3-2-2020 10:00 AM

The Practice of Local Policymaking: Understanding Decision Maker Roles and Agency in Local Implementation Contexts

Katherine L. Salter
The University of Western Ontario

Supervisor
Kothari, Anita R.
The University of Western Ontario

Graduate Program in Health and Rehabilitation Sciences
A thesis submitted in partial fulfillment of the requirements for the degree in Doctor of Philosophy
© Katherine L. Salter 2020

Abstract

This dissertation presents three studies that, collectively, seek to contribute to our understanding of the practice of implementation policymaking grounded in the experience of the practitioner. Herein, policymaking is conceptualized as a shared set of practices enacted by actors purposefully engaged in collective performances. This thesis makes important contributions to the iterative processes of theorizing by advancing knowledge about local policymaking practices in the following ways: 1) creation of the Knowledge Enactment in Practice Settings (KEPS) framework as a guide to assist in the exploration of knowledge-based practices including the co-creation of context; 2) use of new insights informed by the KEPS tool to examine and re-examine existing expectations around collaboration and local governance in implementation policymaking; and 3) a more substantial and nuanced understanding of the experience of decision makers practicing together within co-created settings.

In the first of the three papers, an interpretive synthesis included 35 studies that examined local policymaking to create representations of the types and sources of information and knowledge used, and key knowledge-based roles and activities. Based on this synthesis, an original framework (KEPS) was created. The KEPS framework depicted different aspects of the collective knowledge work of local policymakers which are explored in the following papers. The second paper explored the co-creation of practice in a lead-agency dominated setting within a multi-level implementation project in the Province of Ontario. The experience of dominance, and the potential for a culture of inequality as well as the importance of balance, flexibility and the development of trust for collaboration are discussed. In the third paper, an exploration of how engaged actors function within the practice setting described in the previous paper highlighted the role of power, resources and hierarchical accountability as well as the importance of meaningful engagement. Together, the three studies demonstrated the use of the KEPS framework in the exploration of knowledge enactment settings. Use of the KEPS framework supports the development of a more nuanced understanding of how engaged, local actors experience practice and highlights the need for greater awareness of the ongoing co-creation of practice settings.

Keywords

Summary for Lay Audience

Policy, once made, is not likely to be applied exactly as written. The application of high-level policy, like provincial or federal, in local community settings is a complicated and often messy process. This dissertation presents three related studies that set out to improve our understanding of the experiences of people who participate in the processes of applying high-level policy in local-level projects. This thesis contributes in the area of policymaking by: 1) presenting a new framework to help us explore the processes of decision making; 2) using what we learn to re-examine what think we know from studies already published in the literature and 3) developing a better and more detailed understanding of local decision making that reflects the perspectives and experience of decision makers themselves.

The first of the three studies was a review paper that collected information from 35 published studies to try and represent the types and sources of information and knowledge used in local policymaking, as well as to describe the kinds of roles and activities performed by local decision makers. The Knowledge Enactment in Practice Settings (KEPS) framework was created based on the results. In the next two papers, this framework was used to explore: 1) the ways in which decision makers worked together to define how and where they practiced decision-making and 2) then I explored the experiences of decision makers as they performed within the project they had helped to define. By studying each of these things separately, I found that inclusion and meaningful engagement were very important in the experience of local decision makers and that these features are influenced by rigid project structures and processes that may be adopted from a powerful lead agency. Overall, use of the KEPS framework highlighted the importance of understanding how project processes and structures are defined in finding pragmatic ways to support the meaningful engagement of decision makers.

Co-Authorship Statement

1) Salter, K., Kothari A. Evidence, Information and the Practice of Local Policymaking: An Interpretive Synthesis

   This paper has not yet been submitted for publication.

   The candidate is the principal author and performed the majority of all work associated with this manuscript.

2) Salter K., Kothari A. The Practice of Local Policymaking: Enacting Shared Practice Contexts

   This paper has not yet been submitted for publication.

   The candidate is the principal author and performed the majority of all work associated with this manuscript.

3) Salter K., Kothari A. The practice of local implementation policymaking: Practitioner engagement within a structured, multi-level practice context.

   This paper has not yet been submitted for publication.

   The candidate is the principal author and performed the majority of all work associated with this manuscript.

Dedication

First, I dedicate this work to my loving husband, Steve. He did not hesitate to support me when I announced that I would like to pursue doctoral studies and he remained the best one-person support team I could ever have hoped for throughout this long journey. My brilliant and beautiful sons reminded me every day why I continued and that I should and could do so. Lastly, I honour the memory of my parents – the people who fed my curiosity about the world and built the foundation for my love of learning.

Acknowledgments

I would, of course, like to acknowledge the contributions of my supervisor, Dr. Anita Kothari, who encouraged me, relentlessly, to find my own voice.

I would also like to give special thanks to Dr. Marlene Janzen Le Ber and Dr. Christopher Alcantera who joined my dissertation journey as members of my advisory committee to assist me in finding my way through to the end. Their comments and insights have been invaluable, helping me to see data in new ways and from new perspectives. More than just edits, though, they each offered and provided support that has been received with relief and gratitude.

In the completion of the interpretive synthesis and review, the contributions of several individuals also need to be acknowledged, specifically. Drs. Sandra Regan, Dr. Merrick Zwarenstein and Dr. Anita Kothari all participated in the development of seed citation lists, reviewing selections and negotiating inclusions. In addition, Sarah Masood (M.Sc.) provided read all of the papers identified for inclusion and provided a second set of MMAT ratings for the assessment of inter-rater reliability.

I would also like to acknowledge the assistance and support received from the Health Links support and LHIN-based staff. Without these individuals, data collection would have not been as successful or complete.

Table of Contents

List of Tables

List of Figures

List of Appendices

List of Abbreviations

Abbreviation or Acronym	Definition
CCAC	Community Care Access Centre
CCP	Coordinated Care Plan
EBM	Evidence-based Medicine
EBPM	Evidence-based Policymaking
HL	Health Links
HLLC	Health Links Leadership Collaborative
HQO	Health Quality Ontario
KEPS	Knowledge Enactment in Practice Settings
LHIN	Local Health Integrated Network
MMAT	Mixed Method Appraisal Tool
MOH	Ministry of Health
MOHLTC	Ministry of Health and Long-term Care
SW-LHIN	Southwest Local Health Integrated Network
TOR	Terms of Reference

Chapter 1

1. Introduction

Policymaking cannot be neatly defined by a discrete event or even by an explicit series of decisions or decision-making nodes (1, 2). As a process, it cannot be easily confined to a set of technical, linear stages or limited to a cycle (2, 3); rather, policymaking represents continuing and ongoing efforts by groups of actors to negotiate or co-create shared understandings and practices around issues of mutual concern in order to shape action (4-7). In so doing, policy actors actively frame issues, information, and knowledge, and work to mould what is to be considered and how it is to be acted upon (2, 8, 9).

The practice of policymaking is situated and contextualized, influenced by and influencing multiple spaces, levels and domains (10). In all of those spaces, at each of those levels, the relationship between information or knowledge source, policy actor or decision maker, and context is potentially complicated, conflicted and value-laden (11, 12). Creation of implementation policies at the regional or local levels may be more inclusive of local stakeholders who present a diversity of information and knowledge from multiple sources, including practical judgment, local experience and expertise, in addition to research-based information (13-16). What may be considered 'evidence' used to inform local implementation policy is constituted in social contexts through the mobilisation of knowledge and information in performative and discursive practices (4). 'Evidence', then, may be viewed as a resource that is multi-vocal or diverse and that includes research-based information but is not limited to it. Local decision makers may frame their choices within a sense of responsibility or obligation to the local context and attach importance to diverse knowledge and information resources, or 'evidence', that support these values (17, 18).

Researchers have not often addressed the processes through which knowledge and information is valued in context or the ways in which policy practitioners use their information and knowledge resources collectively to co-create new knowledge and shared understandings (19-21). While there is a burgeoning research literature concerned with the mobilisation and 'uptake' of research-based information that focuses on issues around 'getting evidence into

policy', there has been relatively little attention paid to the actual practices of policymaking as experienced by the policymakers themselves, including the perceptions and agencies of engaged policymaking agents at the local level within a multi-level system (10, 19, 22-25). As a result, theories proposed around the practices of policymaking may not always reflect engagement with the experiences of the policymaker in context (7, 19, 25).

Indeed, focusing on the use of the research-based evidence may have emphasized the interests of researchers rather than engaging with and reflecting the broader experiences of the policymaker in context (7, 19, 25). As a result, our understanding of the practices of policymaking may be limited by research approaches that often tell only part of the policymaking story, emphasizing views around research-based information and research utilization while skirting around the experiences of engaged policymaking actors in context (19, 22, 23, 26). This dissertation is structured as a series of three studies that together represent an attempt to challenge and expand our understanding of the collective practices of policymaking by listening, observing and learning from the perspectives of actors engaged in the "*messy unfolding of collective action*" (p.36) (27) within a multi-level implementation initiative. In this work, a new Knowledge Enactment in Practice Settings (KEPS) framework is developed following an interpretive synthesis of empirical studies examining local policymaking. Subsequently, this framework is used to explore different aspects of collective policymaking practices in the second and third papers corresponding to a) the co-creation of practice contexts and b) how decision makers function within the co-created or adopted practice frame. Insights generated through use of this practice-based lens facilitated re-examination of expectations previously held around the ways in which the processes of shared knowledge work are supported within local implementation settings. Exploration of the practice of policy decision making in context surfaced important themes related to inclusiveness and meaningful engagement of decision makers and served to highlight key factors associated with the practice setting, including those related to resource and cultural dominance and administrative hierarchies of accountability, which in turn had significant impacts on the ways in which engaged actors practiced. Identification of significant factors that influence the ways in which practice settings are negotiated and the experience of collective knowledge work in context should be considered

for inclusion in future iterations of the KEPS framework, as we continue to develop a more nuanced understanding of the practice of policymaking.

1.1   Background

Over the past two decades, there has been increased emphasis placed on the use of research-based evidence to guide and support public policymaking processes (22, 28, 29). This may be attributed, at least in part, to growing expectations for greater accountability and improved efficiency or effectiveness placed on those individuals, groups, or organizations engaged in the public service (30, 31). While the movement toward evidence-informed policymaking has been experienced across a variety of public sectors, including education and the criminal justice system, it has been vigorously pursued within the area of healthcare (32). In healthcare, the agenda established by the Evidence-Based Medicine (EBM) model in which the best evidence is collected and then applied to the provision of care has also informed the related constructs of evidence-based practice more broadly and evidence-based or -informed policymaking (18).

As Cairney and Oliver (18) noted, studies examining evidence-informed policymaking may be problematic in that they are grounded in the model of EBM and propose solutions built on that model rather than adopting the perspectives of policy process or practice from within the policymaking literature. In healthcare, there is a substantial literature around the 'know-do' or 'evidence-practice' or 'evidence-policy' gap that focuses on moving research-based information from academic settings (or from 'knowledge producers') into practice (or decision making) contexts (and to 'knowledge users') (19, 22, 33, 34). While the most current conceptualizations of the EBM model are inclusive of a range of evidence types and sources and do not necessarily privilege the use of research-based information, there remains a common commitment to the gathering and application of the best available research-based evidence (28, 35). Studies of evidence-informed policymaking tend to focus on the identification and use of evidence relative to specific products or outputs with little reference to the process of policymaking – an approach, grounded in EBM, that has been driven more by the interests of researchers than by the needs of

engaged policy decision makers (18, 25, 31). This dominant focus, however, has demonstrated that the complete story of the practice of policymaking has not been told, particularly from the perspective of engaged policy actors or decision makers (19, 22, 23, 26).

Actors engaged in policymaking inhabit complex, negotiated realities that exist within a multi-level system (4, 18, 36). While policy is created at all levels in multiple venues, there are distinctions to be made between the worlds of macro-level policymaking and those of regional or local operationalization and implementation (18, 36, 37). For instance, it is not sufficient to have created 'good policy' that exists at the macro level with no regard for how it will be executed. Policy once decreed is unlikely to be enacted as written (38). Models of highly centralized, top-down control in policy implementation have given way to more distributed models of local governance in which local authorities, collaborating institutions or organizations are tasked with the creation of viable solutions to the issues of operationalizing and implementing initiatives or programmes that fulfill macro-level policy directives (38, 39).

Local governance, as a concept, incorporates the notion that a substantial portion of the work of policy is implementation and that this work involves a diversity of actors, relationships, agendas and possible forms of authority (40, 41). In general, local governance is characterized as more de-centralized, operating across multiple organizations, institutions and community stakeholder groups, and comprising various horizontal and vertical relationships (26, 38, 42). It is often described as equitable, inclusive, deliberative and collaborative with value placed on local knowledge, shared learning and knowledge co-creation (18, 26, 42). But what then, are the implications for evidence-informed policymaking given these ideal principles of local governance? While research-based information may be generally acknowledged to be important in practice, assessment of its value, activation and use, is situated within the contexts of the local policy decision makers (18, 26, 28). Ideally, within these local contexts, collaborative and deliberative processes promote constructive consideration of information from many sources, including research, that facilitate social learning through discursive engagement and the co-creation of shared narratives (23, 43).

It is generally acknowledged that there is no simple way to inject research-based evidence directly into the practice of policymaking at any level (35, 44). What counts as evidence, to the local policymaker, is constructed within a dynamic, complex system in which realities of the decision-making process are often uncertain (45, 46). Decision makers may be 'epistemological bricoleurs', patching together information from many sources to create a hybrid of evidence to support policy and implementation frameworks (47). Research-based information and researchers represent only one of many possible sources of knowledge and information within the practice of local policymaking. Like all other information and knowledge sources, research and researchers are subject to collective discursive and performative processes within the practice environment (23, 26). What is valued as 'evidence' is part of this dynamic context in which some discourses or actors are privileged, and others silenced (Lancaster 2014). Research information may be perceived as useful, not because it is inherently superior or 'good', but because it provides a helpful platform for discursive processes undertaken in the negotiation of implementation policy (21, 23).

Understanding the application, translation or uptake of more research evidence to address 'knowledge gaps' and create policy tells us little about the practices within contexts of policy decision making that determine how engaged actors value, select and use knowledge and information (21). The application of more research-based information might be perceived as desirable by researchers, but the push to fill knowledge gaps tells us little about the processes through which research-based information acquires value within the context of policymaking. Shared narratives, emerging from collective and discursive engagement with the issue at hand, help engaged actors to establish a common understanding of the "*plot of the policy problem*" (p. 349)(23). The value assigned to research information by policymakers, as well as the way it is framed and applied, is situated within the context of this shared narrative (26, 28, 44, 45). To understand the collective processes of knowledge work, and how evidence is defined and used, it is necessary, therefore, to move away from the concepts of knowledge gaps to be filled and evidence uptake and instead focus our attentions on understanding how knowledge work is experienced by actors engaged in the practices of policymaking (21). To that end, more attention should be paid to the performative and interpretive processes within the practice of policymaking

and the ways in which new knowledge, including the shared understandings of the policy issues, the practice context and potential solutions, is co-created (45).

1.2   Purpose of this Thesis

Engaged policy actors or decision makers use knowledge and information from many sources; however, relatively little is known about the processes through which knowledge is negotiated and solutions are co-created within local policy contexts. In contrast to the literature concerned with 'getting evidence into policy', there has been relatively little attention paid to the practices of policymaking as experienced by the policymakers themselves; more specifically, the perceptions and agencies of engaged policymaking agents and how knowledge and information is used, created, conceptualized or valued by engaged decision makers (19, 22, 23). Given the acknowledged complexity of policy and implementation decision making within a multi-level system, there is a need for more studies that help us to understand the knowledge practices of decision makers engaged at the local level of implementation policymaking.

It was the objective, therefore, of this dissertation to challenge and expand our understanding of the collective practices of local policymaking as experienced by actors engaged in implementation decision making by addressing the question; "*How do local actors engaged in a local policy implementation initiative experience the knowledge-based practices of policymaking?*" To address the overall thesis objective, I undertook a study in two parts; 1) an interpretive review and synthesis; and 2) a case study presented in two parts. Both the interpretive synthesis and were informed by a practice-based epistemology.

1.3 Policy as Practice

The focus on moving research into policy may not be consistent with the realities of knowledge evaluation or selection undertaken by those groups of actors who work to co-create shared understandings and negotiate solutions to identified issues within policy implementation processes at the local level. There is a need to develop our understanding of policy practice in a way that is grounded in the experience of the practitioner (i.e., the decision maker or policy

actor) and that can provide a basis for explanation in a way that reflects the experience of the policy actor (7).

To engage with the experiences and activities of local policy actors, one might begin by discarding the notion that policy itself is a fixed artifact (6). Rather than separate policy from practice, policy can be conceptualized as a shared set of practices – enacted between and by groups of actors engaged in collaborative performances (4, 7, 10, 37, 48). Practice reflects human actors' purposeful engagement with their context as they interact with it in order to make sense of it (15, 49). Practice is performative (49). Action and meaning-making, therefore, are central to any conceptualization of practice. The study of practice provides the opportunity to observe what people – actors or practitioners – actually do in context, highlighting discrepancies between normative or theoretical prescriptions and the everyday experience of practice (50). Examining policymaking as a practice further invites us to where the action is by understanding actor roles and agencies within a complex and multi-level system, where policy can be co-created in many venues. Understanding the activities of local policy actors can bring fresh insights into how knowledge and information is conceptualized, valued and enacted within the practice of policymaking.

Practice-based epistemologies are consistent with an interpretivist paradigm. Interpretivist approaches acknowledge humans as creating meaning through their interactions with the world and with each other. Knowledge is negotiated through the interpretations of the knower, mediated by prior knowledge within situated contexts (51). Like interpretivism, practice-based approaches view knowledge as dynamic, emergent, negotiated through situated contexts and interpretations of the knower as people interact with the world and with each other, and also embrace the use of meaning-oriented methods in seeking to engage with and refine understandings of subjective experience of the world (15, 26, 51-53).

1.3.1   Praxiographic Case Study

Schatzki suggested that exploration of practice requires the use of ethnographic methods (54). To understand practice, the researcher should engage with techniques of observation and

interaction. "*To acquire this knowledge, the investigator has no choice but to do ethnography, that is, to practice interaction-observation*" (p.24) (54). Ethnography may be defined as "*a form of social and educational research that emphasises the importance of studying at first-hand what people do and say in particular contexts*" (p.4) (55). The term praxiography is used to describe ethnographic-style research conducted to explore practices rather than cultures (53, 56). Praxiography, as a type of ethnographic inquiry, has been used to study practices in a wide diversity of contexts including healthcare (57), education (58), gender studies (59), agricultural policy (60), international relations (61), and forestry (62), for example.

While ethnography is not a single, standardized or routinized method and there are many different kinds of ethnographic method practices (e.g. praxiography), ethnographies typically require lengthy and sustained, immersive contact, with participant observation serving as the central pillar of data gathering supplemented by interviews or focus groups and collection of relevant archival materials (63, 64). However, it is not often feasible for investigators to engage in and sustain the immersive contact that characterizes ethnographic study. Parker-Jenkins suggested that in light of limited time and other resource limitations, many investigators conduct what may be referred to as ethnographic case studies (64). An ethnographic case study draws on the techniques of ethnography to explore the perspectives and experiences of people in context but is limited by either a shorter, or more episodic period of field engagement (64). In this thesis, an ethnographic case study, that is, a phenomenon of interest occurring within a bounded context (65, 66) was undertaken from a practice-based approach (i.e. praxiographic) to explore the perspectives and experiences of actors engaged in local implementation policymaking using techniques associated with ethnography (i.e. participant observation, interviews and document analysis) to support thick description.

1.3.2 Brief Introduction to the Case Study

In December of 2012, the Ontario Ministry of Health and Longterm Care (MOHLTC) released their "Action Plan for Healthcare" (67). In this plan, the MOHLTC and its representatives described the results of an evaluation made of healthcare services and systems, reviewing progress made and identifying key areas in which further improvement was needed.

As part of the Action Plan evaluation, it was identified that approximately five percent of the population was responsible for using approximately two-thirds of the provincial healthcare resources (67). This top five percent was made up mostly of individuals who had multiple, often complex, health conditions. Many were elderly. Often, the healthcare utilization attributed to this group of 'high-use', complex individuals was associated with unnecessary emergency room visits, avoidable re-admissions to hospital and uncoordinated systems of care across multiple potential providers.

Health Links was intended as a direct response to these identified issues. By creating enhanced, seamless systems of care coordination for each individual with complex needs, inefficient and avoidable over-use of healthcare resources could be avoided, and each individual would receive the care they need, from the appropriate providers, close to home. To begin the process of developing Health Links as part of the Action Plan response, 19 early-adopter pilot projects were created across the province. Each project was charged with improving access to primary care for patients with complex conditions by reducing avoidable visits to their local emergency rooms, reducing unnecessary hospital re-admissions and improving patient satisfaction with their experience of care. Each pilot project was considered to be independent, encouraged to develop its own strategies for implementation in whatever ways the local decision-making group felt were most appropriate to their own local context, and accountable directly to the MOHLTC.

Working with the lessons learned from the evolving early-adopter pilot projects, the MOHLTC facilitated the expansion and standardization of key aspects of the Health Links initiative. In 2014, additional Health Links implementation projects were identified to begin development and accountability for each project was subsumed within the structure of the Local Health Integration Networks (LHINs). Over the next two years, the MOHLTC continued to work with the LHINs to create an Advanced Model for Health Links, which was introduced initially in June of 2015 to facilitate "*the consistent coordination of services and support the expansion of Health Links*" (68).

1.3.2.1   Implementing Health Links in the Southwest Region

The province of Ontario is divided into 14 LHINs. The southwest LHIN is responsible for the planning, strategic integration and funding of approximately 200 health service providers that deliver healthcare services to approximately 1,000,000 residents (http://southwestlhin.on.ca/aboutus/facts.aspx). There was a single early-adopter group established in the southwest LHIN as part of the pilot program for Health Links. As Health Links expanded, there was a need for greater engagement with the provincial initiative identified for the region. At that time (2014), Health Links, as an initiative, moved within the jurisdiction of the LHIN and a LHIN-based, centralized governance group was formed to provide strategic leadership for the six Health Links that had been identified for ongoing development within the southwest region.

In this praxiographic case study, the general areas of interest were identified as the knowledge and information enactment practices experienced by engaged actors within the decision-making groups tasked with the implementation of macro-level policy at local levels. The focus of the case study, therefore, is understanding the experience of policy making actors who acted in decision-making groups formed within the multi-level implementation initiative identified, rather than Health Links itself. The instrumental case[1], embedded in the complex context of Health Links, was defined as a decision-making group or groups operating within a frame of reference defined by provincial level policy or policies (macro level) and tasked with the negotiation and/or creation of locally-referenced implementation policy (i.e. the development of viable strategies or innovations to facilitate the local implementation of Health Links programs and services within the specified frame of reference).

---

[1] Stake identified three types of case studies; intrinsic, instrumental and collective (65). Intrinsic studies, according to Stake are concerning primary with understanding the specific case at hand while instrumental studies are undertaken with the goal of understanding an issue, phenomenon, perspective or experience more broadly. The case, itself, "is of secondary interest" (p.123) (65).

1.4 Structure of this Dissertation

This dissertation is presented in a total of five chapters. This first chapter provides a brief background and introduction to important concepts such as evidence-informed policymaking, and local governance. Chapters two through four present the body of the dissertation. Each chapter is presented as a separate, but integrated, paper containing its own introduction, background, objectives, method, observations, discussion, conclusion and reference list. The final chapter (Chapter 5) presents a general discussion and conclusion.

In this dissertation, I address the question; "*How do local actors engaged in a local policy implementation initiative experience the knowledge-based practices of policymaking?*" To begin my journey of exploration into understanding the practices of policymaking as they are experienced by policymakers at the local level, I completed an interpretive review and synthesis of existing empirical studies exploring local policymaking. This review and synthesis examined the roles and knowledge-related activities of engaged policymakers as well as the ways in which knowledge and information were gathered and assigned value. By querying the reported results of included studies, I was able to illuminate key knowledge-related activities and processes in addition to identifying valued types and sources of knowledge and information in local policymaking practices. The findings of this synthesis were used to inform the development of the Knowledge Enactment in Practice Settings (KEPS) framework. The interpretive synthesis and review are described in Chapter 2.

While each of the central chapters in this dissertation is written as a separate paper, it is important to note that they are all linked together in a specific way. The KEPS framework, created following the completion of the interpretive synthesis and review, formed an important part of this linked structure. Based on the findings described in Chapter two, there are two broad categories of knowledge work highlighted in the framework that correspond to practices identified in the literature: 1) the negotiation of practice context and 2) the negotiation of policy-relevant knowledge (within the practice context created by engaged actors). In the following two papers (Chapters three and four), I used the KEPS framework as an analytic tool in the

exploration of these two aspects of knowledge work within local policymaking practices as experienced by engaged actors.

In the second paper of this dissertation (Chapter three), I addressed the first of these two categories, illustrated within the KEPS framework, by exploring the experiences of the members of a regional level collaborative group (within Health Links) that was tasked with overseeing the implementation of macro-level health policy in local contexts by local Health Links teams, as they worked to co-create the practice setting for this initiative. This included the creation of project definitions, goals, rules for engagement, processes for the distribution of information, and administrative structures, for example. The third paper (Chapter four), also used using the KEPS framework as a guide to address the second category of knowledge work identified in the review and synthesis; that is, the negotiation knowledge relevant to the policy issues at hand, within a shared practice setting. In this paper, I focused on the experiences of engaged actors within the practice frame described in the previous paper. This included actors within the regional decision-making group as well as actor-members of local Health Links decision-making tables.

By adopting a practice-based lens, each study included here focused our attention on the experience of engaged policy actors, prompting consideration of both structure and agency within local implementation contexts, of how the practice setting was structured and how the policy actors then functioned within it. In the final chapter (Chapter five), important highlights from the preceding chapters, including the role of power, vertical accountability and expectations for meaningful engagement, are discussed in the context of practical implications and considerations for future work.

1.5 References

1.   Nutley S, Webb J. Evidence and the policy process. In: Davies H, Nutley S, Smith P, editors. What Works? Evidence-based policy and practice in public services Bristol, UK The Policy Press 2000. p. 13-41.

2.   Greenhalgh T, Russell J. Evidence-based policymaking: A critique. Perspectives in Biology and Medicine. 2009;52(2):304-18.

3.   Colebatch H. Beyond the policy cycle. Crow's Nest, New South Wales: Unwin; 2006 2006//.

4.   Wesselink A, Gouldson A. Pathways to impact in local government: the mini-Stern review as evidence in policy making in the Leeds City Region. Policy sciences. 2014;47(4):403-24.

5.   Stone D. Policy Paradox: The Art of Political Decision Making. 3rd ed: W.W. Norton and Company Inc. ; 2012.

6.   Freeman R, Maybin J. Documents, practices and policy. Evidence & Policy. 2011;7(2):155-70.

7.   Colebatch HK. Policy analysis, policy practice and political science. Australian Journal of Public Administration. 2005;64(3):14-23.

8.   Pope C, Mays N, Popay J. Informing policy making and management in healthcare: the place for synthesis. Healthcare policy = Politiques de sante. 2006;1(2):43-8.

9.   Laws D, Rein M. Reframing practice. In: Hajer M, Wagenaar H, editors. Deliberative Policy Analysis: Understanding governance in the network society. Cambridge, UK Cambridge University Press 2003. p. 172-206.

10.   Freeman R, Griggs S, Boaz A. The practice of policymaking. Evidence & Policy. 2011;7(2):127-36.

11.   Orton L, Lloyd-Williams F, Taylor-Robinson D, Capewell S. The Use of Research Evidence in Public Health Decision Making Processes: Systematic Review. PLoS One. 2011;6(7).

12.   Tenbensel T. Does More Evidence Lead to Better Policy? The Implications of Explicit Priority-Setting in New Zealand's Health Policy for Evidence-Based Policy. Policy Studies. 2004;25(3):189-207.

13.   Kannampallil TG, Schauer GF, Cohen T, Patel VL. Considering complexity in healthcare systems. Journal of Biomedical Informatics. 2011;44(6):943-7.

14.   Hajer M, Wagenaar H. Introduction. In: Hajer M, Wagenaar H, editors. Deliberative Policy Analysis: Understanding governance in the network society. Cambridge, UK Cambridge University Press 2003. p. 1-30.

15.   Wagenaar H, Cook SDN. Understanding policy practices: action, dialectic and deliberation in policy analysis In: Hajer M, Wagenaar H, editors. Deliberative Policy Analysis:

Understanding governance in the network society. Cambridge, UK: Cambridge University Press; 2003. p. 139-71.

16.   Dobrow MJ, Goel V, Lemieux-Charles L, Black NA. The impact of context on evidence utilization: A framework for expert groups developing health policy recommendations. Social Science and Medicine. 2006;63(7):1811-24.

17.   Hajer M. Setting the Stage: A Dramaturgy of Policy Deliberation. Administration & Society. 2005;36(6):624-47.

18.   Cairney P, Oliver K. Evidence-based policymaking is not like evidence-based medicine, so how far should you go to bridge the divide between evidence and policy? Health Research Policy and Systems. 2017;15(1):35.

19.   Oliver K, Innvar S, Lorenc T, Woodman J, Thomas J. A systematic review of barriers to and facilitators of the use of evidence by policymakers. BMC Health Services Research. 2014;14.

20.   Cairney P, Kwiatkowski R. How to communicate effectively with policymakers: combine insights from psychology and policy studies. Palgrave Communications. 2017;3(1):37.

21.   Cairney P, Oliver K. How Should Academics Engage in Policymaking to Achieve Impact? Political Studies Review. 2018:1478929918807714.

22.   Lemay MA, Sá C. The use of academic research in public health policy and practice. Research Evaluation. 2014;23(1):79-88.

23.   Boswell J. 'Hoisted with our own petard' : Evidence and democratic deliberation on obesity. Policy Sciences. 2014;47:345-65.

24.   Boswell J. Deliberating Downstream: Countering Democratic Distortions in the Policy Process. Perspectives on Politics. 2016;14(3):724-37.

25.   Rickinson M, Walsh L, de Bruin K, Hall M. Understanding evidence use within education policy: a policy narrative perspective. Evidence & Policy: A Journal of Research, Debate and Practice. 2019;15(2):235-52.

26.   Zimmermann K. Changing governance - Evolving knowledgeScapes: How we might think of a planning-relevant politics of local knowledge. DISP. 2009;178(3):56-66.

27.   Greenhalgh T, Russell J. Reframing evidence synthesis as rhetorical action in the policy making drama. Healthcare policy = Politiques de sante. 2006;1(2):34-42.

28.   Wesselink A, Colebatch H, Pearce W. Evidence and policy: discourses, meanings and practices. Policy Sciences. 2014;47(4):339-44.

29.   Sá C, Hamlin D. Research use capacity in provincial governments. Canadian Public Administration. 2015;58(3):468-86.

30.   Head BW. Toward More "Evidence-Informed" Policy Making? Public Administration Review. 2016;76(3):472-84.

31.   Lane JP, Rogers JD. Engaging national organizations for knowledge translation: Comparative case studies in knowledge value mapping. Implementation Science. 2011;6(1):106.

32.   Davies H, Nutley S, Smith P. Introducing evidence-based policy and practice in public services. In: Davies H, Nutley S, Smith P, editors. What Works? Evidence-based policy and practice in public services Bristol, UK: The Policy Press; 2000. p. 1-11.

33.   Malterud K, Bjelland AK, Elvbakken KT. Evidence-based medicine – an appropriate tool for evidence-based health policy? A case study from Norway. Health Research Policy and Systems. 2016;14(1):1-9.

34.   Contandriopoulos D, Lemire M, Denis J-L, Tremblay E. Knowledge Exchange Processes in Organizations and Policy Arenas: A Narrative Systematic Review of the Literature. Milbank Quarterly. 2010;88(4):444-83.

35.   Oliver K, Pearce W. Three lessons from evidence-based medicine and policy: increase transparency, balance inputs and understand power. Palgrave Communications. 2017;3(1):43.

36.   Pope C, Robert G, Bate P, Le May A, Gabbay J. Lost in Translation: A Multi-Level Case Study of the Metamorphosis of Meanings and Action in Public Sector Organizational Innovation. Public Administration. 2006;84(1):59-79.

37.   Freeman R. Care, policy, knowledge: Translating between worlds. The Sociological review (Keele). 2017;65(2_suppl):193-200.

38.   Graham A. Pressman/Wildavsky and Bardach: Implementation in the public sector, past, present and future. Canadian Public Administration. 2005;48(2):268-73.

39.   Greenhalgh T. What is this knowledge that we seek to "exchange"? The Milbank quarterly. 2010;88(4):492-9.

40.   Colebatch HK. What work makes policy? Policy Sciences. 2006;39(4):309-21.

41.   Colebatch HK. The idea of policy design: Intention, process, outcome, meaning and validity. Public Policy and Administration. 2018;33(4):365-83.

42.   Fischer F. Participatory governance as deliberative empowerment: The cultural politics of discursive space. American Review of Public Administration. 2006;36(1):19-40.

43.   Ansell C, Sorensen E, Torfing J. Improving policy implementation through collaborative policymaking. Policy and politics. 2017;45(3):467-86.

44.   Green J. Epistemology, evidence and experience: evidence based health care in the work of Accident Alliances. Sociology of health & illness. 2000;22(4):453-76.

45.   Lancaster K. Social construction and the evidence-based drug policy endeavour. International Journal of Drug Policy. 2014;25(5):948-51.

46.   Cairney P. Evidence-based best practice is more political than it looks: a case study of the 'Scottish Approach'. . Evidence and Policy 2016; Early View Open Access.

47.   Freeman R. Epistemological Bricolage: How Practitioners Make Sense of Learning. Administration & Society. 2007;39(4):476-96.

48.   Dickinson H, Sullivan H. Towards a general theory of collaborative performance: The importance of efficacy and agency. Public Administration. 2014;92(1):161-77.

49.	Schatzki TR. Introduction: Practice theory. In: T.R. Schatzki KC, E. von Savigny, editor. The Practice Turn in Contemporary Theory. New York, NY, USA: Routledge Publishers/Taylor & Francis; 2001.

50.	Burawoy M. The Extended Case Method. Sociological Theory. 1998;16(1):4-33.

51.	Yanow D. Thinking Interpretively: Philosophical Presuppositions and the Human Sciences In: Yanow D, Schwartz-Shea P, editors. Interpretation and Method: Emprirical research methods and the interpretive turn 2nd Edition ed. New York, NY, USA: M.E. Sharpe Inc. ; 2014. p. 5-26.

52.	Maxwell JA. Designing a Qualitative Study. 2009 2020/03/17. In: The SAGE Handbook of Applied Social Research Methods [Internet]. Thousand Oaks

Thousand Oaks, California: SAGE Publications, Inc. 2. [214-53]. Available from: http://sk.sagepub.com/reference/the-sage-handbook-of-applied-social-research-methods-2e.

53.	Bueger C. Pathways to practice: praxiography and international politics. European Political Science Review. 2014;6(3):383-406.

54.	Schatzki TR. A Primer on Practices. In: Higgs J, Barnett R, Billett S, Hutchings M, Trede F, editors. Practice-Based Education: Perspectives and Strategies. Rotterdam: SensePublishers; 2012. p. 13-26.

55.	Hammersley M. Ethnography: problems and prospects. Ethnography and Education. 2006;1(1):3-14.

56.	Mol A. The body multiple : ontology in medical practice / Annemarie Mol. Durham: Duke University Press; 2002.

57.	O'Keeffe D, Thomson D, Dainty A. Evaluating the design of hospitals within a practice order network. Construction Management and Economics. 2015;33(5-6):415-27.

58.	Trowler PR. Practice-focused ethnographies of higher education: method/ological corollaries of a social practice perspective. European Journal of Higher Education. 2014;4(1):18-29.

59.	Latham JR. (Re)making sex: A praxiography of the gender clinic. Feminist Theory. 2017;18(2):177-204.

60.	Mather C. Avian influenza multiple: Enacting realities and dealing with policies in South Africa's farmed ostrich sector. Journal of Rural Studies. 2014;33:99-106.

61.	Bueger C. Doing Europe: agency and the European Union in the field of counter-piracy practice. European Security. 2016;25(4):407-22.

62.	Hoogstra MA. Forest market governance: exploring a practice-based approach. In: Arts B, van Bommel S, Ros-Tonen M, Verschoor G, editors. Forest-people interfaces: Understanding community forestry and biocultural diversity. Wageningen: Wageningen Academic Publishers; 2012. p. 291-307.

63.	Huberman M, Miles MB. Theories and Analysis The Qualitative Researcher's Companion. London, UK: Sage Publications 2002. p. 1-36.

64.   Parker-Jenkins M. Problematising ethnography and case study: reflections on using ethnographic techniques and researcher positioning. Ethnography and Education. 2018;13(1):18-33.

65.   Stake RE. Qualitative Case Studies. In: Denzin N, Lincoln Y, editors. Strategies of Qualitative Inquiry. 3rd edition ed. Thousand Oaks, CA, USA: Sage Publications 2008.

66.   Miles MB, Huberman M. Focusing and Bounding the Collection of Data. An Expanded Sourcebook: Qualitative Data Analysis 2nd ed. ed. Thousand Oaks, California, USA: Sage Publications 1994.

67.   Ministry of Health and Longterm Care. Ontario's Action Plan for Health Care. Toronto, ON; 2012.

68.   Health Quality Ontario. Health Links Toronto, Ontario Queen's Printer for Ontario 2020

Chapter 2

2   Evidence, Information and the Practice of Local Policymaking: An Interpretive Synthesis

2.1   Introduction

In recent decades, there has been a dramatic increase in the emphasis placed upon evidence-based policy and decision making; perhaps due in part to greater demands for transparency and public accountability in the policymaking practices of individuals or groups engaged in public service (1-4). The demands for evidence-based policy and decision making have been vigorously pursued across a variety of public sectors including healthcare where, increasingly, the application of evidence to policymaking is viewed as a requirement (2, 5, 6).

Evidence-based policymaking (EBPM) can be conceptualized using a linear problem-solving model underpinned by the notion of technical rationality (7, 8). Technical rationality was defined by Schon (1983) as "*instrumental problem-solving made rigorous through application of scientific theory and technique*" (p21) (9). Within rational models, research evidence is viewed as something that can be injected into the policy decision-making process to address identified issues or problems in a linear and bounded way (8, 10, 11). The success of these models relies on several important underlying assumptions. First, it is assumed that policymaking itself proceeds in a linear or stepwise fashion and is carried out, for the most part, by independent government actors. Further, there is an assumption that identified issues can be addressed through the application of the best available research evidence and that by measuring the right outcome, it is possible to know if this injection of evidence was successful (10, 12). It is also assumed that the systematic application of more evidence will result in correspondingly better decision making and the creation of even better policy (13, 14). However, techno-rational or instrumental views that regard policymaking as a linear, stepwise process do not reflect the messy and interactive dimensions of action that exist in policymaking contexts (10, 15, 16). In addition, there is an absence of robust evaluation evidence to support the assumptions that the application of more, 'best', research-based evidence results in improved outcomes (17).

The focus by researchers on identifying 'know-do gaps' and promoting the increased use of academic research to fill these gaps has been accompanied by a relative lack of attention paid to understanding the collective practices and processes of knowledge production, decision making and implementation within policy contexts (17, 18). However, the rational or instrumental models of problem-solving that have dominated approaches to EBPM represent only one lens through which to view the use of knowledge and evidence in policymaking. Other knowledge use and policymaking discourses, such as knowledge utilization, knowledge transfer or policy learning, for example, examine the use of different types of information and knowledge, and consider how ideas and information flow and are valued throughout policymaking processes (14). Social constructionist accounts examine the dynamic and emergent processes through which participants in the policymaking process engage in the negotiation of 'policy-relevant knowledge' (19), while still others, such as practice-based or 'knowing-in-practice' approaches, emphasize the importance of embodied knowledge and the co-creation of knowledge in context (14). In addition, in taking practice-based approaches to understanding the creation and enactment of knowledge, attention is focused on action – highlighting interactions between people as they engage with each other and with the world (20-22).

Healthcare, and the local contexts in which healthcare implementation policy is created and enacted, are characterized by social complexity, full of human actors with decision-making capacity in which problems are rarely simple to identify or solve (23). Within the EBPM literature, it has been observed that the complex and interactive experiences of practicing decision makers has not been well studied (18, 24). To promote an expanded understanding of the collective knowledge practices of local policymakers within the messiness of local level policy contexts, this study adopted a practice-based approach in completing an interpretive review and synthesis. The interpretive synthesis examined collective practices of knowledge production, decision making and implementation as guided by three inter-related questions: what types of knowledge or knowledge sources are used by local policymakers/policymaking groups in local contexts; how is value assigned to knowledge and information; and how are policymaker roles and knowledge-related activities described within the practice of local policymaking?

I begin by providing a brief review of EBPM, and policymaking in local contexts as a background to this synthesis and continue by introducing a practice-based lens through which one might view decision maker roles and activities in context. Through the use of an interpretive synthesis and review method, I addressed each of the guiding questions, creating a representation of local policymaking practices that included the types and sources of information and knowledge used and valued by engaged, local, policymaking practitioners as well as descriptions of important knowledge-related activities within practice settings. Using this information, the chapter ends by proposing a new framework, called the Knowledge Enactment in Practice Settings (KEPS) framework, for the ongoing study of local policymaking practices in a variety of contexts.

2.2   Background

2.2.1   What is evidence-based policymaking?

Policymaking has been described as a collective process in which people are engaged in the work of making context-sensitive choices about policy and policy options (10, 25, 26). Included in this collective process are choices concerning the integration of available evidence or information from multiple sources with potentially complex contextual factors (13, 27). Research-based evidence represents only one amid many potential sources of information, knowledge and understandings available that can be used to inform policy decisions (27-29). In the paradigm of EBPM, emphasis is shifted away from informal sources of knowledge and placed on evidence derived from formal sources such as research studies employing standardized, scientific methods (2, 30-32). Research evidence, however, while perceived to be systematic and unbiased in its creation, is neither value-neutral nor unproblematic in its application within potentially complex policy contexts (2, 33). Evidence cannot be assumed to be good based solely on characteristics such as internal validity; instead, it may be judged 'good' by decision makers based on perceived feasibility, appropriateness or acceptability in context (15, 34). Decision-makers bring diverse forms of information and knowledge to bear on policy questions and, as a source of information, research may hold no more value than any other,

including expert opinion, individual experience, common knowledge, personal ethics or political ideals (15, 23, 35). Indeed, for actors engaged in the practice of policymaking, choosing what information is defined as evidence may become part of the practice itself and may depend heavily upon the decision-making context (2, 13).

2.2.2   Local policymaking contexts

Where national or broadly regional policies exist (e.g. provincial or state), it is often at the local level where such policy initiatives are operationalized (15). However, operationalization at the local level is not simply a direct translation and execution of higher-level policy (36, 37). Many problems are too complex and too uncertain to allow for effective operationalization of widely standardized policy (36). Often, local authorities, decision makers or stakeholders are engaged in a collaborative and constitutive process, working to develop and deliver plans that will be consistent with the overarching policy vision, while balancing the local need for change with expected policy targets and deliverables (12, 15, 36).

This kind of broad, interactive, and potentially boundary spanning process is representative of a "*different kind of policymaking*" in which policymakers are not necessarily politicians or bureaucrats and policy is not necessarily the product of governments (36). The creation of local health policy, for instance, may engage representatives from hospitals and local healthcare organizations as well as healthcare professionals, patients and other stakeholders, while local health policy leadership may emanate from governmental, hospital or community-based organizations (26, 36, 38). This phenomenon may be reflected in a more interactive, intersectional and collaborative engagement of community stakeholders at local policymaking tables (36, 38, 39). Knowledge practices may vary between sectors as well as between organizations and their representatives. Local stakeholders may each use, understand, or define evidence differently (39).

2.2.3 Taking a practice turn

The concept of practice describes purposeful and flexible arrays of human activity and as such, it reflects interactive and context-bound engagement with the world (22, 40). In practice theory, action is viewed as the key strategy used by individuals to gain knowledge about the world (36). People negotiate the world by acting on it or interacting with it (40). As such, practices are meaning-making, identity-forming and order-producing performances that must be considered in relation to location and cannot be understood in isolation (21, 22, 41). The creation and enactment or application of knowledge cannot be usefully separated from action (21, 36). Knowledge is mediated by the interactions between people and engagement with the world (20-22).

Applying a practice lens provides a frame within which the actions or processes of local policymaking may be explored and encourages an examination of decision-maker roles and activities (22, 42). Viewing policymaking as a knowledge practice serves to focus attention on the knowledge work within the inherent messiness of the process through which local level policy is produced and implemented. Practice-based analysis integrates policy actors, along with their beliefs, values, experiences and actions into the process and introduces an awareness of the importance of practical judgement in context (22, 33, 36). By adopting a practice-based approach to the examination of local policymaking, this study is drawn into the action, exploring knowledge-related roles and activities within the policy context, including how information and knowledge are conceptualized and valued, from the point of view of local, engaged policymakers.

2.2.4 Examining knowledge-related activities in practice

To date, most research on EBPM and knowledge translation has been centered on the promotion of academic research and its use in the creation of public policy rather than examining the process through which policies are created, knowledge is used and co-created as part of the decision-making effort (17, 29). Rather than focus on how or how often a particular type of information from a single source is used, researchers have been challenged to extend their

examination to the ways in which decision-making actors value, make sense of, negotiate or use the variety of information that is presented during the process of creating local level policy (13, 17, 24, 43). Given that the operationalization and implementation of higher level regional, national or international policies is often undertaken at the local level, it is important to understand how decision-making processes work and how multiple sources of information and/or evidence can play a role in local policymaking (15). There is a need to examine the knowledge-based roles and practices of engaged policymaking actors within the local policymaking or implementation settings in order to understand what is conceptualized as relevant and legitimate information or knowledge in context (17, 37, 44).

To begin to address these challenges, this interpretive review and synthesis adopted a practice-based lens to explore and expand our understanding of what information and knowledge is used, understood, valued and created in context as well as the associated knowledge-based roles and activities of local policymakers in the practices of policymaking. The process of exploration was guided by addressing the three following questions:

1. What types of knowledge or knowledge sources are used by policymakers in local contexts?
2. How do individual, engaged decision makers or policy actors assign value to knowledge and information in their local context?
3. What knowledge-based work or activities are described in studies of local policymaking? What are the roles for engaged local actors in carrying out these activities?

2.3   Method

As the present study represents a review focused on exploring and expanding understanding rather than creating an aggregate summary, an interpretive synthesis was selected as the most appropriate review strategy. The method adopted for the present review was informed by the description of the interpretive synthesis method provided by Weed (45, 46), as well as interpretive syntheses performed by others previously (47) (23). Interpretive synthesis methods do not focus on exhaustive searches or comprehensive coverage, as is the case in a

systematic review; instead, they rely on an emergent and iterative process of sampling, interpretation, and inclusion based on relevance (45, 46). Key features of interpretive synthesis methods include:

- the use of an investigator or analyst that functions as an active interpretive agent;

- an acknowledgement that the synthesis represents a possible explanation and not the only explanation or interpretation;

- an iterative and emergent approach to the development of the research questions, sampling frame and the exclusion criteria, and;

- placing a focus on understanding meaning in context (46).

Table 2-1. Review Process

Stage of Review	Description of process
Formulating the objective and guiding questions	This review seeks to understand how and what information and knowledge is used, how it is understood, valued and created in context. Broad explanatory questions were created to guide the review process as follows: 1. What types or sources of information or knowledge are used by actors engaged in the practice of local policymaking and 2. How is value assigned to knowledge and information? 3. What knowledge-work or knowledge activities are practiced by local policy actors? What are their roles?
Identifying seed articles	• Used a non-keyword-based strategy to locate articles for inclusion; identified a sample of 'seed' documents • Initial resources used to identify and inform the selection of seed articles included: citation lists of recent reviews in the areas of evidence-informed decision-making, lists of publications by key authors within the subject area such as those found on Google Scholar and Web of Science, and consultations with advisory team members. In addition, to be considered 'seeds', articles had to be at least 5 years old and have been cited a minimum of 30 times. • Created a list of possible seed citations; compared article content to the research objective and guiding questions (relevance to the area of interest). The initial list was reviewed by and discussed with the advisory committee and a final list of seed articles was approved by consensus.
Forward snowball search	• Using the forward citation mechanisms available on selected online databases (Web of Science, Scopus, PubMed, Proquest), identified all of the published, peer-reviewed articles that cited seed articles since the date of publication. When not available through any of these databases, Google Scholar was used.
Purposive sampling	Articles were considered in terms of their relevance to the guiding questions, to concepts and context rather than to adherence to a rigid checklist of inclusion and exclusion criteria determined a priori. • Did the article explore knowledge/information use? Sources? • Did the article explore processes of policymaking or decision making in local contexts? Exclusions: 1) Articles that described interventions intended to facilitate or promote the use of only one type of information (e.g. research); 2) Articles that placed the use of research-based evidence as the primary focus of the study (e.g. uptake of best practice recommendations, identifying research to practice gaps, research utilization).
Refining the sampling frame	• All potential inclusions were imported into the qualitative analysis software program, NVivo-10, and read in full, reviewing all texts against research queries (see "conducting the synthesis")

(process refinement)	• Refined the sampling frame to focus more narrowly on documents that described the qualitative, quantitative or mixed method studies of local level decision making in policy contexts (not confined to healthcare), articles that did not examine the use or uptake of research-based information in policymaking as the primary focus.
Supplementary search strategies	Citation lists from all included articles, identified review articles and noted commentaries were hand searched for possible inclusion. Additional studies of interest were identified; those meeting sampling criteria were identified for inclusion. Full text versions were imported into the NVivo program for inclusion in the synthesis process.
Interpretation	• Information presented within each study was considered against a series of queries based on refinements of the initial guiding questions that addressed the study objectives more directly: 1) what types of knowledge or knowledge sources are used by policy or decision makers in local contexts? 2) What factors are associated with assigning value to information/knowledge? 3) How are stakeholder/policymaker agencies and/or roles described within the practice of policymaking — specifically with regard to knowledge-based activity? • Information relevant to the queries listed was identified and coded within the NVivo program categorized first by query. Repeated readings of the material and review of query categories resulted in further identification and refinement of content areas and thematic elements within each query/topic area. Reports that included all thematic/content areas identified were generated corresponding to each broad query area. This queried analysis was supplemented by a summative context analysis examining word frequency and use in context in order to provide a way to check the author's interpretation against the original language in context as well as support and enrich the interpretive process. A reflexive journal was maintained by the investigator conducting the primary analysis in to create an opportunity for self-assessment, awareness of positionality, consider assumptions and to foster a more complete understanding of interpretations made.

