on this factor. Each initiative must develop specific strategies appropriate for the context in which it is attempting to make change—'risk management' may not speak to every organisation or health system. Strategies found to be effective in this setting should not be considered a 'template' that can be applied in any situation.

Selection of a risk management focus does, however, illustrate the shift from many previous communication efforts—often focusing on meeting the needs of a culturally diverse population, and relying on concepts (such as cultural sensitivity, multicultural health) that may be less persuasive to decision-makers—to a KT approach focusing on appropriate use of evidence in planning and decision making.

This case study also highlights the importance of careful assessment, and subsequent phasing, of all communication and KT activities. Strategies are

most likely to be effective if there is a clear understanding of what the desired outcome is, and who is intended (and required) to act on findings.

Knowledge translation activities cannot, however, be viewed as linear sequential activities, with clear end points. Although the phases of the KT strategy were introduced in the order described, there remains a continued need to revisit and reconfirm earlier decisions, to reintroduce the evidence presented at earlier stages, and to remind organisational participants of the reason for the service and the evidence on which the service (and supporting policy) is based.

Both 'end of project' and 'integrated' KT strategies were essential to success of the initiative. End of project KT was reflected in effective communication of existing evidence: we know this communication was effective because it was acted upon. Integrated KT was reflected through the creation of the RLAC partnership, and the essential contributions of this collaboration. It would not have been possible to integrate the evidence in context, to identify effective strategies, or even have appropriate access to decision-making settings, had the researcher been working in isolation.

This initiative also reflects how integration of research and contextual evidence can help reposition an issue of 'low awareness' from being perceived as just one more demand for funding in an already overstretched system, to a potential solution for addressing multiple organisational risks, and helping achieve organisational goals.

It is also important to note, that while the initiative incorporated knowledge translation theory, and CIHR funding supported development and evaluation of 'knowledge to action' activities, the language and concepts of 'knowledge translation' were not that evident in committee and organisational activities. As became apparent during activities to evaluate the impact the various strategies, most participants did not perceive themselves as being involved in a 'knowledge translation' strategy. Discussion focused on the practical challenges of how to "get the attention of senior management on this important issue," or "how to 'convince' decision-makers to act based on the evidence." Organisational and community members relied on such concepts as 'strategic thinking,' 'communications,' 'collaboration' or 'community development' rather than 'knowledge translation.' While awareness of the relationship of these concepts and strategies to knowledge translation theory and practice developed over time, this understanding was not critical to the success of the initiative. It was useful, however, to highlight general principles (and the research literature on which they were based) in order to build capacity of committee members—both to enable the committee to continue its work when there was no longer KT research funding readily

available, and to promote transfer of strategies to other issues and settings.

7. Conclusion

The success to date of this knowledge translation initiative suggests that application of KT principles can help promote evidence-informed action on issues which to date have received little attention within healthcare—including the challenge of promoting action to develop appropriate language access services. While there is no ‘template’ for success, several principles can guide strategy development in other settings.

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Biography

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