Table 2-1 briefly summarizes the seven review stages or processes undertaken in the completion of the present review. It is important to note that, due to the dynamic and emergent nature of the interpretive process, these stages were not necessarily performed as discrete, sequential steps. The stages presented in the table often overlapped. Sometimes, a previous stage would be revisited, new primary papers were analyzed, and understandings emerged. For instance, although the interpretation process is described at the end of the table, preliminary analysis began as articles were identified for inclusion and reviewed against a set of guiding questions (see Table 2-1). From the preliminary review of data, in which relevant texts were queried and content assigned to thematic groupings, the early coding frame began to emerge. Interpretive processes continued throughout the review and were not limited to a discrete stage occurring only after all data had been collected.

2.3.1 Searching and Sampling

A search and sampling strategy focused on relevance is most appropriate to an interpretive synthesis. Influenced by the work of Contandriopoulos and colleagues (23) as well

as Greenhalgh and colleagues (48), I began with a core list of seed articles identified through hand searching of citation lists included in recent reviews of knowledge translation and policymaking in the health sciences (23, 28, 43) in addition to the lists of previous publications by individuals identified as influential in the topic area[1]. Seeds are defined as "*foundational or framing articles widely cited as a reference point by authors doing research in the domain of interest*" (p. 7) (49). Articles were selected if they could be considered to have made a significant contribution to the literature or had shaped ideas around the topic of interest, at some point. To be most effective, seed articles should be at least several years old in order to increase the likelihood of exposure (49). For the purposes of the present study, articles were considered as potential seed citations if they were published 5 or more years previously (i.e. 2009 or earlier).

A preliminary list of articles (n=52) was compiled from the handsearching strategies described above.[2] The articles on the list were reviewed, comparing content to the research objective, using the guiding questions as a prompt for article relevance. Using this process, in collaboration with my graduate advisory committee, the initial search list was edited to include 22 articles. Identified seed articles were used as the foundation for a forward snowball sampling technique in which multiple online databases (see Table 2-1) were used to identify articles that had cited each of the seed articles from the time of original publication through June 2014. As forward snowball sampling that relies on primarily on the academic literature may be limited in its identification information from a variety of sources, this technique was supplemented by retrospective hand searching of citation lists within all documents included in the review as well as all identified review articles, commentaries, reports and theoretical articles that did not meet the specified conditions of the sampling frame.

Sampling of articles was based primarily on an assessment of relevance to the review topic rather than adherence to a checklist of detailed inclusion and exclusion criteria (see Table 2-1). A series of guiding questions that reflected the research objectives were developed as a

---

[1] Individuals considered influential in the topic area were determined in discussion with the advisory group. Lists of publications were retrieved from two online databases: 1) Web of Science and 2) Google Scholar.

[2] The preliminary list and seed citations are provided in Appendix 1.

reference to which the investigator could refer throughout the sampling process. Sampling was refined as investigator understanding of what was relevant to the research objective evolved through reading and preliminary analysis and interpretation.

2.3.2 Approach to interpretation and synthesis.

In this interpretive review method, synthesis is focused on the development of explanation and seeks to enrich knowledge and understanding of issues or concepts identified by the research questions (46, 47, 50). To do this, the studies identified for inclusion and the author's interpretations therein provide the raw data for the synthesis process (46). Preliminary analysis began early in the sampling and inclusion process, as described above, and continued throughout the review. The analysis method relied on iterative and ongoing content analysis described as a method used for "*the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns*" (p.1278) (50). To help guide the coding process, text content was reviewed against the focal or guiding questions (see Table 2-1). As coding progressed, major thematic groupings were created and reviewed against both the guiding questions and primary texts in an iterative process. Groups of themes were identified within areas that corresponded to guiding queries.

Identified thematic groupings, within each query, were also examined via summative textual analyses (50). In this study, summative analysis was used to check investigator interpretations and coding definitions against the use of language taken from the original studies. This allowed for a visual representation of each theme and sub-theme to be created that illustrated the dominant languaging present within each coded grouping and provided an opportunity to reflect on, and deepen, the analysis. An example and supplementary information regarding the development of thematic groupings are provided in Appendix 2. All documents were reviewed, and the interpretive analysis supported through the use of the NVivo-10 software program (QSR, Version 10, 2012).

2.3.3 Quality appraisal

To exclude studies on the basis of quality appraisal alone would risk the loss of findings that could potentially offer important and relevant explanatory insights (51). However, appraisal through the use of a tool such as the Mixed Method Appraisal Tool (MMAT) allows the reviewer to describe study quality without placing the studies within a predetermined hierarchy of evidence (52). The MMAT is comprised of 15 criteria presented in 5 sets that are specific to design type (qualitative, randomized controlled trials, non-randomized comparative trials, quantitative observational studies and mixed methods) (52, 53). Application of the criteria does not result in a summed score, but does create a description of study quality based on assessment against a set of criteria (52). Inter-rater reliability of this scale has been reported previously (ICC=0.72) (54). All studies selected for inclusion in the present review were rated using the MMAT by two independent raters. Rater assessments were reviewed for consistency and discrepancies in rating were resolved by consensus. Percentage agreement between raters was calculated for each study type and was demonstrated to be 92% for qualitative studies, 75% for quantitative descriptive studies and 90% for mixed methods studies.

2.4   Results

2.4.1 Search Results and Selected Articles

Thirty-five full text articles were selected for inclusion in the synthesis. The study sampling process is illustrated in Figure 2-1. While there were no restrictions on inclusion by field of study or type or topic of local policymaking placed on the sampling strategy, the use of a health sciences base to inform the development of the seed list was reflected in the composition of studies identified for inclusion. Studies examined policy decision-making in the areas of health, health services and public health (n=20), local and municipal governance (n=10), organizational studies (n=3) and environmental studies (n=2). The majority of studies included
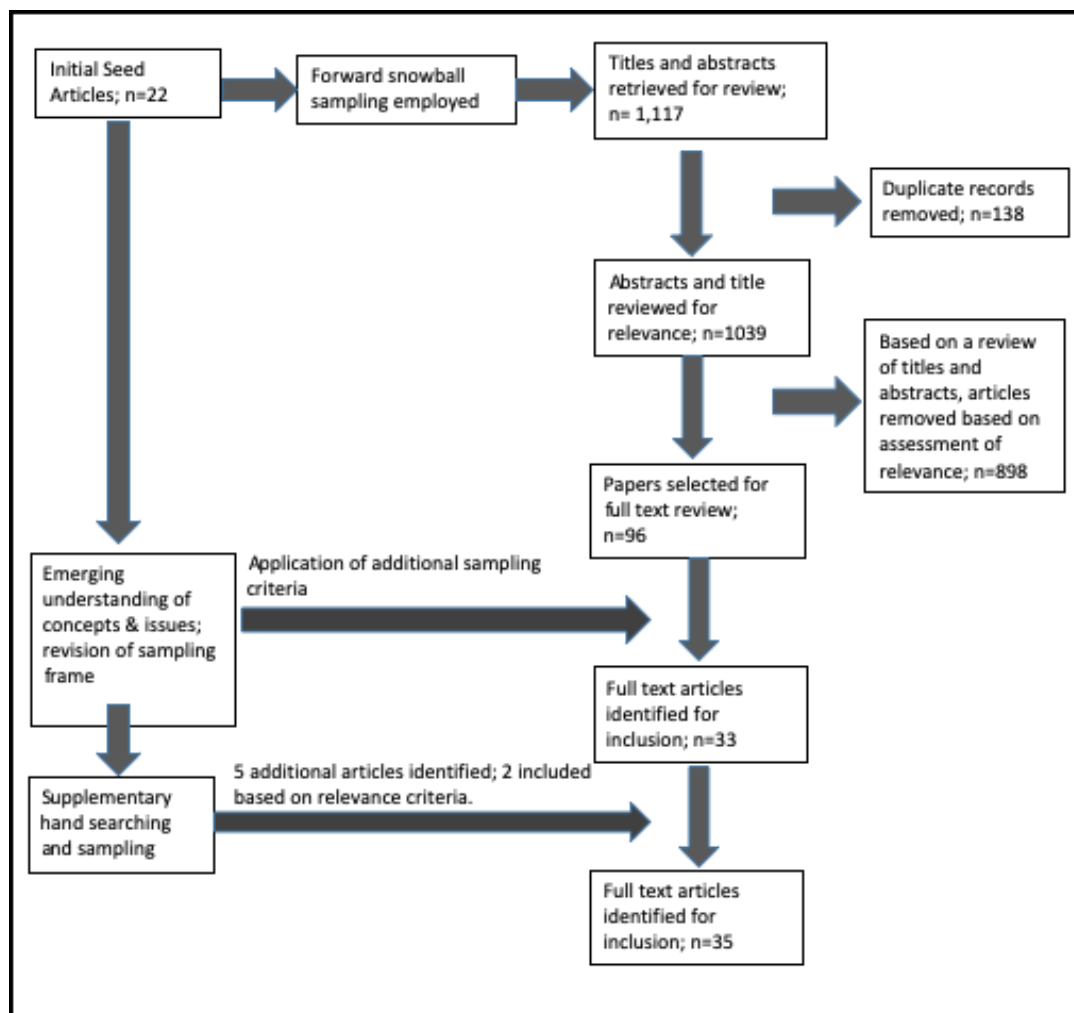
Figure 2-1. Inclusion of articles

were categorized as qualitative via MMAT criteria (n=24) and, as per the tool's screening questions, appeared to present a research question or objective and to collect data to address the question or questions as presented. There was more variability demonstrated around the inclusion of researcher reflexivity. Two of the studies identified as qualitative were explicit in researcher opinion, position, or possible influence; this type of discussion was either absent (n=19) or unclear (n=3) in the remainder. There were eight (8) studies of a quantitative descriptive design identified, all of which used survey tools to gather data from a particular population of decision makers. In most cases, however, there were few details provided about the survey tools used – their developments or origin, or validation efforts and results, for example. In

addition, only one study reported a response rate greater than 60%. The remaining studies (n=3) were categorized as mixed methods. A brief description of all full-text articles including a summary of the critical appraisal process is provided in Table 2-2.

Table 2-2. Summary of studies identified for inclusion

Author(s)/Year; Location	Level of Policymaking	Study Objective	Brief Method Summary	MMAT - Study Classification and missing items
Askim 2007 (55); Noway	Local - Municipality	The authors present 2 research questions: 1) how important is performance information for councillors and 2) why do some use performance information more often than others?	The authors report the results of a national survey of municipal councillors in Norway that questioned respondents about their use of performance information (and other sources of information) for the purposes of decision making. The survey was sent via the postal service to a random sample of 1500 elected councillors -- 750 completed surveys were returned.	Quantitative Descriptive; limited description of development, content or properties of measurement tool. Response rate = 50%.
Askim and Hanssen (56) 2009; Norway	Local - Municipality	To study the role played by citizen input in the decision making of elected officials; to assess how much citizen input is received by local councillors and to what extent that input is used to set local decision-making agendas.	A survey was developed based on interview data. Surveys were sent to all municipal councillors in 4 municipalities (n=180 by postal survey), then to all the mayors in Norway (n=434), and finally to a random sample of 1,500 councillors nationwide (by postal survey). Results were analysed via OLS regression. Included "qualitative data from case research" conducted in 2005.	Quantitative Descriptive; Response rate = 53%.
Askim 2008 (57); Norway	Local - Municipality	To examine the use of performance information in the pre-decision stage of policymaking by local councillors. The authors address two research questions: 1) *Do some councillors make more use of performance information than others?; 2) How can these differences (between the factors) be explained?*	The study used data from a survey of Norwegian councillors originally administered to a random sample of 1500 councillors in 2005. The survey examined the use of various types of information and the perceived importance of the various information types. In 2005, fifty councillors were interviewed (from rank-and-file councillors to mayors) as well as chief and deputy executive officers in six Norwegian municipalities. The statistical analysis used OLS regression.	Quantitative Descriptive; limited description of development, content or properties of measurement tool. Response rate = 50%.
Baghbanian et al. 2012 (58); Australia	Organizational	To discover how healthcare administrators decided to allocate resources.	A mixed-methods approach study; A purposive (non-probability) sample (n=91) was recruited to complete an online questionnaire; a subsample was identified for face-to-face interviews (n=25). All participants were healthcare administrators with responsibility for decision making in the area of financial resource allocations. Interview data (the subject of this paper --	Mixed Method; only qualitative component report; no description provided of limitations associated with mixed method design; reporting of methods

Author(s)/Year; Location	Level of Policymaking	Study Objective	Brief Method Summary	MMAT - Study Classification and missing items
			survey data was reported elsewhere) was coded via focused and selective coding methods (informed by grounded theory).	lacked clarity overall; no account of researchers' reflexivity.
Boydell et al. 2008 (59); UK	Local (Health Action Zones/Investing in Health partnerships)	The authors examine the value of partnerships in producing intangible benefits or assets in the form of knowledge.	Three in-depth case studies of Health Action Zones and one Investing for Health Partnership in Northern Ireland. Each case study involved in structured interviews with 10 partners, group inquiries and meeting observations. Data were analysed using a "sort and code" process to develop a model to describe areas for impact (connecting, learning, acting).	Qualitative; research objectives not clearly stated; no account of researchers' reflexivity.
Burchett et al. 2013 (60); Ghana	Local (community setting)	To explore which factors associated with public health research from other settings are considered to be important by local decision makers when considering whether that research may be applicable within their own setting.	69 purposively sampled decision makers working in the maternal health field participated in semi-structured interviews. Data were analysed using 'framework analysis' techniques.	Qualitative; no account of researchers' reflexivity.
Cameron et al. 2011 (61); UK	Multiple (local evidence to inform policy)	To examine the use of evidence provided from 'commissioned evaluations' of local demonstration or pilot projects; to explore the perceptions of individuals working in policymaking contexts about the use of this kind of evidence.	This project used 4 data sources: 1) mapping exercise of White paper initiatives evaluations (demonstrations & pilot projects with commissioned evaluations used to inform policy processes), 2) survey of all included evaluations, 3) case studies of the White paper evaluations and 4) Interviews (n=9) with policy leads This paper reported the results of the interviews only. Data from interviews were subject to thematic analysis informed by a priori categories established based on a literature review.	Qualitative; reporting of data collection methods lacked clarity; no account of researchers' reflexivity.

Author(s)/Year; Location	Level of Policymaking	Study Objective	Brief Method Summary	MMAT - Study Classification and missing items
de Goede et al. 2012a (62); Netherlands	Local	To provide insight into the interface and mechanisms between local epidemiologists and local policy actors throughout local policy development processes; to describe the construction and presentation of local health messages (if and how epidemiological research is included in local policy memoranda).	Used a case study design. Collected qualitative data from 3 municipalities served by 2 Regional Public Health Services over a 3-year period. 40 semi-structured interviews were performed with researchers, policy advisors, civil servants, administrators, and politicians. An additional 89 individuals were interviewed by telephone. Document data were also collected and reviewed.	Qualitative; Limited information regarding the process of data analysis; no account of researchers' reflexivity.
de Goede et al 2012b (63); Netherlands	Local	To assess the use of mandated local health memoranda by local health officials; to identify factors associated with use of this information	20 regional public health services covering a total of 339 municipalities agreed to participate in the study. 339 local health officials were approached and invited to complete an online questionnaire for the study. 173 completed questionnaires were received. Multiple linear regression analysis was used to examine the data retrieved from the questionnaire.	Quantitative Descriptive; Response rate = 51%.
de Koning 2014 (64) Netherlands /Latin America	Local	To examine how local residents respond to the application of new government policies/reforms. Using the concept of 'institutional bricolage', the role of local actors in reshaping local institutions in practice is emphasized.	Six communities of smallholders were selected to investigate practices from a pool of 16 cases of forest management projects in 4 Amazon countries. In-depth interviews, participant observation, group interviews, group exercises, and questionnaires were used to collect data to inform multiple case studies.	Qualitative; Limited information regarding the process of data analysis; no account of researchers' reflexivity.

Author(s)/Year; Location	Level of Policymaking	Study Objective	Brief Method Summary	MMAT - Study Classification and missing items
Deas et al. 2013 (65); UK	Multiple	To explore the perceptions of key policy actors of the influence of different drivers during the development of policy and program development (e.g. evidence, clinician expertise, existing policy, local context); to explore processes involved in both conceptualization and local implementation of a complex policy intervention.	A national level program was selected as a case study ('Childsmile'). In-depth, semi-structured interviews with stakeholders who could comment on the perceived gap between policy and implemented program were conducted (n=12). A review of policy documents, research evidence, professional guidance and program documents was performed. Data analysis was conducted using the 'Framework' method.	Qualitative; no account of researchers' reflexivity.
DeMartini and Whitebeck 1986 (66); USA	Local (implementation and practice)	To study how a particular group of professionals use knowledge; to examine the conditions that affect knowledge use; to inform knowledge use by decision makers in policy contexts.	Questionnaires were sent to a sample of social work graduates from a school of social work in the Pacific north west. Respondents were asked to list knowledge sources that enabled them to complete job tasks and rate sources in importance. 90 completed questionnaires were received (41% response rate).	Quantitative Descriptive; limited description of development, content or properties of measurement tool. Response rate = 41%.
Dobrow et al. 2006 (34); Canada	Regional (provincial)	To study how context influences the use of evidence in the development of policy recommendations (where evidence is defined as "anything used to support or justify a decision"); to present a conceptual framework re: impact of internal and contextual factors on evidence utilization by expert groups.	Used a multiple case study design. Four cases using expert groups to develop policy recommendations were selected. Groups ranged in size from 11 - 30 members and included clinicians, researchers, politicians and patients/survivors in their memberships. Interviews provided the primary source of data. Documents (reports, meeting minutes/agendas) were also collected and document analysis used to supplement data collected via interviews.	Qualitative; no account of researchers' reflexivity.

Author(s)/Year; Location	Level of Policymaking	Study Objective	Brief Method Summary	MMAT - Study Classification and missing items
Epstein et al. 2014 (67); USA	Mixed (civic engagement) - federal regulatory bodies seeking commentary from groups of stakeholders affected locally	To examine the conceptual gap between the way in which the lay public and professional policymakers think about and discuss policy-relevant information; to reconsider what may be 'legitimate evidence' in policymaking and what counts as effective civic engagement.	Case study. The authors used 'Regulation Room', an online civic engagement system that focuses on broadening effective public participation in rulemaking. Discussion is compiled by moderators and participants are invited to review summaries. Final summaries are submitted to regulatory agencies and regarded as part of formal public comment. Researchers focused on potential 'missing stakeholders' -- individuals, groups, business owners, agencies affected by proposed policies in local communities but who are unlikely to participate in the traditional notice-and-comment processes -- and selected 3 consultations on rulemakings from 1 government department (transportation). Thematic analysis was used to elicit common themes.	Qualitative; Limited information regarding the process of data analysis; no account of researchers' reflexivity.
Escobar 2014 (68); UK	Local -	To conceptualize scripting, show how policy workers perform the practice of policymaking and to contribute to a research agenda that foregrounds practice.	The core method used was participant observation (131 days spread over two years -- 117 meetings, shadowing 4 engagers during 15 alternating weeks of work placements). 44 Interviews were conducted with engagers, officials, councillors, citizens and activists. Analysis was abductive and informed by grounded theory.	Qualitative; no account of researchers' reflexivity.
Florio and deMartini 1993 (69); USA	Local	To examine how information is used by local decision makers to make decisions about healthcare. To determine 1) what types of information decision makers use: and 2) how ideology and interests influence the use of information.	A multisite case study in two rural communities who had participated in a community development process and had completed a strategic planning process. Members of planning committees from each community participated in semi-structured interviews. Interview data were categorized and then sorted using the Generalized Automated Text Organization and Retrieval System (Giordano, Cole, and Zuckerman 1987). Sorted responses were grouped and analysed according to research question.	Qualitative; no account of researchers' reflexivity.

Author(s)/Year; Location	Level of Policymaking	Study Objective	Brief Method Summary	MMAT - Study Classification and missing items
Freeman 2007 (70); UK	Local	To review conceptions of learning developed in the public policy literature and to compare these against policymakers own accounts taken from an empirical study of public health policy decision making.	35 interviews were conducted with individuals holding a range of executive, advisory, and programmatic responsibilities for public health policy in each context. This consisted of public health bureau directors, program directors, project officers, directors of publicly funded research institutes, research officers, and university professors.	Qualitative; Limited information regarding the process of data analysis; no account of researchers' reflexivity.
Freeman and Peck 2007 (71); UK	Local (county council)	To explore the governance of complex public sector partnerships through a detailed case study of a Joint Commissioning Partnership Board (JCPB) in the South East of England.	Data was triangulated from 3 sources: overt non-participant observation of board meetings; a review of 'official' documentation in the form of board minutes; and individual semi- structured interviews with JCPB members. Board meetings were observed on 6 occasions and at each meeting detailed field notes were taken. Interviews were also conducted with board members. Data was coded using the constant comparative method.	Qualitative
Haynes et al. 2012 (72); Australia	Regional (state-wide public health policy)	To explain policymakers self-reported views and behaviours regarding the selection of potential research partners; to provide an analysis of the relationship between policymakers and researchers.	Policymaker participants were identified from policy case examples described by researchers interviewed in a previous study. Study participants (n = 32) included civil servants (n=18), ex-premier, minister or ex- ministers (n=4), ministerial advisors (n=4), non-government organisation officers (n=4), community group representatives and independent advocate(n=2). Data was categorized by question and the subcategorized as the data was explored for emerging themes.	Qualitative; no account of researchers' reflexivity.

Author(s)/Year; Location	Level of Policymaking	Study Objective	Brief Method Summary	MMAT - Study Classification and missing items
Jarzabkowski et al. 2010 (73); UK	Local (education/ organization)	The purpose of this study is to examine how strategic ambiguity is used as a discursive resource by different organizational constituents and how that is associated with collective action around the strategic goal.	This was a case study conducted in a business school over a period of 3 years. Three rounds of open-ended interviews were conducted over the 3-year period for a total of 34 interviews, recorded and transcribed, verbatim. (primary data). These were supplemented by attendance/observation of meetings and panel visits (n=10) and collection of relevant documents including emails. Data was coded and analyzed via thematic analysis.	Qualitative; no account of researchers' reflexivity.
Koch 2013 (74); Switzerland	Local	To analyse whether and how participatory arrangements actually empower citizens and disrupt existing power structures. To examine the exercise of and relationship between 2 forms of power (collective and distributive) in a participatory venue.	Case Study: Document analysis that included an analysis of existing scholarly work, archival records and correspondence between different participating actors and organizations. An analysis for the notes of leading actors based on these archival records was conducted. 5 interviews with public officials was conducted. Data from the interviews was used to support the document analysis.	Qualitative; Limited information regarding the process of data analysis; no account of researchers' reflexivity.
Lavis et al. 2002 (75); Canada	Provincial	To examine the role of health services research in Canadian provincial policymaking	Case study: Researchers selected 4 regulatory policies (as cases) from each of 2 provincial jurisdictions. Authors identified uses of citable research, other types of information, influences such as stakeholders' positions. Semi-structured interviews with policy advisors were conducted. Internal documents relating to the policy development were requested at the end of the interview. An interpretive approach to data analysis was taken.	Qualitative; no account of researchers' reflexivity.

Author(s)/Year; Location	Level of Policymaking	Study Objective	Brief Method Summary	MMAT - Study Classification and missing items
Macnaughton et al. 2013 (76); Canada	Mixed	To examine the ways in which the information/evidence provided by a local demonstration project can provide useful lessons for other jurisdictions; how policy entrepreneurship can link decision making from conception through national level initiative.	The researchers interviewed 19 individuals at various locations in this Pan-Canadian study. These informants included decision-makers familiar with the federal political context, and informants who were more familiar with how the politics and policymaking was applied at each of the sites. Relevant documents were also examined. Content analysis was undertaken informed by constructivist grounded theory.	Qualitative; limited account of researchers' reflexivity.
Metze 2011 (77); USA	Local - USA (municipality)	To examine boundary concepted introduced in a case study project (the Dairy Gateway), if participants reflected on these concepts, and if these resulted in reflective or conflicted conversations. In additions, the author examined which elements of discourse were accepted and became credible.	Conversations of participants in 6 farmer-to-farmer meetings, 6 farmer-to-neighbour meetings and 3 meetings between farmers and environmentalists were analysed to discover the pattern of boundary work within the conversations using Transana 2.21 software.	Qualitative; Limited information regarding the process of data analysis; no account of researchers' reflexivity.
Milat et al. 2014 (78); Australia	Various; Local, regional, national	The objectives of this study were to examine: i) how decisions to scale up interventions are currently made in practice; ii) the role that evidence plays in informing decisions to scale up interventions; and iii) the role policymakers, practitioners, and researchers play in this process.	21 experts (senior public health policymakers, practitioners and researchers) were invited to participate in interviews consisting of a mix of open and closed questions to examine how decision makers had scaled up interventions, how evidence and information had informed the process and what roles they had played in the process. International participants completed the 'interview' in survey/questionnaire format.	Qualitative; no account of researchers' reflexivity.
Oh and Rich 1996 (79); USA	Mixed (federal/state and local policymakers)	To test an integrated model of information utilization containing 4 sets of variables: 1) decision making environments; 2) organization 3) individual	20-25 decision makers were interviewed/state (n=18 states) and completed a simple survey tool re: the production and application of information. Participants included federal and local policymakers, representatives from community organizations and service agencies,	Quantitative Descriptive; limited description of development, content or properties of

Author(s)/Year; Location	Level of Policymaking	Study Objective	Brief Method Summary	MMAT - Study Classification and missing items
		characteristics and 4) characteristics of information	advocacy groups, the lobal umbrella health and social service agency as well as official state organizations and legislators. Analysis focused on OLS multiple regression and likelihood logistic regression techniques to identify factors and their influence re: the use of information in 'bureaucracies'.	measurement tool. Response rate unclear.
Oliver and Jacobs 2007 (80);Switzerland	Organizational	To explore how: guiding principles become integrated in management teams through discursive processes of social learning, and how process techniques from the realm of organizational learning can be used to facilitate the development of guiding principles.	A case study of an organizational strategy team using a two-day, play-based workshop to identify, discuss and share what participants perceived as the organization's identity and set of guiding principles. The intervention had 10 participants, including members of the corporate strategy team (n=7) as well as managers from the human resources department (n=3). The case study, and observations from the intervention, are provided as illustration of the considerations in development of guiding principles/dialogic learning.	Qualitative; Limited information regarding the process of data analysis; no account of researchers' reflexivity.
Oliver et al. 2013 (81); UK	Local	The purpose of this study was to identify the most influential PHP individuals in a major UK city and provide explanations for their success in influencing policy.	Mixed methods study using network analysis (seed sample = 84 - questionnaire) and semi-structured interviews (n=23). Interviews were structured around 6 key concepts; the policy process, use of evidence, power and networks, leadership, public health, governance and context). A framework analysis was used to identify themes and subthemes from the interviews.	Mixed Method; does not describe integration; does not describe limitations associated with mixed method design; no account of researchers' reflexivity; limited description of development, content or properties of measurement tool.
Oliver et al. 2012 (82); UK	Local	To describe an innovative study giving a fresh perspective on policy-making processes in public health.	Social Network Analysis. An electronic survey of a sample of key public health personnel (actors) was undertaken. Data were collected and analysed using UCINET software and visualised using Net draw.	Quantitative Descriptive; reporting of objectives unclear; limited description of development, content

Author(s)/Year; Location	Level of Policymaking	Study Objective	Brief Method Summary	MMAT - Study Classification and missing items
				or properties of measurement tool
Orr and McAteer 2004 (83); UK	Local	To identify how local councillors and officers in local government use concepts of 'consumer' and 'citizen' in discussing public participation. To explore senior politician view re: the purposes of public involvement in local decision making.	Interpersonal interviews, focus groups, 2 surveys (elected councillors and senior officials from local government). A total of 35 interviews were conducted by a 2-person team with strategic level officials and operational level actors. Community activists were involved in a total of 5 focus groups (within each council area). 1,100 surveys were issued to elected councillors (35% return rate). Senior officials received a similar survey (n=114 were returned).	Mixed Method; data analysis poorly described; limited description of integration of methods and results; does not describe limits associated with mixed methods design; no account of researchers' reflexivity; limited description of development content or properties of measurement tool; Response rate = 35%
Peck et al. 2004 (84); UK	Local	To examine the role of 'the Board', and formal meetings as organizational rituals, the way in which they influence priorities.	Case study analysis of the Somerset Joint Commissioning Board for Mental Health. As part of a larger study, meetings were observed over a 3-year period. Documents of the commissioning board were collected reviewed and content analyzed. Participants were interviewed at annual interviews (3 occasions).	Qualitative; Limited information regarding the process of data analysis; limited account of researchers' reflexivity.

Author(s)/Year; Location	Level of Policymaking	Study Objective	Brief Method Summary	MMAT - Study Classification and missing items
Ram and Trehan 2010 (85); UK	Local entrepreneurs	To investigate how critical action learning (CAL) can contribute to policy learning (PL). They aim to address the question: 'How can growth-oriented African-Caribbean entrepreneurs be supported?'	An action learning 'set' was 'researched' over the course of a five-year involvement with a group of 8 entrepreneurs. Researchers adopted mutually supportive roles of process consultants and facilitators. Formal learning sets were tape-recorded and transcribed, process notes were kept to document observations made during meetings, all entrepreneurs were interviewed at the beginning of the research process and again 2 years later. Company documentation was reviewed, and all written material generated by the entrepreneurs during various stages of the inquiry.	Qualitative
Rich and Oh 2000 (86); USA	Mixed (federal/state and local policymakers)	To examine the appropriateness of assumptions of rational actor theories with respect to information acquisition and use. Expectations according to rational actor theory are explicated and data are used to determine whether expectations are met.	20-25 decision makers were interviewed per state over a total of 18 States. Participants included federal and local policymakers, representatives from community organizations and service agencies, advocacy groups, the local umbrella health and social service agency as well as official state organizations and legislators. Each 45-minute interview focused on the process of production and application of information. Analysis was quantitative descriptive in nature.	Quantitative Descriptive; Response rate not reported.
Sinclair 2011 (87); UK	Local	To explore the politics within the practice of CPPs, and to examine the influence of voluntary sector members compared to local authority and other public sector representatives.	Case Study of a community planning partnership. The project included an inventory and review of documents, interviews with senior figures who were considered main participants from public, voluntary and private sector partners. A number of interviews were also conducted with individuals from outside the partnership not formally involved in the CPP.	Qualitative; Limited information regarding the process of data analysis; no account of researchers' reflexivity.

Author(s)/Year; Location	Level of Policymaking	Study Objective	Brief Method Summary	MMAT - Study Classification and missing items
Turnhout et al. 2010 (88); Netherlands	Local	To investigate the way in which participation can influence citizen involvement in policymaking; to examine the intended and unintended consequences associated with citizen involvement.	A case study. Environmental planning and development, conducted over a 6-year period. The current study/report presented is part of a larger study and it limited to material from 3 sources only: transcripts from 70 open interviews, transcripts from 12 multi-stakeholder meetings and 75 relevant documents. Key informants participating in interviews represented all 'major players' and represented a variety of perspectives.	Qualitative; Limited information regarding the process of data analysis; limited account of researchers' reflexivity.

2.5   Synthesis Findings

As this review and synthesis was guided by a series of three questions, findings are presented below in response to those queries.

2.5.1 What types of knowledge/information and knowledge sources are used by policymakers in local contexts?

In the examination of policy practices, it has been suggested that it is useful to make a distinction between information and knowledge (40). Information, Wagenaar and Cook suggest, can be easily codified, and stored in a variety of media for distribution including books, reports, computer files, videos, or newspapers (40). Knowledge, however, "*always requires knowers*" (p.152) (40) and is, therefore, described here, broadly, as embodied. The results of the review and synthesis of the literature (Table 2-3) suggest that three types of information sources (research-based evidence, commissioned reports, and existing policy documents and position statements) and three types of knowledge sources (network knowledge, citizen or community stakeholder input, and personal experience or expertise) predominate in studies of local policymaking in local contexts.

Table 2-3. Types and Sources of Knowledge used in Local Practice Contexts

Information Sources		
Research-based evidence	**Commissioned Reports**	**Existing Policy Documents and Position Statements**

• Cost effectiveness and cost benefit analyses, results of health technology assessments and health economic evaluations (58, 89)
 	
• Guidelines for intervention and practice developed to promote good quality and standardised delivery of services (59, 65)
 	
• Demonstration projects and/or programme evaluations within the local community (60, 89)
 	
• Feasibility assessments produced to examine implementation/project proposals (76)
 	
• Population, epidemiological or administrative data sets produced locally (89)
	• Needs assessments (69)
	• Market surveys (69)
	• Management and financial evaluations (69)
	• Community mapping studies and assessments (69)
	• Program evaluation and performance assessments. *Performance information may appear in a variety of sources including*:
	  • information from public databases (monitoring systems) (55)
	  • performance audits (55)
	  • cost analysis, cost effectiveness information and reporting (61)
	  • user surveys intended to gather the experience from various program user groups (55, 61)
		• Policy and political information from the local context, including local political party programs/agendas may be consulted frequently (56, 65)
		
		• Documentation outlining government priorities and political imperatives pertaining to the current policy under development as well as pertinent funding priorities and initiatives (89)

Embodied Knowledge Sources		
Network knowledge	**Citizen or Community Stakeholder Input**	**Personal Experience or Expertise**
<u>Interpersonal knowledge</u> • Relies on formal networks established across organizations; personal & informal networks and relationships (70, 87) • Collected via dialogue, interpersonal communication, interaction between stakeholders (59, 90) • Mechanisms of collection include: Meetings, conferences, workshops, etc. (70)	<u>Includes</u>: Lay knowledge; local insight about local context; community/constituent input regarding policy proposals; Mechanisms used for information gathering include: • focus groups (34) • public consultation conferences, workshops, proceedings (34), public forums (84) • interactions via social media (putting interactive communications online) or email campaigns (67), email campaigns	• Local policymakers possess knowledge specific to the demands and issues within the setting • Experiential knowledge and expertise informs decision makers' unique perspectives (69) • The transferability of expertise between the expert and the group or groups can depend on how well the individual is embedded in the group or interpersonal network (59)

2.5.1.1   Information Sources

1)   *Research-based evidence* The word 'evidence' frequently conjures associations with information derived from systematic research (86, 89). However, interpreted within the confines of this narrow conceptualization, the articles reviewed showed that 'evidence' may have only a modest influence on policy (61, 66). Policymakers tend to respond to a larger 'body of evidence' made up of different types of information gathered from many sources, rather than rely on a single type of information gained from a single source (78, 90). What is defined as research might also differ depending on the perspective of the potential information user. From the perspective of the local policymaker, research is not a homogeneous grouping of systematic reviews and published academic papers; instead, it includes various existing reports of many types in which a variety of methods may have been used to gather and analyze data to address a question, goal or objective (75). (See Table 2-3)

2)   *Commissioned Reports*. Project consultants may be commissioned to work directly with the decision-making group in order to produce information that will be applicable within the current, local policymaking context (61, 69) (See Table 2-3). These types of reports are often produced by particular types of organizations such as marketing research firms, management consulting firms or membership-based professional organizations (75). Commissioned reports may include specific program or performance evaluations. Performance information, in general, may be defined as systematic information describing outputs and outcomes of programs and services (55, 56). In health policy and planning, the review of performance information is viewed as a necessary part of examining the successes and challenges associated with program initiatives, understanding how to support current issues and setting appropriate goals (55, 61, 70). Evaluation/performance information helps policymakers learn from variations in policy and programming delivered over time (55, 61, 90).

3)   *Existing Policy* (existing policy documents and position statements). Existing local and/or higher level (e.g. macro-level) policy documents may be used to inform policy change or development activities at the local level (See Table 2-3).

2.5.1.2   Embodied Knowledge

Authors reported that stakeholders engaged in the practice of policymaking at the local level need to have knowledge of community needs, local infrastructure, cultural perspectives and social systems as well as the physical environment within which the policy is to be developed and implemented (59, 67, 74, 90). While an appreciation of local context may be derived from variety of information sources, situated or local knowledge could help members of the policymaking group develop a better understanding of the potential impact of the proposed policy 'on the ground' within the applied setting or local context (67). The review and synthesis revealed three important sources for embodied knowledge in context.

1)   *Interpersonal Network Knowledge*. Interpersonal network knowledge refers to knowledge obtained from others external to the local policymaking group through interactions extending across partnerships, associations, organizations, agencies, sectors or communities (59, 69, 70, 75). Seeking out, or tapping into interpersonal knowledge accesses the experience of others, which also includes the perceptions, interpretations or conceptualizations related to the desired insights (66) (See Table 2-3).

2)   *Citizen or Community Stakeholder Input*. Decision makers may seek to include 'local insight' or knowledge obtained directly from community residents in order to increase the contextual relevance and appropriateness of the local policymaking innovations (56, 57, 67, 70, 77, 88).

3)   *Local Expertise and Personal Experience*. Engaged local policymakers are not only 'seekers' or 'receivers' and 'users' of knowledge, they may each also be considered sources. Local policymakers are often community or organizational leaders and have knowledge specific to the demands and issues within the setting; they are able to address issues in context by accessing their own knowledge as local experts (58, 59, 66, 74). The collaborative process of policymaking takes advantage of the pragmatic and situated expertise available within the group of local stakeholders engaged in the process of negotiating a shared solution to a common local

issue (76, 82, 85, 87, 91). Personal experience is the most frequently-used source in developing practices and is viewed as an essential part of knowledge practice (66, 92).

2.5.2 How do individuals engaged in the practice of policymaking assign value to knowledge and information?

The work of making policy includes working with and working through diverse types of information and knowledge from many sources (26). In addition, policy issues framed or conceptualized at the macro level may be re-framed at the meso or micro levels as decision makers situate implementation innovation locally (93). Decision makers involved in the meso or micro level processes of implementation may be more concerned with local sources of information specific to the context, or 'what works here', rather than national-based resources, or information produced and retrieved from sources external to the situated policymaking environment (55, 75, 90). In the evaluation of the information and knowledge that might best inform 'what works here', this review identified a number of important factors used by local decision makers including relevance and internal verification, reliability or dependability and timeliness.

In considering 'what works here', two key factors emerged in determining the relative value assigned to information or knowledge within the process of local policymaking: a) relevance and b) internal verification. Consideration of relevance addresses whether or not the knowledge and information under consideration are perceived to be applicable within the local setting while internal verification addresses whether or not the knowledge and information are consistent with existing knowledge, interests, attitudes, or expectations held by the local policymakers. Perceived relevance and consistency evaluated against internally-held standards based on existing local, or individual knowledge or expectations may be more important than the actual content of information in determining which information is to be considered and applied (86).

2.5.2.1   Relevance

The reviewed articles showed that policymakers want to know how new ideas and information relate to them and to their own context (34, 70). Context refers to where the decision is made (i.e. the internal context) as well as to where the decision is to be applied (i.e. the external context) (34). The external context provides the frame of reference against which knowledge or information is reviewed for contextual relevance (34).

1)   *Use of external information*. Local policymakers participate in a process of 'valuation' through which they assess the relevance of external information, that is, information generated outside of the local context, to the policy setting (60, 70, 90, 94). In this process, fit, acceptability and feasibility may be valued more highly than evidence concerning strategy or intervention effectiveness (60, 94). If external information is not perceived to be locally relevant, it loses value and is less likely to be adopted (60).

2)   *Use of internal or locally-generated information*. In general, locally-generated 'research' and internal information is more highly valued by policymakers than external evidence (94). Locally-generated or internal information is also perceived as more contextually relevant, requiring less interpretation, and is more likely to be translated into policy (94). Information or evidence from local pilot or evaluation studies have been identified as particularly persuasive (94). If members of the policy-making group have participated directly in the generation of the local 'evidence', then the results of the report may be considered more likely to be 'fit-for-purpose' and valued favourably (62, 72). Lack of interaction between information producers and the decision-making group may reduce the likelihood that the information will meet the immediate decision-making needs of the policymakers even if the work was technically well-constructed (72, 79).

3)   *Role of local expertise*. The intangible assets of local expertise or 'lay knowledge' provides information concerning known economic, social, cultural and traditional parameters through which all other information and ideas were filtered and their relative significance determined (59, 67). Reasons for rejection of or support for information rely on a shared

understanding of fit, acceptability and feasibility that is created from situated expertise (66, 74, 94).

2.5.2.2   Internal Verification

The concept of internal verification addresses whether or not the ideas or information supports the expectations of the community and is perceived as consistent with what decision makers understand about their local context (69). Information that is perceived to be inconsistent or counter-intuitive when evaluated against internally-held expectations and understandings is less likely to be used (79).

1) *Internal versus External Information*. When identified issues are familiar, decision makers do not have to conduct broad searches for information to inform solutions. In these cases, they may feel that they already know how to address the issues based on previous experience and will rely on internal sources for information that is readily accessible (86). When confronted with less familiar and more complex issues, broader searches for information that include external sources may be required. Individuals engaged in the practice of policymaking may bring forward information with which they are comfortable and that is consistent with their own interests and the interests of the organization they represent (70, 79); however, to be accepted, information, both internal and external, should be perceived as consistent with the shared interests of the group. Decision makers will have to consider not only the fit between the information and the shared interests of the group, but also the degree to which the external information agrees with the values held within the local policy context (63, 86). Estimations of consistency may also be influenced by individual skills and abilities such as communication skills, networking, and relationship building (34, 88).

2) *Social context, interests and influence*. Studies revealed that information must be considered within the local social and political contexts (34, 58, 69, 86, 94). Recognition of existing social problems, engagement in local politics and/or need for consistency with the current policy can influence the selection, assessment and evaluation of information by local

policymakers (34, 74, 90). Situated, embodied knowledge is more likely to be considered valuable, if it is consistent with the current policy context (88).

Individual as well as collective interests shape which information is selected for presentation within the policymaking context (69, 86). Decision makers often function as idea and information advocates, negotiating for the inclusion of information most consistent with their interests while taking factors such as policy directives, ethics, collective goals, shared or negotiated knowledge, economics and contextual complexity into consideration (58, 69, 94). However, access to information is an asset that is also associated with influence (87). Individuals with the most influence and power in the policymaking body or group may have access to the most complete information from all sources and, as a result, may be the policy practitioners most aware of the consequences or implications associated with the choices presented (56, 79).

3) *Values and Beliefs.* Authors suggested that the congruence or consistency of information with the beliefs and values of individuals engaged in the practice of policymaking is an important factor that affects the likelihood of its use (60, 90). Individual values are influenced by the context or culture in which the policymaker situates themself (62). In addition to individual beliefs and values, whether or not information is used may also depend on its congruence with the beliefs and values of the local community (69). Information that is perceived to be inconsistent with these individual or community-held values-in-context is less likely to be applied. Policymakers may also act on beliefs held about the value of certain kinds of information. If, for example, policymakers believe that academic research is more credible, they may be more likely to seek out or to accept research-based information to inform their decisions than policymakers who have a negative attitude toward academic research (60, 77, 79).

2.5.2.3   Reliability or Dependability

Methodological quality, study reliability or validity are not likely the most important features considered by local policymakers in determining the use of information (34, 86, 92). Rather than reliability, trustworthiness or dependability remains an important consideration,

particularly in the 'valuation' of informal or situated knowledge (70). Rather than rely on tools to determine quality based on methodological soundness, the idea of trustworthiness and credibility may be attached to whether or not the information in the identified study or report supports the position or interests of the policymaker doing the searching (86). Locally-produced or internal information is more likely to be perceived as trustworthy (86).

2.5.2.4   Timeliness

Policymakers make decisions quickly, under conditions of uncertainty, in which information needs change rapidly (61). Authors reported that the need for information is often immediate and decision makers may require evidence before consulting sources are able or willing to provide it (61, 72, 79, 94). Timely information is valued and the facilitation of timely provision of policy relevant research evidence is a key challenge (94). To fill information needs, local policymakers are more likely to turn to readily available internal sources of information (72, 79).

2.5.3   How are policymaker roles and knowledge-related activities described within the practice of local policymaking?

In the reviewed studies, descriptions of activities undertaken in policymaking contexts by engaged actors include co-creating accommodative spaces for generating solutions[3], searching for information and knowledge, negotiating shared frameworks for understanding and co-creating new knowledge, and making practical judgements to inform collective work. According to practice theory, human action is regarded as the essential means by which individuals interact with and gain knowledge about their world (36, 40).

---

[3]There is an ongoing need to balance the interests of the stakeholder with the interest(s) of the policymaking environment. The shared goals of the policymaking group may address a 'greater', or 'common good' that may be perceived as accommodating the goals of the majority of engaged stakeholders rather than standing in opposition or contradiction to any one stakeholder's own interests (73).

2.5.3.1   Establishing a practice context

The context in which the process(es) of policy decision-making occur influences the practice of local policymaking. In local contexts, policymaking groups often include individuals who represent various organizations, institutions and specific local interests that may be directly impacted by the policy in question. Rather than abandon individual or organization interests, however, individual representatives or stakeholders may work accommodatively, putting individual interests to one side temporarily to work toward collectively-held goals on something that is perceived to be for 'the common good' (73, 81, 87). The shared practice space, while encompassing multiple frames, perspectives and interests, holds both the potential for conflict and divisiveness as well as the opportunity to negotiate policy solutions. Ideally, situated interests may be set aside, acknowledged or accommodated, and obvious organizational or institutional boundaries overcome as between-actors dialogue and knowledge sharing promotes reflection and the development of shared understanding (73, 77, 81). Exposure to multiple frames and situated perspectives may promote ways of thinking differently (81, 82) or it may have no real effect on the promotion of individual interests or between group conflicts (77).

While the work of policymaking may be collective, collaborative, or even accommodative, power structures still exist and may be observed in the distribution of resources, including knowledge (74, 76). Along with situated interests, each engaged policymaker has specific knowledge, expertise and other resources that they bring with them to the practice context; however, the policymaker with the most sway or authority may influence what is accepted as relevant and valued (62). Conflicts, or anticipated conflicts in situated interests may influence the information and knowledge promoted as valued in moving toward shared policy goals (69).

2.5.3.1.1   Developing a shared vision

In the context of a local policymaking group, the development of a shared vision or policy goal is an ongoing process and the way in which ideas are created, delivered and manipulated by the group will emerge over time (34, 62, 68, 74, 76). It is important for the group to recognize

that policy solutions emerge from group conjecture, trial and error, investigation and insight around a shared goal (62, 83). Working cooperatively and conferring with others can enhance the quality of the decision-making process, providing peer support and opportunities for reflection that take advantage of 'collective intelligence' in addition to an available pool of local experience/expertise (58, 87).

Agreeing on a shared goal, as well as its pursuit, may require a negotiated accommodation of individual or organizational interests. At various times throughout the policymaking process, local policymakers will have to place their own interests temporarily to one side while the group works collectively toward achieving a shared goal that is perceived as being for the common good (73, 87). Through accommodative practices, it is possible to maintain a sense of respect for diverse interests while developing the means to establish and work within this common ground, negotiate expectations and pursue shared goals (73, 77). Acceptance or acknowledgement of difference between individual policymakers does not require consensus or convergence of all interests. Individual policymakers share their knowledge and information with the group in order to participate in the negotiation of a shared goal and to then work toward that goal (73). However, if too many divergent interests are retained, and entertained simultaneously, or too many working goals are established, it can create conflicting priorities within the group and create an ambiguous (and more difficult to manage) practice environment (73).

2.5.3.1.2 Defining a shared practice setting

The shared determination of policy goals helps to frame the practice setting (76, 77). Further, the practice setting is shaped by decisions that may happen within or outside of the group itself (62). Key policymaking participants (managers, organizers, those with influence or authority) make decisions about when to have discussions, who is to be involved, where the discussions should be held, how the physical setting is to be structured and used and what artefacts (props) should be used to support or accompany deliberation (e.g. reports, minutes, presentations, etc.) (62, 71).

2.5.3.1.3　　　　Key policymaking participants

The notion of a group of stakeholders who are regarded as equals engaged in policymaking may not be reflective of the experience of group members in practice. It is generally agreed that the development and implementation of successful local policy requires the participation of key individuals who are embedded in existing local networks and, based on their credibility and expertise can be regarded as local leaders or as an 'authority' by the group (69, 70, 76, 90). Key policymaking participants, such as these, help to facilitate partnerships and local network connections, promote involvement of stakeholders, and mobilize support for ideas and innovations (70, 90). Key participants who have significant influence are not necessarily 'figurehead' members (e.g. senior organizational leadership or prominent community members), but may be those who are appointed to run and chair meetings (including 'behind-the-scenes' advisory groups, or other working groups) and those who, by virtue of their assigned role, set agendas, broker relationships or act as gatekeepers to what information is shared with the general membership of the decision-making group (58, 74, 82, 87). Key participants can manipulate the knowledge contexts of the practice environment by limiting the scope of information presented, and work to streamline discussion by anticipating questions, preparing informed responses, and sounding out and briefing participants in advance of decision making opportunities (68, 74, 81).

2.5.3.1.4　　　　Defining Routines and Accepted Group Practices.

Policymakers bring standards regarding what is considered 'appropriate', as well as tacit assumptions regarding the way things work based on their 'home' culture of decision making (70, 84, 87). Ambiguity around what may be considered appropriate behaviour in the shared, 'new', policymaking context may constrain the groups' ability to address the goal of the group (70, 80). Having an available set of negotiated practices built on shared experience and understanding promotes more rapid and effective decision-making (71, 80). Creation of the group decision-making culture, embodied in standards, routines, practices, is derived as a result of collective interaction and reflection (77, 80, 87). Shared routines and knowledge used may be represented in architectural practices within the policymaking environment. These may include formal/written processes around the submission (and production) of agenda items, distribution of associated reports, regular reports and updates (70, 84).

More prominent individuals within the decision-making context or representatives who contribute more resources to the setting may have greater influence in the development of the shared process, procedures or decision-making culture (71, 82, 84, 87). Adopted routine and architectural processes may reflect the processes supported by and most familiar to the participants with the most authority or influence (84). In addition, key participants may shape processes or discussions around who will be included as well as what information and/or information sources will have a place within the policymaking context (80). While establishing a set of rules for interaction within the group may promote a sense of comfort or trust and facilitate more rapid working within the group, it can also serve to set constraints around what or whose information is considered acceptable by those individuals with the most influence (84).

2.5.3.2   Searching for knowledge and information

As they negotiate and pursue a collective goal, policymakers consciously set out to collect additional information to create a more complete understanding of the issues in context and to inform possible solutions (55, 56, 61, 86, 92). In addition to the policymaking group, information is gathered from and shared with consultative sources, some of which are made available to the group based on available partnership or network relationships (94). Information or consultation sources are described in Table 2-4.

Table 2-4. Consultation Sources

Source	Description
Policymaking partners	• There is an internal, socially-mediated knowledge exchange in which various forms of information are negotiated, blended and integrated with the policymaker understanding and experience of local context (63, 95). • Policymakers engage in processes of collective reflection in which they exchange concerns and impressions about information and knowledge (86).
Knowledge 'producers'	• Often include, but are not necessarily limited to, academic sources (92). Direct interaction with academic experts promotes understanding about how research-based information might be used (75), increases group feelings of consensus with an expert position (58, 75, 79), and promotes perceived credibility (79). • Local policymakers tend to use people from within their established networks to identify trusted expert sources (59, 72). Shared working history through which policymakers have had the opportunity to assess the strengths, capacities and trustworthiness of the researcher is important in establishing 'go-to' experts (72, 94). • 'Go-to' experts make information resources more readily available to the policy practice and, on invitation, may provide services such as consultation, evidence or information review, appraisal and synthesis (76, 94).
Local non-policymaking stakeholders *('citizens', 'constituents')*	• Information about the context in which policy will be implemented may be obtained through an interactive consultation with community members or citizens (34, 75). • Public consultation processes provide the opportunity for individuals not directly involved in the decision-making process to have their say (88), as well as provide depth and context to available knowledge/information of the policymakers (34, 83). • Direct consultation may be informal (e.g. face-to-face discussions, conversations) or more formal and structured (e.g. consultation exercises, structured meetings/engagements) (75, 83, 88).

2.5.3.3   Creating a shared understanding

As individuals, policymakers need to be able to manage different types and sources of information to engage effectively in the negotiation of policy solutions (70, 76, 82). Within the practice setting, policymakers share knowledge and information, and engage in collective processes of sensemaking which includes relating experiences, reactions and reflections (80, 85).

2.5.3.3.1   Collective Sensemaking

Sensemaking is defined as a social process of meaning-making in which individuals construct shared understanding through ongoing negotiation, comparing and balancing new information, knowledge, conventions and institutions with pre-existing traditions, or interpretations (59, 70, 91). Policymakers take into account the knowledge, opinions, and experiences of other actors within the local context, examine information and determine, through

the application of practical judgement, its applicability to the situation at hand, using it to re-shape existing conventions or create innovative solutions (62, 63, 68, 90, 91).

Key participants in the local policymaking practice who may guide sensemaking or deliberation activities rely heavily on their own experience or expertise in the staging of the collective process (68). This places the specific expertise of select individuals in a place of privilege; however, the inclusion of local expertise within the collective process of sensemaking, makes expertise available to mechanisms of scrutiny, dialogue and negotiation along with other forms of information and knowledge considered by the group (68). Local policymakers engage in sensemaking when they participate in processes such as pragmatic bricolage, dialogue and rhetoric, deliberative process, and negotiation or co-creation of new knowledge.

1) *Pragmatic bricolage.* Learning and knowing are pragmatic, natural and inevitable processes, rooted in practice and defined by context (70, 80). Policy practice is knowledge work. The role of the practitioner or learner is that of a 'bricoleur' or one who assembles the tools or materials required for their work as they progress, keeping them ready until they are needed (70). For local actors, it is important to be able to gather different ways of knowing and assemble them together through enactment, re-shaping, or 'bricolage' into something that is context specific (70, 91). The work of enactment, or performing bricolage, is not simple. It may be difficult to draw apparently heterogeneous knowledge elements together, forge or re-shape connections and negotiate conflict(s) (68, 70, 91). Ideally, local decision makers need adequate time and space, as well as support for local autonomy, adaptation and experimentation through trial by error to perform the knowledge work of bricolage (87, 91).

2) *Dialogue and Rhetoric.* Initially, stakeholders engaged in local policymaking may feel as though the practice language is foreign. Distinct from debate or other competitive forms of communication, dialogue is a specific form of conversation that includes collective interpretation and supports the development of common language (80). As local policymakers negotiate how to work together, over time, they also create a shared framework for communication and interpretation (84, 85, 87). Dialogue also presents an important opportunity for decision makers to actively experience information in the first person, to take ownership of new information and

knowledge and incorporate it into their own perspectives (80). As they practice, policymakers engage in dialogue to co-create a shared understanding of context (both their own decision-making context as well as the broader, policy context), policy problems and potential innovations or solutions (59); they will question judgements, state opinions and register dissent (59, 73, 77, 85). This is an important enactment activity in the negotiation of collective knowledge created within the policymaking practice.

The function of rhetoric is to explain or persuade, and, as such, may be used to enable collective action by managing ambiguity and promoting identification with common goals or shared interests (73). Use of accommodative rhetoric within a group attempts to facilitate cooperation; however, when the perceived need for cooperation passes, participants may choose to adopt the use of less accommodative rhetoric in order to preserve and promote individual or situated interests (73). The construction and adoption of rhetoric can become problematic when it is used to promote conflict and sustain focus on situated interests rather than yield to collectively negotiated goals (96).

3) *Deliberative process*. Dissent and difference are important aspects of deliberation and an accommodative practice space is not necessarily a neutral one (69, 88). Group members are expected to differ in how they wish to pursue the common goal and these differences are a reflection of individual interests or the situated interest of the stakeholder organizations represented within the policymaking group (69). Local policymaking includes processes of negotiating consensus around a common goal through engagement in a situated process of deliberation requiring exchange of dialogue and reflection on a diversity of experience, information and interpretation (74, 83). Within the practice setting, reflection supports deliberation by encouraging participants to consider issues from alternative perspectives, use different language, look for and create shared meanings to change old discourses and offer solutions (68, 74, 85). Power and power structures also play a role in deliberative processes. Deliberation may be directed by influential groups or individuals who act to shape the scope and/or type of information presented by practitioners engaged in consensus building (74, 83).

4) *Negotiation or co-creation of new knowledge.* The emphasis on collective accomplishment and shared understanding fosters a dynamic environment in which negotiation and co-creation of innovation is valued by the group (58, 85). Pre-existing information and knowledge may be regarded as an ingredient in the creative, social process of synthesis or co-creation of new knowledge (66, 80), although this process may be disrupted by strongly held opinions, beliefs or firmly established cultural perspectives (66, 70).

2.6   Discussion

In the present review and synthesis, I identified a body of peer-reviewed literature that reported the examination of policymakers and policymaking at the local level. Taking a practice-based approach, I queried the information presented in those studies and was able to

- create a synthesized representation of what types and sources of information are sought out, used and valued by engaged policy practitioners; and

- illuminate key knowledge-related activities within the practice setting and examine the ways in which practice, knowledge and context are collectively enacted.

Using this information, the Knowledge Enactment in Practice Settings (KEPS) framework for exploring local policymaking practices is proposed.

2.6.1   Inscribed Information, Embodied Knowledge and Valuation Filters

It is well understood that decision makers deal with multiple sources of information and knowledge throughout the process of making policy and that the interplay between the sources introduced into the decision-making setting can be both complicated and conflicted (13, 26). It is not surprising, then, that in the present synthesis I discovered that local level policymakers seek out and use multiple types of inscribed information and embodied knowledge (see Table 2-3). Policymakers respond to and apply a definition of evidence that is representative of a large body of information and knowledge gathered from a variety of sources and they use these things to support effective decision making within the context at hand (34, 78, 90). While research-based

information is used, it may not be a prominent or determining factor in which decisions are supported by the group (39). Instead, policy practitioners tend to rely more heavily on embodied knowledge sources such as local expertise and personal experience to guide collective processes of information review and selection, as well as the various social enactments involved in collective sensemaking.

In the present work, it became clear that both types and sources of information differ in terms of the relative importance assigned to them within the policymaking setting. Single types or even single sources of information, such as research-based information or research academics as consultants, were rarely, if ever, considered in isolation (75, 94). Inscribed information or 'evidence' was often accompanied by practical, context-specific advice and a shared understanding about 'what works here' created from local expertise and personal experience (74, 94, 97). The intangible, embodied and situated knowledge of local practitioners acts as a 'valuation filter', providing the social, cultural, and acceptability parameters, through which all other information identified by the group may be considered for fit and feasibility, relevance and consistency (66, 67, 74, 94, 97), much as a framework or lens acts to guide the exploration or interpretation of research-based data or evidence.

2.6.2   Agency and Enacted Knowledge

In the present synthesis, it was possible to identify two broad categories of social enactment or knowledge work that corresponded to 1) negotiation of policy-relevant knowledge and 2) negotiation of a practice context. Cook and Wagenaar suggested that a) practice and knowledge and b) practice and context are both mutually constitutive (p. 16) (98).

Practice can be represented as social enactments that include collective construction of meaning and sensemaking processes undertaken to negotiate shared understanding, shape action and attention, and to construct and maintain relationships between stakeholders (15, 22, 26, 99, 100). Inscribed knowledge (information), however, cannot speak of its own accord; it must be read, interpreted, discussed or otherwise activated and enacted (2, 101). Embodied knowledge, situated in the experience of the practitioner, facilitates interpretation (97, 101).

Knowledge, then, cannot be reasonably or meaningfully divorced from action (21, 36, 101, 102). The work of policymaking is observed in the activation and enactment of knowledge and information sources. Collective enactment is demonstrated through the way in which policy practitioners make sense of, value, manage, or negotiate all of the information and knowledge that is presented within the practice setting (13, 26). Human agency within settings of enactment is a representation of both creativity and contingency of social action (103). Engaged actors act to assemble resources such as information and knowledge creatively and toward a specific end, but in circumstances of meaningful social interaction, the process of co-creation is not fixed and the result is not inevitable. The policy that is created or the goal that is achieved is not defined by the existing inscribed or embodied knowledge brought to the practice setting, but rather "*by the knowledge enacted or practiced within and throughout it*" by the policymakers engaged in the practice of policymaking (p.123) (104). In addition, the flexibility of collective interpretation or sensemaking processes may be enhanced or constrained by the structures created by the group in establishing the boundaries, routines and norms for the group's social interaction within the practice context (101). Engaged actors do not dwell passively 'in context'; they act with purpose to seek out and select resources (including existing information and knowledge) located within their context that are pertinent to their task and use what they have gathered to negotiate their practice setting.

Studies included in the present synthesis described engaged practitioners as participating in the definition of the practice setting and working to create a collective understanding of the local decision-making context. Policymakers established accommodative interests, created shared goals, learned how to communicate and adopted shared routines. In effect, to establish and maintain an accommodative practice setting, policymakers negotiate, move, and adjust boundaries around a collective purpose (12, 105). While there appeared to be a commitment to a more participatory, and perhaps more collaborative form of policymaking in the studies included in the present synthesis, this does not necessarily indicate a corresponding shift to environments that are necessarily more inclusive or in which power is shared equitably among practitioners (106). Key participants with authority and influence select stakeholder representatives, present information and offer persuasion in order to facilitate a specific agenda (68, 85, 87). Control of

the agenda allows key actors to guide decision-making practices including processes of problem definition and framing that may lead to the prioritization of some interests over others, or reinforcing the interests of individuals already in positions of power (88, 106-108).

2.6.3 Local policymaking as practice: working toward a conceptual framework

If we view policymaking as a practice, we acknowledge that it is a dynamic and relational process; that is, the relationships between practice, context (the elements of situatedness) and knowledge (or the epistemic elements of practice) are not fixed (98). Knowledge is socially constructed, dynamic and emergent (40, 62). In the present review, studies provided descriptions of policy practitioners engaged in knowledge-related activities focused on the construction of shared meaning, participating in collective sensemaking processes undertaken to negotiate understanding, shape action and attention and create policy related to the goals established by the group. Local policymakers searched for existing information and knowledge from a variety of sources, applied valuation filters constructed from experience and expertise and introduced information, engaged in enactment through processes of negotiation, pragmatic bricolage, dialogue and deliberation. This activated, or enacted, collective engagement with inscribed and embodied sources of knowledge within the context of policy practices is what Freeman and Sturdy referred to as the enacted phase of knowledge during which the significance of embodied and inscribed knowledge may be revealed through action, expression, interpretation and negotiation (101). What is 'activated' and expressed is more than a simple representation of inscribed or embodied knowledge; it reflects the discussion, debate, deliberation, and negotiation that facilitate co-creation of new knowledge, which may include the inscription of new policy to satisfy shared goals (101).

As much as local policy practitioners were observed engaging in knowledge-based activities within the studies identified for inclusion, they were also observed working to create a shared practice context within which information and knowledge could be enacted. Local policy practitioners shaped and interpreted their practice setting by engaging in activities that included development of shared visions and goals, defining issues and practice boundaries, determining

components of physical settings for interactions, agreeing upon ground rules and accepted group practices, membership and administrative routines, for instance. However, as part of the processes of collective meaning making, understanding of the practice setting remains unfixed and, as new information or knowledge is activated or enacted within it, adjustment of shared goals, group practices or context boundaries could occur (12). Based on the synthesis findings and informed by the work of Freeman and Sturdy(101), the Knowledge Enactment in Practice Settings (KEPS) framework (Figure 2) was created.
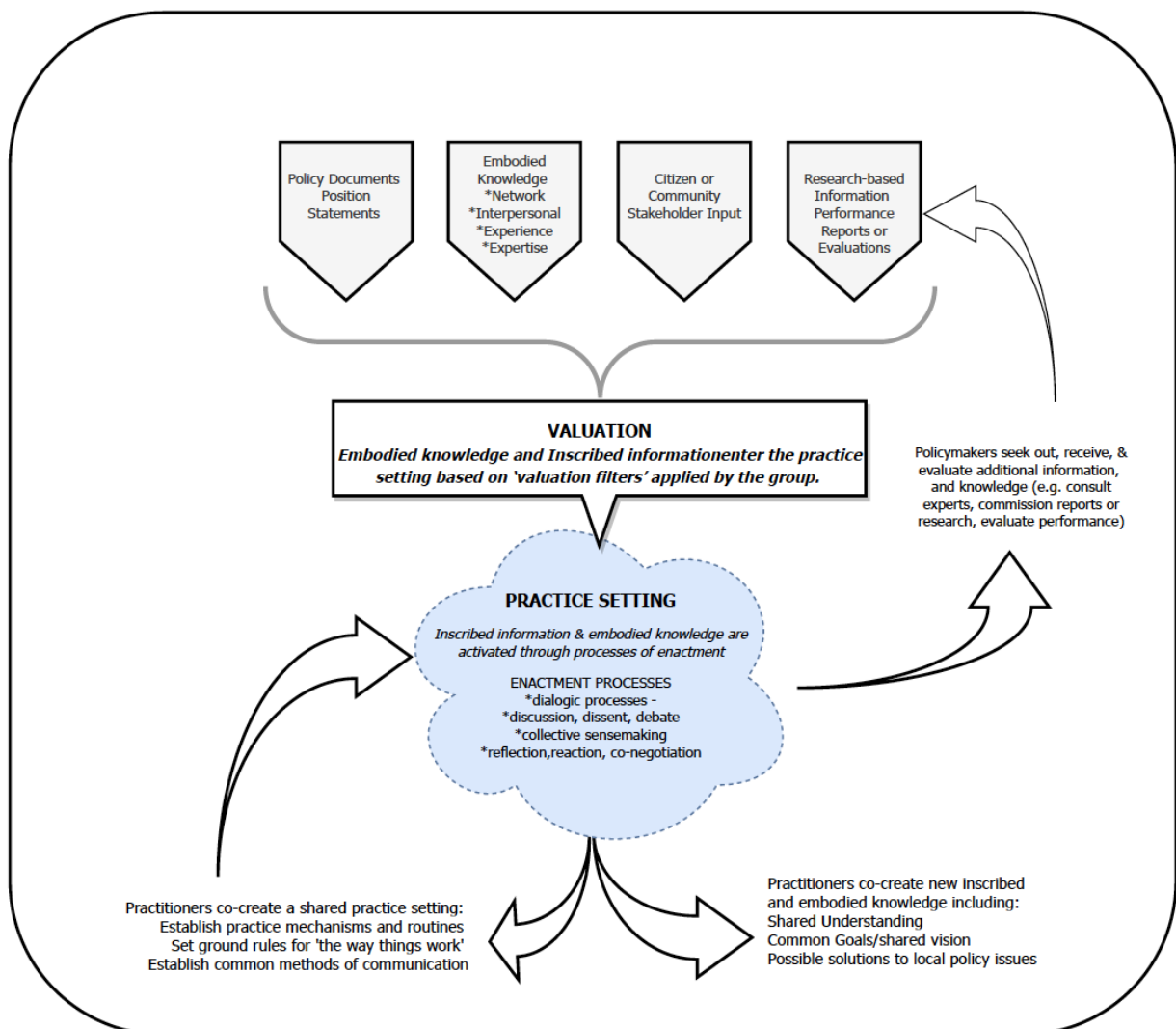
Figure 2-2. Knowledge Enactment in Practice Settings (KEPS) Framework.
Embodied knowledge and inscribed information enter the local policy practice setting via 'valuation filters' applied by engaged actors. Inscribed information and embodied knowledge are activated through processes of enactment that facilitate co-creation of a) the shared practice setting and b) new knowledge.

Processes of enactment are emergent and uncertain — constrained, informed and facilitated by context. The negotiated practice setting itself may function to both enable and constrain practice (98). For example, adoption of accommodative interests may constrain the introduction of information in support of individual interests but enable action and attention toward a shared goal. Over time, practitioners establish a shared framework for communication and interpretation and adopt a shared language used in meetings (84, 85, 87). The meeting, while a common site for policymaking enactment and a crucial venue for negotiation of knowledge, can itself present limits to what might be accomplished based on assigned meeting boundaries or committee structures (98, 109). Patterns of communication adopted may reflect the power structure that exists within the practice context. Behind the scenes activities may determine what kind of information is communicated between engaged practitioners or disseminated outside of enactment contexts (62) and policymakers may wish to maintain control over the flow of information from their home organizations/agencies into the policymaking environment (86). Key policymaking participants (managers, organizers, those with influence or authority) make decisions about when to have discussions, who is to be involved, where the discussions should be held, how the setting is to be structured, identifying and limiting the scope of information presented, and what artefacts, including reports, minutes or presentations, can be introduced to support communication (62, 68, 71, 74).

Limitations. The method used to locate and select studies was both purposive and iterative. Rather than attempt a comprehensive approach to searching the literature, I used methods, appropriate to an explanation-focused review, that would facilitate the selection of a set of studies suited to the objectives of the review. While there have may been published accounts available that were not identified or included, the careful selection of seed studies is likely to have provided a reasonable and appropriate representation of the 'core of the literature' to be used as the foundation for the snowball search and sampling strategies employed in this review (49). Although the studies that were included originated from a number of different regions, countries and policy sectors, the results reported across studies pertaining to information types and sources, and knowledge-based activities appeared relatively homogeneous and well-suited to the synthesis process used. As no specific analysis across locations or policy sectors was conducted, I have tried to limit statements to general types of knowledge and sources, and to

general types of knowledge-based activities or enactments and suggest that these should be regarded as a general frame only. Exactly what type of knowledge or information is enacted within any given context will vary. Different policymaking groups in different situations will engage with different specific types and sources of information and embodied knowledge.

2.7   Conclusion

Viewing policymaking as a practice serves to focus attention on engaged policy actors, along with their beliefs, values and experiences. At the local level, the shift away from rigid, hierarchical structures of authority toward more networked and collaborative decision-making groups means that policymaking is increasingly an activity of 'creating a community of action' that is able to negotiate a shared understanding of context as well as of policy issues and agree on common paths of toward resolution of these issues for a mutual interest or collective good.

There has been relatively little written about the relationship between engaged policymakers, the dynamic policymaking or practice context and processes of knowledge enactment within the practice of local policymaking. The structures and norms, the shared understandings and accommodative, but common interests adopted by the group may constrain or facilitate the enactment of knowledge as it pertains to the negotiation of an agreed-upon policy solution. The focus on collective enactments within the proposed framework highlights the importance of the meeting as key sites for the practice of policymaking (109). Future studies should consider more closely the movement of knowledge and information through activation and enactment paying particular attention to processes of 'valuation' through which knowledge and information may be activated within the enactment context. In addition, the dynamic nature of co-created enactment spaces and the practices surrounding the staging of practice spaces such as meetings, both formal and informal, as the most common venues for local policymaking enactments, merits closer attention.

2.8   References

1.   Lemay MA, Sá C. The use of academic research in public health policy and practice. Research Evaluation. 2014;23(1):79-88.

2.   Wesselink A, Colebatch H, Pearce W. Evidence and policy: discourses, meanings and practices. Policy Sciences. 2014;47(4):339-44.

3.   Sá C, Hamlin D. Research use capacity in provincial governments. Canadian Public Administration. 2015;58(3):468-86.

4.   Head BW. Toward More "Evidence-Informed" Policy Making? Public Administration Review. 2016;76(3):472-84.

5.   Davies H, Nutley S, Smith P. Introducing evidence-based policy and practice in public services. In: Davies H, Nutley S, Smith P, editors. What Works? Evidence-based policy and practice in public services Bristol, UK: The Policy Press; 2000. p. 1-11.

6.   Lane JP, Rogers JD. Engaging national organizations for knowledge translation: Comparative case studies in knowledge value mapping. Implementation Science. 2011;6(1):106.

7.   Sanderson I. Intelligent policy making for a complex world: Pragmatism, evidence and learning. Political Studies. 2009;57(4):699-719.

8.   Nutley S, Webb J. Evidence and the policy process. In: Davies H, Nutley S, Smith P, editors. What Works? Evidence-based policy and practice in public services Bristol, UK The Policy Press 2000. p. 13-41.

9.   Schon DA. The Reflective Practitioner: How professionals think in action. . New York, NY, USA: Basic Books, Inc.; 1983.

10.   Greenhalgh T, Russell J. Evidence-based policymaking: A critique. Perspectives in Biology and Medicine. 2009;52(2):304-18.

11.   Malterud K, Bjelland AK, Elvbakken KT. Evidence-based medicine – an appropriate tool for evidence-based health policy? A case study from Norway. Health Research Policy and Systems. 2016;14(1):1-9.

12.   Stone D. Policy Paradox: The Art of Political Decision Making. 3rd ed: W.W. Norton and Company Inc. ; 2012.

13.   Tenbensel T. Does More Evidence Lead to Better Policy? The Implications of Explicit Priority-Setting in New Zealand's Health Policy for Evidence-Based Policy. Policy Studies. 2004;25(3):189-207.

14.   Sedlačko M, Staroňová K. An overview of discourses on knowledge in policy: Thinking knowledge, policy and conflict together. Central European Journal of Public Policy. 2015;9(2):10-53.

15.   Wesselink A, Gouldson A. Pathways to impact in local government: the mini-Stern review as evidence in policy making in the Leeds City Region. Policy sciences. 2014;47(4):403-24.

16.   Colebatch HK. The idea of policy design: Intention, process, outcome, meaning and validity. Public Policy and Administration. 2018;33(4):365-83.

17.   Oliver K, Lorenc T, Innvaer S. New directions in evidence-based policy research: a critical analysis of the literature. Health Research Policy and Systems. 2014;12.

18.   Fernandez A, Sturmberg J, Lukersmith S, Madden R, Torkfar G, Colagiuri R, et al. Evidence-based medicine: is it a bridge too far? Health Research Policy and Systems. 2015;13(1):1-9.

19.   Lancaster K. Social construction and the evidence-based drug policy endeavour. International Journal of Drug Policy. 2014;25(5):948-51.

20.   Cook SDN, Brown JS. Bridging epistemologies: The generative dance between organizational knowledge and organizational knowing. Organization Science. 1999;10(4):381-400.

21.   Nicolini D. Practice as the site of knowing: Insights from the field of telemedicine. Organization Science. 2011;22(3):602-20.

22.   Schatzki TR. Introduction: Practice theory. In: T.R. Schatzki KC, E. von Savigny, editor. The Practice Turn in Contemporary Theory. New York, NY, USA: Routledge Publishers/Taylor & Francis; 2001.

23.   Contandriopoulos D, Lemire M, Denis JL, Tremblay E. Knowledge Exchange Processes in Organizations and Policy Arenas: A Narrative Systematic Review of the Literature. Milbank Quarterly. 2010;88(4):444-83.

24.   Oliver K, Innvar S, Lorenc T, Woodman J, Thomas J. A systematic review of barriers to and facilitators of the use of evidence by policymakers. BMC Health Services Research. 2014;14.

25.   Lindblom CE. The Science of "Muddling Through". Public Administration Review. 1959;19(2):79-88.

26.   Colebatch HK. What work makes policy? Policy Sciences. 2006;39(4):309-21.

27.   Armstrong R, Waters E, Dobbins M, Anderson L, Moore L, Petticrew M, et al. Knowledge translation strategies to improve the use of evidence in public health decision making

in local government: intervention design and implementation plan. Implementation Science. 2013;8.

28.   Moat KA, Lavis JN, Abelson J. How Contexts and Issues Influence the Use of Policy-Relevant Research Syntheses: A Critical Interpretive Synthesis. Milbank Quarterly. 2013;91(3):604-48.

29.   Nutley S, Walter I, Davies H. Using Evidence: How research can inform public services. Bristol, UK: The Policy Press; 2007.

30.   Wilkinson JE. Using qualitative methodologies to evaluate randomized controlled trials: An ontological and epistemological paradox or a pragmatic recognition that context matters? Worldviews on Evidence-Based Nursing. 2011;8(2):63-5.

31.   Porter S. Fundamental Patterns of Knowing in Nursing The Challenge of Evidence-Based Practice. Advances in Nursing Science. 2010;33(1):3-14.

32.   Mantzoukas S, Watkinson S. Redescribing reflective practice and evidence-based practice discourses. International Journal of Nursing Practice. 2008;14(2):129-34.

33.   Pearce W, Raman S. The new randomised controlled trials (RCT) movement in public policy: challenges of epistemic governance. Policy Sciences. 2014;47(4):387-402.

34.   Dobrow MJ, Goel V, Lemieux-Charles L, Black NA. The impact of context on evidence utilization: A framework for expert groups developing health policy recommendations. Social Science and Medicine. 2006;63(7):1811-24.

35.   Ward V, Smith S, House A, Hamer S. Exploring knowledge exchange: A useful framework for practice and policy. Social Science and Medicine. 2012;74(3):297-304.

36.   Hajer M, Wagenaar H. Introduction. In: Hajer M, Wagenaar H, editors. Deliberative Policy Analysis: Understanding governance in the network society. Cambridge, UK Cambridge University Press 2003. p. 1-30.

37.   Colebatch HK. Policy analysis, policy practice and political science. Australian Journal of Public Administration. 2005;64(3):14-23.

38.   McKenzie B, Wharf B. Connecting Policy to Practice in the Human Services 3rd ed. Don Mills, Ontario, Canada: Oxford University Press 2010.

39.   Lorenc T, Tyner EF, Petticrew M, Duffy S, Martineau FP, Phillips G, et al. Cultures of evidence across policy sectors: systematic review of qualitative evidence. European Journal of Public Health. 2014;24(6):1041-7.

40.   Wagenaar H, Cook SDN. Understanding policy practices: action, dialectic and deliberation in policy analysis In: Hajer M, Wagenaar H, editors. Deliberative Policy Analysis:

Understanding governance in the network society. Cambridge, UK: Cambridge University Press; 2003. p. 139-71.

41.   Nicolini D, Roe B. Surfacing the multiple. Diffractive methods for rethinking professional practice and knowledge. . In: Fenwick T, Nerland M, editors. Reconceptualising Professional Learning: Routledge; 2014.

42.   Freeman R, Griggs S, Boaz A. The practice of policymaking. Evidence & Policy. 2011;7(2):127-36.

43.   Mitton C, Adair CE, McKenzie E, Patten SB, Perry BW. Knowledge transfer and exchange: Review and synthesis of the literature. Milbank Quarterly. 2007;85(4):729-68.

44.   Gabbay J, le May A. Practice-based evidence for health care: clinical mindlines. London, UK: Routledge; 2011.

45.   Weed M. "Meta interpretation": a method for the interpretive synthesis of qualitative research. Forum Qualitative Sozialforschung/Forum: Qualitative Social Research. 2005;6(1; Art. 37):1 - 18.

46.   Weed M. A potential method for the interpretive synthesis of qualitative research: Issues in the development of 'meta-interpretation'. International Journal of Social Research Methodology. 2008;11(1):13-28.

47.   Dixon-Woods M, Cavers D, Agarwal S, Annandale E, Arthur A, Harvey J. Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups. BMC Med Res Methodol. 2006;6:35.

48.   Greenhalgh T, Glenn R, Macfarlane F, Bate P, et al. Storylines of research in diffusion of innovation: a meta-narrative approach to systematic review. Social Science & Medicine. 2005;61(2):417-30.

49.   Lecy JD, Beatty KE. Representative Literature Reviews Using Constrained Snowball Sampling and Citation Network Analysis. Rochester: Social Science Research Network; 2012.

50.   Hsieh H-F, Shannon SE. Three approaches to qualitative content analysis. Qualitative health research. 2005;15(9):1277-88.

51.   Noblit G, Hare R. Meta-Ethnography: synthesizing qualitative studies Newbury Park: Sage; 1988.

52.   Pluye P, Nha Hong Q. Combining the Power of Stories and the Power of Numbers: Mixed Methods Research and Mixed Studies Reviews. Annual Review of Public Health. 2014;35(1):29-45.

53.   Pluye P, Gagnon M, Griffiths F, Johnson-Lafleur J. A scoring system for appraising mixed methods research, and concomitantly appraising qualitative, quantitative and mixed

methods primary studies in Mixed Studies Reviews. International journal of nursing studies. 2009;46(4):529 - 46.

54.   Pace R, Pluye P, Bartlett G, Macaulay AC, Salsberg J, Jagosh J, et al. Testing the reliability and efficiency of the pilot Mixed Methods Appraisal Tool (MMAT) for systematic mixed studies review. International journal of nursing studies. 2012;49(1):47-53.

55.   Askim J. How do politicians use performance information? An analysis of the Norwegian local government experience. International Review of Administrative Sciences. 2007;73(3):453-72.

56.   Askim J. The demand side of performance measurement: Explaining councillors' utilization of performance information in policymaking. International Public Management Journal. 2009;12(1):24-47.

57.   Askim J, Hanssen GS. Councillors' receipt and use of citizen input: Experience from Norwegian local government. Public Administration. 2008;86(2):387-409.

58.   Baghbanian A, Hughes IB, Kebriaei A, Khavarpour FA. Adaptive decision-making: how Australian healthcare managers decide. Australian Health Review. 2012;36(1):49-56.

59.   Boydell L, Haggett P, Rugkasa J, Cummins A-M. Intersectoral partnerships, the knowledge economy and intangible assets. Policy and Politics. 2008;36(2):209-24.

60.   Burchett HED, Dobrow MJ, Lavis JN, Mayhew SH. The applicability and transferability of public health research from one setting to another: A survey of maternal health researchers. Global Health Promotion. 2013;20(1):16-24.

61.   Cameron A, Salisbury C, Lart R, Stewart K, Peckham S, Calnan M, et al. Policy makers' perceptions on the use of evidence from evaluations. Evidence and Policy. 2011;7(4):429-47.

62.   De Goede J, Putters K, Van Oers H. Utilization of epidemiological research for the development of local public health policy in the Netherlands: A case study approach. Social Science and Medicine. 2012;74(5):707-14.

63.   de Goede J, van Bon-Martens MJH, Putters K, van Oers HAM. Looking for interaction: Quantitative measurement of research utilization by Dutch local health officials. Health Research Policy and Systems. 2012;10.

64.   de Koning J. Unpredictable Outcomes in Forestry—Governance Institutions in Practice. Society & Natural Resources. 2014;27(4):358-71.

65.   Deas L, Mattu L, Gnich W. Intelligent policy making? Key actors' perspectives on the development and implementation of an early years' initiative in Scotland's public health arena. Social Science and Medicine. 2013;96:1-8.

66.   DeMartini J, Whitbeck L. Knowledge Use as Knowledge Creation. Science Communication. 1986;7(4):383-96.

67.   Epstein D, Farina C, Heidt J. The value of words: narrative as evidence in policy making. Evidence & Policy. 2014;10(2):243-58.

68.   Escobar O. Scripting Deliberative Policy-Making: Dramaturgic Policy Analysis and Engagement Know-How. Journal of Comparative Policy Analysis: Research and Practice. 2014:1-17.

69.   Florio E, Demartini J. The Use of Information by Policymakers at the Local Community Level. Science Communication. 1993;15(1):106-23.

70.   Freeman R. Epistemological Bricolage: How Practitioners Make Sense of Learning. Administration & Society. 2007;39(4):476-96.

71.   Freeman T, Peck E. Performing governance: A partnership board dramaturgy. Public Administration. 2007;85(4):907-29.

72.   Haynes AS, Derrick GE, Redman S, Hall WD, Gillespie JA, Chapman S, et al. Identifying Trustworthy Experts: How Do Policymakers Find and Assess Public Health Researchers Worth Consulting or Collaborating With? PLoS One. 2012;7(3).

73.   Jarzabkowski P, Sillince JAA, Shaw D. Strategic ambiguity as a rhetorical resource for enabling multiple interests. Human Relations. 2010;63(2):219-48.

74.   Koch P. Bringing Power Back In: Collective and Distributive Forms of Power in Public Participation. Urban Studies. 2013;50(14):2976-92.

75.   Lavis JN, Ross SE, Hurley JE. Examining the role of health services research in public policymaking. Milbank Quarterly. 2002;80(1):125-+.

76.   Macnaughton E, Nelson G, Goering P. Bringing politics and evidence together: Policy entrepreneurship and the conception of the At Home/Chez Soi Housing First Initiative for addressing homelessness and mental illness in Canada. Social Science & Medicine. 2013;82:100-7.

77.   Metze TAP. Deliberative governance in synergy with government: a case study of credible environmental improvements in the Dairy Gateway, USA. International Review of Administrative Sciences. 2011;77(1):31-49.

78.   Milat AJ, King L, Newson R, Wolfenden L, Rissel C, Bauman A, et al. Increasing the scale and adoption of population health interventions: experiences and perspectives of policy makers, practitioners, and researchers. Health Research Policy and Systems. 2014;12.

79.   Oh CH, Rich RF. Explaining use of information in public policymaking. Knowledge & Policy. 1996;9(1):3.

80.   Oliver D, Jacobs C. Developing guiding principles: an organizational learning perspective. Journal of Organizational Change Management. 2007;20(6):813-28.

81.   Oliver K, De Vocht F, Money A, Everett M. Who runs public health? A mixed-methods study combining qualitative and network analyses. Journal of Public Health (United Kingdom). 2013;35(3):453-9.

82.   Oliver K, Everett M, Verma A, de Vocht F. The human factor: Re-organisations in public health policy. Health Policy. 2012;106(1):97-103.

83.   Orr K, McAteer M. The modernisation of local decision making: Public participation and Scottish local government. Local Government Studies. 2004;30(2):131-55.

84.   Peck E, Six P, Gulliver P, Towell D. Why do we keep on meeting like this? The board as ritual in health and social care. Health services management research : an official journal of the Association of University Programs in Health Administration / HSMC, AUPHA. 2004;17(2).

85.   Ram M, Trehan K. Critical action learning, policy learning and small firms: An inquiry. Management Learning. 2010;41(4):414-28.

86.   Rich R, Oh C. Rationality and Use of Information in Policy Decisions. Science Communication. 2000;22(2):173-211.

87.   Sinclair S. Partnership or Presence? Exploring the Complexity of Community Planning. Local Government Studies. 2011;37(1):77-92.

88.   Turnhout E, Van Bommel S, Aarts N. How Participation Creates Citizens: Participatory Governance as Performative Practice. Ecology and Society. 2010;15(4).

89.   Milat AJ, King L, Newson R, Wolfenden L, Rissel C, Bauman A, et al. Increasing the scale and adoption of population health interventions: Experiences and perspectives of policy makers, practitioners, and researchers. Health Research Policy and Systems. 2014;12(1).

90.   Lavis JN, Ross SE, Hurley JE, Hohenadel JM, Stoddart GL, Woodward CA, et al. Examining the Role of Health Services Research in Public Policymaking. The Milbank quarterly. 2002;80(1):125-54.

91.   Weiss CH. The Many Meanings of Research Utilization. Public Administration Review. 1979;39(5):426-31.

92.   Deas L, Mattu L, Gnich W. Intelligent policy making? Key actors' perspectives on the development and implementation of an early years' initiative in Scotland's public health arena. Social Science & Medicine. 2013;96:1-8.

93.   de Koning J. Unpredictable Outcomes in Forestry-Governance Institutions in Practice. Society & Natural Resources. 2014;27(4):358-71.

94.   Hutchinson JR. A Multimethod Analysis of Knowledge Use in Social Policy: Research Use in Decisions Affecting the Welfare of Children. Science Communication. 1995;17(1):90-106.

95.   Pope C, Robert G, Bate P, Le May A, Gabbay J. Lost in Translation: A Multi-Level Case Study of the Metamorphosis of Meanings and Action in Public Sector Organizational Innovation. Public Administration. 2006;84(1):59-79.

96.   Barwick MA, Peters J, Boydell K. Getting to uptake: Do communities of practice support the implementation of evidence-based practice? Journal of the Canadian Academy of Child and Adolescent Psychiatry / Journal de l'Académie canadienne de psychiatrie de l'enfant et de l'adolescent. 2009;18(1):16-29.

97.   Wieser B, Karner S. Deliberating Genome Research: Discursive Strategies and Performative Roles. Science as Culture. 2010;19(3):327-49.

98.   Green J. Epistemology, evidence and experience: evidence based health care in the work of Accident Alliances. Sociology of health & illness. 2000;22(4):453-76.

99.   Cook SD, Wagenaar H. Navigating the Eternally Unfolding Present: Toward an Epistemology of Practice. The American Review of Public Administration. 2012;42(1):3-38.

100.   Geels FW. Ontologies, socio-technical transitions (to sustainability), and the multi-level perspective. Research Policy. 2010;39(4):495-510.

101.   Guzman G. The grey textures of practice and knowledge: review and framework. European Business Review. 2013;25(5):429-52.

102.   Freeman R, Sturdy S. Introduction: knowledge in policy — embodied, inscribed, enacted. In: Freeman R, Sturdy S, editors. Knowledge in Policy: Embodied, inscribed, enacted. Bristol, UK: Policy Press 2015.

103.   Yanow D. Accessing local knowledge. In: Hajer M, Wagenaar H, editors. Deliberative Policy Analysis: Understanding governance in the network society. Cambridge, UK Cambridge University Press 2003. p. 228-46.

104.   Jackson PT. Making Sense of Making Sense: Configurational analysis and the double hermeneutic. In: Yanow D, Schwartz-Shea P, editors. nterpretation and Method: Emprirical research methods and the interpretive turn New York, NY, USA: ME. Sharpe Inc.; 2014. p. 267-83.

105.   dos Santos Freitas M. Enacting knowledge in a European project In: Freeman R, Sturdy S, editors. Knowledge and policy in research and practice Briston UK: Policy Press 2015. p. 123 - 39.

106.   Williams P. Collaboration in public policy and practice: perspectives on boundary spanners. Chicago, IL;Bristol, UK;: Policy Press; 2012.

107.   Oliver K, Pearce W. Three lessons from evidence-based medicine and policy: increase transparency, balance inputs and understand power. Palgrave Communications. 2017;3(1):43.

108.   Dandy N, Fiorini S, Davies AL. Agenda-setting and power in collaborative natural resource management. Environmental Conservation. 2014;41(4):311-20.

109.   van Hulst M, Yanow D. From Policy "Frames" to "Framing": Theorizing a More Dynamic, Political Approach. The American Review of Public Administration. 2014;46(1):92-112.

110.   Freeman R, Sturdy S. Knowledge and policy in research and practice In: Freeman R, Sturdy S, editors. Knowledge in Policy: embodied, inscribed, enacted Bristol, UK: Policy Press; 2015. p. 201-18.

2.9 Appendices to Chapter 2.

2.9.1 Appendix 1. Preliminary search list and results of discursive process to create list of seed citations*

Citation Proposed	Excluded	Included
Addleson, M. (2013). "Will the real story of collaboration please stand up so we can see it properly?" Knowledge Management Research & Practice **11**(1): 32-40.	X	
Alexander, J. A., et al. (1998). "Governance in Public-Private Community Health Partnerships: A Survey of the Community Care Network SM Demonstration Sites." Nonprofit Management and Leadership 8(4): 311-332.	X	
Birch, S. "As a matter of fact: evidence-based decision-making unplugged." Health Economics **6**(6): 547-559.	X	
Bowen, S. and A. B. Zwi (2005). "Pathways to "Evidence-Informed" Policy and Practice: A Framework for Action." PLoS Medicine **2**(7): 600-605.		X
Campbell, D. M., et al. (2009). "Increasing the use of evidence in health policy: practice and views of policymakers and researchers." Australia and New Zealand Health Policy 6 (6) (1743-8462 (Electronic).	X	
Checkland, K. (2004). "National Service Frameworks and UK general practitioners: street-level bureaucrats at work?" Sociol Health Illn 26(7): 951-975.	X	
Choo, C. W. (1991). "Towards an Information Model of Organizations." The Canadian Journal of Information Science **16**(3): 32-62.	X	
Culyer, A. J. and J. Lomas (2006). "Deliberative processes and evidence-informed decision making in healthcare: Do they work and how might we know?" Evidence and Policy **2**(3): 357-371.		X
DeMartini, J. and L. Whitbeck (1986). "Knowledge Use as Knowledge Creation." Science Communication **7**(4): 383-396.		X
Dobrow, M. J., et al. (2006). "The impact of context on evidence utilization: A framework for expert groups developing health policy recommendations." Social Science and Medicine **63**(7): 1811-1824.		X
Dobrow, M. J., et al. (2004). "Evidence-based health policy: context and utilisation." Social Science & Medicine **58**: 207-217.		X
Fafard, P. (2012). "Public health understandings of policy and power: Lessons from INSITE." Journal of Urban Health 89(6): 905-914.	X	
Florio, E. and J. Demartini (1993). "The Use of Information by Policymakers at the Local Community Level." Science Communication **15**(1): 106-123.		X
Forbes, A. and P. Griffiths "Methodological strategies for the identification and synthesis of 'evidence' to support decision-making in relation to complex healthcare systems and practices." Nursing Inquiry **9**(3): 141-155.	X	
Freeman, R. (2007). "Epistemological Bricolage: How Practitioners Make Sense of Learning." Administration & Society **39**(4): 476-496.		X
Greenhalgh, T. and J. Russell (2006). "Reframing evidence synthesis as rhetorical action in the policymaking drama." Healthcare Policy **1**(2): 34-42.		X
Greenhalgh, T. (2010). "What is this knowledge that we seek to "exchange"?" Milbank Q 88(4): 492-499.	X	
Hajer, M. (2005). "Setting the Stage: A Dramaturgy of Policy Deliberation." Administration & Society **36**(6): 624-647.		X
Hutchinson, J. R. (1995). "A Multimethod Analysis of Knowledge Use in Social Policy: Research Use in Decisions Affecting the Welfare of Children." Science Communication **17**(1): 90-106.		X
Julnes, P. and M. Holzer "Promoting the Utilization of Performance Measures in Public Organizations: An Empirical Study of Factors Affecting Adoption and Implementation." Administration Review **61**(6): 693-708.	X	

Reference		
König, T. and T. Bräuninger (1998). "The Formation of Policy Networks." Journal of Theoretical Politics **10**(4): 445-471.	X	
Landry, R., et al. "Utilization of social science research knowledge in Canada." Research Policy **30**(2): 333-349.	X	
Langley, A., et al. (1995). "Opening up Decision Making: The View from the Black Stool." Organization Science **6**(3): 260-279.		X
Lavis, J., et al. (2009). "SUPPORT Tools for evidence-informed health Policymaking (STP) 14: Organising and using policy dialogues to support evidence-informed policymaking." Health Research Policy and Systems **7**(1): 1-8.	X	
Lavis, J. N., et al. (2008). "Evidence-informed health policy 1 – Synthesis of findings from a multi-method study of organizations that support the use of research evidence." Implementation Science **3**: 53.	X	
Lavis, J. N., et al. (2004). "Use of research to inform public policymaking." Lancet **364**(9445): 1615-1621.	X	
Lavis, J. N., et al. (2002). "Examining the Role of Health Services Research in Public Policymaking." Milbank Q **80**(1): 125-154.		X
Lewin, S., et al. (2009). "SUPPORT Tools for evidence-informed Policymaking in health 11: Finding and using evidence about local conditions." Health Research Policy and Systems **7**(1): 1-14.	X	
Lindblom, C. E. (1959). "The Science of "Muddling Through"." Public Administration Review **19**(2): 79-88.	X	
Lomas, J. (1993). "Diffusion, Dissemination, and Implementation: Who Should Do What?" Annals of the New York Academy of Sciences **703**(1): 226-237.		X
Lomas, J. (1997). "Research and evidence–based decision making." Australian and New Zealand Journal of Public Health **21**(5): 439-441.		
Lomas, J. (1997). Improving research dissemination and uptake in the health sector: beyond the sound of one hand clapping. Hamilton, Ontario, Canada, Centre for Health Economics and Policy Analysis. http://www.cwhn.ca/en/node/22393 (last accessed 17.12.2019)	X	
Lomas, J. (2005). "Using Research to Inform Healthcare Managers' And Policymakers' Questions: From Summative to Interpretive Synthesis." Healthcare Policy **1**(1): 55-71.		X
Lomas, J. (2007). "Decision support: a new approach to making the best healthcare management and policy choices." Healthcare quarterly (Toronto, Ont.) **10**(3): 16-18.	X	
Lomas, J. and A. D. Brown (2009). "Research and advice giving: A functional view of evidence-informed policy advice in a Canadian ministry of health." Milbank Quarterly **87**(4): 903-926.	X	
McDonough, J. E. (2001). "Using and misusing anecdote in policymaking." Health Aff (Millwood) **20**(1): 207-212.		X
Mitchell, S. M. and S. M. Shortell (2000). "The Governance and Management of Effective Community Health Partnerships: A Typology for Research, Policy, and Practice." Milbank Q **78**(2): 241-289.	X	
Oh, C. H. and R. F. Rich (1996). "Explaining use of information in public policymaking." Knowledge & Policy **9**(1): 3.		X
Ouimet, M., et al. (2006). "What factors induce health care decision-makers to use clinical guidelines? Evidence from provincial health ministries, regional health authorities and hospitals in Canada." Social Science & Medicine **62**(4): 964-976.	X	
Ouimet, M., et al. (2009). "The absorption of research knowledge by public civil servants." Evidence & Policy: A Journal of Research, Debate and Practice 5(4): 331-350.	X	
Oxman, A., et al. (2009). "SUPPORT Tools for evidence-informed health Policymaking (STP) 1: What is evidence-informed policymaking?" Health Research Policy and Systems **7**(Suppl 1): 1-7.	X	
Oxman, A., et al. (2009). "SUPPORT Tools for evidence-informed health Policymaking (STP) 15: Engaging the public in evidence-informed policymaking." Health Research Policy and Systems **7**(1): 1-9.	X	
Rich, R. and C. Oh (2000). "Rationality and Use of Information in Policy Decisions." Science Communication **22**(2): 173-211.		X
Rich, R. F. (1979). "The Pursuit of Knowledge." Knowledge **1**(1): 6-30.	X	
Sanderson, I. (2003). "Is it 'what works' that matters? Evaluation and evidence-based policy-making." Research Papers in Education **18**(4): 331-345.		X

Sanderson, I. (2006). "Complexity, 'practical rationality' and evidence-based policymaking." Policy and Politics **34**(1): 115-132.		X
Shaw, S. E. and T. Greenhalgh (2008). "Best research - For what? Best health - For whom? A critical exploration of primary care research using discourse analysis." Social Science & Medicine **66**(12): 2506.	X	
Von Hayek, F. A. (1989). "The Pretense Of Knowledge." The American Economic Review **79**(6): 3.	X	
Walker, L. and L. Gilson (2004). "'We are bitter but we are satisfied': Nurses as street-level bureaucrats in South Africa." Social Science and Medicine **59**(6): 1251-1261.	X	
Weiss, C. H. (1979). "The Many Meanings of Research Utilization." Public Administration Review **39**(5): 426-431.		X
Wilson, M., et al. (2012). "Community-based organizations in the health sector: A scoping review." Health Research Policy and Systems **10**(1): 36.	X	
Yin, R. and M. Gwaltney (1981). "Knowledge Utilization as a Networking Process." Science Communication **2**(4): 555-580.		X

*As described in section 2.5, initial lists of articles identified using manual search techniques were distributed to my advisory committee, along with article abstracts and links to PDF documents of full text articles wherever possible, along with basic inclusion criteria, and the queries used to guide selection on the basis of relevance. Advisors were asked to provide input based on their own expertise. Seed list inclusions were made by consensus following discussion of the searched articles. Citations marked included in the table formed the list of citations used in the forward snowball search strategy.

2.9.2 Appendix 2. Supplementary Coding and Analysis Information

Developing Thematic Groupings

Query Grouping: What types of knowledge/information and what knowledge/information sources are used by policymakers in local contexts?			
Aggregate Theme (parent node)	**Sub-themes (child node)**	**Sub-themes (grand-child node)**	**Emerging concepts (open coding)**
Information Sources	Research-based evidence		-Research; research utilization data
	Commissioned reports		-Project reports; performance reports; program evaluation; organizational assessments
	Existing policy		
Embodied Knowledge Sources	Interpersonal Network Knowledge		-Existing policy; political position statements
	Citizen or Community Stakeholder Input		-Information specific to networks, partnerships or relationships
	Local Expertise and Personal Experience		-Citizen input -Experience; expertise; tacit knowledge; anecdote -Reports from social media; Media

Query Grouping: How do individuals engaged in the practice of policymaking assign value to knowledge and information?			
Aggregate Theme (parent node)	**Sub-themes (child node)**	**Sub-themes (grand-child node)**	**Emerging concepts (open coding)**
Relevance and internal verification	Relevance	Use of external information	-Relevance; applicability to context; usefulness; Stage of decision-making process
		Use of internal or locally-generated information	-Consistency
		Role of local expertise	-Popular familiarity; guidance of familiar and knowledgeable others
	Internal verification	Internal vs. external information	- Values and beliefs (individual/ shared)
		Social context, interests and influence	-Political climate – political values
		Values and beliefs	- Reliability; trustworthiness; rigour
Reliability or Dependability			- Accessibility; timeliness; availability
Timeliness			

Query Grouping: How are policymaker roles and knowledge-related activities described within the practice of local policymaking?			
Aggregate Theme (parent node)	**Sub-themes (child node)**	**Sub-themes (grand-child node)**	**Emerging concepts (open coding)**
Establishing a practice context	Developing a shared vision		-Defining context; Working together to address common goals;
	Defining a shared practice setting		-Communication;
	Key policymaking participants		-Key influencers; Membership dependent; Representation; Boundary spanners;
	Defining routines and accepted group practices		

Searching for knowledge and information			-Understanding 'the way things work'; routines and practices; power; interests; accommodation
Creating a shared understanding	Collective sensemaking	Pragmatic bricolage	-Search activities; seeking out knowledge producers; looking for citizen/stakeholder input; community participation
		Dialogue and rhetoric	
		Deliberative processes	- Sensemaking; pragmatic bricolage; learning
		Negotiation or co-creation of new knowledge	-deliberative processes, rhetoric, dialogue
			-knowledge creation; exchange of knowledge and information

Summative Textual Analysis – an example

Under the third query grouping in the above Table (roles and knowledge-related activities), the sub-theme of collective sensemaking was identified. As I completed coding from the original articles, I performed a textual analysis on the codes identified as belonging to this sub-theme and produced a visual representation (Figure 1 – below)

Figure 1. Word Cloud: Theme – Sensemaking

Dominant text across codes and across sources supports the sensemaking theme as important knowledge work. My reflexive notes made following this analysis noted that:

"The language seems to reflect work around knowledge, information and evidence. It is all about processes – there are lots of outstanding verbs here to tell us what people do in sensemaking – they are understanding, generating, introducing, engaging, articulating, negotiating, constructing. Sensemaking is both individual and collective. It is local and framed in the context (of the sense maker?). It is important."

Chapter 3

3   The Practice of Local Policymaking: Enacting Shared Practice Contexts

3.1   Introduction

Policy implementation can be considered a process of creating negotiated output that involves many actors and agencies, interests and organizations, beliefs and values, all of which shape policy outcomes in context (1). National or broadly regional policies may be brought into effect at the local level; however, many issues are too complex and local contexts too uncertain for the direct, standardized operationalization and application of macro level policy initiatives (2-4). The processes of making decisions for the creation and implementation of policy may be problematized by the multiple levels and decision-making contexts in which policymaking is practiced. Categories or representations of scale are fundamental to the way in which social actors make sense of policy or implementation issues and articulate their work (5, 6). Each level of engaged actors or decision makers will have their own set of tasks and goals depending upon their own jurisdiction or context (7) but are still interconnected. Work at the meso level, where the translation of policy can be represented by the implementation or oversight of specific regional programs, is tied to both macro and micro level frames (8). The constructions of scale and the interconnectedness of hierarchical spaces may be implicated in enabling relationships that support specific configurations of power and space (5), such as those that support vertical accountabilities, for instance.

Implementing macro-level policy in local settings is not a process that is likely to resemble a simple, orderly exercise in linear or instrumental problem-solving. It is more likely to be messy and uncertain, characterized by conflicts, gaps in information, negotiation and ambiguity than it is to be orderly and rational (1, 9, 10). However, local implementation is an integral part of the overall policy process and, as such, should not be dismissed simply as a task for administrative follow-up (1, 9, 11). The procedures, guidelines or regulations that support implementation are created and function at the local level because of the way in which people

collectively define the context in which they must act (8). Appreciating the context of implementation policy-making practice, and how it is defined by local policymaking practitioners, is an essential element in grasping the work of local decision-makers as they co-construct and maintain shared and actionable understandings around implementation.

Creation of local implementation policy, defined here as the procedures, guidelines or regulations that support the collective actions of implementation, has become increasingly decentralized as policymakers adopted more collaborative and networked strategies of engagement to address complex local challenges (12). The concept of collaborative governance has evolved to identify and explain the more flexible and democratic modes of collective problem-solving and decision-making that have emerged to address local implementation policy (13, 14). At the meso or local levels, policymakers are not necessarily politicians or bureaucrats. Often, local or regional authorities and community stakeholders work in collaborative settings to develop and deliver plans for implementation that must balance over-arching macro policy definitions, targets, and deliverables with a shared understanding of local and practical needs (2, 4, 15).

The success at putting forward cohesive, pragmatic solutions to issues of local implementation may depend, in part, on the ability of the collaborative group to co-create an accommodative and inclusive practice setting that can support constructive knowledge enactment processes (16). Well-designed practice settings can help to establish common ground for effective, collaborative work (17). Reviews of the collaborative decision making and governance literature, like the one published by Ansell and Gash (18), have provided models for collaborative decision making that include descriptions of factors associated with the elements of 'institutional design' (e.g. inclusiveness, ground rules, structures and process, etc.) and underlying architectural 'starting conditions' (e.g. historical relationships, power and resource asymmetries, etc.) that should be considered in the negotiation of the practice setting. However, there have been relatively few studies that have engaged with the knowledge enactment practices of the policy actors engaged in co-negotiating the practice setting (19).

In the previous study, described in Chapter 2 of this dissertation, an interpretive review and synthesis of the local policymaking literature used a practice-based lens to focus on local policymaking. Based on the results of that synthesis, the Knowledge Enactment in Practice Settings (KEPS) framework was offered to facilitate exploration of knowledge enactment practices within local policymaking contexts. Using the KEPS framework as a starting point, this study will continue to explore new information and accumulate "theoretically informative" (p.6) (20) knowledge that will contribute to ongoing processes of theorizing about the practices of local policymaking. The KEPS framework highlights two areas of knowledge work within local policy contexts: 1) the co-creation of practice settings, and 2) the co-creation of knowledge. In this study, the KEPS framework was used as an analytic tool to help gather, interpret and explore new information about the experience of co-creating a practice setting for an implementation policy initiative from the perspective of engaged policy actors[1].

First, background information is presented regarding the practice of local implementation policymaking, collaborative governance, and the significance of a negotiated practice setting to collaborative governance. Given that the existing descriptions of collaborative settings within the literature may articulate ideals, and promote assumptions or expectations, around how collective decision-making practices should work, particular attention was given to the application of a practice-based lens that promotes engagement with the actor and actor experience in context, thus preparing for the examination of current experience against past assumptions, which has been identified as an important element in the ongoing process of theorizing (20, 21). The present study employed a case study methodology to examine the co-creation of a regional (meso-level) practice setting, negotiated and adopted by a group of decision-makers convened for the purpose of implementing macro-level policy in local contexts. This co-creation of practice setting included the development of shared project definitions, and collective

---

[1] The KEPS framework will be used as an analytic tool to explore the other broad area of knowledge work identified in Chapter 2 – the co-creation of knowledge – in the next study reported in Chapter 4 of this dissertation.

understandings of common purpose in addition to elements such as rules for engagement and mechanisms for information and knowledge movement within the initiative. Examination of co-creation of practice settings using a backdrop of existing literature-based assumptions and expectations highlighted the disconnect between ideal narratives and the experiences of local implementation policy practitioners in context. Based on the experiences of engaged actors, collaborative practices in initiatives that are situated within well-resourced and prominent lead agencies are discussed.

3.2   Background

3.2.1   Local implementation policy and collaborative governance

Increasingly, collaborative forms of governance, intended to maximize engagement of all interested stakeholders, are used at the local level of implementation initiatives (12). Rather than remain bound within the constraints of sectors, organizational or institutional boundaries, collaborative local implementation efforts rely on the development of relationships or networking between organizations and the mobilization of resources including information and knowledge (7, 13, 14, 22). In the case of health policy, leaders from local hospitals and healthcare organizations as well as healthcare professionals, patients, and other stakeholders may work together with leaders from local government and non-governmental community-based organizations to create strategies to facilitate the implementation of health programs and services, as mandated by macro level policy, within their local community or catchment area (4, 11, 23).

Collaborative modes of governance have been characterized in the literature in a variety of ways including networked, participatory, collective or deliberative (24). All of these descriptions refer to multi-organizational arrangements, involving governmental and non-governmental (community-based) actors working together using consensus-based, deliberative processes to solve implementation or coordination problems that cannot be solved by techno-rational problem-solving approaches (24). Fischer suggested that governance, in this sense, refers

to a new kind of space for decision-making, not as an indication of politics or political action occurring within these spaces (25). Indeed, the inclusion of multiple individuals from a variety of organizations, agencies or institutions offers the opportunity to create an inclusive decision-making setting with input from diverse interests and perspectives (12). While this strategy holds the potential for conflict and divisiveness, it also provides local policy actors with the opportunity to work collectively and positively to co-create a shared definition of their common purpose, identify implementation issues and negotiate innovative solutions (13, 15, 26-28).

3.2.2   The Negotiated Practice Context

The process through which a group negotiates a shared understanding of their common purpose represents a collective process of knowledge co-production that is important in forming a collaborative practice (16). Drawing on a variety of formal and informal sources of knowledge and information (Chapter 2), local policymakers negotiate new knowledge in the form of shared definitions and understandings of goals, and work to co-produce shared settings in which decision-making is practiced (18, 24, 29). Practice contexts, or the contexts of implementation decision-making, are not fixed. Rather, they are emergent and are actively co-constructed and re-constructed over time. A collaborative group functions because people at different points do something and what they do is the result of how they collectively define and interpret the situation in which they are called to act (30, 31).

The collaborative relationship, then, depends to some degree on the ability of engaged stakeholders to create a negotiated, collective understanding of their practice frame and establish common ground by moving and reforming boundaries around a collective purpose (2, 13, 15), while determining what practices are considered to be acceptable or desirable within the group (12, 32). Individual or organizational interests do not need to be abandoned; rather, they should be acknowledged and put temporarily to one side, as the group works together to establish a shared vision that is perceived as good for the common interest (22, 33-35). From this perspective, the decision-making space is not just full of competing interests, as is the case with non-collaborative processes, but instead is shaped by collectively negotiated understandings (14),

taking into account the starting conditions, such as existing power or resource asymmetries, that could facilitate or discourage the establishment of collaborative practices (18).

3.2.3 The Practice of Policymaking

This conceptualization of negotiated practice settings reflects the application of a practice-based epistemology to the examination of policy or decision-making processes. When you apply this lens, practices can be viewed as social enactments that include collective construction of meaning through processes such as sensemaking in order to negotiate shared understanding, facilitate relationships or shape action (2, 11, 36, 37). People act to gain knowledge of the world; they work to negotiate meaning, identity and order by acting or interacting with the world and with each other (30, 31, 38). The creation of knowledge, then, cannot be usefully separated from action and reflects a context-bound engagement with the world (4, 31, 38). Indeed, knowledge, practice, and context are all part of a mutually co-constitutive system (39). Knowledge is dynamic and emergent, continually negotiated, produced and re-produced through cycles of enactment (40, 41). Freeman and Sturdy proposed a new phenomenology of knowledge that provides a basic language of observation that may be helpful in thinking about knowledge in the practice of policymaking (41). According to their proposed phenomenology, knowledge may be viewed as existing in three phases: embodied (or held within human actors), inscribed (e.g. held in documents) and enacted. Enactment is rooted in social interaction within a situated and dynamic practice context and is mediated by existing, embodied knowledge, as well as tangible artefacts, like inscribed texts (41).

The interpretive synthesis, described in the previous paper (Chapter 2), revealed that local policy actors engaged in two broad categories of knowledge enactment processes corresponding to the negotiation of practice contexts as well as of policy-relevant knowledge (see Figure 3-1: Knowledge Enactment in Practice Settings – KEPS – framework). In that synthesis, identified studies described decision-makers as participating in collective processes to define the practice setting by establishing common interests, creating shared goals, and setting ground rules and routines for group interaction in addition to creating strategies, procedures or policies to address common interests and reach shared goals. A project that brings a policy- or decision-making
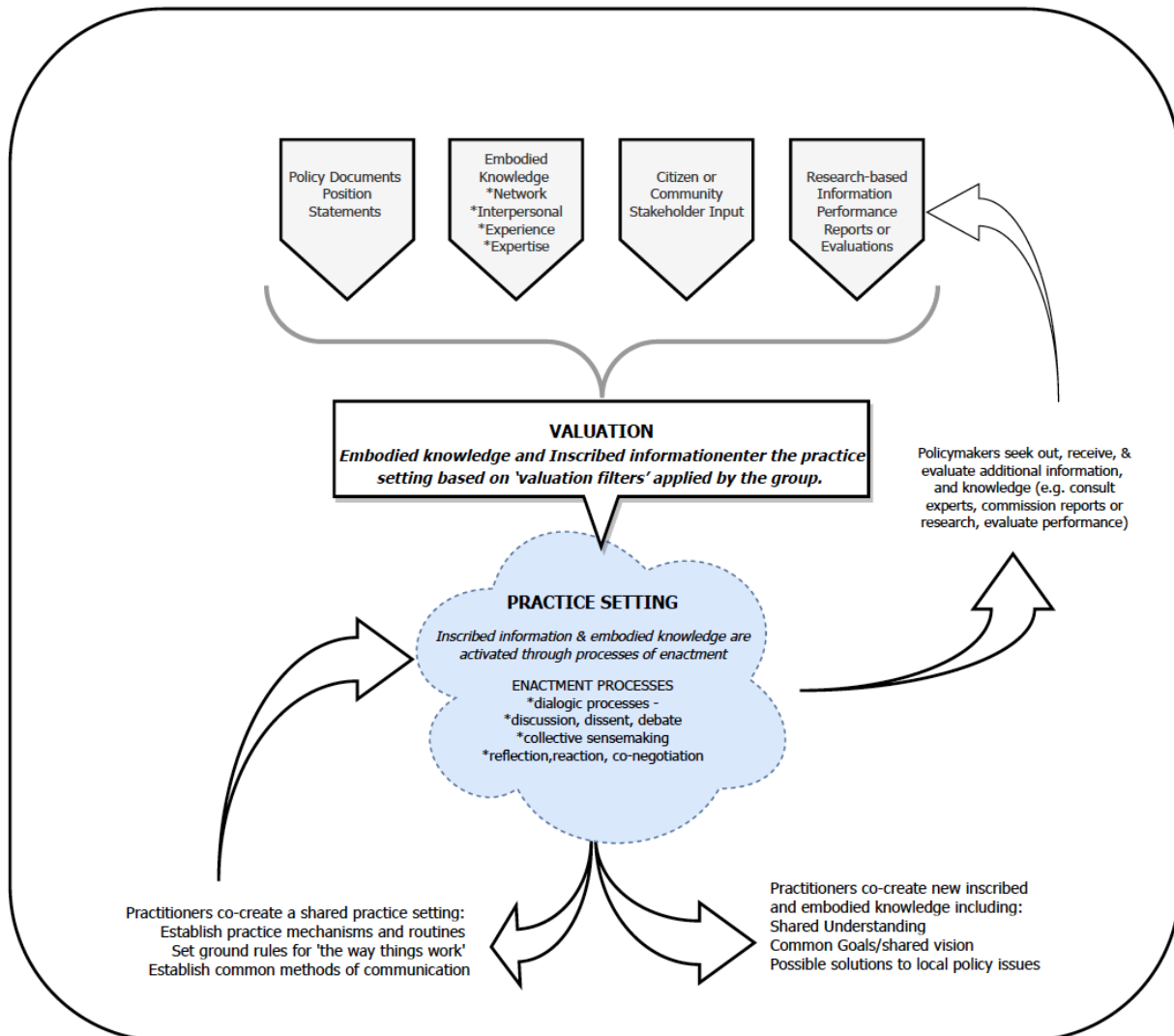
Figure 3-1. Knowledge Enactment in Practice Settings (KEPS) Framework.
Embodied knowledge and inscribed information enter the local policy practice setting via 'valuation filters' applied by engaged actors. Inscribed information and embodied knowledge are activated through processes of enactment that facilitate co-creation of a) the shared practice setting and b) new knowledge

group together offers the opportunity for the creation of a generative and accommodative space in which group members can negotiate a collective and actionable understanding of their purpose and derive a shared way of doing things together. In this way, the practice setting is a social construction defined by the knowledge enacted within it, and mediated by artefacts that may include knowledge, experience, documents or processes from previous decision-making experiences, brought to it by engaged agents (39, 42). As an artefact of new knowledge-in-

practice, whether embodied or inscribed, the shared and 'actionable understanding' of the local practice setting is not necessarily fixed and may continue to evolve as part of the emerging present and ongoing knowledge enactments in context (39, 41).

3.2.4   Objective: Exploring the co-creation of collaborative practice settings

Through processes of knowledge enactment, local policy actors work together to co-create practice settings, co-negotiating shared understandings around issues and goals, administrative structures and processes, and ground rules for the ways things work, for example. The co-created practice setting can enable or constrain collaborative enactment undertaken to enact emerging changes to practice as well as possible solutions to implementation issues (39). Understanding the processes of implementation policymaking is essential for building the capacity of local implementation policymaking groups to support the development of collaborative practice settings that provide opportunities for shared sensemaking and inclusive decision making, are consensus-based and make use of deliberative processes (1, 12, 18, 24). Though time consuming, the success of creating deliberative practices may rest upon such factors as the development of trust, and a willingness to put aside individual interests, at least temporarily, in favour of support for a commitment to a shared interest, that is perceived to have benefit for all involved and that may be referred to as the 'common good' (15, 17, 18, 25, 26).

However, these descriptions may often articulate idealized expectations around how collaborative settings should look and how collective practices should work within them. There has been relatively little written about the shared work of co-creating practice contexts in policy- or decision-making groups formed for the purpose of implementing macro-level policy at the local level. Using the KEPS framework presented in the previous paper (Chapter 2) as a guide, the present study will address this gap by focusing on the exploration of the broad category of collective knowledge work related to the co-creation of the local practice setting. In this paper, I describe a case study in which I examined the following:

- the co-creation of a meso-level (regional) practice setting, negotiated and adopted by a group of decision-makers convened for the purpose of implementing macro level policy in local contexts;

- the co-creation of shared project definitions and a shared, actionable, understandings of common purpose; and

- the role of knowledge and information in the negotiation of the practice setting.

Further, examination of these elements was set against a backdrop of expectations derived from the existing collaborative governance literature in order to highlight the disconnect that existed between the ideal narratives and the experience of policy practitioners in context and to encourage the development of a more nuanced understanding of the co-creation of practice settings that reflects practitioner experience and perspective.

3.3   Method

3.3.1 A Case Study Approach

For this study, the area of interest was identified as knowledge and information enactment practices and the co-creation of practice settings within collaborative, decision-making groups tasked with the implementation of macro-level policy at local levels. Adoption of an instrumental, embedded case study approach facilitates an '*in situ'* investigation of a specific issue or area of interest that is not necessarily intrinsic to the case itself (43, 44).[2] An embedded case was defined as a decision-making group operating within a frame of reference defined by provincial level policy or policies (i.e. at the macro level) and tasked with the negotiation and/or creation of locally-referenced implementation policy (i.e. the development of viable strategies or innovations to facilitate the local implementation of services or programs within the specified

---

[2] Unlike intrinsic case studies, instrumental case studies are undertaken to pursue understanding of issues of interest, rather than of a specific case itself, while embedded cases focus on identified subunits within a larger context as the primary focus of study (43,44).

frame of reference). Insomuch as practices can be understood most simply as what actors do, in context, as part of their everyday life, an ethnographic approach to practice provides the researcher with a means to access an immersive, first-hand encounter (45). Practice-based approaches to ethnographic-style research have been termed praxiography (46, 47). A praxiographic case study is one in which ethnographic methods are applied within a practice-based approach to facilitate understanding. Furthermore, praxiographic approaches are intended to reflect a flexible research strategy that may mix and blend multiple techniques as the researcher learns by doing (47-49). Therefore, a practice-based, ethnographic approach was taken to explore knowledge-based practice within an embedded case.

3.3.1.1   Case Selection

The selection of an embedded case in the present study was theoretical and purposive. Huberman and Miles suggested that case selection should provide a learning opportunity, relevant to one's purpose, in which processes of interest are easily observable (50). Similarly, Stake suggested that the most important feature of case selection should be learning opportunity (43). Intensity sampling, that identifies information-rich cases, helps to fulfill the criterium of learning opportunity that is crucial for instrumental, embedded case study (51).

To identify a potentially information-rich (intensity) case relevant to purpose, a site-based strategy was used to identify structured groups involved in translating and implementing macro-level health policy at the meso and local levels (47). Information was gathered from several formal and informal sources that included graduate level classes in health policy, conversations with academic advisors and other policy experts, and a provincial government health policy conference to assist in the identification of an appropriate case. Using this information-gathering strategy, it was determined that: a) the Health Links Initiative (see section 3.3.2 below), part of the Ministry of Health and Long Term Care (MOHLTC) Action Plan for Healthcare (52) had originally been launched as pilot projects that were locally-driven; b) Health Links pilot projects had been implemented across the Province of Ontario but the program was about to undergo significant changes; c) an early adopter group had been established within the southwest region

of Ontario; and d) the southwest region was in the process of changing its governance structure. In addition, the Health Links (HLs) initiative at the southwest Local Health Integration Network (LHIN) identified the formation of decision-making groups at both the regional and local levels, which suggested opportunities for multi-level exploration of knowledge and information enactment practices within the case. Given all of these factors, it was decided that Health Links represented an intense, information-rich case suitable for investigation within the specific area of interest.

3.3.2   Introduction to the Case Study Context. Health Links: An Overview of an Implementation Initiative

In December of 2012, the MOHLTC in Ontario announced the Health Links initiative as part of their 2012 Action Plan for Healthcare (52). The Action plan for Healthcare represented an opportunity for the provincial government to take stock of recent healthcare reforms and identify key areas in which further improvement was needed. Identified areas for improvement included the reduction of avoidable emergency room visits, decreasing the number of avoidable readmissions to hospital, and eliminating uncoordinated care systems in which people were unable to access appropriate care close to home. As part of the Action Plan assessments, it was identified that 5% of the population were using approximately two-thirds of the provincial health care resources. This 5% was made up mostly of individuals who had multiple or complex health conditions, many of whom were also senior citizens. The initial goal of the Health Links implementation projects was to address the resource utilization demands of this group. The Government of Ontario established 19 early adopter projects as part of the pilot wave of Health Links. Each of the 19 early adopter projects was viewed as independent and was encouraged to develop strategies for implementation that were most appropriate to their local context within a low-rules policymaking environment.[3] Since the initial 'early-adopter' pilot wave, the initiative

---

[3] There can be several different types or categories of rules or rule structures applies within decision making environments (53). In the pilot phase of Health Links, projects were intended to be community-focused and collaborative, having few rules of authority or of scope applied to policymaking processes by the macro level policymaker.

evolved and expanded in a series of implementation waves and by March 2016, 82 Health Links programs had been established across the province.

3.3.2.1 Health Links in the Southwest Region

At the time of this study, the province of Ontario was divided into 14 local health integration networks (LHINs) (54). The three-fold purpose of the LHINs is to provide better access to high quality healthcare and services; to facilitate coordination of local service provision, and to provide management for the local healthcare system that is both effective and efficient (55). Each LHIN is formally accountable as a crown agency to the MOHLTC for planning, coordinating and funding both health services and the delivery of home and community care within their respective jurisdictions (55). The southwest LHIN (SW-LHIN) is responsible for the planning, strategic integration and funding of approximately 200 health service providers that deliver health care services to its almost 1,000,000 residents. (http://southwestlhin.on.ca/aboutus/facts.aspx). As part of the pilot program for Health Links, a single early adopter program was established within the SW-LHIN. In early 2014, there was a targeted expansion planned for Health Links across the province. In the SW-LHIN, five additional local initiatives were identified for development.

3.3.2.2 The Embedded Case: The Health Links Leadership Collaborative

Within the Health Links implementation initiative, a LHIN-based regional governance group, the Health Links Leadership Collaborative (HLLC), was created to provide strategic leadership for the process of translating Health Links from the provincial level to the six local Health Links projects identified for implementation within the region. The structure of the Health Links initiative in the SW-LHIN is provided in Figure 3-2. The HLLC held its inaugural meeting in February of 2014.
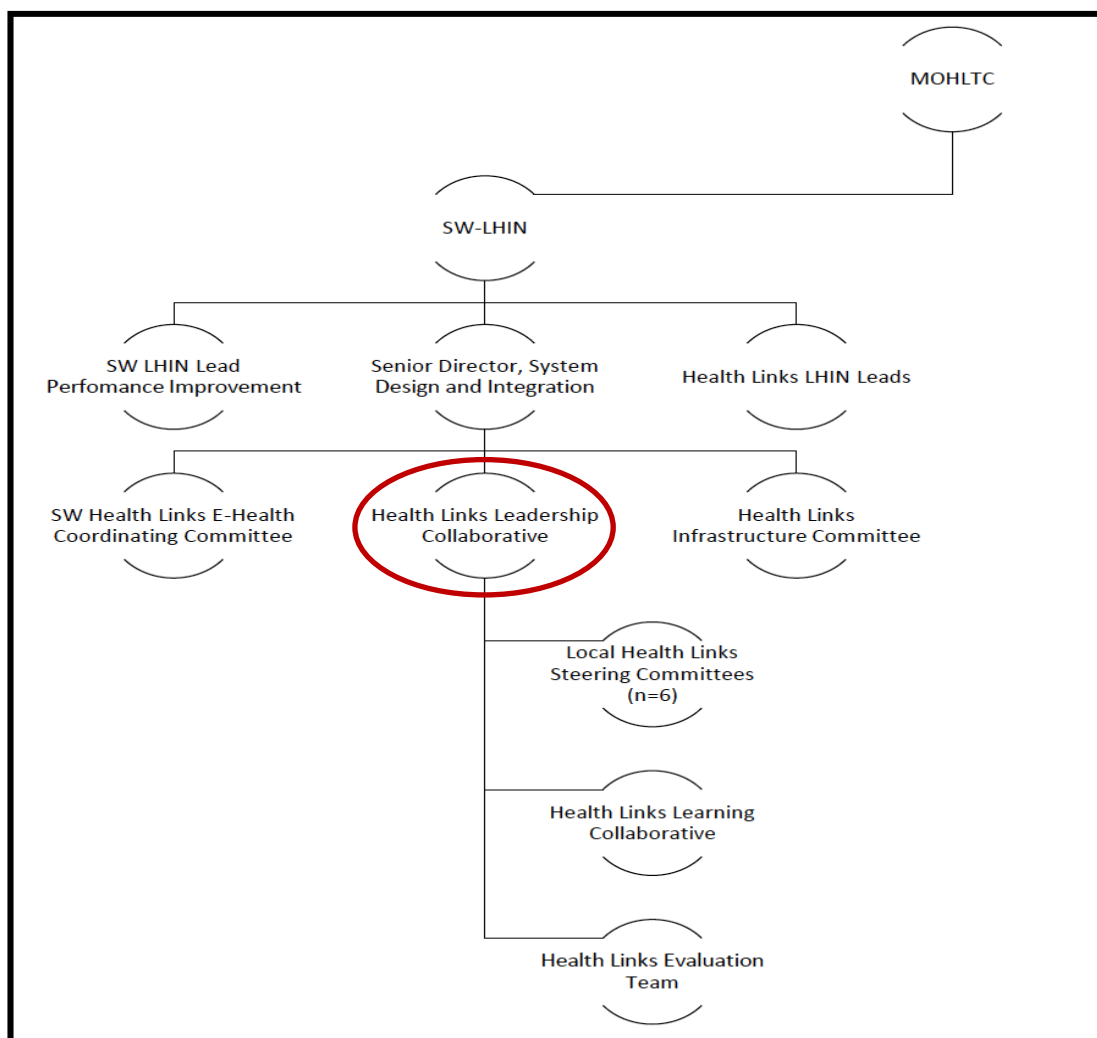
Figure 3-2. Health Links Initiative

An introduction to leaders within the HLs initiative at the SW-LHIN was facilitated by existing interpersonal connections in July of 2014. Following my introduction, I submitted a proposal for research to the HLLC and made a presentation, in person, in October 2014, inviting the participation of the HLLC. During the meeting, the committee members took, and passed, a vote in favour of inclusion in this project. Periods of research engagement and observation, as well as document access via the initiative's shared online storage and communication site, was determined in negotiation with the LHIN-based project team supporting the Leadership Collaborative and its members.

Ethics: This research study received ethics approval from the University of Western Ontario Research Ethics Board (#105852)[4]. In accordance with the approved study proposal, data were anonymized through the assignment of codes to designate both decision-making group and role. A master list of codes was created and stored separately from the data. Quotes appearing in the text of this report are attributed using the code assigned to its source.

3.3.3 Data Collection

The approach to data collection was three-pronged, incorporating document review, participant observation and interviews with key informants, as recommended for both interpretive approaches and ethnographic methodologies (47, 56).

3.3.3.1   Document Review

All documentation created, collected and/or distributed within the HLLC, including all agendas, minutes and supplementary materials provided by or to committee members from the time of inauguration in February 2014 until the end of the observation period (January 2016), was gathered for close reading (56). In addition, I was provided with all agendas, minutes and update documents associated with another regional level group that I did not observe (i.e. the Health Links Infrastructure Committee), for the period of March 2015 through December 2015[5]. The majority of documents reviewed were not in the public domain and were distributed only to members of LHIN-based committees. They were provided to me with the permission of the Health Links Leadership and in accordance with the project's approved ethics protocol. Each

---

[4] Notices of ethics approval are located in Appendix A.

[5] A summary of data collected is provided in Appendix B.

document was provided with a unique identifier, referencing document source, to facilitate increased confidentiality and maintain participant anonymity.

3.3.3.2   Participant Observation

I attended all meetings of the HLLC for a period of 13 months from January of 2015 to January of 2016, inclusive. This yielded a total of 12 observations. Observation was not structured but was guided loosely by an initial framework of sensitizing questions to provide direction and focus (57)[6]. I recorded, as field notes, activities and interactions of individuals and the handling of artefacts within the policymaking context (47). Following each meeting, I reviewed all notes paying particular attention to the use of inscribed knowledge (i.e. written information including reports, journal articles, evaluations, letters, emails, briefings, websites; (58)) and embodied knowledges (i.e. knowledge held in bodies and minds of engaged actors observed as anecdotes, contributions of practical experience or expertise, feedback, or advice, for example; (58)) as well as enactment processes (i.e. active processes around information and knowledge that include sensemaking, discussion, debate, interrogation, for example; see Chapter 2) within the meeting space. In addition, I kept a separate set of reflexive notes recorded after each meeting.

3.3.3.3   Key informant/expert interviews

Conducting semi-structured interviews is appropriate to understanding process and providing insight regarding the "hows and whys" of what appears to be happening in context (47, 59, 60). When combined with observational data, interviews contribute both breadth and depth to interpretation (59). At the beginning of the observation period, all individuals in attendance at the

---

[6] Sensitizing Questions: Who are the actors within the context and are there identifiable 'actor groups' within the context? What are the apparent roles or functions of these identified actors/actor groups? How do these roles or functions relate to knowledge enactment? What types/sources of knowledge are referred to/valued most by the group? Why? What kinds of discourses or enactments contribute to the decision-making process used by the group?

HLLC meeting (January and February 2015) received verbal and written invitations to participate in individual interviews.[7] Invitations to participate in interviews, along with letters of information were distributed with meeting materials to follow-up with individual members who did not attend in person (e.g. attended via teleconference) or who were absent from the meeting. All members, except for one individual who judged their own attendance to be infrequent, agreed to be interviewed. From this resulting pool of volunteers, key informants were selected to represent a range of roles/relationships within the committee, decision-making experience and organizational representation. Selected informants were invited to participate in one-on-one interviews.

Interviews focused on how the informants viewed their own role within the committee, their activities with regard to information seeking, knowledge use and sensemaking, their interactions with others, and the group's decision-making processes.[8] A single, external informant from the macro policy level was also identified by the HLLC as an important influence on knowledge processes for key actors within the group and was, therefore, provided with an invitation. A brief description of interview participants is provided in Appendix B. Semi-structured interviews (n=16) were each approximately 1 - 1.5 hours in duration and were conducted either face-to-face at a location of the participant's choosing or via telephone, at the participant's convenience. Interviews were recorded digitally, data was transferred to and transcribed verbatim by a professional transcriptionist, in accordance with the approved ethics protocol.

---

[7] Attendance at HLLC meetings ranged from 14 – 28 individuals. Membership lists (by March 2015) included 28 individuals representing 10 organizations. Ten members were local HL project leads and co-leads while 7 represented other community partners. Eleven HLLC members represented either the LHIN or the CCAC.

[8] All ethics-approved interview guides for use in semi-structured interviewing are provided in Appendix C.

3.3.4 Analysis

Praxiographic research is explanation-focused (47). In the same vein, interpretive analysis promotes an examination of situated, collective meaning-making grounded in the life world of human actors practicing within policy contexts (56, 60). In this study, interpretive analysis was informed by the phenomenology proposed by Freeman and Sturdy (41) and the epistemology of practice (39). Further, analysis was undertaken from the point of view that knowledge is negotiated through the situated contexts and interpretations of the knower (61), thus placing an emphasis on researcher engagement with what the practitioner does and experiences in context (62). In this case, 'practitioners' were the actors engaged within the context of the Health Links implementation initiative as members of the HLLC.

Data collected included transcribed digital recordings from semi-structured interviews, field notes from direct observation of committee meetings and all documents received, both background and contemporaneous materials. Data analysis overlapped with data gathering and proceeded in an iterative manner (43, 63). Textual data was analyzed through a combination of content analysis and thematic comparison (64). All electronic documents (case documents and field notes) were entered into Nvivo-10 software, as were all digital transcripts. Making use of the NVivo-10 software to gather, organize and re-organize data, coding was conducted on two levels. First an initial line-by-line close-reading and open coding was used to assign initial codes, refining the process and adding (or removing) codes as patterns emerged from the data (65).[9] Theoretical coding was also conducted to group codes together in associated categories as a means to seek out higher order concepts (64, 65). Analysis drew from all data sources, constantly comparing across them to ensure that the interpretation and concepts that emerged from them were situated in context.

---

[9] Supplementary coding information is provided in Appendix 1.

3.3.4.1   Addressing Trustworthiness

In consideration of study rigour, I employed careful intensity sampling to identify the primary case, according to the criterion of 'learning opportunity' (43, 66). In addition, over a period of prolonged engagement, I used multiple data sources and collection methods that were adequate and appropriate to the practice setting (43, 61). The use of self-reflexive journals and notations throughout data collection promoted self-awareness throughout the analysis process and contributed to overall sincerity of the study (66). To support credibility through crystallization, multiple types of data were collected from a variety of sources (66). As in appropriate when applying ethnographic method, thick description was used to provide elaboration, clarification and meaningful illustration with supporting detail (43, 60). Results were also presented at a meeting of the HLLC and discussed with members following the presentation. Member reflections provided by HLLC committee members revealed that the descriptions presented were perceived as valid and members felt that the findings represented their experience in general. Indeed, it was reported that some of the insights presented supported upcoming changes to staging decision making within the HLLC. However, members also emphasized that the HLLC and the Health Links initiative was still evolving and would continue to do so as macro-level policy changed and they, themselves, learned more about how they could best function together as a decision-making group.

3.4   Results

In the previous paper (Chapter 2), I introduced the KEPS framework in which two broad categories of knowledge enactment processes are depicted; 1) negotiation of an accommodative practice setting; and 2) negotiation of policy-relevant knowledge. Broad engagement by practicing policy or decision makers in the joint development of ground rules, shared definitions and determination of goals is essential in the creation of a mutually agreed upon decision-making

context within which policymakers can work together (18, 24, 29).[10] Engagement over time, in the creation and maintenance of an adaptive and accommodative space, supports the development of mutual appreciation, commitment and trust (18).

> *We have to have trust. And I think that there has to be some expectations set, both by the local group, but also by you know, by the people that know… so there has to be, this is the expectation, we trust each other, we're going to be generous with each other and we have to get to there. (HL_1)*

3.4.1   Starting Out or Starting Over

The notion of collaborative or accommodative contexts in which knowledge is enacted collectively by engaged policymaking practitioners is an ideal one that relies, at least in part on the idea that participants should feel like they are entering the process on somewhat equal footing (18, 69). However, actors engaged in local policymaking practices bring embodied knowledge with them to the emerging practice context. This includes knowledge about existing imbalances in power and resources between committee members, the perceived benefits or incentives associated with collaboration, and any accumulated history of interaction between themselves and other decision makers or organizations represented within the group – all of which have been identified as particularly important variables that can affect the way in which decision makers collaborate (18). If, as a new endeavour begins, one organization wields substantial power and influence, it becomes more likely that the processes adopted to define the practice context will reflect the interests of the most powerful. From analysis of the data,

---

[10] A policymaker or policymaking decision maker may be defined as an individual with the power or authority to make choices related to the formation of policy (67). Policy can be defined as "*authoritative decision making related to choices about the goals and priorities of a policymaking body*" (p. 50) (67). Policies may be constructed in various forms including regulations, practice standards, mandates, or ordinances, for example. Stakeholders may be defined as "*a person, group, or organization involved in or affected by a course of action*" (p.2) (68). Stakeholders may be 'lay stakeholders', unpaid citizens who represent individuals with similar interests, or 'professional stakeholders', who are paid to represent organizational or political interests (63).

concepts coalesced around the HLLC's starting conditions. The sub-themes of accountability, resources and funding, and existing relationships were identified (see Table 3-1).[11]

Accountability. In the case of Health Links, the SW-LHIN was appointed as the central 'lead organization' to whom the leadership collaborative and all of the individual Health Links were to be held accountable for performance (see Table 3-1). The SW-LHIN was also the organization responsible for the planning, coordination, integration, and funding of health services in the region. This over-arching, regional accountability structure was non-negotiable. It was put in place by the SW-LHIN in agreement with the macro level policymaker (i.e. the MOHLTC) and, as such, formed part of the frame or boundary within which the HLLC decision-making practice context would function. As part of this accountability structure, the early adopter project in the region became accountable directly to the SW-LHIN, as mandated by the macro-level policymaker (see Table 3-1).

Funding and other resources. The SW-LHIN is a large, well-resourced organization with an established administrative infrastructure.[12] Although funding for Health Links was not initially granted directly to the LHIN in the early adopter phase of the initiative, this changed early in the period of observation (see Table 3-1). Instead of granting funds directly to each local health link project, the macro level funding agency provided funds to the lead LHIN organization which then proceeded to examine each local project to determine allocation on the basis of its assessment.

---

[11] To support thick description, each aggregate theme presented in this paper is accompanied by a table in which all sub-themes are listed and selected data to illustrate and support the development of each coded sub-theme is provided, across data collection modalities (i.e. document data, participant observation and interviews). Dates are provided to reflect development within the thematic groupings over time.

[12] In 2015-2016, the SW-LHIN reported an operating budget of 5 million and a special projects budget of 2.1 million Canadian dollars. The largest expense for the SW-LHIN in both those budget areas was salaries. The SW-LHIN employed 35 full-time staff whose salaries were funded via the operating budget and an additional 14 full-time staff who were funded through the special projects stream (65).

Table 3-1. Starting Out or Starting Over

Sub-Theme	Inscribed Knowledge	Enactment observation	Participant experience (key participant interviews)
Accountability Structure	**Terms of Reference (ToR):** The Health Links Leadership Collaborative will be accountable to the South West LHIN. **May 2014 (meeting materials):** Each HL must develop a letter of cooperation. Early adopter HL used the Letter of Cooperation template from MOHLTC to develop their TOR; Accountability • Letters of cooperation – should consider a consistent approach across the LHIN (developed a template for distribution) **September 2014 (Draft of Terms of Reference):** The HLLC will ... Determine what shared accountability looks between HLLC and HL levels; **Draft of Driver Diagram (October 2014):** Change Idea = Determine what shared accountability looks between HLLC and HL levels; Secondary driver = Governance Agreements within Health Links; Primary driver = Shared Leadership and Accountability **Implementation Framework Discussion minutes (November 2014):** Each Health Link Steering Committee will work with each other and the LHIN to define shared accountability mechanisms. This could include Memorandums of Agreement between health care providers and Service Accountability Agreements among the LHIN and health service providers **Infrastructure Committee Update (November 2015):** Two of our HLs have decided to embed the content of the Letter of Cooperation into their Health Link Steering Committee Terms of Reference	**November 2015:** <u>Performance CCP indicators</u>. Member suggested that there needs to be a single lead organization identified around the provision of coordinated care plans to promote continuity, standardization and transparency (noted: tensions around who should lead – primary care/CCAC) – since counting these are important re: accountability HL lead emphasized that we need to work together, share what we are doing and what is working. CCAC representative noted that the group should not be prescriptive – need to be "in it together". [Project staff asked to support steering committees to support shared information re: development of provincial indicators/accountability "looking to add patients from other aligned initiatives to our reports"]	*Early adopter: So, yes, we are now accountable to the LHIN although we do not have an agreement with the LHIN, but the Ministry has transferred accountability but we have no agreement...my accountability for performance is to the LHIN, but there is no signed agreement to say that. (HL1_L1)* *...the joint, the joint accountability – ways in which we are already jointly accountable, it just needs to be entrenched in the rule book if we're going to be focused on rules. (HL0_L1)* *A number of organizations are accountable to the ministry of health through an accountability agreement with our LHIN. A number of other organizations are accountable to the primary services branch of the ministry, not to the LHIN. And there's a chasm between those two. A number of other health service organizations are not accountable to anyone, just bill OHIP and go on their merry way. And the we've got the Emergency services branch of the ministry, we've got municipal governments, we've got MCSS and MCYS funded organizations who are all sitting at that table, long term care branch of the ministry, all sitting at that table, the LHIN is driving this or the ministry of health is driving this through the LHINS but there's no kind of communication mechanism or engagement mechanism or accountability mechanism for the broader health system to participate in this and in order for us, for the broader health system to participate in this, that needs to be in place. (HL2_L1)*

Sub-Theme	Inscribed Knowledge	Enactment observation	Participant experience (key participant interviews)
Resources/Funding	**Terms of Reference:** The LHIN will also provide support to the Collaborative through its project/planning resources (staff time, information, etc.). Administrative support to the Collaborative will be provided by the LHIN administrative resource. **May 2015 (Inscribed meeting minutes):** LHIN will be reviewing how to allocate funds locally; LHIN staff will be connecting with individual HLs following the meeting; Will review spending patterns of HL, review on how to allocate funding; Determination needs to be made by May 8th to get plan back to MOHLTC; Will go to May 2015 South West LHIN Board meeting for approval; MOH will then execute funding to primary care if they are the Lead Agency **July 2015 (Inscribed meeting minutes):** MOHLTC update - Approval of new Health Link Business Plans will be by the LHINs; process to flow money to LHINs for new HLs still unknown **November 2015 (Meeting materials – slides re: Guide to the Advanced Health Links Model)•** MOHLTC Funds Health Links in accordance with priorities • Maintains overall accountability for Health Links performance, LHIN by LHIN	**May 2015:** Participants were provided with an update regarding funding allocations from the province – to be identified at the LHIN level – shared among all health links in the region that have been approved. There were many questions posed around changes in rules for the funding of new HLs still in the business planning stage. "*Other LHINs have come up with plans for bridge funding*". (information presented by senior LHIN member – queries/sensemaking limited by time; discussions were "*taken offline*"). "have tight timelines", but we are "*dealing directly with the LHIN*" rather than the Ministry in terms of implementation	*I think that there is a level in behind there that you may or may not see you may hear about at the meeting but you won't see it. That is the LHIN decision making around funding. In that particular piece, I would say that the experiential and the political evidence is much — is valued and influences that much differently than at the leadership collaborative. So I think that is kind of a basket in behind the leadership collaborative that is different and it is very important decision making for health links in the SW. (LCE_PM)* *It wasn't as big a deal before the LHIN started to also make the funding decisions but now it is more LHIN decision making vs. shared. (HL1_L1)* *It is about getting things rolling in a timely manner and figuring out from fiscal year to fiscal year whether or not you can keep your staff and the potential that human resource might be lost year over year if you know and the level of risk as a lead organization are you willing to you know continue to pay this project manager on good faith until July or September not knowing for sure if you are going to get all of the money to support that position, yet you locally that you need to figure out a way to do that in order to have continuity of health links implementation. (LCE_PM);* *I do know that finance is a definite struggle for them in that each of those lead organizations have a commitment to hire a manager or project team that is responsible for overseeing the implementation of the health link in their specific locale. But, that is difficult when you are not sure of your funding. (HLE1_1)*
Existing Relationships	**Terms of Reference:** Collaborative members are representing their Health Link and/or health service organization and/or health service sector. **Meeting materials (guiding principles document)– January 2015:** How we will collaborate/work together as Health Link teams? Maintain open dialogue, discuss 'elephants in the room' and	**January 2015:** Setting some ground rules for respectful interaction/dialogue in the practice space: LHIN/CCAC project manager presented information compiled from external sources (2) re: 'how to be an effective participant' and asked for feedback.	*Could we surface more at the leadership table? Do the elephants get talked about? Do the issues get put on the table? Are we all polite to each other and then we go away and live in our own camps and stuff? …some history still lives around the table especially at local health links tables, and so it is first to understand it, but in order to make policy locally, you have to get over it. And, so, I think that it is one of the things that has slowed local*

Sub-Theme	Inscribed Knowledge	Enactment observation	Participant experience (key participant interviews)
	tough issues that challenge the status quo • Create a safe blame-free place for <u>collaborative/ consultative/ open dialogue</u> • <u>'Take your title off at the door'</u>		*policymaking down...If everyone was at the same place and was saying things working are well and not working well, then in other areas I think you'd be in a better position to do that, but because right now, you know, it feels like a very targeted conversation, it creates this awkwardness you know (HL2_PM)* *There is a general mistrust of CCAC across the province and within our current health link. There is a systemic belief that CCAC really wants to own the health system and this whole thing around care coordination so why would you give up care coordination to an organization that only deals with 10% of the total patient population not sure that is benefiting the patient and it's not very patient centered all of the research demonstrates the patient navigation should be housed in primary care so there's that underlying struggle there is an there is also very strong sense that those then in the CCAC are too cozy, it's not a good situation, I don't think (HL1_L1)* *Each of those steering committees has one or two lead organizations at the table...one or 2 people at the table at the steering committee who represent a different level of accountability and risk than anyone else around that table. They are, and it depends on the local nuance, whether or not that gets bared and brought forward for some local discussions on how best to manage that and I have seen it both ways (LCE_PM)*

It is the LHIN that will be making those decisions and, as you know, they are constrained to making decisions to within fiscal years, so the process will be that they will give a pot of money on an annual basis. The LHIN may find that out after the fiscal year begins — usually that is the timing, then they need to do their information search to understand who is in the most need and figure out to divvy that money up between the Health Links and on the ground you have people still trying to do the work. (LCE_PM)

In the capacity of lead organization, the LHIN has previously established relationships with many healthcare organizations that would become involved in the Health Links initiative as stakeholders — most notably, Community Care Access Centres (CCAC), Community Health Centres (CHC), Long-term Care (LTC) facilities, Community and Support Services, Mental Health and Addictions Services and local hospitals. Outside of the health links initiative, all of these organizations receive funding from the provincial (macro) level via allocations administered through the LHIN organization.

Existing relationships. The HLLC held its inaugural meeting in February of 2014 hosted by the SW-LHIN. Membership was to be "*comprised of Health Link Leads, decision makers, leaders and clinical experts from across the LHIN who would have significant ability to impact the Health Link mandate*" (HLLC ToR September 2014). Individuals invited to join the HLLC by the LHIN-based project leadership all held leadership roles within their respective healthcare organizations, capable of representing their organization or sector's perspectives. As members of the HLLC, "*collaborative members are representing their Health Link and/or health service organization and/or health service sector*" (HLLC ToR September 2014). Based on initial document data, early participants (n=23) on record included LHIN and CCAC representatives (n=11), local HLs leads and co-leads (n=10), one representative from a regional, tertiary care facility (n=1), and one from a community and social services organization (n=1). Recruitment continued throughout the fall of 2014 to February 2015, during which time discussions in this area focused on identifying additional sector or organizational representation, in areas where

there were perceived gaps within the committee ("*we want more sector participation around the table*" LCE_C). Over that period, group composition continued to shift but, by early spring, seemed to coalesce with 28 members listed on attendance records, including 10 HL leads and co-leads (representing 6 HLs sites) and 7 members representing organizations other than the LHIN/CCAC. There were 11 members of the collaborative who were LHIN or CCAC-based employees.

The prominent, central role of the SW-LHIN organization within the healthcare sector means that leaders from stakeholder organizations involved in Health Links were familiar with and were likely to have a history of interaction with the SW-LHIN. The CCAC, for instance, was regarded as the operational or functional arm of the SW-LHIN, while the SW-LHIN itself is seen as "*a planning entity, not an operational entity*" (LC_M2). In general, the SW-LHIN and CCAC were perceived as working closely together to facilitate the implementation of all projects in the region. Neither existing patterns of previous relationships between participating representatives nor the organizational/sectoral interests represented by individual actors could be left entirely outside of the collaborative space. As one HL lead noted, committee members have history together and "*some of the history still lives around the table*" (HL1_L1). SW-LHIN-based organizers recognized that embedded knowledges representing previous issues and experiences would be brought into the room with the individual members, and thus, introduced basic ground rules for interaction to be included in the Terms of Reference (ToR) (see Table 3-1).

In an HLLC meeting attended early in the observation period (January 2015), LHIN-representatives presented these 'ground rules' as modifications to the group's proposed ToR. A very brief, time-restricted, feedback session followed and a set of revised rules for group interaction was added to the ToR document (ToR revision, March 2015), based on the comments provided by committee members. While collective engagement over time is important in the growth of commitment and trust (17, 18), the degree to which committee members were actively engaged in the initial development of the group's ground rules for interaction was not discernible from this type of brief interaction that began with the presentation of a ready-made solution presented by the LHIN-based representative. From the brief discursive process observed (i.e. a

presentation to inform followed by a short interval in which feedback was invited), it was not possible to determine if there had been some sort of other mechanism used outside of the practice context, such as private conversations or emails, whereby committee members had the opportunity to acknowledge existing relationships, consider additional information, and negotiate innovative and effective solutions for continued productive communication and interaction. However, statements from key informant interviews demonstrated that issues from past interactions may have remained "*elephants in the room*" (LCE_PM) at current decision-making tables. (See Table 3-1)

3.4.2 The Way(s) Things Work

3.4.2.1 Initiative Structure and the Role of the HLLC

Freeman and Sturdy suggested that meetings are crucial enactment sites where different kinds of embodied and inscribed knowledges are acted upon through a variety of discursive processes (41). When the leadership collaborative convened its inaugural meeting, both inscribed information[13] and embodied knowledge were available to participants who were tasked with considering the definition of HLs, the structure of HLs within the SW-LHIN, the role of the HLLC and basic ground rules for committee processes. The inscribed information and presentations provided by LHIN-based representatives were considered helpful in terms of informing committee members about the role of the HLLC within the Health Links initiative, overall (see Table 3-2) and placing the mandate for the group firmly at the regional level.

---

[13] Inscribed information provided to participants at the inaugural meeting included: an overview of MOHLTC policy ('What is Health Links?'), definitions of coordinated care planning, an introduction to the IDEAS program, overviews of strategies developed to facilitate physician engagement, information regarding the importance of E-health and E-enablers, information to support the integration of the Health Links initiative into the LHIN organization, a presentation regarding indicators and the reporting of indicators through the LHIN, and an initial draft of the terms of reference (including examples from the early adopter HLs.

> *… to me [the HLLC] is about the system…the system answers to questions,*
> *as opposed to necessarily just representing my health link, like it is our perspective*
> *on making a decision about how we are going to do something across the LHIN*
> *(HL2_L1)*

Likewise, the meeting materials and session presentations provided by the LHIN served to frame the structure of the initiative as well as its place within the lead organization. LHIN processes and structures were outlined for the committee and all attendees were provided with an example of how a similar initiative functioned within the boundaries of the LHIN organization. Members were informed of the importance of strategic alignment with other LHIN initiatives in order to "*ensure system wide planning and support for Health Links*" (Terms of Reference, February 2014). Inscribed knowledge presented at the meeting included an example of an initiative with which Health Links would be aligned (e.g. the Access to Care Project) and provided an opportunity to demonstrate the hierarchical organizational structure used to establish new project initiatives.

Although processes of deliberation, collaboration and negotiation among actors in implementation settings are common, large agencies, such as the SW-LHIN, often rely on hierarchical organization to deal with the interdependencies and integration of aligned projects and to help maintain conditions of bureaucratic stability while adapting to changing implementation conditions (14, 22, 70). It is likely the individuals invited to attend the inaugural meeting of the HLLC would have been familiar with the organizational hierarchy of the LHIN given its position of prominence within the region (embedded knowledge). The stability and availability of a well-resourced, established administrative support infrastructure and a ready-made structural hierarchy that was at least somewhat familiar to HLLC members was advantageous in terms of generating and supporting early forward momentum for the initiative. However, adoption of traditional and familiar structures may have served to constrain thinking about the way the initiative could be structured and limited processes that might have led to innovative ways of 'working differently'.

Table 3-2. The Way(s) Things Work

Sub-Theme	Inscribed Knowledge	Enactment observation	Participant experience (key participant interviews)
Initiative Structure	**February 2014:** Slide presentation -- Aligning the Work of Health Links and other LHIN Programs/Initiatives; Slide presentation -- Driving Health Links forward and Reporting • Health Link level vs. LHIN level **February 2014**: Lead organization (LHIN) is seen as the coordinator to ensure things are moving forward and conduit with the MOH; doesn't make decisions on behalf of the group, but in collaboration with the group **September 2014**: (meeting agenda/slide presentation) How we will we collaborate/work effectively as a team? • Health Link Leadership Collaborative team • Health Link Steering Committee team • Health Link Working Group team • Coordinated Care Planning Conference team **October 2014**: The Health Links Leadership Collaborative will be accountable to the South West LHIN; Health Links Leadership Collaborative as oversight • MOHLTC and Health Quality Ontario (HQO) support		*I think that one thing that is lacking is a governance structure. These health links are very loose and you know a lot of the work takes place in the provider organizations. But, it is kind of off the sides of people's desks so I think that there is a need for a governance structure — something that makes it clear how decisions are made — how process changes are done and recorded and implemented, monitored. -- there is a belief that there is not enough money available to hire the kind of people that they need to manage and monitor the work that is going on. Somebody needs to be taking a lead and it can't just be something you are doing off the side of your desk.(HLE1_1)* *We have quite a sort of top-down approach I think with this health links that is maybe missing that community development perspective,…you know, how do we wrap around this problem in a different way, because we are just going to probably end up doing more of the same.(HL2_L2)*
Role of the HLLC	**February 2014: (initial presentation of HLLC; initial draft of ToR – based on ToR document from early adopter health link);** HLLC will provide leadership for the development and evolution a comprehensive, integrated and coordinated system of Health Links for the south west through monitoring of metrics and knowledge sharing. The HLLC will be accountable to the SW-LHIN. **October 2014 (meeting materials – Implementation frameworks)**: …while understanding that each population may have unique features; Implementation strategies will be framed at the LHIN, Health Link, and local team level to fully implement coordinated care planning.	**May 2015**: Examining definitions of care coordination, processes and accountability is useful time spent. Should do this in this leadership room – and then take the work back across the LHIN, It is important to have difficult conversations about responsibility and accountability (What is care coordination? Whose responsible for it? Need to address this at the system level)	*…at that point I was still, well I was definitely really learning about what the leadership collaborative would do, like after the first couple of meetings (LC-M1)* *The leadership collaborative brings together the leads from each of our local areas that have the responsibility for implementing health links or providing leadership to health links -- give input on things that we feel should be in common across the LHIN to support implementation of health links and to really be a place where we can collaborate as leaders around successful implementation of health links (LCE-C)* *The kind of focus there it is more about what's the standard, what do we try to make the same, and what can*

Sub-Theme	Inscribed Knowledge	Enactment observation	Participant experience (key participant interviews)
	November 2015: (Guide to the Advanced Health Links Model) LHIN • Sets regional priorities for Health Links and ensure alignment with provincial priorities • Funds Health Links in accordance with priorities • Maintains overall accountability for Health Links performance • Drives operations through implementation of plans and support for adoption of provincial tools • Identifies and implements regional supports and tools as required	**June 2015**: In the session with representatives from surrounding LHIN health links, the purpose of the HLLC was described as -- to develop structures and processes to ensure appropriate partnerships across Health Links in the South West and Health Links in neighbouring LHINs. To ensure all individuals supported by each Health Link receive seamless quality of care regardless of their place of residence, including when they are supported by service providers from multiple Health Link areas.	*be different… so that's one of those core questions that I think comes up and revolves around various decisions (HL1_M3)* *…people need to communicate more effectively and we need to avoid…there are all these 10,000 foot statements, but the message was no, no, no, we are not going to use their documents because we are so unique…people are starting to share tools more than ever, like process flow maps and that kind of stuff, but <u>in the development piece…I saw a lot of the same documents re-created</u>" (LC_M2)* *… to me [the HLLC] is about the system…the system answers to questions, as opposed to necessarily just representing my health link, like it is our perspective on making a decision about how we are going to do something across the LHIN (H2_L1)*
Terms of Reference	February 2014 & May 2014 (**Meeting agenda and minutes**): The terms of reference were worked on collectively by HLLC members. Brief description in minutes (Feb: "*The draft Terms of Reference was reviewed and suggested changes noted to be incorporated*". May: " *…did not receive any further feedback since last meeting. Discussion that language may need to be enhanced around equity, decision making, social determinates of health and patient experience. Group agrees to keep co-chair model.*") **September 2014 (agenda and meeting minutes):** Terms of reference presented as "final", for "decision" (Some additional edits recommended…Decision: Terms of Reference endorsed") **October 2014 (agenda and meeting minutes):** Terms of reference listed as presented for "information and review" (Suggestions for revision were invited – meeting minutes October 2014).	**January 2015**: {*process of presentation by LHIN-based member to inform, review, discuss in a time limited way – suggestions for revision*} Core/common principles document was presented (to be applied to the Individual roles and participation section of the ToR) -- "how to be an effective meeting participant" was reviewed (the ground rules for respect/dialogue that were pulled together from multiple sources) - added "should commit to be fully present to the task" - group discussion around this – don't want to tell people to not be on email during the meeting, but still want people to be present and focused on the task at hand. Turn off devices: The group agreed	One participant recalled: *When we were doing the terms of reference, it reminded me of doing group work in university and sitting at a computer and doing a project on a screen in a class room that we booked on a Sunday afternoon… [terms of reference] that's always a slow painful thing (HLO-L1)* *There is a constant umm, a constant reference back to ensure that we are meeting the goals that we set. There is a constant review of the terms of reference and our purpose. (LC_M1)*

Sub-Theme	Inscribed Knowledge	Enactment observation	Participant experience (key participant interviews)
		to - commit to being present in the meeting, while having to deal with urgent issues and that the two bullets dealing with respect and integrity could be condensed into one; ACTION: recommendations made for inscription	
	March 2015: HLLC Terms of Reference with Guiding Principles (final)	**June 2015**: Guiding principles [**All SW LHIN HLs will be** person-centred – acknowledge SDoHs; establish integrated partnerships within the broader community; acknowledge and embrace primary care; incorporate the need for objective evaluation; work with frontline staff to ensure quality improvement (accountability); commit to a shared leadership approach; adopt innovative and efficient approaches to information sharing and exchange] were reviewed with visiting representatives from neighbouring LHINs – suggestions for revision by LHIN guests included more emphasis on SDoHs, taking a broader view of issues around health (current wording from an 'outside' perspective appears too medically-focused)	**Re: Local HL Steering Committee** -- *We've been struggling as every group does to sort of finalize terms of reference, which just never seems to be easy for, and there's always the issue, the whole issue around you know, you know you build these terms of reference but you know these terms and then you know no one ever lives by the terms (HL3N_L1)*
	Driver Diagram (November 2015 – change Ideas associated with the Primary Driver of "Shared Leadership and Accountability): Develop cross-sector QIPs/SAAs between the LHIN and local HL member organizations; <u>each HL Steering Committee to have Terms of Reference that meet shared accountability principles (between members)</u>		*[developing Terms of reference]...that was quite the process let me tell you. You know a lot of the things that we talk about at that table, I find frustrating because I mean its important, you have to lay the groundwork, you need to have these things, but some of the, its things that we will never look at again, will never lay eyes on again, it might not even actually drive how we do things because just because its on paper, if we're not referring back to this then you know things are going to go how things go, so you know, while important, its preventing us from progressing to the next stage in the development of the group (LCE_C)*

...everyone is talking about steering committees and working groups and stuff...using old model thinking, where experience and knowledge use gets stuck in old clinical models and no one looks across the board (LC_M2)

As the lead organization, the LHIN administered funding allocations, provided administrative support and infrastructure for the initiative. This consolidation of project roles within a powerful centralized bureaucracy served to accentuate existing imbalances in power and resources within the group. Policymakers questioned their own role within the LHIN-based structure and struggled to find a sense of ownership of the project. *We need to ask "where is the 'ownership' in Health Links? ...we need to look at new ways to work and to communicate (HL2_L1). The leadership collaborative? It is more LHIN-decision making than shared decision-making*; LCE-PM). [14]

3.4.2.2   Terms of Reference

In a collaboration, actors that represent stakeholder groups should feel that they are genuinely able to influence group process (71). Co-creation and formal inscription of process and structure is, therefore, an important feature in establishing clear and transparent expectations for the collaborative group that helps to foster the development of procedural trust (28, 69, 72-74).

At the inaugural meeting of the HLLC, participants were presented with a draft of the Terms of Reference (ToR) for the committee. This draft document was prepared by representatives of the lead organization, based upon the terms developed and used by the early adopter steering committee (sharing inscribed information). Meeting minutes reflected the

---

[14] It became evident, early in process of data review and analysis, that local decision makers, while participating in establishing the HLs context, experienced some tensions in finding and defining their own role. When asked, individual participants revealed that they did not necessarily identify with the label "policymakers"; although they did agree that they were involved in creating regional or local implementation policy, procedures or guidelines. However, participants often considered themselves to be professional stakeholders or stakeholder representatives rather than policymakers.

presentation of the inscribed information as well as some collective, discursive process around the review and revision of proposed terms; however, it is not possible to know the extent of discussions or what embodied knowledges contributed to any changes made to the original, draft document as this meeting was not observed and data collection was limited to review of document data. Review of the ToR document drafted following these initial sessions did not reveal substantive changes made to the original (see Table 3-2). Once the group endorsed a version of the ToR, (see Table 3-2) processes around any future adjustments to the agreement were all very similar to those described above. A 'solution' or revision was presented to inform the committee of changes and a very brief opportunity for review and discussion was provided. The process brought inscribed information, prepared and presented by SW-LHIN representatives, into the practice space and provided a limited opportunity for engaged stakeholders to contribute their own knowledge to and participate in a collective and discursive feedback process that helped to shape the groups' expectations. However, it is likely that the most significant opportunities for collective engagement in creating shared understandings around how things could work occurred within the first few meetings of the newly formed collaborative. Early meetings allocated more space on the agenda to the development of the terms of reference, which could have supported more collective engagement in setting processes for the HLLC than was reflected in the brief, meeting minutes. Early meetings were smaller, and attendance reported reflected participation by individuals representing the LHIN, the CCAC and HL leads.

3.4.3 **Setting the Stage**

Staging is a core practice for lead organizations (75, 76). For the purposes of the present paper, staging refers to the activities that serve to shape or organize practice settings and can include scheduling, including the frequency and duration of meetings, and selection of the physical setting (75, 76), for example. In addition, staging may extend to the provision of structural supports to facilitate the purposeful assembly of interactions (31, 75).

3.4.3.1   Staging Through Administrative and Infrastructure Support (Backbone)

The dedicated support or resources of an administrative or "backbone" organization committed to staging and infrastructure has been identified as important to successful collaboration between multiple organizations and their representatives (77). In the case of the Health Links initiative, the lead organization assumed the role of administrative backbone for the project, providing support to the initiative and to the collaborative through its project/planning and administrative resources (ToR, March 2015).

Scheduling of all HLLC meetings was accomplished via the LHIN's administrative support, as was the (electronic) distribution of all meeting materials, notices, updates and newsletters produced by the LHIN-based initiative team. All meetings of the HLLC were housed in the physical space occupied by the regional LHIN organization, which is located in the major urban centre located in a southern, central sub-region of the LHIN. This location meant that to attend meetings in person, members from other sub-LHIN regions had to travel distances ranging up to approximately 215 kilometers. Several committee members never attended a HLLC meeting in person, electing to 'phone-in' and participate by teleconference only.

Adoption of specific institutional practices such as the timing and scheduling of meetings, or the production and distribution of the meeting materials were in accordance with the routine administrative support practices of the lead organization (28, 78) and were not determined through processes of negotiation or accommodation. While this decision would ensure that administrative functions were carried out within the limits of the resources available within the lead organization, it also meant that, in terms of a shared practice context, stakeholders representing the lead organization (i.e. the organization with the most resources, authority and influence) would also be the most comfortable in the meeting settings, and most familiar with the 'way things work' (78). In addition to administrative support services, two positions were created and funded through the CCAC (see Table 3-3) to provide additional project support: a Health Links Program Lead and a Health Links Project Manager (see Table 3-3). These positions were part of a support team that filled a role that was "*potentially different than at other LHINs*"

(LCE_PM). The team "*set the stage around, for instance, Ministry direction or structures or things like that that are standard and expected" (LCE_PM).* The team supports local and regional level stakeholders by "*providing them with information*" (HL3N_L1), "*putting in guidelines*" (LCE_PM), and assisting people with meeting MOHLTC requirements.

3.4.3.1.1   Infrastructure Committee

The role of the HLLC was to provide regional leadership and oversight for the HLs initiative in the southwest. The HLLC was also the point at which the HLs initiative interfaced directly with the LHIN organization. To support coordinated planning and integration with the SW-LHIN structure and strategic planning, there were other supporting LHIN-based structures and mechanisms that existed around this interface. One such structure was the Health Links Infrastructure Committee. Members of this small "executive" group included key SW-LHIN employees in addition to both the Health Links program lead and project manager. The group functioned alongside the HLLC, in part to support the creation and revision of LHIN-based administrative documents and reports, but also to facilitate the interpretation and subsequent distribution of information within the Health Links environment (see Table 3-3). Collaborative members were asked to help facilitate alignment and integration with other LHIN programs and initiatives to "*ensure system wide planning and support*" for the initiative (Terms of Reference, March 2015). When information from the Ministry was received regarding new indicators to be reported, and changes to the target population with the announcement of the Advanced Health Links model, the Infrastructure Committee discussed the potential for local changes and possible impacts associated with the receipt of this information prior to releasing the information to the leadership collaborative or posting it to the online information site (Infrastructure Committee Updates June, July 2015). Potential strategies around adjustment in local HLs definitions pertaining to the target population were developed in this committee before the new information from the macro level policymaker was presented to the HLLC (Infrastructure committee July, August, September, November 2015).

Table 3-3. Setting the Stage

Sub-Theme	Inscribed Knowledge	Enactment observation	Participant experience (key participant interviews)
Administrative support	**Terms of Reference**: The Health Link Lead and Project Manager along with the CDPM/Primary Care Lead from the LHIN, will work with the co-Chairs to provide secretariat (administrative/executive) support to the Collaborative. The LHIN will also provide support to the Collaborative through its project/planning resources (staff time, information, etc.). Administrative support to the Collaborative will be provided by the LHIN administrative resource. **July 2014 (meeting minutes)**: Health Links program lead and project manager welcomed to their new positions. **Terms of Reference**: Efforts will be made to ensure that Meeting Agendas and related materials are prepared and distributed one week in advance of Collaborative meetings. Agendas are to be approved in advance by the co-Chairs	**General observation**: Scheduling of meetings was accomplished via the LHIN's administrative support, as was the regular meeting venue. All meetings of the Health Links Leadership Collaborative were housed in the physical space occupied by the regional LHIN organization. **January 2015:** This meeting marked a change to monthly, shorter meetings. Conducted a brief evaluation – what did participants think? Content? Length? Participants emphasized the importance of sharing information and having the opportunity to bring information forward to the group -- "It is important to be able to raise issues as you work through the process". Project team suggested – a "call" could go out for agenda items to promote "broad sharing" (recommended 10 days before the next meeting)	*…the LHIN support, like the leadership that's being provided by the LHIN, assigning admin…as we're sitting here, [admin support] is scheduling a whole bunch more leadership collaborative meetings…having the meetings booked well in advance, and attended, I think that those are the things and I think we've developed, we're developing trust with that group (HLO_L1)* *I come to that because you may or may not know that the actual Health Links leads actually employees of the CCAC. So this would be another example of where the LHIN comes to the CCAC and says we want to put some horsepower behind a system initiative will you house those people to move the agenda forward? (LC_M2)* *We have tried, strategically to put LHIN-wide resources in place — with {project lead and project manager} and the QI coaching resources and really make sure that people know how to make use of that becomes really important. (LC_M1)* *…by the time I arrive at the meeting, those slides that are coming forward – I've already seen them… (LC-M2)*
Infrastructure and alignment	**September 2014 (Meeting materials)** Health links is not an isolated initiative – should build on, support, leverage other programs, initiatives, services that exist in the region. **November 2014 (meeting materials – implementation frameworks):** The new Health Link model aligns with the South West LHIN Integrated Health Service Plan 2013 – 2016 (IHSP) and the South West LHIN's Blueprint vision of an integrated health system with strong linkages to other partners. Other LHIN initiatives such as Access to Care, Behavioural Supports Ontario, Hospice Palliative Care and mental health re-alignment also support the goals and objectives of Health Links making alignment and coordination between these and other programs/initiatives	**February 2015:** Discussed the importance of compiling a list of complementary projects and thinking of ways to learn from them (e.g. via invited presentations, for example), possibilities for development of synergies and alignment opportunities.	*If there are barriers or issues that staff needs support on, the senior (LHIN) sponsor plays a role in that. If there's, you know, from a broader issues perspective, there is a strategic direction setting role that we play from a LHIN level. It is sort of how we refer to how we have supported work from the LHIN perspective (LCE_C)* *Health Links is supposed to fit nicely under either chronic disease or primary care, but it doesn't really. I think that it is a separate sort of initiative that is sort of a cultural initiative as opposed to some of the process stuff that we have going on in some of the other thing (LC_M1)* *Working with the LHIN IHSP, working with our Board and equipping them to go the Board-to-Board sessions being ready on that, tracking what the LHIN is doing and*

Sub-Theme	Inscribed Knowledge	Enactment observation	Participant experience (key participant interviews)
	essential to ensure system wide planning and support for Health Links. **Implementation Frameworks Discussion Document (Created: September 2, 2014; revised Nov 21/14, February 26, 2015, Dec 14/15)**: The Health Link model aligns with the South West LHIN Integrated Health Service Plans 2013 – 2016 (IHSP), 2016 – 2019, and the South West LHIN's Blueprint vision of an integrated health system collaborative. **April 2015 (meeting materials):** Draft oversight structure document presented, identifying linkages between health links and other complementary projects	**March 2015: (materials included IPM document – October 2014)**; There is a lot of time spent focused on the language of standardization within the LHIN; trying to figure out complex care and the top 5% and how health links (and its goals and activities) fits with activity in other projects in chronic disease management and complex mental health and palliative care in the southwest, for instance.	*understanding what the LHIN needs around health system transformation, it is all important (LC_M2)*
		May 2015: Discussion around the official release of the Donner report (home and community care) does signal some opportunities for alignment, but we will have to watch what the Ministry chooses to do with it.	
		June 2015: Presentation and discussion of the Integrated Health Service Plan (IHSP) -- LHIN-based collective plan, describes new and emerging work over a 3-year time period. Creation/revision of the plan requires advisory group engagement. Information was presented by LHIN representative -- Introduced information as part of a collection of "policy lite" documents that serve to guide and inform LHIN work (eg. Vision 2022, IHSP documents, the triple aim framework)	
	October 2015 (Infrastructure committee_HL Update): We need to ensure that every HL metrics report includes all triple aim pieces [LHIN Vision 2022], [program lead] to review with the HLs; HLs will likely need continued support from the LHIN for a few more future reports, but will get to a point where they own their report	**October 2015**: Release/discussion following the release of the Price/Baker report and the ramifications at the LHIN and sub-LHIN level of a broad system re-organization? Need to think about governance and how to interface horizontally. Suggestion: This scope of transformation needs change management to support it.	*I think that the government and the LHINs have a really big job to do...helping to contextualize what these, how these various initiatives all fit in to this broader vision (HL3N_L2)*
		November 2015: Home and Community Care Policy and Regulation Changes: This is a system-wide integration model – any complex care patient falls within this model – and a subset of these complex patients will be health links patients (how do these changes impact the scope of health links?)	

3.4.3.2   Staging Information for Enactment and Supporting Alignment

While the work of knowledge enactment within the practice setting may be seen as a collective or even collaborative endeavour, the established structure and processes of the policy or decision-making environment influence the way in which knowledge or information-based resources are distributed and enter the enactment spaces. Individuals who control agendas, and decide which information is presented within any potential enactment setting have influence over what knowledge is exchanged, what kinds of engagement can occur and what strategies might be adopted to reach enactment goals (27, 35). The emergence of shared understandings to support an accommodative practice context (and its immediate enactment goal such as the resolution of an agenda item, for instance) would depend, in part, upon the information and knowledge resources that entered the practice space.

Within the HLs initiative, there was a specific structure established to guide the way in which information entered knowledge enactment settings. In general, information of potential interest to the HLLC was curated by the LHIN-based project team and/or the Infrastructure Committee. Information received from external sources, including the macro-level policymaker, was interpreted and processed by the LHIN-based project team before being presented, distributed or posted to a shared information site for HLLC members. One member of the HLLC noted that "*If information comes in randomly, from different sources that leaves it open for interpretation. If it is something that is going to cause people, even if we don't think it is going to, some alarm or uh oh or they think that now the landscape is changing or something is happening -- if it gets in some other way first, there still needs to be context and key messaging around right sizing it."(LC_M2)* If information was identified as required to support the presentation of an issue on an HLLC agenda, the role of the paid project staff was to "*do research and bring forward information for the group" (LCE_PM).*

Curated information, especially that which was to inform enactment, was frequently provided in-meeting in the form of draft documents inscribed by SW-LHIN project staff (e.g.

Terms of Reference, the Drivers Diagram, Core Principles document, etc.). Draft documents were usually accompanied by slide and verbal presentations also prepared and delivered by LHIN-based members or project staff. All meeting materials were reviewed by members of the Infrastructure Committee prior to distribution (Infrastructure Committee Updates_2015). While the use of inscribed drafts may be practical and efficient in terms of helping to coordinate action by creating a starting point for thinking about issues, like initiative structures and processes for instance, the provision of these materials can also be used to create a particular frame for the way in which the practice context, or implementation issue, is to be understood by the group. Given the relative influence of the organization responsible for the inscription of the draft document, it could also function to reinforce organizational stability (79).

Committee members were invited to suggest items for inclusion on the meeting agenda. To support this invitation, it was suggested that a call for items be put out 10 days in advance of each meeting of the HLLC (HLLC Meeting minutes January 2015). However, control of the agenda (that is, what items appeared on the agenda, in what order and how much time was allocated to each item) remained within the lead organization. Each agenda was created and reviewed by LHIN-based project staff and approved by the LHIN-based committee chair prior to each meeting (Terms of Reference, Infrastructure Committee_HL updates 2015).

3.4.4 Why are we here? Creating a Shared Vision

The joint exploration of collective purpose, as well as the shared determination of initiative goals, helps engaged practitioners to frame the accommodative practice context (4, 12, 80). The initiative is defined not only by the information and knowledge brought into the practice context, but also by the knowledge that is enacted within it (42). From processes of enactment, shared understanding of initiative definitions and goals emerge. As reflected in documents, observation and interviews, the HLLC explored both the definition of the initiative and their shared goals for Health Links in the region as well as the ways in which they expected to reflect their progress and accomplishments through evaluation.

Table 3-4. Why are we here? Creating a Shared Vision.

Sub-Theme	Inscribed Knowledge	Enactment observation	Participant experience (key participant interviews)
Defining Health Links	**February 2014 (meeting materials and supporting documentation)** Based on the MOHLTC Healthy Change Report, and the policy statement entitled Patients First, Action Plan for Health (2012), and prepared LHIN presentation materials: Health Links is "*a new model of care which seeks to improve patient outcomes by improving care coordination and integration at the patient level, all while delivering better value for investment; Health Links is about supporting those with complex needs to stay in the community.*" **February 2015 (LHIN Meeting materials):** Health links is... aimed at breaking down the silos of care for Ontarians, making access to health care easier and less complicated. It is about creating an environment where traditional and nontraditional health care partners come together and develop a more coordinated approach to supporting those most vulnerable individuals – seniors and those with complex conditions. Identifying these individuals and working with all the agencies who are now providing or who could be providing wrap around services to keep these patients safe and well in their homes is a critical activity for Health Links. **June 2015.** MOHLTC Webinar. Release of Advanced Health Links changes to the LHINs. Includes an "enhanced governance structure, integrated performance management framework and a quality/best practices framework" to drive broader system integration across the province, enable standardized, coordinated care and ensure shared accountability.	**February 2015:** Need to define health links. Lengthy discussion about how to portray or "sell" health links in the context of the LHIN communication strategy to be developed for health links -- "*most people think it is how service should be delivered anyway*". "*It is not really about the top %5 -- it is about revising care delivery*", "*it is about us working differently, not about being attached to any one organization*", "*it is about delivering care in a new way*" Health links is a "*way of working, not an intervention*". It is an "*opportunity to talk about how we are working to tear down barriers*" **June 2015: (re: breaking down silos and working with nontraditional partners).** Inter-ministerial working is complicated and sets up barriers (working with the Ministry of Corrections or with Community and Social Services, for instance). There is no way to facilitate timely discussions and there are no road maps for information sharing across ministries or for setting up ways to alleviate service use barriers across these boundaries. Other ministries seem to have no idea, at the provincial level, of what Health Links is trying to do. **July 2015: Discussed standardization of the target population** (Advanced Health Links) -- would represent a minimum standard so that each health link could still have the flexibility to target who they feel are important to achieve the best outcomes for	*Early adopter environments: Health links were launched in December of 2012 under what was called "a low rules environment" meaning that people received a certain amount of funding and there were some key activities that they were expected to address...other than that ...It was a low rules environment where you were...they were really hoping for people to come up with out-of-the-box ideas for how we could improve the care and services for this top 3-5% of the resource users in the province — those with complex, chronic illnesses who, while consuming a lot of these healthcare resources are really poorly served. HLE1_1)* *This space is a very interesting space in that the way health links kind of came to be and the work up behind it isn't huge and there is a big expectation around figuring it out as you go (LCE_C)* ***Health links is what everybody thinks we already do**, we just need to start doing it, and that usually gets a rise out of people - if you market it people will understand it less because they'll say okay where's the building, and then you have to describe there's no building, and then they go, and at the end of the day they go why don't you already do that?(HLO-L1)* ***It is about how we are working together**, I think that to a large degree it is an exercise in understanding each other and how we connect and interconnect.(HL2_L1)* *I get the insanity of having every local community you know doing it slightly different from a, if you were sitting in*

Sub-Theme	Inscribed Knowledge	Enactment observation	Participant experience (key participant interviews)
	September 2015: (LHIN meeting materials) MOHLTC released an updated guideline (August 2015) to be used as a common process for identifying and working with complex patients. Should include: <u>Patients with four or more chronic/high cost conditions, including a focus on mental health and addictions conditions, palliative patients, and the frail elderly</u> **and** who may be impacted by the following: economic characteristics (low income, median household income, government transfers as a proportion of income, unemployment) and social determinants (housing, living alone, language, immigration, community and socials services etc.)	the populations we serve locally. Members of some health links expressed uncertainty about reaching the right people – as well as accessing current data sources to help them in identifying potential patients – they were reassured by the LHIN representatives that struggles with patient identification are common across the province. **September 2015**: New information was provided regarding the 'new' target populations for health links including population definitions supplied by the MOHLTC. **November 2015**: The HLLC was provided with an analysis of geographies that included the numbers of patients in each health links geography that were identified with 4+ comorbidities. Concerns were voiced about getting care to the right people and having the right data to support decisions.	*Toronto but you know, if that was the local need then why didn't they just stick with it and to impose this other whatever this thing is, if you really wanted it then why didn't you say that from the start, and just then we could have saved a whole bunch of time developing our own business plan and so it, that, its been a little bit confusing in terms of you know do you want it to be purely local or do you want it you know more... (HL2_PM)* *...you started and you say that this is what health links is going to be and we are going to roll it out and everybody is going to get to do this and then you are changing the game (HL2_L1)*
What is the goal of Health Links?	**July 2014: Driver Diagram – Aim:** "To reduce avoidable healthcare utilization in order to better meet the needs and support patients and families with the greatest health care needs in the South West LHIN" **October 2014: (Meeting materials)** The aim [of Health Links] is to improve the health care experience, outcomes, and equity of access for people with the greatest needs by improving the level of communication and collaboration among providers. **June 2015 (meeting materials included driver diagram);** What are we trying to accomplish? <u>To reduce avoidable healthcare utilization</u> in order to better meet and support individuals and their families <u>with the greatest health care needs</u> in the South West **Advanced Health Links Guide (MOHLTC information provided in LHIN meeting materials presentation November 2015):** Health Links aims to <u>identify people who would benefit most</u> from coordinated support from multiple health and	**June 2015**: Looking at the Integrated Health Services plan and reflecting on a comment that "our principles seem to be very medical" – "we need something there to ensure that we remain patient-focused". "Looking at the language – putting the needs and support of individuals first, and then...which will result in 'x' outcome. This is also reflected in the drivers diagram. It also needs to change there". Discussion: Are expectations around the inclusion of equity clear enough? There is an ongoing struggle around what is included. Equity is assumed to be 'built-in', but what is missed is then specified, but it ends up looking like that is all that	*I don't know that we have consensus as to why we're all around the table. And what are our collective motivations to be there. I don't think we have consensus around that. (HL2_PM)* *I am not entirely sure we are all reading off of the same sheet of music -- I am not convinced that we all have the same mental cartoon in our heads about the effect that we are trying to achieve with Health Links. (LC_M1)* *So, in Health Links, I am growing tired of listening too often to what I would call a health service provider lens to health links as the selling feature for health links. Like, we should sell this as because it is going to make health service providers lives so much better and my comment is really, foundationally, this was about trying to make patients, caregivers, and families care experiences better (LC-M2)*

Sub-Theme	Inscribed Knowledge	Enactment observation	Participant experience (key participant interviews)
	social service providers - those with high care needs who would be best supported with a team approach; Health Links aims to bring local health and social service providers together to close the gaps that often occur when a person moves from one provider to another. This approach will allow for more coordinated care and faster follow-up when people are discharged from hospital, reducing the likelihood of readmission and preventable emergency visits, leading to a healthier life.	there is. The "embeddedness of equity is not well reflected". "***The health equity lens is not well represented, but this is how our planning should be approached***". **October 2015**: Need to think about how to interface better, horizontally, with organizations -- Work with other agencies to align definitions of coordinated care planning across the system, to make sure that when there is coordinated planning it can fall under the umbrella of health links. **November 2015**: Project lead asked for feedback on the drivers diagram -- In the last month, we (the project team) looked at where there were synergies with the palliative care driver diagram (worked with the palliative care rep LG – another LHIN initiative) – mostly around equitable access to care; [Project team] to more forward from this exercise and revise evaluation framework based on this	
Evaluation Metrics	**June 2014 (Evaluation and Control Plan):** Identified seven (7) <u>select</u> provincial health link indicators re: strategic system level alignment. The indicators were associated with the identified high level aim of the initiative as stipulated on the initiative's driver diagram. **November 2014 (implementation framework)** Successful Health Links will: • Enhance the health system experience for individuals with the greatest health care needs • Reduce the average cost of delivering health services to people without compromising the quality of care **June 2015 (meeting materials – provincial indicators)** for the South-west • Reduce average cost of patients with high care needs (long term) • Reduce avoidable healthcare utilization (ED visits and acute inpatient discharges) • Reduce readmission rates within 30 days (selected case mix groups) (Overall; for pilot group) • Increase proportion of patients with high care needs that have a coordinated care plan • Average confidence scores for patients with a CCP (self-reported) • Increase number of Health Links actively care planning in the South West. <u>Other Identified</u>	**June 2015** It is not mandated that actions related to improving readmissions be in each QIRAP (Quality Improvement Report and Analysis Platform) -- Should we have some principles around the follow up process with patients? - Some area provider tables are having a discussion around a common element in their QIP - How do we collectively work towards the metric? - We want to encourage innovation - We should share what we are doing and learn from others' successes – "<u>*Need to highlight the patient voice – otherwise the metrics look system driven only*</u>" **July 2015:** language of the update (from the province regarding indicators that was shared with the collaborative) requires some clarification; particularly – time re: referral to home or primary care – they have not released clarifying materials;	*2 years after it has been stood up, we have actually been given the indicators and some of the critical bits of information around choosing patients and stuff (LC-M1)* *we got 11 metrics out of the gate, but no data definitions around them and still today we have no consistent definitions. We are 3 years into the strategy. I get that some of that stuff has to evolve, but this has been a very long process.(LCE_PM)* *if our target population has changed then how are we going to be nimble and change and we have done that and I think that they want to know real numbers too around our progress...but are they the right indicators? They need to continue to evolve and as people on the ground, we need to try to provide input on what those indictors should be (HL1_M3)* *I think that the Ministry is concerned about how many coordinated care plans when they were comparing apples to oranges in terms of what we have fundamentally believed*

Sub-Theme	Inscribed Knowledge	Enactment observation	Participant experience (key participant interviews)
	provincial measures: • Reduce ALC Rate • Increase the number of people discharged from hospital seeing their family healthcare provider within 7 days of discharge from hospital • Reduce rate of ER visits best managed elsewhere • Reduce hospitalizations for ambulatory care sensitive conditions • Reduce wait time from primary referral to specialist consult visit • Reduce the time from referral to home care visit • Increase proportion of patients with high care needs that have regular and timely access to primary care **November 2015 (Guide to Advanced Health Links):** Current program indicators are identified as: 1) Number of patients with a coordinated care plan developed through the Health Link; and, 2) Number of patients with regular and timely access to a primary care provider. Three "new additional indicators" were identified as to be added over a period of one year to address longer term outcomes. In addition, a number of short-term indicators that focus on patient enrollment, patient identification and care coordination were to be introduced by the Ministry in coming months. **December 2015 (MOHLTC Q2 report – Advanced Health Links update):** The indicator used in QIRAP is the Number of Health Link patients with a coordinated plan of care developed through the Health Link during the past Quarter. Coordinated Care Plan Indicator Provincial Definition: To be included, the CCP must a) Be developed with the patient/ caregiver and two (2) or more health care professionals AND b) Contain a plan for one (1) or more health issues.	Use of # of coordinated care plans as indicators -- Number of coordinated care plans provincially – relative to the possible 'users' – not about just creation – also how it is done, assessed, maintained and sustained. If we are to do this well, indicators should be more than just a check re: creation of coordinated care plans. Shift in indicators for collection 11 to 5 (number of plans, primary care attachments, time to HL, readmission, ED visits best managed elsewhere) These are the core although they encourage the 'full suite' of the evaluation tools **October 2015:** Following a provincial health links leads meeting, it has become obvious that we are not all measuring the same thing. The data does not reflect variations in the definition of care coordination planning. Measurement is all over the map. **November 2015:** The definition being used to complete the CCP indicator has not always been the one applied in the south-west. We need more innovative ways to get more people around the table – to understand processes and how this has been tracked/recorded – some people will need more than the minimum definition to identify CCP. When is this counted? Timing changes the numbers. We need to follow a consistent process. **December 2015:** The minimum definition does not reflect approaches and processes which have been so different – at least 3 people must be included – now we know that and this is better, but as it is it is an injustice to some health links and their innovative processes. Right now, this is just numbers that speak to volumes.	*that a coordinated care plan is under what the Ministry saw as the vision is the infrastructure we are putting in place so that a coordinated care plan is about really changing — dropping the organizational barriers and allowing the frontline to really say I need you, I need you this is who the patient is identifying (HL1_L1);* *a coordinated care plan is clearly now defined by the Ministry as least 2 providers and the patient and so some of the low rules environment and people have been very innovative and it has been 2 providers where maybe next week 2 providers meet and then go to meet with the patient (and I don't know anything about timing, I'm just talking) or it could be that one provider goes and interviews the patient and then goes and takes it to a group of providers and so my question is how much is that adding to our best practice cadre when in fact it no longer might meet the current definition (LC_M2)*

3.4.4.1 What is Health Links?

Among the background materials presented to invited participants at the first leadership collaborative meeting was information based on reports from the MOHLTC that was intended to answer the question, "What is Health Links?" (see Table 3-4). While preliminary definitions for HLs were borrowed from the macro level (8), the way in which HLs was understood by the regional governance group reflected the embodied experience and expertise of local policymakers and stakeholders. For instance, in working through the development of a strategy for how the group would communicate the idea of Health Links to other groups, healthcare organizations and professionals, it became clear that, based on their experiences with the early adopter Health Link as well as through the development of readiness or business plans, that local decision makers agreed that Health Links should not be viewed as a program or an intervention, but rather as a "*way of working*" or an approach to care that "*offers the opportunity to think differently about how services are delivered*" (February 2015 meeting observation) (see Table 3-4). The experiences of individuals working in the early adopter, low-rules environment, contributed to the collective negotiation of 'what is Health Links?'. While original materials provided by the LHIN (February 2014) noted that Health Links "*aims to improve the health of the small portion of the population, with complex healthcare needs, who are using a high proportion of healthcare resources by fostering collaboration among health service providers in order to develop, implement and monitor coordinated care plans for these people*", one actor noted that it was the latter part of this statement that mattered most. "*It is not so much about the top 3-5% of service users, but more about the revision of care delivery and understanding how we work together to provide care the way everyone already thinks it should be provided -- in a coordinated way with the patient at the centre of the process*" (February 2015 meeting observation). Indeed, the locally-derived definition put forward for Health Links in LHIN-generated materials emphasized the idea of working differently, by "*breaking down silos of care*" and engaging "*traditional and non-traditional care partners*" to develop a more coordinated approach to support "*seniors and those with complex conditions*" (Meeting materials February 2015) (see Table 3-4).

3.4.4.2   What is the Goal of Health Links?

As well as having a shared understanding about what Health Links is, engaged committee members placed value on coming to an agreement about "*the effect that we are trying to achieve with Health Links*" as a committed group with "*a common vision or a common goal or whatever that term is — they need that common vision*" (LCE_PM). In June 2014, HLLC members participated in the creation of a drivers diagram for the HLs initiative. This tool was intended to help groups examine "*change concepts and ideas and answer the question what changes can we make that will result in an improvement?*" (Meeting materials June 2014). The collective development of the drivers diagram was considered important as "*it could be used to develop a common vision and be a communication tool to bring partners together*" (HLLC minutes, July 2014). The overall goal for the Health Links initiative (see Table 3-4) emerged as an inscribed product of that collective exercise. It appeared on all versions of the drivers document distributed to the group and was incorporated into LHIN-based documentation requiring an aim statement (e.g. implementation frameworks document, IPM document) (November 2015 meeting materials; June 2015, meeting materials). It should be noted, however, that the actors engaged at the time of its development were early members of the leadership committee only. Newer members did not necessarily feel as though the issues of "*collective motivation*" or "*the effect we are trying to achieve*" had been discussed or settled (see Table 3-4). When asked to review the formally inscribed goal at a later date, the broader membership made suggestions for updates that they believed would better reflect a common commitment to health equity and patient-centeredness while moving away from a traditional, medical focus (June 2015, meeting observation) (see Table 3-4).

Part of the difficulty in reaching, revising and inscribing a shared understanding about "collective motivation" or goals for HLs (or even in facilitating a discussion around what they wanted to achieve) was the continuously shifting policy guidelines and updates received from the macro-level policymaker throughout the period of observation. At the beginning of the observation period, Health Links had entered the 2.0 phase of development, shifting away from a locally focused, low-rules environment toward a more standardized application of policy. This

shift brought changes in governance and accountability structures as well as funding models. Over the course of the data collection period, the regional initiative was in an almost continuous state of flux as the macro-level policymaker prepared for the transition from Health Links 2.0 to a more standardized, province-wide implementation as represented in the Advanced Health Links model (81).

> *I think you know as they're rolling it out like initially it was a lot of, there's a sense that it could be very individual and different, and it's looking now like there's more desire for standardization. So maybe it was kind of let's put it out there and see what we get and then we'll build on that or maybe it was just lack of communication, ability to communicate intent, so I don't know whether it was lack of specificity of a vision or whether it was lack of ability to communicate it, I'm not sure. (HL2_L1)*

Although the official Guide to Advanced Health Links (81) was not released until late in the observation period (November 2015), information sharing and regional change to support this revision to the provincial initiative began five months earlier. Information from the macro level policymaker was staged for introduction to the HLLC by the lead organization and was introduced to leadership collaborative meetings over the course of several months (see section 3.4.3.2). From the perspective of the LHIN-based project staff, managing the flow of information from the province in this way sometimes added to the tensions experienced within the leadership collaborative. It was a struggle to get "*the right level of information to people so that they felt positioned to be able to make a decision*" (LC_M2). For project staff, who felt information sharing to be part of their role, it was particularly difficult when some of the information released from the macro level was "*still embargoed*" (LCE_PM) and the staff had to wait until the LHIN gave them the "*okay to engage on some parts of it*" (LCE_PM). The sense of uncertainty regarding the shared vision for the Health Links initiative was clearly reflected in the observations offered by key informants who struggled with the interpretation and adoption of Ministry-imposed project definitions in addition to increasingly specific requirements around

target populations, and data collection and reporting expectations, especially when these did not align well with locally-derived understandings of project goals.

3.4.4.3   Evaluation Metrics

Although investigation of progress toward shared goals helps to inform the ongoing development of the practice context over time, data collection or evaluation was not observed as a prominent topic for discussion within the HLLC, initially. This did not mean that evaluation or reporting metrics were not important. There was a LHIN-based evaluation and control plan that was reviewed with the HLLC in 2014 (see Table 3-4), and a LHIN-based HLs evaluation team was established (see Figure 3-2). The workings of data collection and reporting were, mostly, part of the infrastructure and support team processes set up within the lead organization and that functioned "behind" the HLLC itself. As the macro-level policymaker introduced additional specifications around target populations and reporting requirements in support of the Advanced Health Links Model, the subject of evaluation metrics became more prominent within the practice space of the HLLC, placing a spotlight on issues of accountability (8). Discussion around revision of the collective aim of Health Links was put to one side while the initiative leadership re-negotiated boundary configurations around the work of Health Links, re-examining what or who might be included in the work based on the updated macro-level guidelines. When the primary program indicator for Advanced Health Links was announced by the Ministry, (see Table 3-4), the group became focused on making sure that the efforts of Health Links in the region could fit into the definitions as provided so that care plans, targeting "*the right people*" could be counted and MOH-specified targets met (October, November, December 2015 observations) (See Table 3-4). As one decision maker noted, "*the expectations of the funders drove things, so you know, things like numbers and care plans, we've got to get our numbers of care plans up because that is what the Ministry is counting*" (HL1_L1). However, approaching evaluation as an exercise in counting care plans did little to address the group's shared vision around 'working differently' together or demonstrating "*that coordinated care, whether Health Links or anything else, is meaningful and valuable and that everyone's interests can be met by participating*" (HL2_L2).

3.5   Analysis and Discussion

Increasingly, implementation of macro level policy in complex local contexts has relied on the broad cross-sector engagement of local or regional actors in a collective effort. I engaged in a process of data collection and analysis to describe the co-creation of an implementation policymaking practice environment, including the collective development of shared definitions and goals, adopted by a regional-level policymaking group. The group was established to provide regional governance and had a mandate to deliver strategic direction and create guidance at the level of a regional system to support the implementation of a macro-level policy in local settings. The practice-based KEPS framework was used as a lens to guide descriptions of actor experience in context, which were also framed within the expectations for creating practice settings for collaborative governance found within the research literature.

In general, I observed that the actors engaged in the case study initiative did participate in collective processes specifically focused on co-creating a practice setting. In addition, once invited to participate in a 'collaborative', actors expected to contribute in a way that had the potential to influence group process. However, the observed experiences of engaged actors did not necessarily meet the individual actors' expectations around collaboration or reflect the expectations or ideals around the ways in which collaborative practices should be developed as described in the academic-based literature. For instance, while actors expected and were committed to participating in the negotiation of a practice context, the degree to which actors did this, and the areas or issues in which they were able to exert an influence relied, in part, upon the adopted, institutional frame and the areas in which it was most flexible. In the case of Health Links, invited actors were most often engaged in creating a shared understanding around the definitions and goals of the implementation initiative. These were aspects of the practice setting unique to Health Links. However, they were constrained in their contributions to other, less flexible, institutional aspects of the practice setting, like the staging of meetings, control of the agenda or the inclusion of information, for instance. These more institutional structures and processes were largely determined by the lead agency even prior to the inaugural meeting of the

leadership collaborative group. Within the frame of the lead agency, these elements were part of the adopted practice context and were viewed by committee members as part of the way things work.

The adoption of initiative structure, processes and mechanisms of a centralized lead organization is not an uncommon occurrence, particularly within the context of health policy implementation (82). However, the addition of collaborative decision-making groups, like the HLLC, within the institutional lead agency's established bureaucratic processes and mechanisms creates an initiative with a hybrid structure. Inclusive, collaborative groups are assembled to bring a diversity of information and perspectives to address issues and generate innovative solutions in ways that could not be achieved should the lead, or any other single organization, work independently (24, 83). Although the adoption of established, hierarchical, organizational structures and administrative processes might create challenges in co-creating collaborative or accommodative practice settings situated within the overall initiative, it does not necessarily mean that they cannot co-exist. Below, I offer more detailed discussion in several key areas that were observed as challenges in co-creating collaborative practices, including perceptions of authority and ownership, establishing credibility and trust, and issues of power in collaborative practices.

3.5.1   Perceptions of authority and ownership

Observation of the HLs initiative revealed an initiative structure mostly defined by a regionally powerful government agency that assumed multiple roles including that of lead agency, provider of the administrative and infrastructure resources, and administrator of all funding allocations. From the information provided in the inaugural HLLC sessions, it was apparent that this new implementation initiative would be managed from within the structure of the LHIN's existing bureaucracy in the same way as other previous and concurrent implementation projects. Adoption of existing structures and processes provided by the lead organization was very efficient in terms of the timely provision of resources including

administrative and infrastructure supports, as well as ensuring strategic alignment with other LHIN-based initiatives in the region.

The availability of a stable and well-resourced process and structure meant that decision makers did not have to spend as much time framing their practice setting but could begin to consider issues of implementation more quickly, thereby establishing an early forward momentum for the initiative. However, throughout the period of observation, the macro level policymaker was actively engaged in policy revisions to facilitate standardized implementation across its jurisdiction. The frequent changes to macro level policy prompted local policymakers to re-visit initiative definitions and re-examine shared vision or goals within the frame of the initiative's accountabilities as presented by the lead agency. Complex, multi-level implementation efforts may benefit from having established, well-resourced structures in place that include dedicated staff and supports to help the initiative maintain focus and frame new challenges, fulfill accountability requirements and meet deadlines (77), while the local policymakers work to re-negotiate the boundaries around the shared practice context in keeping with adjustments made at the macro-level (13, 15). Given that all of the individual actors observed, with the exception of paid LHIN-based project staff, were doing the work of Health Links "*off the side of their desks*" (HL2_M3) and were all senior level decision makers with demanding schedules outside of Health Links, the use of the well-resourced infrastructure of the LHIN, and the roles played by the LHIN-supported project staff, were viewed as important assets. However, as Ansell and Gash noted, collective engagement up front in the negotiation of a shared practice context works to foster trust, commitment and a sense of ownership among engaged actors (18). In the case of the HLLC, the use of a strong lead organization and the adoption of LHIN structures and processes, while efficient, convenient and appreciated, may have had some effect on establishing actor trust in the collaborative and a sense of ownership within the collaborative. When asked, interview participants noted that HLs was perceived as a LHIN-owned initiative rather than as a shared endeavour and the participants themselves identified more as stakeholders than policymakers with decision making authority within the initiative.

3.5.2 Trust, Legitimacy, and Credibility

Participating in the collective negotiation of the practice context helps to build trust from the outset. Inclusive, deliberative modes of working can support the development of trust and ownership as well as promote improved transparency around funding, resources, timelines and accountability requirements; however, the collective effort required 'up front' to negotiate key features of a shared practice context can be difficult and time-consuming and, therefore may be considered inefficient (18, 84-87). To foster commitment to continued engagement in collaborative processes over time, there needs to be an initial and ongoing investment in the negotiation of practice contexts (88, 89). For instance, in addition to up front efforts, lead organizations should be open to the re-assessment of 'the way things work', evaluating existing processes and structures and considering how well they are functioning in support of the work of the collaborative body (82). Thoughtful and flexible processes that can adapt to changes in the practice context over time help to support initiative stability, legitimacy and credibility, which aids in the development of actor commitment and trust (89-91). Although trust has been identified as an important factor in governance effectiveness, and was identified as important by HLLC participants themselves, powerful lead organizations do not, in fact, require high levels of trust relationships among collaborating stakeholders (82). Instead, trust may remain highly centralized, focused mostly within the organization and its representatives, including paid project staff (82).

The SW-LHIN is perceived as a prominent and legitimate organizational actor. In adopting the structures and processes of this dominant lead organization, committee members endorsed and supported the perceived legitimacy of the SW-LHIN in assuming the role of lead agency (92, 93). Perceived legitimacy also supports credibility (92); that is, the belief, put forth by the HLLC and the macro-level policymaker, that LHIN-based structures and processes are appropriate to the implementation initiative. However, credibility also refers to the quality of collaboration (92) and the perceived trustworthiness of initiative structures and processes to facilitate collective processes of knowledge enactment that support the transformative, and discursive processes associated with collaboration (24, 83). In this case, the appointment of the

SW-LHIN as lead agency and the adoption of the LHIN-based hierarchical structure, while perceived as legitimate, also created a tension between the need for efficiency and administrative support to meet the requirements imposed by vertical accountabilities and the shared expectations for inclusive, shared decision making within the regional governance group. Tension can also be heightened in situations where structures are managed prescriptively and offer little flexibility to accommodate the deliberative problem-solving and shared decision-making efforts of collaborating actors (24, 88). If a group has adopted stable, but relatively inflexible processes and structures that are mostly controlled by the dominant lead organization, there may be a tendency to rely on strategies outside of the collaborative setting to respond or adapt to implementation issues as they arise. For instance, the lead organization may rely on sub-committees or strike issue-based working groups to inform the governance group and present it with organization-approved responses to issues or possible courses of action (82). In the current case study, there were several sub-committees established including the infrastructure committee and the evaluation committee, along with working groups created to examine a variety of topics, that worked outside of the collaborative frame of the HLLC itself.

3.5.3   Issues of Power

Acknowledging, understanding and re-distributing power in context has been identified as a significant challenge in the process of balancing inclusive and collaborative modes of knowledge work within an established, hierarchical organizational structure (94). There is an expectation that the adoption of a collaborative mode of working, in any context, will promote more inclusive forms of decision making that, in turn, facilitate the sharing of power so that individual actors may engage in knowledge enactment processes on equal footing (95). Although inclusive decision making in a collaborative context based on distributive power-sharing is ideal, in practice, actors engaged in these kinds of implementation policymaking practices do not typically enjoy equitable positions of power (72, 96). Instead, most collaborative efforts are influenced by an existing architecture of previous relationships and embedded knowledges, and emerge from power structures that are already in place (18, 69, 95, 97). The processes and structures adopted by the group or initiative around inclusion influence the perception of whose

expertise is valued as well as who gains access to the decision making that is applied to initiative progress (83, 98). Knowledge and information become relevant and valued, and groups co-create shared a shared understanding of 'the common good' and how to achieve it through the collective performance of the processes of enactment (93, 99). If a single lead organization is perceived as having control over the mechanisms that support inclusion and engagement of actors, in addition to knowledge and information, this may be perceived as increasing existing power asymmetries and establishing dominance within the practice context.

In the case of Health Links, examination of the initiative's starting conditions revealed that engaged actors participating in the HLLC shared a history of previous relationships and were familiar with the workings of the prominent and powerful LHIN organization. In addition, the membership of HLLC meetings was dominated by representatives of the lead organization and its acknowledged 'functional arm', the CCAC. From these starting conditions, an asymmetry of power quickly emerged within the enactment context that clearly favoured the lead organization. Power asymmetries that exist within the practice context are augmented by the authority of ownership, particularly when ownership is perceived to belong to a dominant lead agency or organization (100). A lead organization, like the SW-LHIN, that is acknowledged as the owner of an initiative has the perceived authority to shape the practice context – based on existing structures and mechanisms – to control the agenda, stage meetings, control the scope and depth of information that is distributed to the committee membership, as well as promote specific interpretations of information and issues (91, 100). This asymmetry in power within the practice setting conflicts with expectations of deliberation and meaningful inclusion that may be held by individual actors working within practice settings, particularly those characterized as collaborative (93, 95). While stability, efficiency, and legitimacy have been associated with the adoption of existing bureaucratic structures, and may be beneficial in terms of efficient governance (82, 91), careful attention should be paid to the impact of these structures on the collaborative intent and knowledge enactment within practice settings.

Regional decision makers brought with them an understanding of the mechanics of the SW-LHIN's institutional process, as well as a general understanding of 'the way things work'.

While they may have worked together to negotiate some elements of their practice setting (like the shared understanding of initiative definition, for example), they also may have felt disempowered in terms of what they could contribute to many of the LHIN-based structures and processes, given the relative power of the lead agency within the context of their collaboration. The accepted and acknowledged 'ways things work' include the way in which practice contexts are staged and information framed within them (e.g. meeting location, management and control of meeting agenda, decisions about meeting structure and timing, what information is included or excluded). All of these elements can contribute to and support the existing power asymmetry or be viewed as points of possible intervention at which re-assessments of 'the way things work' might be used by engaged actors to promote institutional flexibility and facilitate the development of stakeholders' collective capacity to engage in deliberative settings by promoting a re-distribution of some elements of (101). For example, responsibility for arranging meeting locations, setting the agenda or fulfilling the role of chairperson could be given to a representative of an organization that is not also the lead agency. Given the asymmetry in power and influence wielded by the organization that controls funding allocations, and fulfills all administrative functions including staging all meetings, the role of administrative lead could be filled by a separate, independent organization to promote power-sharing and engagement by all stakeholders within the practice setting (77).

Limitations. In consideration of transferability, it is important to acknowledge the potential uniqueness of Health Links implementation initiatives and governance within each LHIN's own jurisdiction. Within the context of each LHIN, Health Links initiatives are likely to have been operationalized within specific structures based on their own regional characteristics and requirements as well as on their individual LHIN's accountability agreement with the MOHLTC and the fulfillment of their mandate within the LHIN system. Although as an instrumental case study, the issue of interest was neither the LHINs nor HLs per se, the individual structure of each lead agency (e.g. the LHIN) should be taken into consideration when consideration the information presented here in other decision-making contexts. To assist the reader in evaluation of the transferability thick description was used based on data collected from multiple sources.

Credibility, as an aspect of trustworthiness, is also enhanced by collection of data from multiple sources using a variety of methods (43, 66). In two instances, the collection of data did not include all three modalities (e.g. collection of documents, participant observation and interview). This could have a negative effect on the confidence the reader has in the study in these areas, in particular. However, I believe that inclusion of the all data available offered the opportunity to enrich insights and understandings in two important areas:

1) <u>Background and Early Development of the Initiative</u>. My observations of the Health Links Leadership Collaborative began in January of 2015 following communications and a presentation in the fall of 2014. However, the HLLC first convened in February of 2014. I was furnished with all material distributed to HLLC members during that time (e.g. MOHLTC policy documents, presentation materials, meeting minutes), but data collection during the period of February 2014 – January 2015 was limited to these documents that were gathered retrospectively. Although this period was not observed, the experience of attending those early meeting was recounted in the interviews of HLLC members who had been present during the development of the HLLC. While it would have been ideal to have observed all meetings from inception of the HLLC, personal narratives gathered were consistent with the documentation provided and together they served to illuminate the development of important architectural information used within the practice setting observed from January 2015 – January 2016.

2) <u>Infrastructure Committee</u>. After beginning observations, and receiving updated documentation regarding the initiative structure, I became aware that there was an infrastructure of groups, committees and individuals that worked outside of the HLLC to support the implementation initiative at the level of the LHIN. One such committee was the Infrastructure Committee. Although I did not observe any of the meetings of this group, I was provided with all meeting materials (output) from this group over a 9-month period. While the addition of observation and interview data would have been ideal and would have allowed me to explore the relationship of this LHIN-based group to the ways things worked within the HLLC more

completely, inclusion of document data from this source served to enrich the analysis around the interpretation and distribution of information and knowledge.

3.6   Conclusion

Cook and Wagenaar suggested that practice, knowledge and context are mutually co-constitutive (39). In other words, as described in the previous study (Chapter 2), practice shapes knowledge and actors engaged in the practice of policymaking also shape the environments in which they practice. For instance, engaged actors or stakeholders collaborate in the negotiation of practice boundaries around shared interest, common purpose and a mutual understanding of rules for engagement (2, 12, 13, 16). The practice context, in this view, is not simply a passive background against which policy issues are addressed and solutions negotiated (38). Rather, it is shaped and affected by engagement in processes of collective knowledge enactment within a negotiated space.

The KEPS framework, presented in the previous study (Chapter 2), highlighted collective processes of knowledge enactment that are informed by embodied and inscribed knowledge and activated within shared decision making (i.e. practice) contexts (Figure 3-1). The practice setting itself, was viewed as a co-created product of knowledge enactment – along with policy relevant knowledge, and inscribed strategies or solutions for implementation. This framework acknowledges and, for the purposes of exploration, separates the co-creation of context from the co-creation of policy-relevant knowledge-in-practice. In so doing, it offers the researcher the opportunity to study each aspect separately, in addition to the interaction between them; that is, the way in which negotiated and/or adopted structures affect the collective enactment of policy-relevant knowledge. In the present study, the KEPS framework was used to provide an analytic lens through which I could place a focus on enactments of information and knowledge, as well as on the engagement of local policymakers in knowledge enactment pertaining to the ongoing co-constitution of practice settings.

Within the case of the decision-making group presented, based on all forms of data collected, it was possible to view the development of the practice setting itself (e.g. the structures and processes, rules of engagement, shared definitions and goals) separately from collective efforts to address issues pertaining more directly to the creation of regional strategies or guidelines related to implementation of policy through the lens provided by the KEPS framework. It was identified that this case represented a collaborative leadership group situated within an implementation structure common to the healthcare sector — that is, one with a central, well-resourced, well-known and credible lead organization. Although the HLLC was convened to function as a collaborative decision-making group guiding the progress of the initiative from a strategic level, it did so within established bureaucratic structures and processes that were, for the most part, adopted or approved rather than co-created by committee members. In interviews, informants expressed difficulty in accepting the label of policymaker, but expressed a commitment and desire to practice as decision makers. On examination of actor experience, I noted that opportunities to engage in the co-creation of their practice setting was limited to specific areas that did not include 'the ways things work' within the institutional or administrative frame of the lead agency. Instead, actor contributions were largely constrained to input around 'shared vision' for Health Links.

It has been suggested that if local policymakers or decision makers are not meaningfully engaged in a process of co-creating the structures and processes that frame their practice context, then the opportunity exists for the actor(s) or organization(s) with the most power and resources within the setting to manipulate the processes of enactment to suit their own vision (72). In cases where the lead organization controls structure, processes and funding, as well as dominates membership, a culture of inequality may persist even though individual decision makers have been defined as equals within the rules of engagement adopted for use in the collaborative space. However, the opportunity also exists for the lead organization to provide a well-resourced, organizational frame that is flexible enough to support and facilitate collaborative groups within its overall structure. Lead organizations should support the ability of engaged decision makers to have an effect on structure and process, should their practice require it, thereby building trust within the collaborative setting and demonstrating a commitment to fostering meaningful

engagement. Support for collaborative practice, even within a structured, stable, organizational hierarchy, could yield the innovative and transformational '*collaborative advantage*' that inspires the creation of such groups (24).

3.6.1 Contribution and Future Steps

The initiative structure identified here in which a collaborative group is located within a dominant, hierarchical agency is not uncommon in the contexts of healthcare policy implementation. By setting engaged actor experience against a backdrop of ideal expectations found in the academic literature, and employing the KEPS framework as an analytic lens, this study was able to highlight processes around the co-creation and adoption of a practice setting that differed both from the theoretical ideal and from the personal expectations of individuals relating to 'collaboration'. This study contributes, therefore, to the development of a richer and more nuanced understanding of how engaged actors experience knowledge enactment practices related to the creation of practice contexts in local implementation policymaking. In addition, this work has contributed to the accumulation of knowledge about the role of lead agencies and the use of lead agency structures in fostering settings for collaborative decision making and how these are experienced by engaged decision makers. For example, in the present case, adoption of structures and processes from a lead agency contributed to the efficiency and stability of the initiative; however, actor engagement was constrained to specific areas that did not affect the institutional frame of the lead agency. Further analysis, re-examining the data to identify factors that might support or constrain actor engagement in knowledge enactment in this setting revealed three important concepts: 1) dominance and the role of a dominant lead agency; 2) flexibility of institutional structures and processes and opportunities for actor engagement; and 3) the distribution of power. These concepts should be considered for future study and applied to the ongoing development of the KEPS framework.

As noted above, using an aid such as the KEPS framework to assist in the exploration of the co-creation of practice context apart from the co-creation of policy relevant knowledge

provides the researcher with the opportunity to examine and describe not only the development of the practice setting but also to examine the way in which co-created or adopted structures and processes affect the collective enactment practices of local implementation policymaking. In the next paper in this series (see Chapter 4), the focus will shift from the co-creation of context to the ways in which actors experience engagement in the collective practices of local implementation policymaking within the adopted institutional frame.

3.7   References

1.   Barrett SM. Implementation Studies: Time for a Revival? Personal Reflections on 20 Years of Implementation Studies. Public Administration. 2004;82(2):249-62.

2.   Wesselink A, Gouldson A. Pathways to impact in local government: the mini-Stern review as evidence in policy making in the Leeds City Region. Policy sciences. 2014;47(4):403-24.

3.   Colebatch HK. Policy analysis, policy practice and political science. Australian Journal of Public Administration. 2005;64(3):14-23.

4.   Hajer M, Wagenaar H. Introduction. In: Hajer M, Wagenaar H, editors. Deliberative Policy Analysis: Understanding governance in the network society. Cambridge, UK Cambridge University Press 2003. p. 1-30.

5.   Jones KT. Scale as epistemology. Political Geography. 1998;17(1):25-8.

6.   Papanastasiou N. How does scale mean? A critical approach to scale in the study of policy. Critical Policy Studies. 2017;11(1):39-56.

7.   van Popering-Verkerk J, van Buuren A. Decision-Making Patterns in Multilevel Governance: The contribution of informal and procedural interactions to significant multilevel decisions. Public Management Review. 2016;18(7):951-71.

8.   Pope C, Robert G, Bate P, Le May A, Gabbay J. Lost in Translation: A Multi-Level Case Study of the Metamorphosis of Meanings and Action in Public Sector Organizational Innovation. Public Administration. 2006;84(1):59-79.

9.   Colebatch H. Beyond the policy cycle. Crow's Nest, New South Wales: Unwin; 2006 2006//.

10.   Greenhalgh T, Russell J. Reframing evidence synthesis as rhetorical action in the policy making drama. Healthcare policy = Politiques de sante. 2006;1(2):34-42.

11.   Colebatch HK. What work makes policy? Policy Sciences. 2006;39(4):309-21.

12.   Dickinson H, Sullivan H. Towards a general theory of collaborative performance: The importance of efficacy and agency. Public Administration. 2014;92(1):161-77.

13.   Williams P. Collaboration in public policy and practice: perspectives on boundary spanners. Chicago, IL;Bristol, UK;: Policy Press; 2012.

14.   Fischer F. Participatory governance as deliberative empowerment: The cultural politics of discursive space. American Review of Public Administration. 2006;36(1):19-40.

15.   Stone D. Policy Paradox: The Art of Political Decision Making. 3rd ed: W.W. Norton and Company Inc. ; 2012.

16.   Yanow D. Neither Rigorous nor Objective? Interrogating Criteria for Knowledge Claims in Interpretive Science. In: Yanow D, Schwartz-Shea P, editors. Interpretation and Method: Emprirical research methods and the interpretive turn 2nd Edition ed. New York, NY, USA: M.E. Sharpe Inc.; 2014. p. 97-119.

17.   Ansell C, Sorensen E, Torfing J. Improving policy implementation through collaborative policymaking. Policy and politics. 2017;45(3):467-86.

18.   Ansell C, Gash A. Collaborative Governance in Theory and Practice. Journal of Public Administration Research and Theory. 2008;18(4):543-71.

19.   Rickinson M, Walsh L, de Bruin K, Hall M. Understanding evidence use within education policy: a policy narrative perspective. Evidence & Policy: A Journal of Research, Debate and Practice. 2019;15(2):235-52.

20.   Kislov R, Pope C, Martin GP, Wilson PM. Harnessing the power of theorising in implementation science. Implementation Science. 2019;14(1):103.

21.   Weick KE. Theory Construction as Disciplined Imagination. The Academy of Management Review. 1989;14(4):516-31.

22.   Sinclair S. Partnership or Presence? Exploring the Complexity of Community Planning. Local Government Studies. 2011;37(1):77-92.

23.   McKenzie B, Wharf B. Connecting Policy to Practice in the Human Services 3rd ed. Don Mills, Ontario, Canada: Oxford University Press 2010.

24.   Doberstein C. Designing Collaborative Governance Decision-Making in Search of a 'Collaborative Advantage'. Public Management Review. 2016;18(6):819-41.

25.   Fischer F. Participatory Governance: From Theory To Practice. In: Levi-Faur D, editor. The Oxford Handbook of Governance. Oxford Handbooks Online: Oxford University Press 2012.

26.   Baghbanian A, Hughes IB, Kebriaei A, Khavarpour FA. Adaptive decision-making: how Australian healthcare managers decide. Australian Health Review. 2012;36(1):49-56.

27.   De Goede J, Putters K, Van Oers H. Utilization of epidemiological research for the development of local public health policy in the Netherlands: A case study approach. Social Science and Medicine. 2012;74(5):707-14.

28.   Freeman R. Epistemological Bricolage: How Practitioners Make Sense of Learning. Administration & Society. 2007;39(4):476-96.

29.   Sorensen EVA, Torfing J. Making Governance Networks Effective and Democratic Through Metagovernance. Public Administration. 2009;87(2):234-58.

30.   Shotter J, Tsoukas H. Performing phronesis: On the way to engaged judgment. Management Learning. 2014;45(4):377-96.

31.   Schatzki TR. Introduction: Practice theory. In: T.R. Schatzki KC, E. von Savigny, editor. The Practice Turn in Contemporary Theory. New York, NY, USA: Routledge Publishers/Taylor & Francis; 2001.

32.   Cook SDN, Brown JS. Bridging epistemologies: The generative dance between organizational knowledge and organizational knowing. Organization Science. 1999;10(4):381-400.

33.   Jarzabkowski P, Sillince JAA, Shaw D. Strategic ambiguity as a rhetorical resource for enabling multiple interests. Human Relations. 2010;63(2):219-48.

34.   Metze TAP. Deliberative governance in synergy with government: a case study of credible environmental improvements in the Dairy Gateway, USA. International Review of Administrative Sciences. 2011;77(1):31-49.

35.   Oliver K, De Vocht F, Money A, Everett M. Who runs public health? A mixed-methods study combining qualitative and network analyses. Journal of Public Health (United Kingdom). 2013;35(3):453-9.

36.   Geels FW. Ontologies, socio-technical transitions (to sustainability), and the multi-level perspective. Research Policy. 2010;39(4):495-510.

37.   Guzman G. The grey textures of practice and knowledge: review and framework. European Business Review. 2013;25(5):429-52.

38.   Nicolini D. Practice as the Site of Knowing: Insights from the Field of Telemedicine. Organization Science. 2011;22(3):602-20.

39.   Cook SD, Wagenaar H. Navigating the Eternally Unfolding Present: Toward an Epistemology of Practice. The American Review of Public Administration. 2012;42(1):3-38.

40.   Salter KL, Kothari A. Knowledge 'Translation' as social learning: negotiating the uptake of research-based knowledge in practice. BMC Medical Education. 2016;16(1):76.

41.   Freeman R, Sturdy S. Introduction: knowledge in policy — embodied, inscribed, enacted. In: Freeman R, Sturdy S, editors. Knowledge in Policy: Embodied, inscribed, enacted. Bristol, UK: Policy Press 2015.

42.   dos Santos Freitas M. Enacting knowledge in a European project In: Freeman R, Sturdy S, editors. Knowledge and policy in research and practice Briston UK: Policy Press 2015. p. 123 - 39.

43.	Stake RE. Qualitative Case Studies. In: Denzin N, Lincoln Y, editors. Strategies of Qualitative Inquiry. 3rd edition ed. Thousand Oaks, CA, USA: Sage Publications 2008.

44.	Casey D, Houghton C. Clarifying case study research: examples from practice: Dympna Casey and Catherine Houghton explore the use of case studies with examples from their research. Nurse researcher. 2010;17:41+.

45.	Miettinen R, Samra-Fredericks D, Yanow D. Re-Turn to Practice: An Introductory Essay. Organization Studies. 2009;30(12):1309-27.

46.	Mol A. The body multiple : ontology in medical practice / Annemarie Mol. Durham: Duke University Press; 2002.

47.	Bueger C. Pathways to practice: praxiography and international politics. European Political Science Review. 2014;6(3):383-406.

48.	Littig B. On high heels: A praxiography of doing Argentine tango. European Journal of Women's Studies. 2013;20(4):455-67.

49.	Parker-Jenkins M. Problematising ethnography and case study: reflections on using ethnographic techniques and researcher positioning. Ethnography and Education. 2018;13(1):18-33.

50.	Huberman M, Miles MB. Theories and Analysis The Qualitative Researcher's Companion. London, UK: Sage Publications 2002. p. 1-36.

51.	Miles MB, Huberman M. Focusing and Bounding the Collection of Data. An Expanded Sourcebook: Qualitative Data Analysis 2nd ed. ed. Thousand Oaks, California, USA: Sage Publications 1994.

52.	Ministry of Health and Long-term Care. Ontario's Action Plan for Health Care. Toronto, ON; 2012.

53.	Theesfeld I, Dufhues T, Buchenrieder G. The effects of rules on local political decision-making processes: How can rules facilitate participation? Policy Sciences. 2017;50(4):675-96.

54.	Ministry of Health and Long-term Care. Local Health Integration Networks 2012 [Available from: https://web.archive.org/web/20120625214541/http://www.health.gov.on.ca/transformation/lhin/lhin_history.html.

55.	Ministry of Health and Long-term Care. Ontaio's LHINs: Queen's Printer for Ontario 2014 [Available from: http://www.lhins.on.ca/Pan-LHIN%20Content/LHINs%20Accountability.aspx.

56.   Yanow D. Accessing local knowledge. In: Hajer M, Wagenaar H, editors. Deliberative Policy Analysis: Understanding governance in the network society. Cambridge, UK Cambridge University Press 2003. p. 228-46.

57.   Pauly BM. Direct Observation as Evidence. Encyclopedia of Case Study Research. SAGE Publications, Inc. Thousand Oaks, CA: SAGE Publications, Inc. 302-5 p.

58.   Smith-Merry J, Gillespie J. Embodying policy-making in mental health: the implementation of Partners in Recovery. Health Sociology Review. 2016;25(2):187-201.

59.   Barlow CA. Interviews. Encyclopedia of Case Study Research. SAGE Publications, Inc. Thousand Oaks, CA: SAGE Publications, Inc.; 2010. 496-500 p.

60.   Soss J. Talking our way to Meaningful Explanations: A practice-centred view of interviewing for interpretive research In: Yanow D, Schwartz-Shea P, editors. Interpretation and Method: Emprirical research methods and the interpretive turn 2nd edition ed. New York, NY, USA: M.E. Sharpe Inc. ; 2014. p. 161-82.

61.   Yanow D. Thinking Interpretively: Philosophical Presuppositions and the Human Sciences In: Yanow D, Schwartz-Shea P, editors. Interpretation and Method: Emprirical research methods and the interpretive turn 2nd Edition ed. New York, NY, USA: M.E. Sharpe Inc. ; 2014. p. 5-26.

62.   Freeman R, Griggs S, Boaz A. The practice of policymaking. Evidence & Policy. 2011;7(2):127-36.

63.   Cepeda G, Martin D. A review of case studies publishing in Decision Management 2003-2004: Guides and criteria for achieving quality in qualitative research. Management Decision. 2005;43(6):851-76.

64.   Pope C, Ziebland S, Mays N. Qualitative research in health care: analysing qualitative data. Br Med J. 2000;320:114 - 6.

65.   Stanley M. Qualitative Descriptive: A very good place to start. In: Nayar S, Stanley M, editors. Qualitative Research Methodologies for Occupational Science and Therapy. London, UK: Routledge; 2014. p. 37-52.

66.   Tracy SJ. Qualitative quality: Eight a"big-tent" criteria for excellent qualitative research. Qualitative Inquiry. 2010;16(10):837-51.

67.   Berkowitz B. The Policy Process. In: Mason DJ, Leavitt JK, Chaffee MW, editors. Policy & Politics in Nursing and Healthcare. 6th ed. Philadelphia, USA: Elsevier Saunders; 2012.

68.   Lemke AA, Harris-Wai JN. Stakeholder engagement in policy development: challenges and opportunities for human genomics. Genetics in Medicine. 2015;17(12):949-57.

69.   Dandy N, Fiorini S, Davies AL. Agenda-setting and power in collaborative natural resource management. Environmental Conservation. 2014;41(4):311-20.

70.   Scharpf F. Games Real Actors Could Play. Journal of Theoretical Politics. 1994;6(1):27-53.

71.   Sabatier P, Shaw L, K. Are collaborative watershed management groups democratic? An analysis of California and Washington partnerships. . Journal of Soil and Water Conservation. 2009;64(2):61a-4a.

72.   Fung A, Wright EO. Deepening Democracy: Innovations in Empowered Participatory Governance. Politics and Society. 2001;29(1):5-41.

73.   Innes JE, Booher DE. Collaborative policymaking: govermance through dialogue. In: Hajer M, Wagenaar H, editors. Deliberative Policy Analysis: Understanding governance in the network society Theories of Institutional Design. New York, NY: Cambridge University Press; 2003. p. 33-60.

74.   Bickerstaff K, Walker G. Shared Visions, Unholy Alliances: Power, Governance and Deliberative Processes in Local Transport Planning. Urban Studies. 2005;42(12):2123-44.

75.   Escobar O. Scripting Deliberative Policy-Making: Dramaturgic Policy Analysis and Engagement Know-How. Journal of Comparative Policy Analysis: Research and Practice. 2014:1-17.

76.   Hajer M. Setting the Stage: A Dramaturgy of Policy Deliberation. Administration & Society. 2005;36(6):624-47.

77.   Kania J, Kramer M. Collective Impact. Stanford Social Innovation Review. 2011;9(1):36-41.

78.   Peck E, Six P, Gulliver P, Towell D. Why do we keep on meeting like this? The board as ritual in health and social care. Health services management research : an official journal of the Association of University Programs in Health Administration / HSMC, AUPHA. 2004;17(2).

79.   Freeman R, Sturdy S. Knowledge, policy and coordinated action: mental health in Europe In: Freeman R, Sturdy S, editors. Knowledge in Policy: Embodied, inscribed, enacted Bristol, UK Policy Press; 2015. p. 61-75.

80.   Macnaughton E, Nelson G, Goering P. Bringing politics and evidence together: Policy entrepreneurship and the conception of the At Home/Chez Soi Housing First Initiative for addressing homelessness and mental illness in Canada. Social Science & Medicine. 2013;82:100-7.

81.   Ministry of Health and Long-term Care. Guide to the Advanced Health Links Model. 2015. Available from

[http://www.health.gov.on.ca/en/pro/programs/transformation/docs/Guide-to-the-Advanced-Health-Links-Model.pdf].

82.   Provan KG, Kenis P. Modes of Network Governance: Structure, Management, and Effectiveness. Journal of Public Administration Research and Theory. 2008;18(2):229-52.

83.   Feldman MS, Khademian AM, Ingram H, Schneider AS. Ways of Knowing and Inclusive Management Practices. Public Administration Review. 2006;66(Special Issue: Collaborative Public Management):89-99.

84.   Rusch L, Swarts H. Practices of Engagement: Comparing and Integrating Deliberation and Organizing. Journal of Community Practice. 2015;23(1):5-26.

85.   Larrick RP. The Social Context of Decisions. Annual Review of Organizational Psychology and Organizational Behavior. 2016;3:441-67.

86.   Topp L, Mair D, Smillie L, Cairney P. Knowledge management for policy impact: the case of the European Commission's Joint Research Centre. Palgrave Communications. 2018;4(1):87.

87.   Williams O, Fullagar S. Lifestyle drift and the phenomenon of 'citizen shift' in contemporary UK health policy. Sociology of health & illness. 2019;41(1):20-35.

88.   Tenbensel T. A successful mix of hierarchy and collaboration? Interpreting the 2001 reform of the governance of the New Zealand public health system Policy & Politics. 2011;39(2):239-55.

89.   Emerson K, Nabatchi T, Balogh S. An Integrative Framework for Collaborative Governance. Journal of Public Administration Research and Theory. 2012;22(1):1-29.

90.   Johnston EW, Hicks D, Nan N, Auer JC. Managing the Inclusion Process in Collaborative Governance. Journal of Public Administration Research and Theory. 2010;21(4):699-721.

91.   Fedele P, Brusati L, Ianniello M. Organizational underpinnings of interactive decision making: an empirical inquiry. International Journal of Public Sector Management 2016;29(4):310-26.

92.   Levelt M, Metze T. The legitimacy of regional governance networks: Gaining credibility in the shadow of hierarchy. Urban studies (Edinburgh, Scotland). 2014;51(11):2371-86.

93.   Klijn EH, Skelcher C. Democracy and Governance Networks: Compatible or Not?. Public Administration. 2007;85(3):587-608.

94.   Hoppe R. Institutional constraints and practical problems in deliberative and participatory policy making. Policy & Politics. 2011;39(2):163-86.

95.   van der Arend S, Behagel J. What participants do. A practice based approach to public participation in two policy fields. Critical Policy Studies. 2011;5(2):169-86.

96.   Lowndes V, Sullivan H. Like a horse and carriage or a fish on a bicycle: How well do local partnerships and public participatiion go together? Local Government Studies. 2004;30(1):51-73.

97.   Orr K, McAteer M. The modernisation of local decision making: Public participation and Scottish local government. Local Government Studies. 2004;30(2):131-55.

98.   Huxham C, Vangen S. Managing to Collaborate - and getting a buzz from it. Managing to Collaborate: The Theory and Practice of Collaborative Advantage. Abingdon on Thames, UK: Routledge; 2005. p. 251-7.

99.   Vaughan S, Rafanell I. Interaction, consensus and unpredictability in development policy 'transfer' and practice. Critical policy studies. 2012;6(1):66-84.

100.   Purdy JM. A Framework for Assessing Power in Collaborative Governance Processes. Public Administration Review. 2012;72(3):409-17.

101.   Huxham C, Vangen S. Using Power. Managing to Collaborate: The theory and practice of collaborative advantage New York, USA: Routledge; 2005. p. 173-86.

3.8 Appendices to Chapter 3

3.8.1 Appendix 1. Brief Coding Summary

Aggregate Theme (parent node)	Sub-themes (child node)	Emerging concepts (open coding)
Starting out or starting over	Accountability Structure Resources/Funding Existing Relationships	-Understanding mandate; Responsibility; Reporting; Accountability; inscribing formal accountability relationships -Funding information; Changes to funding; Resource supports; Sharing resources -Partnerships and collaborations; Roles of stakeholders; Representation and membership; Sector engagement; Working history; shared language; understanding the ways things work
The Ways Things Work	Structure Role of the HLLC Terms of reference	-Structure of the initiative; appointments and invitations -Role of leadership group; Function of committee; Place within the initiative -Communication (means, modes) -Creating rules of engagement; ways of working together; negotiating terms of reference;
Setting the Stage	Administrative Support Infrastructure and Alignment	-Behind the scenes; infrastructure support; organizational routines; - Staging meetings; information selection and dissemination; access to information -LHIN frameworks; Strategic directions and planning; Integrating Health Links/Fitting in;
Why are we here? Creating a Shared Vision	Defining Health Links What is the goal of Health Links? Evaluation Metrics	-Change ideas; Core values and guiding principles; Situating the advanced health links model; -What issues are part of Health Links; finding focus; what work is Health Links; -Creating a shared goal; defining program function; who are project stakeholders; Who is Health Links for? -Defining success (what does the province say; what does the HLLC say); understanding drivers and indicators; defining outcomes; measuring progress (how we know if we are successful)

Chapter 4

4   The Practice of Local Implementation Policymaking: Practitioner Engagement Within a Structured, Multi-Level Practice Context

4.1   Introduction

Increasingly, the practice of creating of local implementation policy reflects the pragmatic inclusion of collaborative strategies of engagement to address complex social challenges (1-3). Alternative community or collaborative governance models that promote cross-boundary working and stakeholder inclusion have become the new standards for local policymaking practices (4, 5). Lateralization through collaborative governance is about establishing partnerships, networking, and creating opportunities for pragmatic ways of working toward common goals through the development of shared understanding and collective problem-solving (2, 6). Rather than remaining bound within the constraints of socially-constructed sectors, organizational or institutional boundaries, collaborative ways of working in governance and implementation rely on the establishment of relationships, foster inclusion, and promote the mobilization and exchange of information and knowledge, ideas and resources, as is appropriate to the context (6-9). It has become common practice for senior leadership of public organizations to be engaged in collaborations with other agencies or institutions intended to facilitate the implementation of macro-level policy in local or meso level settings (8). In community or collaborative governance, for instance, both lay and professional stakeholders are involved as policy or decision makers engaged in the practice of developing and managing the implementation of programs that affect them and their communities (10, 11).[1] Modes of

---

[1] Policy can be defined as "*authoritative decision making related to choices about the goals and priorities of a policymaking body*" (p. 50) (12). Policies can take many forms including regulations, practice standards, mandates, or ordinances, for example. A policymaker or policymaking decision maker may be defined as an individual with the power or authority to make choices related to the formation of policy (12). Stakeholders may be defined as "*a person, group, or organization involved in or affected by a course of action*" (p.2) (13). Stakeholders, who can also be involved as decision makers, may be 'lay stakeholders' (i.e. unpaid citizens who represent individuals with similar interests) or 'professional stakeholders' (i.e. individuals paid to represent organizational or political interests)(10, 11).

collective decision-making, like collaborative governance, that have emerged to address the issues of local policy implementation (8, 11) have the potential to address multi-level, as well as multi-agency and cross sectoral, implementation issues in context. These types of decision-making, that are rooted in collective, discursive practices, provide opportunities for engagement in transformative knowledge work wherein something new, like the procedures, guidelines or regulations created to support local implementation, is co-created through collaboration (14).

The construct or idea of collaboration, or collaborative governance, brings with it certain expectations. The literature suggests that practices associated with collaborative governance are inclusive of diverse types and sources of knowledge and information, favour deliberative processes, are consensus-based, and put all actors on an equal footing within the practice space (15-18). Individual actors, when invited to participate in a collaborative, decision-making group may bring expectations for collaboration and contribution with them based on their own knowledge and experience. However, the experience of collaborative practice may not necessarily meet either collective or individual expectations. In the previous paper (Chapter 3), I described a regional-level, collaborative group convened to create strategic plans for the implementation of a macro-level policy at a local level. In that group, the administrative processes, and bureaucratic structures put in place to support the initiative were mostly adopted from a dominant lead agency rather than negotiated by engaged actors. While engaged actors expected to participate in the negotiation of how things would be structured and how processes would work within the initiative, their contributions were mostly constrained to areas that could be considered unique to the specific project itself and that were outside of the existing lead agency's own institutional design, such as defining the initiative, or setting shared goals. It may be that inclusion and meaningful engagement in the practices of local policymaking have more to do with the institutional design of the practice setting than the collaborative intent or expectations of the actors themselves (6, 15, 19).

Adoption of established administrative processes and organizational structures from a centralized, lead institution to support a new implementation initiative is not an uncommon practice (20, 21). The use of a set of existing processes from a prominent organization to support

a familiar 'way things work' provides legitimacy and stability to new local implementation initiatives, and the use of template documents supplied by the lead agency, like terms of reference or partnership and accountability agreements, helps move the initiative forward quickly. In collaborative policymaking environments, it is important to establish a structural or "institution design" framework within which actors are able to communicate and act together (15, 22). What is the effect of adopting often hierarchical bureaucratic structures from an appointed lead organization, rather than co-creating a shared practice setting, on the collaborative expectations held within the decision-making group? In shared knowledge enactment settings, can the ideals of a deliberative ethic and a collaborative intent, supported by engaged actors, be balanced with the pragmatic, institutional framework provided within the administrative supports and bureaucratic structure adopted from a lead organization? To address these questions, it is important to examine the practices of local implementation policymaking at the level of the day-to-day experience of engaged actors within the shared decision-making context (2, 23, 24). The discursive, knowledge-creating and -negotiating practices or knowledge enactments of actors engaged in social processes of collaboration give meaning to defined practice spaces (2, 6).

The intent of local policymakers engaged in collaborative decision making may be to embody an inclusive and deliberative ethic; however, existing accounts that reflect the experience of practicing policy actors are few (2). Practices of policymaking do not necessarily look like what might be expected based on previous academic accounts given and the dynamics of the practice environment are only partly defined by the administrative structures and processes adopted from the lead organization (17). Individual local policy actors have agency and engage with collective knowledge enactment processes in different ways for various possible reasons (2). The ways in which policy actors engage in knowledge enactment within a given setting may, in part, be determined by the way in which the setting is structured (25), or the degree to which they were able to provide meaningful contributions in negotiating the terms of its creation.

Therefore, to address this perceived knowledge gap, it is important to explore and reflect the experiences of engagement in knowledge enactment processes from the point of view of engaged practitioners as they practice in context. In the previous study (Chapter 3), I used the

Knowledge Enactment in Practice Settings (KEPS) framework to aid in an exploration of the co-creation of a practice setting. To contribute to the accumulation of knowledge in support of the ongoing processes of theorizing (26, 27) around knowledge enactment in the practice of policymaking in local implementation settings, in the present study, I once again used the KEPS framework as an analytic tool to explore the way in which actors at the regional and local levels of the multi-level initiative described in the previous study engaged in the practices of policymaking together within the co-created and adopted initiative structures.

In the following sections, I present a background that includes a discussion of collaborative governance models in the context of multi-level implementation, and underlying assumptions pertaining to equity and power sharing, the ethic of deliberation, knowledge enactment and the practice of policymaking. The case study described in the previous study was expanded to include implementation decision making groups at the local level in addition to the regional leadership group. I use the inclusion of additional implementation groups and engaged actors in the study to explore the shared experiences of actors engaged at both the regional and local level in the practices of policymaking within an initiative structured within a centralized lead agency. Analysis revealed that engaged actors valued and expected collaboration. However, often actors struggled to define their roles within practice settings that were often dominated by a powerful lead agency with clear messages around strategic alignment and accountability. Opportunities for shared, meaningful discursive practice were limited and actors perceived themselves as being used as consultants rather than included as equal participants in a decision making endeavour. Implications associated with these findings are discussed including the importance of finding balance between inclusive modes of working and existing bureaucratic structures and accountability frameworks, and issues of dominance, authority, ownership and power in an implementation practice structured around a centralized lead agency.

4.2   Background

4.2.1   Collaborative governance approaches

In the implementation of health policy, leadership from local government agencies and healthcare institutions may be joined by representatives from non-governmental and non-health sector community organizations as well as patients or families to co-create locally-informed strategies that support and facilitate implementation of health programs and services as mandated by macro-level policymakers (10, 28, 29). Collaborative governance approaches bring these diverse stakeholders from multiple sectors together to work through "*formal, consensus-oriented and deliberative processes*" (p.544) (15) to generate innovative solutions to implementation issues beyond what each agency, organization or individual actor could create on their own (15, 30). Collaborative partnerships among local decision makers are formed not just to fill the role of advisors to governmental agencies, but as part of the policymaking body responsible for developing and implementing local policy (31). Collaboration, deliberation and the cultivation of partnership relationships between government and non-governmental actors and agencies are important to the development of implementation policy (32). However, decision-making associated with policy and implementation in multi-level governance (e.g. macro, meso, micro) is complicated by between-level requirements and accountabilities.

Although it is generally believed that processes of local policymaking are improved by adopting more lateral, equitable and inclusive approaches to governance (14, 17), there has not necessarily been a straightforward or simple transition from traditional hierarchical structures to more collaborative approaches (32). Rather than adopt primarily lateral accountability relationships, there remains a focus on hierarchical accountability in many cases, particularly to other levels within formal, centralized project structures or to higher, over-arching levels that represent formal policymaking authority (32, 33). As was the case in the local Health Links initiative reported in the previous study (Chapter 3), collaborative or alternative governance structures are often coordinated within powerful public sector lead organizations through which

vertical accountabilities are administered at the meso or regional level and whose representatives dominate decision-making groups (20, 25, 31, 33). The lead organization may provide administrative infrastructure, control project funding, and coordinate key knowledge enactment and decision-making activities; however, this type of structure centralized around a lead organization may also set up decision making contexts in which power is perceived as asymmetrical (20, 25). This, in turn, can create tensions within the practice of policymaking between the desire for stability and efficiency facilitated by adopting the structures of a powerful, well-resourced lead organization and the expectation for engagement in an inclusive and collaborative decision-making environment.

Balance, therefore, is required, especially at the meso level of policymaking, to promote collaborative ways of working toward the co-production of innovation solutions for micro-level implementation while maintaining vertical accountability structures designed to fulfill requirements created at the macro level (34). It has been suggested that, to facilitate balance between inclusive, lateral models of governance and decision making adopted within levels and the existing accountability requirements and hierarchical process structures between levels, collaborative processes should extend vertically as well as horizontally (35, 36). However, the inclusion of more policymaking actors in collaboration between as well as within policymaking levels is not necessarily associated with a change in perceived ownership, shared authority or a re-distribution of power within decision-making spaces. In some instances of collaborative governance, actors who represent the central, lead organization or public agency may still assume primary or sole responsibility for the administration of vertical accountabilities even while facilitating and participating in collaborative practices (31, 33).

4.2.2   Sharing Power and the Deliberative Ethic

It is generally accepted that deliberative endeavours are intended to facilitate re-distribution of power and promote equity among engaged actors (6, 17, 18, 37, 38). Representatives of relevant stakeholder groups should present and share equally in the ability to influence the decision-making process (31). In actual practice, neither organized collaboration

nor deliberative practices stand apart from existing power and institutional structures (18, 39). While it is possible to design collaborative, equitable and inclusive group mechanisms that distribute power within the practice setting, the operationalization of these designs and their underlying deliberative intent depends upon the capacity of lead organizations to share resources, including power, and to work outside traditional institutional and hierarchical structures (4, 17). Despite support for the 'ethic' of deliberation, and actor or stakeholder expectations for meaningful engagement in collaboration, conditions of unequal power persist (4, 40).

Underlying the support for the deliberative ethic and prioritization of collaboration, there is an assumption that the inclusion of a diversity of actors will facilitate engagement in practices accommodative to the development of shared goals. Actors participate in deliberative processes, through discursive mechanisms such as discussion, negotiation, problem-solving and strategizing (34). These strategies promote the inclusion of community stakeholders and the enactment of local knowledge in the negotiation of shared interest in the common good (14, 16, 25). The situatedness of context-specific expertise allows for a timeliness of information provision, and under ideal conditions, supports a way to streamline implementation by local stakeholders (25).

4.2.3 Knowledge Enactment and the Practice of Policymaking.

The decisive characteristic of policymaking as a practice is the obligation to act upon the situation at hand (29). Policy practitioners act to define and shape their environment, and to learn how to proceed together toward a shared goal in a way that makes sense (15, 29). As Freeman and colleagues pointed out, practice is "*invariably carried out in conjunction and collaboration with others, in ways that are familiar to and are warranted by others*" (p. 131)(41). Practice is purposeful, pragmatic and reasonable, requiring practical judgement and reflection (29, 41). Deliberative practices are inclusive of diverse information and knowledges and acknowledge the interplay between lay and expert sources (42).

Practices can be viewed as social enactments that include collective construction of meaning through processes such as sensemaking in order to negotiate shared understanding,

facilitate relationships or shape action (28, 43-45). People act to gain knowledge of the world; they work to negotiate meaning, identity and order by acting or interacting with the world and with each other (46-49). The creation of knowledge, then, cannot be usefully separated from action and reflects a context-bound engagement with the world (29, 46, 47). Actors engaged in the practice of policymaking interpret their existing architecture of traditions, as well as the structures, rules, processes and discourses within the practice space, and apply them in 'real time' (17). Indeed, knowledge, practice, and context are all part of a mutually co-constitutive system (50). Knowledge is dynamic and emergent, continually negotiated, produced and re-produced through cycles of enactment (51, 52).

Freeman and Sturdy proposed a 'phenomenology of knowledge' as a 'common observational language' that can be used for talking about knowledge and knowledge practices (52). In it, the authors described three basic forms or phases in which knowledge exists: 1) embodied (held within human actors), 2) inscribed (held in artefacts) and 3) enacted (knowledge-in-action) (52). Enacted knowledge is viewed not simply as a 'type' of knowledge, but also as a process of 'activation' in which the significance of embodied and inscribed knowledge may be revealed through discussion, debate, deliberation and negotiation (52, 53). Results of a recent interpretive review and synthesis of selected literature that explored the practice of policymaking in local contexts (Chapter 2), revealed that local policy practitioners collectively shaped and interpreted practice settings by engaging in knowledge-related activities, or enactments that included the development of shared visions and goals, defining issues and practice boundaries, determining components of physical settings for interactions, agreeing upon ground rules and accepted group practices, membership and administrative routines. In addition, within the practice settings that they worked to co-create, decision makers participated in enactment processes of collective sensemaking, deliberation and negotiation of new policy-relevant knowledge. These two broad categories of knowledge-related work are depicted in the KEPS framework (see Figure 4-1).
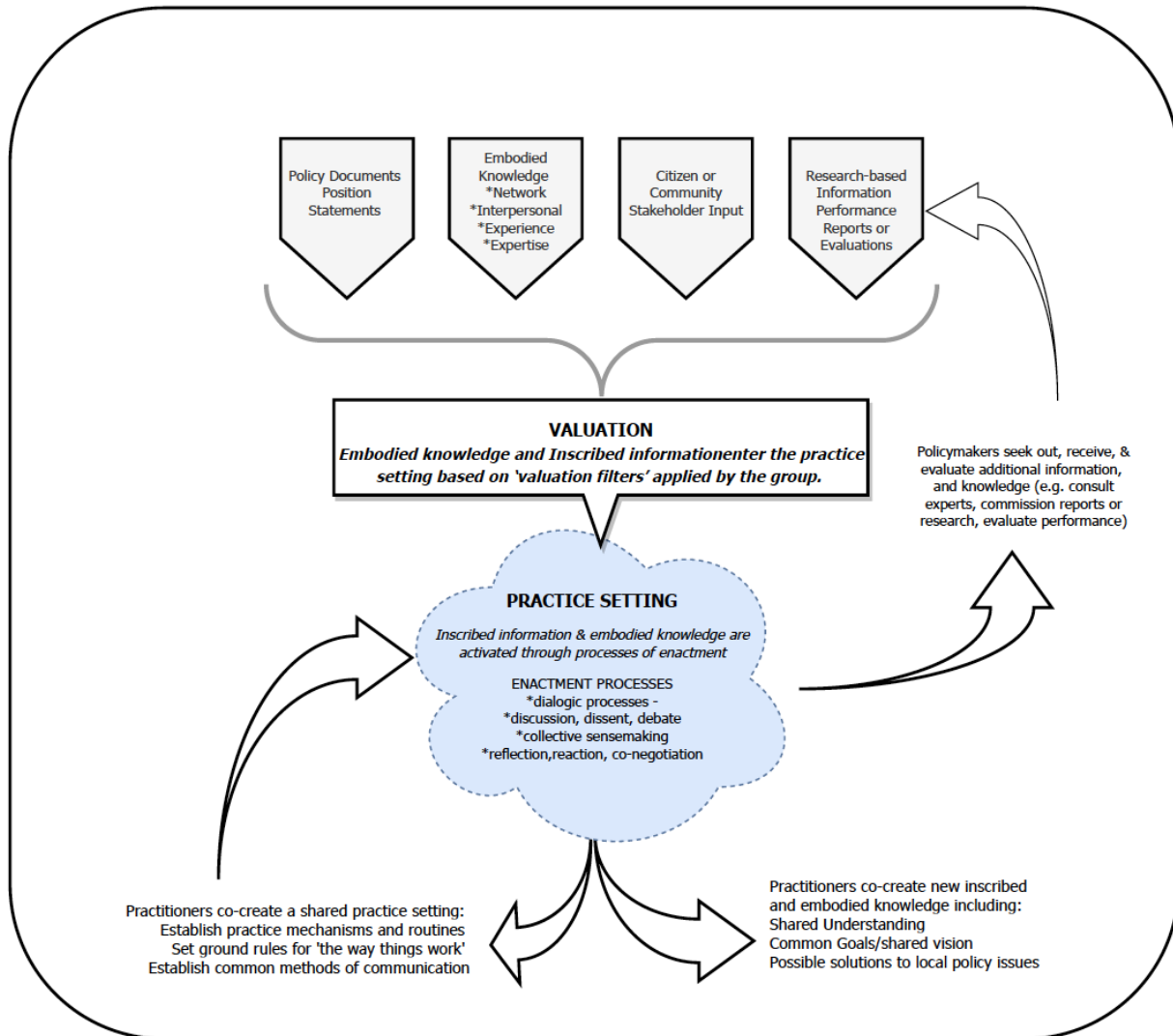
Figure 4-1 The Knowledge Enactment in Practice Settings (KEPS) framework.
Embodied knowledge and inscribed information enter the local policy practice setting via 'valuation filters' applied by engaged actors. Inscribed information and embodied knowledge are activated through processes of enactment that facilitate co-creation of a) the shared practice setting and b) new knowledge.

Collective processes of enactment, like deliberation, are essential to support the co-creation of shared understandings and solutions for implementation issues as policy moves between levels from macro to local implementation (54, 55). The shared understanding of the practice or decision-making setting is not fixed, however, and as new knowledge is 'activated', adjustment of shared goals, collective processes or context boundaries may occur (56). Engaged

decision-makers learn together how to create practice spaces in which they can collaborate meaningfully through processes of enactment.

4.2.4 Objectives: Understanding Local Policymaking Practices in Context

4.2.4.1 Meaningful Engagement in Practice Settings

Collaborative forms of governance should not just promote ideas of inclusiveness through the pursuit of larger membership rosters but should encourage and support the meaningful engagement of stakeholders who contribute a broad diversity of knowledge and information to the practice setting. This increases the enactment capacity of governance groups, allowing access to a more complex range of interpretations, experience and perspectives with which to address local issues (14). Strategies, innovations, solutions should be articulated and forged through collective action, reasoning and negotiation, including participation in deliberation, planning and problem-solving (36). Further, it has been suggested that collaborations should never be merely consultative, but instead should support opportunities for open, fair, and inclusive communication, a balanced representation of relevant interests and the inclusion of knowledge and information from all stakeholder sources (4). To support meaningful engagement in knowledge enactment by all engaged stakeholders, there must be space available within the practice setting for diverse voices to be heard (6). However, the ways in which collaborative practice settings are created and the institutional frame that is adopted to organize the practice setting can influence the ways in which policymaking is practiced.

4.2.4.2 Understanding Experiences of Collaborative Practice

Collaborative governance models bring diverse stakeholders from multiple sectors together to co-produce locally relevant strategies, and innovative solutions to issues of implementation; however, processes of local policy implementation processes are tied through mechanisms of vertical accountability to multiple levels. At each level, there is the potential for the adoption of varying practice structures and processes as well as varying opportunities for the

meaningful engagement of policy actors in collective knowledge enactment. In the previous study (Chapter 3), the formal bureaucratic structure and administrative processes used to frame the practice context for the case study initiative were adopted from the lead agency. When working within institutional structures adopted from a lead organization, processes within and between levels should work together in a way that balances the advantages of the resources and stability made available via the lead organization, with the intended ethic of deliberative, collective enactment within collaborative decision-making groups established at each level.

But, how might this balance be achieved? To do so, one would need to understand both the practice setting and the experience of practice within it. The discursive, knowledge-creating and -negotiating activities or enactments associated with the social processes of collaboration work to give shared meaning to the defined practice spaces (2, 6). Therefore, to explore collaborative practice settings situated within dominant lead agency structures, it is important to consider the co-creation of identified knowledge enactment spaces, the experience of practice from the perspective of the actor engaged in those spaces (2, 23), and the relationship between practice and setting.

At the present time, there are relatively few existing accounts that reflect both the creation of the practice setting and the experience of engaging in policymaking practices within the same setting, from the perspective of the engaged actors. To address this gap, I returned to and extended the case study reported in the previous paper (Chapter 3) to include decision-making groups and policy actors engaged within local implementation projects in addition to the regional leadership and oversight group. Using the KEPS framework to guide my exploration, and taking a practice-based approach, I focused on the experiences of engaged regional and local decision-makers who practiced local implementation policymaking within the contexts of Health Links – an implementation initiative that was observed to be structured around a centralized and dominant lead agency. Engagement with decision making groups at the levels of the regional governance group and local implementation projects afforded the opportunity to compare the experiences of regional and local stakeholders as they acted within the institutional and administrative frame adopted from the lead agency. I also explored stakeholder perceptions of

their roles in facilitating collaboration and engagement, in contributing to information and knowledge processes, and in the work of decision-making within the enactment spaces identified.

4.3   Method

4.3.1   Nested Case Study Approach

To facilitate an '*in situ'* investigation of knowledge and information enactment within decision-making groups themselves, a case study approach was adopted (57-59). The approach to conducting a praxiographic case study provided in the previous study (Chapter 3) represents the foundation for the current study which extends and expands the previous study. The present study expanded on the previous case study by adding multiple, nested elements. Multiple, embedded case study is appropriate to research that is attempting to understand inter-related activity and generate explanations to promote improved understanding (60). A nested case study is a specific type of multiple case study in that it focuses on elements within one broader, unifying or principal case (61). The nested elements or cases[2], taken together, form "*an integral part of a broader picture*" (p. 517) (61).

4.3.1.1   Case selection

A site-based strategy using lead organization informants was used to identify structured, order-making groups involved in translating macro-level health policy at the meso and local levels (62). Using an intensity strategy, that seeks to identify information rich cases to support

---

[2] As in the previous study (Chapter 3), a case was defined as a decision-making group that operated within a frame of reference defined by macro or provincial level policies or initiatives (i.e. Health Links/Advanced Health Links Initiative of the Ministry of Health and Long Term Care (MOHLTC)), or by the regional governing body (southwest Local Health Integrated Network (SW-LHIN)) and tasked with creating locally-referenced policies or guidelines, and the development of viable strategies or innovations to facilitate the local implementation of services or programs.

the learning opportunity available by use of a particular case (63), the Health Links implementation initiative was identified.[3] Health Links (HLs) was a provincial-level program, initially trialled as a pilot project across the Province of Ontario as a low-rules, locally-driven project in which early adopter groups were encouraged to focus on developing implementation strategies specific to their own location. At the time of selection, the Health Links initiative was undergoing widespread changes, both provincially and locally. Locally, there was an early adopter group as well as a newly-formed, regional governance 'collaborative' created to support changes to Health Links implementation enacted at the macro level and plans had been submitted to the Ministry of Health and Long-term Care (MOHLTC) to fund the formation of two additional local Health Link projects. All of these features contributed to an information-rich case study opportunity in keeping with an intensity, or learning opportunity driven, selection strategy.

Following conversations with the Health Links Leadership Collaborative (HLLC) chairperson, the LHIN-based project manager and project coordinator, as well as attending a meeting of the leadership collaborative, it was determined that there were three local decision-making groups (i.e. local steering committees) that could be included in addition to the HLLC.[4] The three local, project steering committees identified were considered eligible for inclusion as they had received approval of their submitted business plans, funding, had already formed decision-making groups and had either started to meet as a committee or were about to begin. Invitations were issued to the local steering committee co-leads during a presentation at the leadership collaborative, who then returned to their respective committees to discuss the

---

[3] Case selection has been reported in a previous paper. The previous description can be found in Chapter 3 of this dissertation.

[4] One of the identified committees represented a combined steering committee that considered implementation issues for two of the local Health Links projects identified. In this case, two adjacent HLs projects formed a single joint, steering committee to oversee and coordinate implementation to "*ensure we have alignment*" (HL3N_L1) and to minimize challenges experienced by patients and providers that might participate or "*cross over between both groups*" (HL3N_L1).

proposed research with their membership. Subsequent to these discussions all three identified steering committees voted to participate in the thesis research.
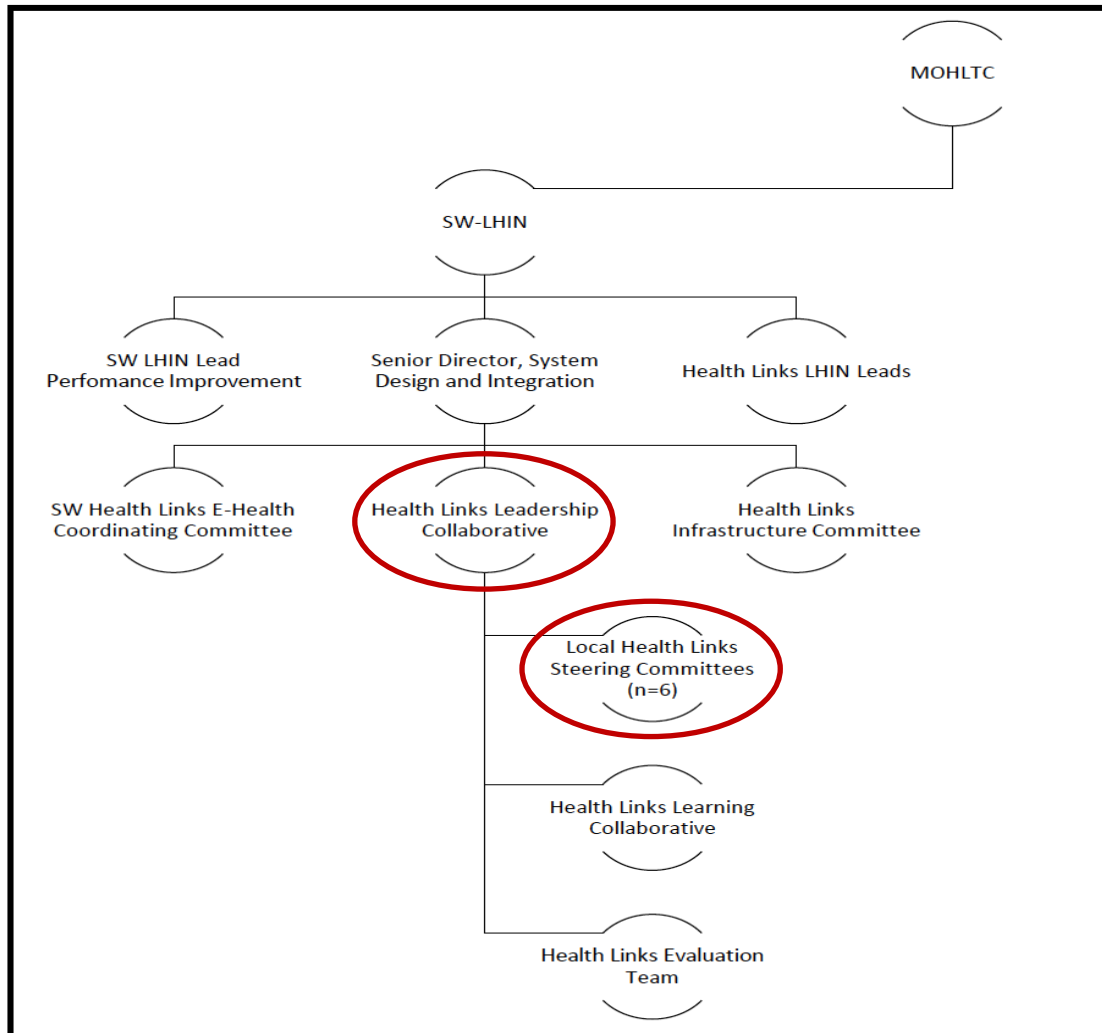
Figure 4-2. Health Links Initiative Structure.

4.3.2 Introduction to the Case Study Context: A Brief Overview of Health Links

Health Links was part of the Action Plan for Healthcare announced by the Province of Ontario's Ministry of Health and Long-term Care in 2012 (64). Since the announcement of Health Links, the initiative evolved and expanded in a series of implementation waves and by

March 2016, 82 programs had been established in the Province of Ontario. In 2014, a total of six Health Links programs were identified for implementation within the catchment area of the SW-LHIN. Subsequently, a governance group was created at the regional level to provide strategic leadership all Health Links programs identified for eventual implementation in the southwest. The HLLC held its inaugural meeting in February of 2014. The structure of the Health Links initiative in the SW-LHIN is provided in Figure 4-2.[5]

The highlighted groups in Figure 4-2 were identified for possible inclusion in the present study. Local project groups corresponded to SW-LHIN sub-regions. Groups in four of the six areas had established steering committees at the time of data collection. Each local Health Link group included, at a minimum, a primary care provider, representatives from the South West Community Care Access Centre (CCAC), hospitals, and community service providers (Integrated Planning Model document, October 2014). It was a formal expectation that local Health Link partners would share goals and information and be jointly accountable to the lead organization for performance (Terms of Reference, HLLC). Size, composition and representation of all groups observed is presented in Table 4-1. All members received project descriptions, letters of information and signed letters of consent to participate. All members were also asked if they would consider possible participation in semi-structured interviews and all consented.

Table 4-1. Composition of Local Policymaking Groups Observed

Group Observed	Number of group members in attendance	Number of organizations represented
HLLC*	14 - 28 individuals	10
HL1	10 – 14 individuals	8
HL2	10 – 19 individuals	14
HL3	13 – 17 individuals	8
*Note: Each stakeholder organization was not necessarily represented by a single individual. The LHIN, for instance, is represented by multiple individuals. At the HLLC, for example, LHIN representatives typically comprised approximately 1/3 individuals in attendance, leads (co-leads and project managers) representing individual health links in the SW accounted for another 1/3.		

---

[5] The Health Links Initiative, the Local Health Integration Networks and the formation of the Health Links Leadership Collaborative was reported in greater detail in a previous study. To review that description, please refer to Chapter 3 of this dissertation.

Ethics: This research study received ethics approval from the University of Western Ontario Research Ethics Board (#105852).[6] The ethics protocol guaranteed confidentiality and anonymity to those participants who agreed to participate in face-to-face interviews. In order to create and maintain those conditions, documents were assigned codes to designate source, type and date received. Members of HLLC and steering committees were assigned codes based on their decision-making group membership, and role. A master list of codes was created and stored separately from the data. Quotes appearing in the text of this report are attributed using the code assigned to its source.

4.3.3 Data Collection

To focus on the level of action, what actors actually do, the approach to the case study was informed by practice-based ethnographic methods (62, 65, 66). Data were collected using a three-pronged approach appropriate to practice-based ethnography (i.e. praxiography) to ensure information was gathered from a variety of sources using a variety of methods (60).

Data gathered in a previous study exploring the co-creation of practice contexts were included in the present study.[7] To expand data collection efforts to include data from local groups and engaged actors and maintain methodological consistency, the same three-pronged approach was used (i.e. participant observation, collection of documentation, and conducting semi-structured interviews with key participants). Periods of research engagement and observation within the decision-making groups identified were determined in negotiation with each engaged group. As a result of these negotiations, and in light of the number and frequency of meetings scheduled by each group over the one-year research period, there were six local HLs

---

[6] Notices of ethics approval are located in Appendix A.

[7] Descriptions of the data collection processes used in the previously reported study may be found in Chapter 3 of this dissertation.

steering committee meetings observed in addition to the 12 observations completed within the HLLC.[8]

Documentation was collected from each local committee throughout all periods of observation, which lasted from six to nine months, depending on the frequency with which meetings were scheduled in each local steering committee. This allowed data collection for all groups, including the HLLC, to be completed at approximately the same time (January 2016).

Semi-structured key informant interviews were also completed at the local project level. Possible interview participants were identified from a pool of volunteers created at the time of recruitment to the study by asking all committee members if they would be willing to participate in an interview. Informants were selected purposively to represent a range of roles, decision-making experience, organizational representation and perspectives. All participants invited to participate in interviews consented to be interviewed. It is of note that some of the individuals interviewed (such as the Health Links project co-leads, for example) were members of both the HLLC and a local steering committee (n=12). Interviews of individuals with dual membership were longer than those for participants engaged with a single group as participants were asked to consider and answer questions from both the regional and local perspectives.[9] Interviews were 1 – 1.5 hours in duration and were conducted at the participant's convenience. Interviews were digitally recorded and professionally transcribed. Data was transferred and for transcription purposes in accordance with procedures approved within the ethics protocol.

4.3.4 Analysis

Interpretation, in praxiographic study, employs "*a strategy of looking down*" to "*feel around in local contexts*" (p.7), in order to appreciate and understand situated practices (62). In

---

[8] A summary of data collected is provided in Appendix B.

[9] All interview guides used in semi-structured interviewing are provided in Appendix C.

this study, an interpretive lens informed by the KEPS framework and the epistemology of practice was used (50). Analysis was undertaken from the point of view that knowledge is negotiated through the situated contexts and interpretations of the knower (67). This perspective reflected the study emphasis on researcher engagement with what the practitioner does and experiences in context (41).

Analysis of transcribed digital recordings from semi-structured interviews, field notes from direct observation of committee meetings and documents received (both historical and contemporaneous materials) overlapped with data gathering and proceeded in an iterative manner (60, 68). All documents (case documents and field notes) were entered received as or converted into digital formats and imported into Nvivo-10 software, as were all digital transcripts of interviews. Making use of the NVivo-10 software to gather together, organize and re-organize data, coding was conducted on two levels using an analytic process based on a combination of content analysis and thematic comparison (69). Analysis drew from all data sources. For each group, an initial line-by-line close-reading of all data and open coding was used to assign codes.[10] Codes representing early groupings of ideas, or themes emerging from the data were then added (or removed) as the coding process was refined over time (70). In addition, analysis looked across data sources and emergent themes were compared across decision-making groups while seeking to identify and describe similarities and differences between experiences within the regional governance group and local HLs steering committees.

4.3.4.1   Addressing Trustworthiness

The case study investigation was supported by prolonged engagement (13 months), as well as through the use of multiple data sources and collection methods (60, 71). The use of multiple types of data collected from a variety of sources further supported study credibility through triangulation. Triangulation is a process of helping to clarify or crystallize meaning through the use of varying sources or perspectives (60, 71). As is expected in reporting case

---

[10] Supplementary coding information is provided in Appendix 1.

studies, thick description was provided to provide meaningful illustration and supporting details with a view to transferability (60, 72).

Study findings were also presented at a meeting of the HLLC that included an opportunity for questions, comments and a follow-up discussion with committee members following the meeting. Member reflections provided at that time revealed that the descriptions of study findings as presented were perceived as valid and members felt that the presentation represented their experience in general.[11] Indeed, it was reported that some insights provided reflected upcoming changes to processes and structures being initiated for some of the groups, most notably within the leadership collaborative. However, members also emphasized that the Health Links initiative, in general, as well as all the committees including the HLLC had evolved since the time of observation, were still evolving and would continue to do so as macro-level policy continued to change and they learned how to adapt and work together.

4.4   Findings

From the analysis of all case study data sources, it was possible to identify four major thematic categories related to processes of enactment that surfaced within the regional governance and local project decision making contexts observed. These major thematic groupings were given the following labels: 1) *Finding ways to connect and interconnect*, 2) *Looking up while looking out*, 3) *Going with the flow* (of information and knowledge), and 4) *Practice is voice-activated*. Additional sub-themes were identified within each major grouping. A complete list of all themes, sub-themes and their relative occurrence across cases from which data was collected appears in Table 4-2.

---

[11] Note that the membership of the HLLC included leads and project management from each of the steering committees observed. Feedback received was not, therefore, confined to the regional level only.

Table 4-2 Themes identified across groups

Major Themes and Sub-themes Identified*	Regional HLLC	Local HL1	Local HL2	Local HL3
Finding ways to connect and interconnect (supporting actor engagement) • It is about the relationships • Making space for contributions that matter • Leadership facilitates and models	● ● ●	● ● ●	● ● ●	● ● ●
Looking up while looking out • Making sense of roles and responsibilities • Whose project is it anyway?	● ○	● ●	● ●	○ ●
Going with the flow (of knowledge and information) • Your information vs. my learning • Share, share, share	○ ○	● ●	● ●	● ●
Practice is voice-activated • Primed for agreement • Making talk meaningful	● ●	○ ○	● ●	● ●
*Themes were identified across all groups. The relative strength or degree to which the theme appeared within each group is indicated by the circles where bold, filled circles indicate a more frequent appearance of the theme.				

4.4.1 Finding ways to connect and interconnect (Supporting Actor Engagement)

The working practices of policymaking are collective; that is, they are carried out "*in conjunction and collaboration with others*" (p. 131) (41). The need for engagement in collaborative action is conditional on the understanding that the actors engaged in the practice could not achieve their goals independently. The actors (stakeholders, decision makers or policymakers) perceive themselves to be interdependent and rely upon connections with others, as well as on their shared participation to achieve implementation goals (4, 15). As reflected in meeting materials distributed to the regional governance group, Health Links actors emphasized the idea of working differently, by "*breaking down silos of care*" and engaging "*traditional and non-traditional care partners*" in the development and implementation of a more coordinated approach to support "*seniors and those with complex conditions*" (Meeting materials, HLLC, February 2015). For engaged decision makers, it was also "*about how we are working together*", "*an exercise in understanding each other and how we connect and interconnect*" (HL1_L1; HL2_L1).

The importance of working together and supporting the engagement of partners, old and new, in the Health Links implementation project was reflected at both the regional and local project levels in three identified sub-themes areas; 1) *It is about the relationships*, 2) *Making space for contributions that matter*; and 3) *Leadership facilitates and models* (see Table 4-3).[12]

4.4.1.1   It is about the relationships

To create a shared, collaborative initiative may require the development and maintenance of social relationships between potential collaborators in the policy issue under development (73-75). Partnerships and networking create opportunities for collaborative action as well as for examining new ways to span or remove organizational and professional barriers (2). This theme reflected the work, observed or anticipated, around building positive connections and fostering relationship or partnerships (old or new) of the work of Health Links implementation.

So much of what happens in everything in health care, but in this initiative as well, is about relationships. Ultimately, the care that people receive will be about the relationships that people have with their providers and that their providers have with each other… how people are responding on the ground whether their relationships that are developing and what are the relationship issues that are surfacing that people are trying to work through. (HL1_L1)

…it is very much about relationships…and having that network of people who are available to share their experiences…(HL_L1); if you don't have the relationships, it doesn't matter how brilliant the rest of your work is, it is not going to find purchase… it is, I think, the most critical piece. (HL_M2)

---

[12] Each aggregate theme in this paper is accompanied by a table in which all sub-themes are listed. In support of thick description and to illustrate the emergence of each coded sub-theme data are provided from both the regional (HLLC) and the local HLs levels. Data are presented in columns to facilitate comparisons across levels (e.g. regional vs. local) and, where possible data are grouped together to highlight similarities as well as tensions identified within the themes.

Table 4-3. Finding ways to connect and interconnect

Sub-Theme	Regional Governance group	Local Project groups
It is all about relationships	<u>Building Relationships</u> • it is all about having conversations and about the relationships that exist and developing those further and {X} does such a great job in that space… There are definitely other aligned initiatives that could have been at the table, but I think that {X} is doing a good job of linking with those groups outside of the table and I think that is working reasonably well and you can only bite off so much at a time; there was certainly an opportunity to think more broadly outside of the health paradigm, but to be honest, I am not sure it was a mistake not doing that because I think that we had so much to kind of get our arms around and I think that those other partners should be at the local steering committee tables (LCE_C) • **April 2015**: Presentation (LHIN-member) emphasized importance of strengthening relationships/networks, and partnership development– building capacity to create a decision-making environment inclusive of indigenous communities. <u>Engaging/Connecting (gathering perspectives)</u> • if you have someplace that you can connect with the key people that you need around the table to make and I mean in this instance it is making sure that all the sectors are represented, right and you make sure that everybody's at the table that should be and that everyone feels that they are valued equally as a partner in it, right. (HL1_M3) • when you're trying to do something like this because you need to get enough perspectives around the table that you're broad in thinking about your vision of how you're moving forward… you need to figure out, there will be different relationships, and you negotiate as you go (HL1_L1) • I think that the lead organizations who pull together the partnerships umm really looked at the same old same old and I would say that public health was not involved very much. Long-Term care has not really been involved very much. It has been basically CCACs, primary care and hospitals. And, while at an individual patient level they certainly pull in really interesting groups of providers and non-health care folks to address patient needs at the Health Links level we really haven't seen much beyond the triad (HLE1_1) • if we don't at a higher governance level understand the social determinants of health I think that it prevents a more… deeper discussion at a very system level of governance because what they can bring to the table is additional information that can help to support those frontline	<u>Building Relationships/Networking</u> • A good-sized area to look at (HL1_M2) and so I see that, kind of that health link area and the work that's been done in terms of networking and thinking about this group as a system • We were a founding member of health link because I loved the idea, like obviously to serve people really well you have to go beyond community services, these things, the specific partners we're engaging, so one of the big next ones is primary care and hospital service because people are in and out, and right now as community service agencies, we don't have access to information as people go in and out of hospital (HL1_M3) • it's about you know getting people involved in that relationship development as well as the information sharing, like both are happening. (HL1_M3) • There were a lot of lessons learned from my experience that I was able to bring to the table and also to kind of broker some of those relationships (HL2_PM) • In terms of the broader north-south, I think that will be a slower evolution in terms of finding the optimal way to relate and develop policies, programs, practices that are aligned with each other (HL3S_L2); I could see that there will be other organizations that do become engaged in this process as this initiative expands, but you know I think to get to the stage where we're at right now, you sort of needed to have, you need a good representation but you also needed a core group so that decisions could be made and things could more forward (HL3S_L2) <u>Engaging/Connecting (gathering perspectives)</u> • I think that we could do a better job in engaging some more community agencies such as community living. I think that as we develop further I would like to see municipality representation as well as policy representation and those sorts of things so we do recognize that (HL1_L1) • You have the leadership -- you have some of the grassroots champions -- I don't know who else I would try to get there. (HL1_M4); • HL2 by design is not meant to be, it isn't designed to be in the community, so when we have grass roots community efforts supporting a vulnerable individual group, community, we see pretty quick results that aren't all sophisticated and you know, documented and whatever, but you see that sense of community development that does build momentum in the build on its own success.(HL2_M1)

Sub-Theme	Regional Governance group	Local Project groups
	that have those agencies that are more involved in the social determinants of health. (HL1_L1)	• I think that as, as organizations you know depending on where their particular focus is, if they see this as a strategic priority they will make sure they are at the table and I think that's a good thing. So I think we have worked very hard to ensure that you know our representation is both across service requirements as well as you know population based and a population based focus, so I think that's a real strength for us. (HL3N_L1) Identifying tensions/challenges • And so we have quite a sort of top down approach I think with this health links that maybe is missing that community development perspective (HL2_M1) • I think that it is very LHIN-heavy at those meetings and I think that is a bit of a problem. The LHIN is focused on the health side and is very health services oriented (HL2_M1). • this is cross-organizational and it is very difficult — it is difficult to make change when you work within an organization or across a family health team or two and the CCAC and the LHIN and primary care physicians and mental health agencies and they have got to want to work together. And that comes from mutual respect and relationships (HL3S_L1)
Making space for contributions that matter	Value/meaning • I think one of the things about an initiative like this is getting various perspectives at the table and then having those different perspectives, so they all have value right, it's just because it is those different perspectives and you're trying to bring them together in a unique way (HL1_L1); I think at the larger table — at the leadership table, I think myself — there are 2 of us who represent mental health and addictions, I still feel that is my role there — to make sure that population doesn't get forgotten (HL1_M3) • Engagement means having the space to sit around the table and have the conversation. Great representation from stakeholders in that the right people are around the right table having the right conversation. (LC_M1) Role • That is what I see sort of over all of our roles at that table (regional) to be — to put that stuff on the table and then sort of hash it out such that we can go back and say listen — we hashed it out. I hear what you are saying — I hear what you are saying. That was voiced and yet the final decision was this and we — every single health link was supporting that and we are moving forward in that way. So, it is that opportunity to have the voices heard before the decision is made. (HL2_L1)	Value/meaning • what has to come to our steering committee in Huron Perth that we have to approve that we need to have input in and I think you have to have some understanding about what that is so that nobody is feeling like why weren't we consulted on that, you know and then get caught up and that it is very clear — the boundaries are clear the parameters are clear your expectations are clear of everyone that is sitting at the table. I think that we have done a fair job of that here. (HL1_M1) Finding a Role • I want to be a true partner, not a convenient partner and that's what the community you know can sometimes feel (HL3S_L1) • We know we have the primary care, we have hospital people, we have the CCAC folks there, we have good representation from the community, you know again LTC is there, there are people there from like the [CHC] so I think they've done a good job of sort of bringing those folks together BUT it's the usual suspects kind of thing. Like it's the same people sitting around the same tables debating the same, like different issues, and, and I mean they could make the same complaint against me because I'm on every friggin' you know different group; I saw my role as one of more of an interested community member and that could maybe ask, maybe ask

Sub-Theme	Regional Governance group	Local Project groups
	• I think that there is a point where engagement and buy-in is one thing but empowerment and ownership -- and tipping over the fulcrum and getting into that key bit that speaks to momentum is important. (LC_M1)	questions you know, look at the information, provide a perspective that was kind of maybe an outsider's perspective (HL2_M2) • I sit around and they say well shouldn't we have a representative from you know from housing or should we have Emergency services and yea, yea that's great, but I still haven't got a care plan done and, and could I instead engage those people more effectively on sort of an individual care plan as opposed to just putting bums I seat around a steering committee (HL2_M3) • if there's ever a situation where there's too many ideas on the table and not enough direction about how to proceed, so I mean that's a danger with having so many organizations involved. And I guess you probably wouldn't, just personally, wouldn't take very much for me to shut down if I am bumping against some real resistance to being that voice for my population. Like if I feel resistance strongly, I probably would tend to back down, just in terms of, that's just my, how I perceive, but in the face of somebody who's identifying that shouldn't be a priority then that would lose the inclusiveness feeling that I have had from the group so far. (HL3_M1)
Leadership facilitates and models	• **Terms of Reference (February 2015):** The co-chairs [chair] will be responsible for facilitating the meeting in a way that ensures advancement of the agenda, keeping discussions on track ensuring that discussions are directed toward tangible actions or outcomes • Sometimes policy — we have done lots in the absence of having a clear policy framework as long as we have a clear direction, but sometimes where are levers around policy and other sort of enablers that can become really important in moving an initiative forward whether it is your board's incentives — all sorts of things from that perspective — you can thing about those things as well. So… **Leadership is key for sure**. (LCE_PM) • I have intentionally tried to draw out people into the conversation to make sure that everyone is on side with the direction -- in particular, where we have been discussing an issue that will have implications for all of the health links ultimately and some people really have their head in the space because they are in the midst of implementation and others may be sitting back because they are not there yet and it is difficult for them to weigh in — yet, knowing that we are setting the direction that you know all of them need to follow, I have really tried to be intentional about pulling folks in --We did not ram a decision down peoples' throats	Partnership/Collaboration • there are differences in some leaders being able to lead in a partnership collaborative mode and leaders feeling that they are in charge and I will let you guys know when I need you to show up. You probably noticed that I had an opinion about that up at the HL3 meeting, in that that's okay, but at the end of the day, the initiative is supposed to be about partnership.(LC_M2) • I think in the case of HL1 is the truly kind of collaborative vision that I would say {the lead} and her strengths that she's brought to that, I think that has allowed a collaborative approach that's really different, so that I would say is a real strength (HL1_M1) • it is about ensuring that everyone is an equal partner and feels like they are an equal partner and that everyone is getting the same information right in that there is a good flow of information in that people are getting what they need and can ask for what they need if they are not getting it. I think you have the good resources and good support for any sort of initiative and leaders (H1L1_M2) • I think that the fact that you know, the group as a whole recognized that collaboration with, was a priority, I think is fantastic, and if you think about the leaders need to you know one of the roles of leaders is to exemplify the values of you know of an organization or a sector or an

Sub-Theme	Regional Governance group	Local Project groups
	— there was flexibility to re-group and go back and look at this differently (LCE_C)	initiative, I think that given that we are coming together and we are collaborating, I can't see how that does not then flow down in to the other, and create almost an expectation of you know, of the more operational type stuff, the engagement (HL3N_L2) Facilitating • If you keep people on the outside for too long then you will find yourself alone trying to lead a system initiative, because either people will disengage or they will become disenfranchised with the process more or less. (LC_M2) • This has become a distributive leadership model. The leadership is shared and it is based, not on hierarchy, but it is based on what you bring on the table and how you facilitate and manage that change. I think that is where that change is allowed to happen because it is not based on one leader within one organization.(HL1_L1) • My observation is that transparency is helpful to groups being able to being committed to moving forward.(HL3S_L2) • {The lead} used language herself about -- I understand that I signed the contract, but I need you guys to know that we are all accountable. She facilitated dialogue that made people know that this was a shared leadership model out of the gate.(HL1_M4) • HL2 also now has a project team that is very much working in a style that is open saying tell us, share ideas and they manage conflicts well when people don't agree. So, I think that the leadership style influences and models to other people -- you know -- bring the stuff into the room or if the leadership style isn't like that then conversations occur outside and then that then undermines the trust and the collaboration (LC_M2) Tensions • you have to have something to consult on and a small group of people to work on something so that you have given some thought of what you would be presenting to a bigger group and then you are always accused of not being collaborative and then you get into this endless cycle (HL3N_L1) • I feel like the leads are trying to figure out who they are and what they are supposed to be doing even though they are 6 months or more into this process and I don't know if that is a reflection of change in the leadership roles so people haven't journeyed with the process and people don't feel confident. (LC_M2)

At the regional, leadership collaborative level, attentions were focused on getting key decision makers around the table to ensure the right mix of perspectives was available to contribute to the co-creation of a shared vision for HLs implementation within the region. The leadership collaborative brought together "*the leads from each of our local areas*", as well as "*other regional partners that have a role of health links are invited to that leadership collaborative table to provide strategic leadership, guidance to the initiative — to give input on things that we feel should be in common across the LHIN to support implementation of health links and to really be a place where we can collaborate as leaders around successful implementation of health links*" (LCE_C). Representation from the SW-LHIN and its functional arm, the CCAC and the Health Link Leads (including co-leads and/or associated project managers) comprised more than two-thirds of the actors attending most leadership collaborative meetings observed. From the perspective of the lead organization, there was a sense that inclusion and multiplicity of perspectives around the regional decision-making table had to be balanced with the need for a manageable, right-sized process. As a LHIN-representative noted, "*you can only bite off so much at a time*" and, there was "*so much to kind of get our arms around*" (LCE-C). Other, informing relationships or connections were viewed as something that could be negotiated as required over time, and maintained outside of the decision-making context by project staff or included as partners at the local steering committee tables (see Table 4-3). There was a feeling of urgency in moving forward with implementation and a need to balance forward momentum with the time it would take to establish new relationships (LCE_C).

In general, there was very little discussion observed of how to cultivate this right mix of engaged stakeholders within the HLLC. Although representation was considered appropriate in terms of skills and resources available to the group, interviewed participants did express concern with the way in which the committee membership had been structured.

I think both the Steering Committee and the Leadership Collaborative have good representation when it comes to the health care system. I think that everyone is there that should be there — but the patient voice is really the only thing that is

missing, but it is a difficult thing to bring; You are limited by the fact that they are
only health funded organizations sitting around the table — those are the only
sectors; How do you engage people outside of the health care system that probably
need to be involved. I don't think there has been any thought around how to do that
(HL1_L1)

As one LHIN-based actor noted, this may have been a reflection of "*the accountability and risk*" (HL2_L1) associated with the role of lead organization. The issuing of invitations to join the regional governance group may have been viewed as part of the role of the SW-LHIN organization – the perceived owner of the implementation initiative. However, the absence of discussions around membership within the observed meetings of the HLLC was not associated with a lack of embodied knowledge to support enactment in this area. Interviews revealed that individual actors, who were all experienced decision makers and leaders, had clear ideas about the development of a collaborative group suited to the new way of working that was Health Links. Actors expressed concern regarding "*all of those people from the LHIN at the table*" (HL2_L1) and, while acknowledging the need for LHIN and Health Links project representation, expressed a desire for collaboration with representatives from agencies and sectors from "*outside of a health link per se*" (HL2_L1) or "*outside the health paradigm*" (LC_M2). In addition to thinking "*more broadly outside the health paradigm*" (LC_M2), participants noted important gaps from within the healthcare sector citing a lack of representation from hospitals, family physicians, and patients *"in planning roles" (HL2_PM).*

At local tables, there was more active discussion observed around how to identify interdependencies, especially outside of the health care sector, and how to engage potential stakeholders in the efforts to design and implement HLs locally. The importance of establishing and maintaining community relationships was a common theme in interviews conducted with representatives from all local HLs project groups. It was noted that the relationship connections that were identified as most needed were those that crossed traditional organizational and sectoral divides, those that could help develop "*grassroots champions*" (HL1_M2) and contribute "*community development perspectives*" (HL2_M1). Discussion at local steering

committee tables extended beyond the simple identification of potential committee members to the need to consider strategic priorities and foster trust between groups, organizations and/or sectors (see Table 4-3).

> *I wish that the barriers (around engagement) could just be broken down a little bit and I unfortunately feel that there is a perceived threat no matter how we try and frame it… it still stays very tied to you know what they offer and where their worth is at – their interests and their identity as an organization. (HL2_L1)*

4.4.1.2   Making space for contributions that matter

Collaborative arrangements are not created just to promote ideas of inclusiveness but are also established to engage with more diverse interpretations, information, experience and perspectives in support of addressing complex problems in context (14). Development of relationships in collaborative spaces should be about more than offering an expanded membership list or having more bodies around a decision making 'table'. Meaningful engagement means bringing voices that might not otherwise be heard into decision-making spaces and making room for those voices to be heard (6). At all levels, there was importance assigned to meaningful engagement by decision makers and the ability of these actors to bring their voices to Health Links' decision-making spaces.

As part of the Terms of Reference adopted at the regional level, inclusion in the leadership collaborative was based on the potential ability of each actor to "*impact the Health Links mandate*", in addition to their ability to "*provide resources to the group*" in the form of "*time, expertise and information*" (HLLC ToR). Once included in the regional decision-making group, actors interviewed expressed a belief that it was their role to engage with the HLLC as the voice for their sector, community or organization – to bring their expertise and experience to the conversation and contribute before decisions were made (see Table 4-3). For some actors, the opportunity to be meaningfully engaged also meant working toward identifying and developing

stakeholder ownership and fostering empowerment – both ideas that were viewed as critical in sustaining forward momentum (see Table 3):

> *Identifying those stakeholders that need to be owning the process is critical. I think that having change champions are important from the engagement side. From the empowerment side, I think that we need change evangelists. (LC_M1)*

At the local tables, actors participating in the newly-established, local HLs steering committees struggled with balancing their desire for a broad-based inclusiveness and making sure the voices of all collaborators were heard in a positive and receptive environment with the forward progress needed to accomplish expected or desired project outcomes. Relationship-building was viewed, at times, as being antithetical to the timelines, progress or evaluation requirements created by the regional, lead agency in order to satisfy accountability to the macro-level policymaker. Time and effort spent in expanding collaborative relationships were not identified as improving engagement in project implementation. Instead, too much time spent making sure the right people had been invited and could all participate meaningfully was viewed as running the risk of losing focus on the purpose of implementation ("*we forget that we're trying to do care plans*" (HL2_PM)) or setting the group up for confusion or conflict by having "*too many cooks in the kitchen*" (HL3_M1). Some actors worried that the members invited represented 'the usual suspects' and that discussions would quickly become stale and routine (see Table 4-3). It was noted, however, that "*every group is, or every organization, I think is coming to the table wanting this to be a collaborative process*" (HL3S_L1).

Involvement of local decision makers early in the process in a way that makes clear that they have real opportunities to influence the decision-making agenda, as well as the final outcome, may improve a sense of ownership and generate more knowledge (76). Supporting collaborative relationships and learning how to manage inclusive engagement in a productive way may be something that is done together over time. The longest established HL in the region demonstrated the value of establishing clear boundaries and expectations around input, discussions and decision-making processes so that "*nobody is feeling like why weren't we*

consulted on that and then we get caught up in that" (HL1_M1). Over time, as collaborative relationships developed through engagement at that site, members reported bringing knowledge and experience to the table, and also gaining "*understanding of what other people bring to the table and so it was really two-way. I have learned so much about what other organizations do but also what we can do collectively to break down organizational barriers*" (HL1_M2).

4.4.1.3   Leadership facilitates and models

In their integrative framework for collaborative governance, Emerson and colleagues suggested that leadership is an essential driver for collaboration (4). Effective, facilitative leaders support inclusion, help to create and support clear rules of engagement, ensure all voices can be heard and encourage local policymakers to listen to each other, thereby helping to build trust in the shared, deliberative process (14, 15). Ideally, leaders strive to nurture an accommodative practice context through the constructive management of difference allowing room for dissent and supporting transparency of process (15, 35).

Leadership, and style of leadership, was observed by actors as an important feature of engagement at both the regional and local levels. "*Leadership style influences and models for others*" (LC_M2). At both levels, the role of leadership in facilitating inclusion and creating a space in which all voices could be heard was noted to be an important factor in engagement of stakeholders. Leaders that worked in an "*open style*", facilitated a shared and collaborative way of working within enactment spaces that included encouraging discussion and managing dissent, which supported the development of trust and engagement in participants (see Table 4-3). At the regional level, features of facilitative leadership were framed formally, within the Terms of Reference for the HLLC. Facilitative leadership was described as the ability of the leader to strike a balance between creating a sense of inclusion and space for contribution with the need to establish a clear direction and keep the project moving forward "*toward tangible actions or outcomes*" (HLLC ToR). The local early adopter HL, created in advance of the involvement of the LHIN as the lead organization, supported a model of distributed leadership in which all actors had been welcomed as equal and accountable decision makers "*out of the gate*" (LC_M2) (see Table 4-3).

Leadership styles that were perceived to be less collaborative, or non-transparent, in which the leaders were observed to work separately to deliberate solutions for presentation and feedback to the decision-making group, were seen as risking the disengagement or disenfranchisement of actors from an initiative that "*is supposed to be about partnership*" (LC_M2) (See Table 4-3). In the single group in which leaders appeared to favour a less inclusive and more consultative model, struggles with actor engagement and significant fluctuations in attendance were noted. Development of basic rules for engagement and addressing the need for the creation of a shared understanding of common purpose were not placed on the agenda for approximately six months post-inception. As one member noted "*our biggest challenge is maybe having a common vision of what the purpose of the group is, and how it should function*" (HL3N_L1). Although template documents were provided by the regional committee to assist by providing an institutional frame on which to base structural and administrative aspects of the local practice setting, leaders from this group expressed reluctance to make use of them:

> *It was {XX} a few weeks back that I remember saying that they would take these things and then go and invent them locally — that is not what I sent the forms for. (LCE_C)*

4.4.2 Looking up while looking out

Centralized approaches to shared governance that are coordinated around a single lead agency may include both horizontal and vertical network relationships (20). In the health sector, this approach to project process and structure is often used, assigning the role of lead to agencies such as regional hospitals, health authorities, or public health agencies, based on the agency's position as a key regional resource (20). The HLs initiative employed a similar lead organization approach in providing a stable, but hierarchical, structure for its regional implementation efforts (see Chapter 3). In this broad thematic area that explores the relationship between engaged actors and the lead agency's role and institutional frame, two sub-themes were identified: 1) Making

sense of expectations roles and responsibilities and 2) Whose project is it anyway? (see Table 4-4).

4.4.2.1   Making sense of roles and responsibilities

The institutional frame structure for the Health Links initiative was identified as operationalized at the level of the regional governance group (see Chapter 3). Within this frame, the lead organization or SW-LHIN was accountable to the macro level policymaker for project outcomes as defined by the MOHLTC. Each of the local projects, through agreements signed by the Health Links leads (and the organizations they represented), were accountable to the SW-LHIN. Although the early adopter project was originally accountable directly to the MOHLTC, this was adapted to accommodate revised structures put in place across the province as the HLs initiative continued to evolve at the provincial level. This vertical accountability structure, operationalized through the lead agency, had an effect on the way in which engaged actors developed an understanding of their own role(s) within the implementation initiative.

Engaged decision makers at both the regional and local levels were presented with the formal structure of project accountabilities early in the initiative's development process. In materials provided to inform the first meeting of the leadership collaborative observed for this study (January 2015), the lead organization clarified its position as the initiative coordinator, acting to ensure forward momentum and to facilitate communication with the MOHLTC. Accountability to the LHIN for the HLLC, and the use of letters of cooperation between the central lead organization and local projects were inscribed in early drafts of the HLLC's terms of reference (February 2014, May 2014, November 2014). In addition, each local project had been involved in the development of a business plan that had been submitted to the LHIN and to the macro level policymaker prior to approval of their local Health Links, establishing proposed roles and accountability structures before the inception of each local group.

Table 4-4. Looking up while looking out

Sub-Theme	Regional Governance group	Local Project groups
Making sense of roles and responsibilities	<u>Understanding the system</u> • need to understand what is going on in the health care system so what are the opportunities to educate, you know our leadership with respect to the future vision of the health care system and what is the ministry, what is the ministry's role and what is the LHIN's role (HL3S_L2) • from a broader issues perspective, there is a strategic direction setting role that we play from a LHIN level. It is sort of how we refer to how we have supported work from the LHIN perspective (HL1_L1); <u>Resources/using our resources</u> • we need to collectively look at how we are using our resources you know efficiently and effectively and where those opportunities are for you know, for better collaboration and integration so I do see that as a resource, you know and talking about availability of resources (HL3N_L1) <u>Understanding accountability</u> • setting the stage around for instance Ministry direction or structures or things like that that are standard and expected — reporting mechanisms and those sorts of things that are very structural and it is the expectation of the role that I have that I set that stage, but also assist people in meeting those requirements (LCE_PM) <u>Measuring process</u> • We are 3 years into the strategy. I get that some of that stuff has to evolve, but this has been a very long process.(LCE_PM); in terms of are they the right indicators: I guess I would say at this point I don't have, my expectations of that are that they should continue to be, they need to continue to evolve and as people on the ground we need to try to provide input and advice on what some of those indicators would be, because I don't think they'll be able to determine at the, you know, at Queen's Park but as long as they're continuing to evolve, I'm okay with that because I don't think, yea because it is imperfect and I think that's all you can do, continue to evolve it and as long as you feel like there's a conduit of information that's going up and down, then I think that's good (HL1_L1) • in public service that's always one of the drivers right is what's being counted, we need to do that -- what you see at the on the ground level you have to be able to make that visible in some way to decision makers and how, to be able to tie it in to the directions that are happening, whether it be at the LHIN level or ministry level, which are hopefully similar, they usually are, but at that level of policymaking so that you're	<u>Understanding accountability and accountability structures</u> • I think it is really important to know on a high level — what is coming from the Ministry and what is coming from the LHIN and then in Steering committee - we do have to stay connected that way and that is very valuable information; We report to the steering committee who in turn reports to the LHIN who then in turn reports to the Ministry so there are some things that the working group needs to be accountable for in order to kind of meet those needs of the powers that be (HL2_WGL) • It is having to hold back and wait to see what is going on high up before we can move forward with a lot of stuff. We better wait and see. It is so important to stay aligned with that but I feel that sometimes it weighs us down. (HL2_PM) • if you think about that local level policymaking — you do have one or 2 people at the table at the table who represent a different level of accountability and risk than anyone else around that table. They're, and that depends on the local nuance, whether or not that gets bared and brought forward for some local discussions how best to manage that and I have seen it both ways (HL2_L1) <u>Reflecting work in outcomes</u> • have to say in Huron and Perth I'm very pleased with the fact that its not about okay we need to just do a bunch and send them off, its still about trying to do this in a way that has that integrity around what we're trying to do, so that I really appreciate because I think it is easy to get very driven by numbers of things that you're doing (HL1_M3) • …it seems like everyone is generally focused on the outcomes…that might be for different reasons. Obviously, some have more, more invested perhaps from a financial perspective or a workload perspective (HL3N_L2); I think that we really have to drill down to the subjective stuff and figure out what those indicators are and what the scales and measure of that can be (HL3S_L2);

Sub-Theme	Regional Governance group	Local Project groups
	able to create those links for people so they can see the benefit of what you're doing (HL1_L1)	
Whose project is it anyway?	Standardization/Consistency • **Observation (January 2015; HLLC)** On completion of the 'core principles' discussion to complete/finalize HLLC's terms of reference, chair suggested that the document could be used as a template for the local steering committees that were just beginning. • **Observation (January 2016: HLLC)** Member comment noted: "At the leadership table, its interesting because you have almost a different level of decision making and the kind of focus here is more about what's the standard and what's, like what do we do, what do we try to replicate, what do we try to make the same, and what can be different so that's one of those core questions that I think comes up and revolves around various decisions" Regional strategy vs. Local autonomy • **Observation (January 2015; HLLC)** "*Who are we to tell other groups how to function, each group should do this on their own*"; LHIN-rep response was to acknowledge all groups have their own way of working, but "<u>*this is an opportunity to provide a core document with some key principles so that each group does not have to establish a new set that in the end all sounds the same*</u>". A single HL lead objected to this, ending "*we are unique*". • Folks around the table haven't valued as much the 'we are going to come here and make the decisions about how to implement' but more it is a community of practice — and then go away and use it in my own personal practice or own local approach (LCE_PM); I always try to balance my perspective around what it helpful from a consistency or systems perspective vs. what is reality from the local perspective. But, absolutely, for me, there is always a bit of a tension around getting that balance right and where I might tend to be more the advocate for greater consistency I sometimes have to release some of that to allow for the local variation that makes sense (LCE_C)	Standardization/strategic or 'regional' guidelines • I feel like what the LHIN is bringing forward informs us about parameters and what we bring forward informs us about again the milieu we are working in and how we need to whatever those parameters are — what we need to do to make them work for us. (HL2_L1) • You have strong LHIN representation which is important, because people get their direction from the LHIN (HL1_M4); The LHIN needs to again be kind of clear about what they will allow I guess or support, I guess that is a nicer word — what they will support or not support (HL1_L1); Regional strategy vs. Local autonomy • …I mean what the LHIN is wanting matters to us but that isn't necessarily what drives every decision because we're looking at our population, our resources, our physicians, you know just what our specific needs are to this area and so that also drives a lot of decisions. We want to meet the LHIN requirements, but we also I think we're feeling if we're going to build something that is sustainable then it has to work for us (HL3S_L2); [project manager] and I share that philosophy and she lets us have our local autonomy and innovation and she will probe and you know like assist us if we happen to negotiate something but I just think that it makes a difference. There are other projects where the person is not as skilled and they and it feels like very top down (HL3N_L1) • That is something that I find it is this whole push pull between local autonomy and passion and energy for change with top down directive type Ministry accountabilities and it pops up quite regularly. Not all the time, but it does pop up when you start talking about decision making. Like they are not — it is hard to figure out what their role is at times.(HL3N_L2) • I think that there has to be some expectations set, both by the local group, but also by you know, by the people that know, so there has to be, this is the expectation, we trust each other, we're going to be generous with each other and we have to get to there. (HLO_L1)

Framing can be characterized as a kind of sensemaking work that helps actors interpret meaning in uncertain situations (77). Once informed of project structures that established formal accountabilities, actors engaged in ongoing, interactive processes of sensemaking – trying to discover what meaning this structure would have for them in context and how to collaborate effectively and consistently at different levels. At each level, there was a different set of perceived roles and understanding of responsibility in context that would influence the way in which decision makers framed their understanding of the inter-level accountabilities established within the HLs initiative. At the regional governance group, for instance, members expressed a need to take a systems approach to understanding, and a desire to examine both the role of the SW-LHIN and that of the MOHLTC within the system as a whole in order to understand what was required of them. However, the perception that one must accept and adopt the policy information, and all strategies coming from the MOHLTC and the SW-LHIN meant that there were constraints placed on what could be challenged.

> *The other piece is the policy and intent from the strategic level -- the Ministry and the LHIN level. That information is important because you have to align; we use the resources and information that comes from the Ministry or the LHIN as our reference point because we need to make sure that we are aligned in our activities with the way that they are envisioned by the Ministry or the LHIN. (LC-M1)*

At both the regional and local levels, actors were assisted by the LHIN-employed program lead whose own role included "*setting the stage around, for instance, Ministry direction or structures or things like…reporting mechanisms and those sort of things*" and supporting groups in meeting structural requirements. However, the expectations associated with accountability were not always clear. As the macro level policymaker released changes associated with adoption of the Advanced Health Links model (78), and these changes were interpreted and disseminated to local decision making groups via the SW-LHIN, actors struggled with the way in which evolving evaluation parameters influenced both shared understandings

around project definitions and the requirements linked to accountability (participant observations November, December and January 2016).

Framing expectations around accountabilities was viewed as significant, and necessary, as it placed certain limits around what could be discussed, enacted and implemented within the local context (see Table 4-4). The boundaries around implementation, viewed through the framings linked to accountabilities, were often shifting as the macro level policymaker prepared to release a new version of the Health Links initiative. Local contexts were constrained by a need to '*wait and see what is going on high up*' (HL2_PM) before they could move forward. Requirements around the populations to be included and the indicators to be assessed evolved throughout the period of observation. Toward the end of the observation period, each local project was required to collect a few key indicators as defined by the macro level policymaker and funder, including number of coordinated care plans completed. Each local Health Link provided a report to the SW-LHIN "*who then in turn reports to the Ministry*" (HL2_PM). This resulted in new sources of tension and uncertainty for local decision makers who felt that the key indicator selected to demonstrate benefit lacked meaning and did not represent the innovative work done in many communities to address local need ("*There are lots of things we are doing because of Health Links that are not captured by the metrics*" HL1_L1 -- observation December 2015).

4.4.2.2   Whose project is it anyway?

At the regional level, the HLLC was responsible for what it identified as "*system level strategies*" concerning the alignment of initiatives within the LHIN, while working to address "*the needs of the identified population*" as well as the "*development of collaborative regional initiatives to address system-level barriers to the success of health links*" (HLLC, Terms of Reference). In addition, the role of the HLLC was described as one which provides leadership and oversight to Health Links and assists with "*coordination of activities and processes across health links where possible*", as well as with the "*standardization of processes, and tools across Health Links*" (HLLC, Terms of Reference). There was a tension experienced, particularly by decision makers who represented the LHIN and by those who took up the roles of local Health

Links leads, in balancing the roles of HLLC member and its requirement for consistency, standardization and oversight with their perceived responsibility to the needs of their local communities and the desire to prioritize locally-based solutions to implementation issues (see Table 4-4). Given the relative dominance of the LHIN, and the vertical accountability structures present within the project, any negotiations between LHIN-based project representatives, Health Links leads and local steering committees were conducted "*under the shadow of hierarchical authority*" (p.41) (79).

> *There have definitely been some tensions in the project in terms of local level activity and where we might think that things should be from a LHIN perspective. So, it is a balance of figuring out, you know, how much you push on things and how much you let communities figure things out for themselves (LCE_C)*

> *I mean what the LHIN is wanting matters to us but that isn't necessarily what drives every decision…We want to meet the LHIN requirements, but we also I think we're feeling if we're going to build something that is sustainable then it has to work for us (HL3S_L2)*

4.4.3   Going with the flow (of information and knowledge)

Through staging practices such as selecting and/or providing meeting locations, scheduling the frequency and duration of meetings, and the provision of structural supports, lead organizations may influence the way in which knowledge or information-based resources are distributed between decision-making actors and enter into enactment/decision-making spaces (37, 80). Closely related to staging, scripting practices are used within decision-making spaces to provide cues for enactment through the adoption of processes that may include mechanics to guide the selection, presentation and dissemination of information to engaged stakeholders (80). In the previous study, I explored some of the ways in which the lead agency for the HLs initiative shaped the decision-making environments at the regional level through various staging activities (see Chapter 3). This previous examination focused on the structures and mechanisms

adopted to support the initiative and its decision-making environments including the mechanics (routines or processes) used to guide the flow of information into the HLLC enactment space. In the present study, the influence of these structures and mechanisms on actor engagement with knowledge and information movement into and out of the practice environment were reflected in two themes: 1) Your information vs. my learning and 2) Share, share, share (see Table 4-5).

4.4.3.1   Your information vs. my learning

The structures and processes that were adopted to guide the movement of information into knowledge enactment spaces at the regional level of Health Links were part of the LHIN-based infrastructure adopted by the implementation initiative by the HLLC (see Chapter 3). In brief, potentially relevant information was selected, interpreted, processed into documents, and distributed to HLLC member through a variety of means and media (e.g. email, shared online storage, slide and verbal presentations, in-meeting paper distribution) by members of the LHIN-based project support team. Observation revealed that this process of staged information access did not change significantly at the local level, where decision makers were provided with information prior to or during meetings that was selected and/or screened by project staff and distributed through the same means and media as listed above.

Table 4-5. Going with the Flow (of information and knowledge)

Sub-Theme	Regional Governance group	Local Project groups
Your information vs. my learning	<u>Curating information/Role of LHIN-based staff</u> • There is a lot of political information that I bring to the leadership collaborative. Both at their meetings and through I post a little bullet points forum on health chat for them when there are key nuggets of information that I am gleaning from the provincial level that I think would be helpful for people to have (LC_M2) • If information comes in randomly, from different sources, that leaves it open for interpretation. If it is something that is going to cause people, even if we don't think it is going to, some alarm or uh oh or they think that now the landscape is changing or something is happening -- if it gets in some other way first, there still needs to be context and key messaging around right sizing it (LC_M2) • We are asking for clear information from the Ministry that will help us make right or wrong decisions. (LCE_PM); I would say that staff do research and bring forward information for the group to make decisions. That is the approach that they have asked for staff to do the work-up.(LCE_PM) <u>Experience/Embodied knowledge</u> • They bring their experience and their knowledge to the table, but the background work needs to be done ahead of time and that is helpful for them to make decisions. (LCE_PM) • if there is anything that people have valued it is that opportunity to learn from each other. Having those opportunities to come together just to hear from each other just seems to be my read of what the group seems to value most in the process (LCE_C)	<u>Bringing information in/moving information</u> • I think you know that we have people who participate in the learning collaboratives and other LHIN meetings around health links as well; we are having people participate in those types of meetings and bring back information to the table so we are ensuring that we are collecting the information that we need (HL3N_L1); • You know quite often I will bring back information from the leadership collaborative and then also like so {the Lead} is the main person that I've reached out to so any information that she has had to share (HL3N-L2) • I think that the important information that gets shared is really what each member can kind of bring - everyone is very welcoming of what each member can bring and I think that has been very important information (HL2_WGL) <u>Complexity/Quantity/Information Management</u> • I guess a challenge would be too much information flowing at us and trying to keep up with that and still do our jobs (HL1_M2); It is fairly complex so I'm pretty sure there are times where I don't feel as informed about you know where is this, some of the specifics about where things might be added, but part of that might be just my own opportunity or ability to you know track everything as carefully because it is fairly complex and there's a lot, like you could spend full time on this easily, just trying to track what's going on (HL1_M3) • we do that sort of brainstorming [usually with the other co-lead] in order to you know, figure out the you know, and sift through the relevance of that information to our own particular situation (HL3N-L2) • we have a white paper, we have a presentation and we have a bunch of notes, we find that nobody accesses it [stored online]. I don't know if there is no value because 'I am too busy' and they can't take on reading a 50-page paper or whether it is.... So, the briefing note and then discussion has seemed to be a good way for people to receive the information and then we typically would follow that up with -- 'here's the original source, if you want more information' (HL2_PM); • I am not sure how we do keep up -- you have to have a project manager who is managing that information but then able to chunk it out in ways and don't and don't make us look for it. When a couple of meetings ago --

		well, it is all in the reports, but if it is important enough -- you need to get it to our attention (HL2_M3) • Is the group clear about what, what information you require for me because I'm not going to sit in a meeting for two hours just to sit and listen to you know, different organizational perspectives or you know different stakeholder perspectives on how to deliver this model. Bring me in when you really need me there to help you make a decision (HL3S_L2)
Share, share, share!	• by having people like us (project staff) being able to move up and down that hierarchy of structures within health links it gives us an opportunity to feed some of that information from those frontline staff and physicians right through to the leadership collaborative and potentially I have opportunities to get it to the province if it is applicable and then other way as well (LCE_PM); the communication outward. I really think that is 80 - 90% of my role (HL2_PM) • Is the information taken back to the tables? Not really. And how to people move along in their journey...by using that information to inform it and right now I am not sure that there is that much -- there is not a lot of using it to inform it to go forward. Using/taking the information back and using it is a question mark... for me. Whether it gets translated back to the local tables (LC_M2)	Sharing information – openness/equity • ...if the idea here is to build you know a system that's working together you know in a very cohesive manner then we need to make sure that everybody is getting key information at the same time --and that information is not percolating through the grapevine and is based on who you know (HL3N_L1) • You can't have strategic decisions made at a LHIN level and then not share that, right? Any of the things that we do tend to communicate particularly at a steering committee level tend to be big -- they tend to be the game changers. Like hey our criteria has completely changed (HL2_L1) • I have always felt that any information that came out of the Ministry needed to be diffused across the partnership organizations — really understanding that I couldn't be the only owner of the knowledge so really identifying here are some opportunities to learn more and bring it back to the health links (HL1_L1); there is a network expectation...That we network and bring information back to take information out. (HL1_M3) Sharing information -- hierarchy • In terms of our relationship with the LHIN and some of the groups that they are offering — the LHIN leadership collaborative and things the learning thing — that is more of a top down, here is some information for you — go and execute. I would say that for our group probably, there is not as much buy-in to that (HL3S_L2) • I will bring back information from the leadership collaborative...in order to you know, figure out the you know, and sift through the relevance of that information to our own particular situation (HL3N_L1) • I don't think that there is really a mechanism for going back up. I mean I think that there are always mechanisms for information to flow down. You can almost drown people in information, but for information to go back up I don't think so (HL1_L1) Sharing between HLs

		• it is information sharing among the health links across the South West — I think that it will be important to look at health links on a broader basis (HL2_WGL) • it is about not re-inventing the wheel. Here is something that you can pull and use if you feel that it is amenable and useful to you (HL2_PM)

At both the regional and local levels, examination of the data revealed a range of actor perceptions around what kind of information and knowledge they had access to, and/or could contribute as part of their active engagement within enactment settings. In general, there was a shared expectation among participants that the groundwork for meetings would be completed, and materials distributed to attendees in advance of meetings by project staff. "*Staff do research and bring forward information…at the steering committee level again, it is a staff role, not a decision maker role*" (LCE_PM). On observation in enactment settings (i.e. meetings) at both the regional and local levels, it was noted, for example, that committee members did not bring formal, inscribed information with them to meetings to introduce spontaneously in support of discussion around agenda items. This may have been, in part, because there was no perceived need for individual actors to supplement the information provided to them by the lead organization or the local project team with additional formal, inscribed material (see Table 4-5). As one HLLC member noted, "*I haven't observed anybody to kind of not have the information they need… there's really digestible amounts of activity if you stay connected to that meeting*" (HLO-L1). Others perceived the input from the LHIN staff to the stakeholders as overwhelming, stating that the amount is "*hard to sift through to get at what is really important…It is a lot to take in and try to sort through*" (HL1_M2). Sometimes, the information provided, while plentiful, was perceived as "*fuzzy or a bit grey*" (LCE-PM) and project staff felt that the desire for clarity from engaged actors exceeded the availability of "*clear information from the Ministry that will help us make right or wrong decisions"* (LCE_PM).

The project team was generally perceived as essential in "*bringing that provincial, you know, voice*" (HL1_M1) through its "*connections to all the tables*" (HL1_M1). In the eyes of the stakeholders, the project team performed the important first steps in "*long distance translation of knowledge and information"*(LCE_PM) from the MOHLTC, not only in providing ongoing policy updates (see Table 4-5), but also in communicating *"where the Ministry has compiled a lot of really good information that they have gotten from the health links over the past two years"*(LCE_PM)*,* disseminating that information to the regional and local tables, and helping them in the process of "*interpreting that and thinking about what that means within each individual persons' and each individual teams' practice"* (LC_M1). However, there were also

concerns voiced about potential bias given the way in which information inputs were managed by the lead organization

> *"...from that perspective, it does tend to be, I won't say one sided, but it is not balanced in terms of the information inputs into the process". (LCE_C)*

Rather than provide formal or inscribed information, engaged actors were expected to bring their "*knowledge and experience to the table*" (LCE_PM). On observation and interview, embodied knowledge and experiences were appreciated contributions to enactment settings. Experience shared at the HLLC from the local tables by Health Links leads and project managers, for example, represented an opportunity for shared learning between actors engaged in local projects at different stages of implementation (e.g. *"[HL1] is a good example, like they're, I love hearing about where they're at"* (HLO_L1)) as well as a means to support "*consistency of practices*" (LCE_PM) and reduce duplication of effort where possible by "*not re-inventing the wheel*" (LC_M2). Participant observation revealed that general progress and activities, special events, numbers of coordinated care plans in progress and completed, and patient success stories from local tables were shared regularly during roundtable update sessions at the HLLC; however, individuals working at the level of the local working group reported less success in relaying problems, issues or concerns to the level of the HLLC.

> *I would love to be having more of a voice to bring some of these things up. And, I can — through {our project manager} and through the {Health Links Program Lead} etc., but I must tell you from my position and this is being very candid that it takes a long while for some of us in the weeds to, I am sorry, make the point that we really do know what is going on -- it takes a long time for our voice to get through those channels. (HL2_WGL)*

At the regional level, there were occasional, direct requests observed for HLLC committee members to submit inscribed information following meetings so that it could be posted online for shared access by all HLLC members. These requests included materials

relating to specific areas of interest or experience, such as inscribed materials obtained from educational conferences or workshops, and template documents, for example.

> *We're doing some work in privacy work here…that's on our work plan for the area provider table. So that's been a request of that committee, they actually just requested again if we had our, if we had our one pager done -- I feel like we can bring some things to the table that, that we're doing here that hopefully makes it easier for everybody. (HLO_L1)*

4.4.3.2   Share, share, share!

Meetings are key enactment contexts. They are routine, socially accepted, micro-institutions of decision-making where shared understandings or conceptualizations of policy are co-constructed (54, 81). From these important enactment sites, output is generated, often in the form of documents (54), but also in the form of the embodied knowledge/experience of actors. The inscribed and embodied output of meetings, like the HLLC, becomes the input to be included in collective processes of enactment in future meetings, of this or other groups within the initiative (54).

As was the case for information moving into enactment spaces, information movement out of meeting spaces was framed by the structure of the initiative itself. The leads, co-leads and project managers for each individual Health Link within the region participated at the regional governance level of the initiative as members of the HLLC with the expectation that they would work to "*develop consistent practices across all Health Links in the South West*" (Implementation Frameworks draft document review, October 2014 meeting minutes). It was also expected that, in aid of the development of consistent practices, HLs leads and project managers would transfer information and knowledge gained from participation in the leadership collaborative directly to their local project groups. However, this was not always easily observed by those involved at the regional level:

Is the information taken back to the tables by the leads? Not really. And how do
people move along in their journey? By using information to inform it, but right
now I am not sure that there is that much – there is not a lot of using it to inform it
to go forward (LC_M2).

While some of the information and documentation provided by the LHIN was considered important, what the local HLs leads chose to share at the project level was informed by their own knowledge and expertise as it pertained to their own, local setting and what they felt was most relevant to their own circumstance at the time.

I feel like what the LHIN is bringing forward informs us about parameters and what
we bring is about what we need to do to make them work for us (HL3S_L2).

The reinforcement and reproduction of regional level outputs in local level enactment settings was supported by the knowledge support roles of the Program Lead and Project Manager, two staff members resourced through the lead organization. Between them, these staff members shared the responsibility of attending all steering committee meetings and working group meetings within the region in order to facilitate knowledge and information sharing throughout the region at all levels of implementation. Presentations summarizing macro-level policy updates or information and knowledge outputs from the regional level were often provided by one of these project representatives at the local level (see Table 4-5). As these two key individuals were firmly embedded in initiative structures and processes, they were able to facilitate connections "*with what is happening at the LHIN and with other Health Links*" (HL2_L1). Their connections "*to everything*" (HL1_L1) helped them to facilitate the sharing of information, expertise and experience between project groups, laterally, as well as support information movement from the macro and meso levels to local contexts.

As the initiative progressed, and projects developed, facilitating lateral connections helped groups to learn from each other's experience and avoid "*re-inventing or thinking that they*

need to invent something to move their Health links forward when it may already exist somewhere else and they are just not aware" (LC_M2). Actors shared inscribed outputs, often from working group meetings "*like process flow maps and all that kind of stuff*" (HL2_PM), which then became information entering the enactment spaces in other local HLs practice contexts.

> *We just shared a whole whack of our documents and stuff with them because now it is a nice template for them. We just said just do what you need to do to tailor it for you – it is information sharing among the health links across the South West – I think that it will be important to look at health links on a broader basis. (HL2_PM)*
>
> *...pretty much everything that we work off of you know, we adapt, it's an adaptation of something from one of the other Health Links. (HL3_L1)*

4.4.4 Practice is voice-activated

Discursive processes or activities are the media through which knowledge enactment (and re-enactment) occurs. In other words, talk enables practice (67). The social process of collective sensemaking, that includes discursive practices such as negotiation, discussion, and debate, mediates the interpretive practices of decision-making actors (36, 67, 82). In enactment settings, then, actor-embodied knowledge is of critical importance. Embodied knowledge, such as actor experience and expertise, helps to make sense of and place contextualized value on formal or inscribed knowledge (72). Local practices of policymaking are social and discursive, but also pragmatic. Local decision makers consider and make sense of information in light of experience and expertise and they use common sense in so doing (36).

In the Health Links initiative, where formal or inscribed information moved into enactment spaces via project structures and mechanisms controlled by the lead organization, the role of engaged actors within decision making spaces was defined, to a large extent, by the activation/enactment of the embodied knowledge they could bring to the practice setting at either

a regional or local level. Indeed, the ideas of working differently through building relationships, supporting meaningful engagement, and of bringing diverse 'voices to the table' have been identified as significant to the participants within the themes described here. The process/experience of fulfilling their roles[13] and contributing to the implementation dialectic is reflected in the two subthemes 1) Primed for agreement and 2) Making talk meaningful (see Table 6).

4.4.4.1 Primed for agreement

In the previous study (Chapter 3), I described the way in which decision-making practice contexts were structured and staged within the Health Links initiative around a central, dominant lead organization. As noted above, the movement of information into practice spaces was managed by the project teams at either the LHIN or local levels. In addition, the selection of items to appear on the agenda, in what order and how much time was allocated to each item was also determined by the same lead organization, or project, representatives.

---

[13] Local decision makers experienced some tensions in finding and defining their own roles within HLs implementation context. When asked, individual participants revealed that they did not necessarily identify with the label "policymakers"; although they did agree that they were involved in creating regional or local implementation policy, procedures or guidelines. HLs actors, invited to participate in decision making committees, more often considered themselves to be professional stakeholders or stakeholder representatives than policymakers.

Table 4-6. Practice is Voice-Activated

Sub-Theme	Regional Governance group	Local Project groups
Primed for agreement	<u>Presenting or framing?</u> • I find that the meeting is very structured in that it feels like there are particular presentations that occur, mainly from LHIN related staff that I am never really sure how engaged the leads of the …how are leads receiving this information (LC_M2) • [project manager planned ahead to come at [a topic] 2 or 3 different times to get the group to a place where they felt comfortable because there were so much in those slides and I didn't know what half the things were and where they were at. So, getting the right level of information to people so that they felt positioned to be able to make a decision — I think we had some learning around that (LCE_PM) • I would say for the leadership collaborative that sometimes it has felt a little bit more like we're just kind of going the direction that we have been you know of whoever is presenting that information as opposed to having a full on discussion and feeling like everyone has had a real opportunity to give their input (HL1_M3) <u>Consulting/Creating consensus</u> • I feel at times the group is more consulted on a decision that is being made by the LHIN to move action forward, but I don't know that I would fully describe it as consensus -- that it was by consensus versus through a consultation process -- Considering that it is decision makers that we have in the group. (LC_M1) • … It's like why am I here if all you want is my, is my check mark or my stamp (HL3S_L2) • I get the emails about hey, this decision was made and how come I wasn't a part of it, and where did this come from (LCE_C)	<u>Presentations or framing?</u> • **Re: presentation:** I think that so, this meeting was…was {person X}….and I think that a lot of the LHIN work is happening at that level so {X} develops things. Now, {X} has a dual reporting responsibility to {org1} and {org2} so I think that reflects at least 2/3 of the equation. So I do think that it is more around the LHINs vision for what the health link should look like (HL2_PM) • I sometimes find with these kind of groups is that you get to the point, like to start off really well and then you know you get to the point where the work gets hard and so instead of doing the hard work, you start doing like presentations and you start having people present -- it becomes this, this information sharing, which is I guess useful, but its strays away from the purpose (HL2_M2) <u>Consensus-creating</u> • It is consensus. Things are circulated, you read it. You give your — your say yes we should try that — no we shouldn't or modify. But, I think it is through consensus. (HL!_M4); • Mostly consensus building — yes. We try to bring as much informed information to the group as we can. Sometimes I will do a little pre-work about this is how I see it happening, but please tear it apart and give me your feedback and challenge me where you know. (HL2_PM) • I do appreciate that the group seems to umm — can easily decide if there is in fact consensus and not flog a decision on which there is already consensus (HL2_L1) <u>Decision making</u> • I think that there's been an attempt to make decisions; But we don't have a good sort of strategy or process for actually being able to do that, so and part of that is I think you know some strong personalities at the table -- in the north you know, the louder that you are the or the more adamant you are about something there's definitely people that are more persuasive than others -- there actually haven't been a whole lot of decisions made in the north, and yea part of that is because I guess we have difficulty coming to a consensus on most things and you run out of time and come back to it at the next meeting (HL3S_L1); • We do not make the decisions, as co-leads, we make sure that it is a team decision …(HL3S_M2)

Making talk meaningful	**Strategic collaboration** • …this is the table which is very much more closely tied to the LHIN decision makers and obviously, and the provincial decision makers, so it's well I think it's still collaborative you know, and the various participants, like again the composition is there and the desire is there. It just feels more tied to those other kind of, I'll call them the political driven, those kinds of needs and of course it is because that's where its placed, right. (HL1_L1) • if we are making decisions for the entire LHIN — if there is any contention about it we have to put that discussion on the table (HL2_L1) • **Observation (May 2015)** "There is potentially the opportunity to put some of those things on the table in a different way and to hear from others that yes, this is something that we should be asking the LHIN to focus on because it is a challenge for all of us" (HL2_L1) **Colourful conversations** • …we are going to really concentrate and focus on what we need to do to get that done and then talk around the table and then have discussion -- have ayes, nays, abstainers, and carry on from there. I don't think we've done that (LC_M1) • …I wouldn't be able to put my finger on something and say that we all decided as a group definitely to do 'x' where the idea came from the group and the suggestion came from the group and we all agreed. (LC_M2) • instead of having what I would call a really tough conversation about the priorities, it was too hard to think about as a group that everyone sort of said whatever, just go for it and I am not sure that we got the best decision out of that because we did not manage that difficult conversation in its most productive way. (LC_M2) • Let's have our debate and bring what we know to the table and then — like a board meeting. We bring what we know to the table, we have our discussion — we make the decision and then we can all walk away and say that regardless of what our original perspective was and whether we really like the decision or not, we were at the table — we had the input — the decision was made and we are going to follow it (HL2_L1) • I don't want to make it sound like we all said no and they said yes and then went ahead, but I'm trying to think of colourful conversations where it was less like informing or we got consulted and we gave input (LC_M2) • The learning collaborative – there was a lot of lively conversation from a lot of people who were really unsure that the learning collaborative approach was the right approach and made lots of concerns about the	**Exploring/Learning (doing the work together)** • you need that vision. You need that vision of what we want to achieve, but that is the information you need. You have to know what you are working with first. Then, once you have that vision you can say, okay what is the next step. What is the next one, and the next step. (HL1_M1); I see a lot of exploring, asking questions and pushing the envelope. A lot of why can't we do that? What is stopping us from doing that? Is there any current legislation that is preventing us from doing that? What do we have to alter to know that we can do that. we know where we want to go but as we go through we need to go through the process of learning (HL1_M1) **Decision making 'latitude' (what can we influence?)** • the struggle I regularly find in steering committees is how much people love to get into the weeds and how that detailed information becomes a real focus and umm an aligning that with what the actual activity of a steering committee (HL2_L1) • It is difficult to have those conversations about -- so exactly how much latitude have we got to make decisions. If you are talking about 3 million dollars -- have we got 3 thousand dollars or do we have 3 million -- like don't tell us we have 3 million and have us meet a gazillion times and then find out that the province has dictated 2.5 million of it and we actually only have some 500,000 in latitude. So, when they said that each Health Link should do the research and find out what their needs were and then work on those and then I haven't worked out completely what is going on now, but for them to turn around and then say no, now we are going to standardize it. I mean -- what does that mean? (HL2_M3) • if there aren't decisions to be made, if there aren't in that sort of more rigid framework -- I can send a briefing out to you -- you can call me if there are any questions -- but pulling the group back together for what we -- I am struggling with that because we are not operating as a steering committee in my sort of humble opinion. And yet, we haven't really had a lot of decisions to make (HL2_PM) **Finding process** • they [the north group] seem to get really caught up in process and have, from what I can see difficulty moving forward because they're getting caught in the weeds all the time with details.-- we have a different philosophy about how we want to go about things and, and those meetings they dominate them, there's you know more people there from the north, they do have some problems that they need to work through and although that's not the appropriate table to do it at, they're also

	ability to get teams to go and pull them out of their clinical practice. The was voiced quite loudly in my opinion. Yet, the learning collaborative went ahead (LC_M2)	chairing the meetings -- that is one thing I find really wonderful about the south meetings is that they're, you know, they're informative, everyone is participating, you know I think people leave feeling like they were able to contribute whereas yea, its more difficult in the, in the north to feel that way, its just, it's a different, its structured differently (HL3S_L1); • I think that will be a slower evolution in terms of finding the optimal way to relate and develop policies, programs, practices that are aligned with each other (HL3S_L2); …we make sure that there is room for dissent and that we have opportunity to discuss most things. (HL3S_L2)

At the regional level, presentations were a commonly used mode for bringing an enriched view of inscribed material into the discursive practice space. Through presentation, SW-LHIN representatives provided narratives that helped to add to and frame formal information that had been distributed to committee members prior to each meeting. Examination of agenda documents, other supporting materials and observation records throughout the year-long observation of the HLLC revealed the use of presentation by SW-LHIN representatives to activate and frame inscribed documents on multiple occasions at every meeting. Presentations were categorized on agenda documents, produced by the LHIN-based team, as having one or more 'expected outcome(s)'. These presentation outcome categories included 'inform/information/learn from each other', 'input or feedback', 'discussion', 'agreement/next steps/decision'. The most common 'outcome' or purpose was to provide information, followed by discussion, input/feedback and agreement/decision, in that order. Presentation itself works as a kind of framing discourse through which actors begin the work of sensemaking (81, 83). Presentation, Freeman suggested represents "*an attempt at preliminary stabilisation*" (p.7)(81) by setting the scene against which other stakeholders offer their contributions.

Given that one of the priorities of the lead institution was to provide regional level consistency for the initiative, information was provided, often by presentation, with the intent of helping to frame a process around "*setting a direction that, you know, all of them need to follow*" (LCE_C) so that the group could move together toward a decision. There was a clear intention on the part of leadership at the HLLC to "*draw people into the conversation*" (LCE_C), but this inclusion was also intended "*to make sure that everyone is on side with the direction*" (LCE_C). Members perceived meetings as "*very structured…with particular presentations that occur, mainly from LHIN-related staff*" (LC_M2). Even when presentations were labelled on agenda documents as having the outcome of 'discussion', there was typically little time allocated on the agenda for both presentation and a fulsome and inclusive sensemaking discussion. There was a sense, voiced by participants (see Table 4-6), that strategies or solutions were being created elsewhere and that the group was being consulted via presentation, asked for feedback and finally for assent. "*I am not sure that people feel that that is what we are making -- that we are making decisions there. I think that there is a sense that it is a fait accompli and that we are just*

being told". (HL1_L1) One decision maker described it as "*consensus through a consultation process*". (LC_M1)

As per the HLLC Terms of Reference, the local Terms of Reference documents supplied by each steering committee, and each respondent interviewed, decisions were made "*by consensus*". This was not surprising as the goal for many deliberative or collaborative groups is to reach consensus (15, 36). Consensus, itself, however, implies that the group of decision makers is presented with and provided the opportunity to consider and discuss information from multiple sources and be engaged in the development of strategic alternatives generated from collective exploration of all interests, options and concerns (30, 36, 84). Engaged actors should be involved in practices of co-creating or co-innovating strategies or solutions that address what is understood as the shared policy goal (49). Consensus following presentation, as observed, was not necessarily something that was co-created or explored, negotiated over time, but rather something that was acknowledged or accepted often with silence or a nod.

> *I think that LHIN Lead's style as chair is very much to watch the body language in the room — make a statement — what I am hearing or it seems like everyone is in agreement and then pause and give people an opportunity to say no…wait a second I actually don't agree and we need to talk about it a bit more. Not that this has occurred, but it is the style in acknowledging that consensus has been reached. (LCE_PM)*

At the local HLs steering committee tables, meetings were less dominated by information activated in presentation format, although each local table varied in the way in which meetings were conducted. In part, this could be associated with the style of leadership adopted by the representatives of the lead organizations (see previously described theme 'Leadership facilitates and models', section 4.4.1.3). Overall, there appeared to be a greater (or more overtly expressed) expectation for members to take responsibility for their contribution to 'knowledge activation'; that is, to read all informing materials, and for 'activation' to be accomplished through provision

of feedback, questioning, and challenging or discussing information that had been distributed (see Table 6), though the responsibility for personal preparation was not embraced universally.

> *I had a request last week for someone to access health chat [online document*
> *sharing site] who has been part of the steering committee since day one. So,*
> *obviously accessing the materials pre-meetings has not been working for her*
> *because she has never accessed them. (HL2_PM)*

At the early adopter table, specifically, there were only a few, carefully selected presentations observed that informed discussions and co-development of implementation strategies by committee members that had been ongoing over a period of months (e.g. improving service accessibility via the use of tele-home videoconferencing services – August, October, January). Information activated by presentation became part of lively and emergent deliberations within the group that illustrated their commitment to "*collaborative values so that I think is jointly held, so I think that for the most part, that's the way that would work*". (HL1_M4)

While updates from the HLLC by LHIN-based project representatives were provided on a regular basis at all tables, these rarely took the form of a lengthy formal presentation. However, all tables relied on the presence and availability of the LHIN representatives to provide guidance and support in translating information and accountability requirements coming from the macro and meso policy levels. All local steering tables reported commitment to the use of a consensus style of decision making, but some participants, particularly from the most recently-established Health Links, felt restricted in their capacity to make meaningful, consensus-style decisions given constraints put in place by the lead organization in response to vertical accountabilities.

> *I realize that the LHINs have a great deal of top down management from the*
> *Ministry so….and to give them credit you know they don't talk about that…They are*
> *micro-managed so they micro-manage. (HL3N_L1)*

I think that the Ministry makes the decisions around the 'who' and that is tied to our

funding so there is absolutely no question. I think that the LHIN makes the decisions

around what needs to happen and says to me, 'here's your project

deliverables...deliver'. I don't really know what is left for the steering committee to

decide. (HL2_L1)

4.4.4.2   Making talk meaningful

In collaborative enactment settings, engagement in discursive processes like discussion or deliberation is how people make sense of situations and find their way to create solutions or take action (29). To facilitate the creation and maintenance of forward momentum for the HLs initiative, the regional leadership collaborative prioritized efficiency and stability over more difficult and time-consuming, discursive alternatives in establishing practice context. The structures and rules applied within practice settings influence the information and knowledge enacted within them as well as the nature of the discourses (54). Control of the mechanics of the meeting is powerful – it restricts what information matters, who talks about it, how it is framed and interpreted, who can speak about it and who records the meeting (54). The SW-LHIN controlled the way in which most information entered the project (at the regional level), how it was presented and by whom. By controlling the agenda, the lead organization could also exert some control over discursive processes available to stakeholders within the enactment space, both by limiting the time available for discussion and moving potential conflict or dissent outside of the room.

Among those actors interviewed, discussion was identified as an important aspect of decision making. Actors expressed the idea that collaborative processes should include some form of generative discussion wherein knowledge and information is shared around the table, strategies are devised, and decisions are negotiated (see Table 4-6). However, instances of this type of generative discussion could not be identified by stakeholders engaged at the regional level of HLs initiative when they were asked to do so during interviews. Instead, actors indicated that they felt that discussions held in HLLC lacked two key features to be considered truly

collaborative or meaningful in terms of generating solutions within the HLLC. First, although the HLLC LHIN-based chairperson felt that "*we have been open to hearing people's concerns and trying to address them before we got to a place where we needed decisions to be made*", engaged actors felt as though they had no real capacity to effect change based on their contribution of knowledge and experience to the discussion. Reliance on presentations, staged most often by representatives of the SW-LHIN, and guided discussion with limited opportunities for feedback may have contributed to the perception that decisions had already been made and relatively little could be done to effect change (85). In addition, there were accountability requirements and political considerations between the lead organization and the macro level policymaker that placed limitations on the actions or strategies that could be taken.

> *..so the Ministry funds them to deliver 'x' so I am thinking that they may have prescriptive things as well that happen and they also share information -- as opposed to ... To me, you know, decision making is 'hey -- here are our options and you say -- I would like to go this way". To me, that's a decision. Me saying to you, this is what we need to deliver, this is how I propose we get there do you endorse this -- yes. If you say no, I can't say, then we are not going to do it. I don't have the ability to take that off the table. So, to me that is not really a decision then is it? (HL2_L1)*

Secondly, their participation in the enactment setting, whether through input, feedback or discussion 'outcomes' did not necessarily have meaning and impact as reflected in the strategies adopted. There was a feeling that decisions were made elsewhere "*and then they are handed to us*" (HLO_L1) and that the work of creating strategies and making decisions "*happens in the background*" (HL2_L1).

> *I feel like they told us that this was it, and basically consulted...I heard lots of conversation, I heard some uncertainty and the document came back for the decision as it was with a few wordsmithing changes and the decision went ahead... I don't want to make it sound like we all said no, and they said yes and then went*

ahead, but I'm trying to think of colourful conversations where it was more like
decision making and less like informing. (LC_M2)

Collaboration by consensus or agreement is often viewed favourably, while conflict or dissent (e.g. "*colourful conversations*" (LC_M2)) may be viewed as something that is outside of collaboration and may be actively discouraged (2). However, to foster the dynamic practice settings in which solutions to problems of implementation might be co-created, interpretive flexibility and opportunities to engage in disruption or dissent should be available to the group (3, 9, 34). How much dissent is allowed within the practice space shapes how information-sharing and discursive processes are interpreted (6).

During observation of HLLC meetings, I noted that, while discussion or feedback was invited, it was not uncommon for conversations or questions to be "*taken offline*" (participant observation (LCE_C)); that is, moved outside of the meeting space to be addressed later in conversation with the chairperson or other LHIN representative. In one such meeting (May 2015), committee members were encouraged to "*be bold in their conversations [in meeting]*
rather than only in parking lot conversations" (LCE_C), but also, in two subsequent instances within the same meeting, they were asked to "*take the discussion offline*" (LCE_C) following a series of questions that appeared to be stimulating conversation following LHIN-based presentations. Of course, this strategy may simply have been employed in service of time management. Adherence to and completion of agenda items was perceived as highly valued within the lead organization (in conversation; LC_M1). Dissent, when framed in this context, may be interpreted as inefficient by the representatives of the SW-LHIN.

 The SW-LHIN was also perceived owner of the initiative so, to their representatives, limiting the opportunity for dissent by moving contentious questions or lengthy discussions outside of the enactment space may have been viewed in a more positive light. However, when negotiation and deliberation is taken out of the room by those in leadership positions, it does not serve to reinforce or establish feelings of trust (13). Instead, re-location of deliberation outside of the meeting (i.e. the practice space) restricts engagement in enactment processes to only those few individuals who might have participated in the follow-up conversation and effectively ends

collective engagement in sensemaking or in co-negotiating alternate strategies or solutions. This strategy could have contributed to the perception that implementation strategies were being developed elsewhere (outside of the HLLC) and that the knowledge and experience brought to any in-meeting discussion by the committee members would have little effect on the directions for Health Links as presented by the SW-LHIN.

The opportunities for 'meaningful engagement' in discursive processes at each steering committee table also varied by leadership style (see 'Leadership facilitates and models', section 4.4.1.3) as well as the ways in which each decision-making table worked to support member inclusion (see 'Making space for contributions that matter' section 4.4.1.2). At the early adopter table, for instance, there were more open discussions and opportunities for dissent observed. In that group, decision makers had always been viewed as equal collaborators in the development of strategies around implementation and continued to "*push the envelope*" as the steering committee engaged with ideas around access to care, sustainability and spread, and became the testing ground for the electronic Coordinated Care Plans (CCPs) in the region. Since the early adopter project had been established prior to the appointment of a lead agency for the south west region, it may have been subject to fewer of the struggles experienced by the other tables in sorting out how to balance a strong vertical accountability structure with the expectations for local autonomy and understanding what their decision-making roles and responsibilities would or should be within that setting.

Actors participating at the newer health links experienced more uncertainty around how to contribute to meaningful decision making in support of local implementation. Both groups struggled with what they were doing ("*I would like to see the group come back to steering*" HL2_PM), how team members would work together ("*we have different philosophies about how we will work together*" – "*I think it will be a slower evolution in terms of finding the optimal way to relate*" HL3S_L2), and identifying what decisions there were for them to make given the strong presence and perceived oversight of the lead organization (see Table 4-6). Individual representatives struggled with ways in which to bring their knowledge and experience to decision making contexts in which there appeared to be very little opportunity to participate in

the meaningful deliberation of decisions that would move implementation forward. This was reflected in a group tendency to get "*caught up in the weeds*" (HL3N_L2) and become mired in lengthy process-based negotiations.

> *...we get into protracted discussions about decisions that don't maybe feel as... — but, maybe again, if you are grappling with trying to find a decision that is actually yours to make — I can get why. Yes, this is actually a decision that we can make so let's really dig into that. (HL2_L1)*

4.5   Analysis and Discussion

In health policy implementation, it is not uncommon for initiatives, like Health Links, to employ a project structure built around a central, well-resourced lead organization. At the regional or strategic level of the Health Links initiative, engaged actors endorsed the adoption of existing lead agency structures and processes to support and advance the work of the implementation initiative (see Chapter 3). Within the HLLC, actor contributions to the co-creation of practice settings were most frequently observed in sensemaking discussions pertaining to the creation of shared definitions or goal setting rather than co-negotiating an agreement about 'the way things work'. This included structures and processes around the staging of meetings, or the identification, inclusion and movement of knowledge and information, for instance (see Chapter 3).

A multi-level implementation initiative, like the one described here, that brings a collaborative group or groups together represents an opportunity for engaged actors to co-create shared a practice context that supports meaningful engagement in collective action toward a common goal. The way in which decision-making practice settings are structured and operationalized influences the ways in which knowledge is enacted within them (25). At both the regional and local project implementation levels, collaborative decision-making groups were formed to engage local decision makers in the collective work of co-creating implementation strategies for the Health Links initiatives while working within the broad, hierarchical

structures/processes adopted from the SW-LHIN organization. Using the KEPS framework, the present study explored and described the shared experiences of decision-makers engaged in the practices of policymaking within the initiative structures adopted, created or endorsed by the regional leadership.

Engaged actors may expect to be included in a collaborative process that represents an underlying ethic of deliberation and meaningful, equitable engagement (25, 33). Results of the current study revealed that collaboration was valued and expected by participating actors at both the regional and local levels of implementation practice. However, there were tensions revealed between the expectations for collaborative engagement at each level and the requirements established around vertical accountability between levels. In general, decision makers struggled to find their place and define their roles within an initiative that was perceived to be owned and controlled by a dominant lead agency. Actors perceived themselves to have limited opportunities to be engaged in meaningful collective and discursive practices of knowledge enactment. When asked, they found it difficult to identify collective decisions that they had been a part of making. They did not identify with the label of 'policymaker', perceiving themselves to fit more readily into the role of stakeholder or representatives. Some actors noted that they felt as though they were used as consultants, primed for agreement with solutions created elsewhere, rather than participating as negotiators in consequential discussions that could be linked to actionable decisions. The centralized, lead agency's work in pursuit of regional strategic alignment, and vertical accountability was supported by the staging and scripting of knowledge and information within the initiative, including control over meeting agenda and process, and the use of framing presentations all of which appeared to limit opportunities for meaningful engagement in collaboration and co-creation of implementation solutions.

In the sections that follow, I will discuss the implications of working in a collaborative practice setting that is framed within the contexts of a dominant lead organization, the importance of finding balance to support inclusivity and meaningful engagement as well as issues of authority, ownership and power.

4.5.1   Collaborative Practice Settings within a Centralized Lead Agency

Practices of implementation policymaking, including shared processes of knowledge enactment, do not stand outside of an institutional or contextual frame – whether that frame is adopted, as is, from a lead agency, or co-created in varying degrees (17). For initiatives like Health Links that are structured around a single public-sector agency, the responsibility for and coordination of all major activity rests with that agency (20, 33, 86, 87). Within publicly funded institutions, like the SW-LHIN, there is a great deal of importance placed on the notions of timely and efficient implementation and delivery of public service as well as on vertical accountability as per the agency's mandate and accountability agreement with the MOHLTC (33, 88). Adoption of the bureaucratic structure available within the large regional institution of the LHIN provided the initiative with both resources and organizational stability, which in turn, contributed time and efficiency to the implementation process; however, it came with the roles and responsibilities associated with vertical accountability as structured and administered by the lead agency.

The ongoing attainment of efficiency goals, particularly around fulfilling and reporting mandated accountabilities in a timely fashion, can conflict with the ideals of deliberative and inclusive decision-making (20). Individuals invited as collaborating decision makers bring expectations of participating in practice settings that favour inclusive processes of knowledge enactment and that seek to balance the demands of macro-level accountability targets and deliverables with the negotiation of shared vision around issues of regional oversight and local implementation (32, 45, 56). Unfortunately, rather than find a balance between inclusive and deliberative modes of working and existing bureaucratic structures, the commitment to inclusion and collaboration that exists at the beginning of initiatives may be challenged by or even set aside to respond to the demands of strategic coordination and the responsibilities associated with vertical accountability, including any legal or jurisdictional mandates or service agreements that pre-date the current implementation initiative (32, 86, 88, 89).

4.5.2 Dominance in Practice Settings

There is a danger for lead organizations to create dominance within implementation initiatives through a variety of means that include establishing greater proportional representation in decision-making groups, retaining and administering control of resources and funding, and managing information in a way that places the lead agency in the position of expert (25). In addition, accountability or partnership agreements, like the ones required between the SW-LHIN, the HLLC and each local implementation steering committee, while setting out clear guidelines and responsibilities around 'the ways things work' within the initiative, can also function to reinforce hierarchical, bureaucratic structures that serve to shift perceptions of authority, ownership and dominance toward the lead agency (16, 32, 33).

The Health Links project team, employed by the lead agency, played significant roles in the administration, oversight and coordination of initiative processes at both the regional and local levels. Representatives of the Health Links lead organization, along with representatives of the *de facto* 'functional arm' of the agency, the CCAC, were a dominant presence at the regional leadership table. At the local level, where LHIN project staff were welcomed as valued translators of information and requirements disseminated from higher levels, decision makers still struggled to balance local autonomy with the applied hierarchy of accountability in order to support alignment with the SW-LHIN as mandated by formal letters of collaboration. In the end, no matter how open or inclusive their enactment spaces, it was perceived by local actors that strategies or solutions co-created at the local level had to align with the requirements of the central lead organization, which constrained the decision-making or enactment flexibility available to each local group. In general, within the broader Health Links initiative, hierarchical accountability was observed to be perceived as more important than collaboration at the local level which was accepted or rewarded in terms of its alignment with the strategic priorities of the lead agency.

The lead agency and its representatives appeared to have better and more timely access to information than other actors, and greater control over what information was included, at what

time, and to whom it would be disseminated. The structures and processes adopted for the initiative and administered by the LHIN included those processes that controlled the way in which carefully curated information resources entered knowledge enactment spaces (see Chapter 3). In addition to a proportionally strong presence in the meeting space by LHIN and CCAC representatives, the frequent use of presentation by LHIN-based project staff to frame information, guide interpretation and set a direction *"that, you know, all of them need to follow" (LCE_C)*, created a feeling that the collaboration was more LHIN-driven than open, and inclusive. Engaged actors struggled to define their role as experienced decision makers within the initiative. While most expected to participate as valued contributors, bringing their knowledge and experience to the negotiation of new strategies for Health Links, some perceived themselves to be positioned more as consultants expected to ratify LHIN-derived solutions than as equal collaborators participating in 'colourful' and open discursive practices.

4.5.3   Looking for Balance

Instead of setting aside collaborative modes of practice to respond to the demands of strategic coordination and accountability, it has been suggested that inclusive modes of working could be an important and vital complement to institutional structures and processes, offering opportunities to explore effective and innovative problem-solving around the demands of regional coordination, vertical accountabilities, and the tangible issues of implementation (32, 86, 89). For instance, Tenbensel and colleagues suggested that within centralized structures, regional decision-making groups could focus on higher level decisions while devolving decisions related to local implementation to local groups (32). In this way, local authorities, leaders, professionals and other community representatives apply their expertise, working to develop and deliver plans for implementation that balance macro policy definitions, targets and deliverables with a shared understanding of local needs (29, 45, 56). In broad terms, this seems to be the approach taken by the Health Links initiative in the SW-LHIN.

There were, however, tensions created between the requirements imposed by the initiative's centralized and hierarchical structure and the expectations or 'ethic' associated with

collaborative modes of working. Local policymakers engaged in the Health Links initiative were familiar with the structural frame adopted from the dominant lead organization (Chapter 3). They accepted and acknowledged the importance of their shared commitments to initiative accountabilities as it related to the agreed-upon terms and conditions outlined within rules of engagement as well as all partnership agreements between local steering committees and the SW-LHIN. However, actors engaged in collective, and collaborative, efforts might also reasonably expect to participate in the articulation and generation of strategy, planning, negotiation, and deliberation (36). Health Links actors had expectations about how they might contribute based on a shared understanding that this particular initiative was also defined, in part, by working together differently. Decision makers were invited to participate on their respective committees, whether at the regional or local levels, in their capacity as experienced leaders within their own sectors or organizations and were invited to 'come to the table' set by the SW-LHIN or the local Health Links project, to share their resources, particularly in the form of their knowledge and experience. Actors expressed a commitment to the importance of discussion in decision-making and had anticipated that they would be involved in meaningful collaborative processes that included their own contributions of knowledge to the negotiation of implementation solutions. The themes identified here illustrated the actors' connection with ideas associated with a deliberative practice ethic including relationship-building, facilitative leadership, creating meaningful engagement and supporting open, and inclusive discursive practices to encourage the negotiation of solutions to identified implementation issues, for instance.

However, in enactment practice settings in the Health Links implementation initiative, the requirements of the central lead organization, particularly related to vertical accountability and hierarchical structures bureaucratic structures, often over-shadowed the deliberative expectations of decision-making actors. Within the boundaries of the formal meeting agenda at the regional level, there was an emphasis placed on maintaining a forward momentum in a particular direction, driven by the SW-LHIN, within the structure established by the SW-LHIN. Representatives of lead organizations, who cannot be considered neutral parties within collaborative settings, may have promoted a vision of implementation issues and potential

solutions that were also created and framed by the lead organization (31, 32). Interpretation of new information, and strategic planning were taking place elsewhere, outside of the formal decision-making space, and were presented for feedback, modest input, and approval. At local tables, the requirements of vertical accountability, the need for strategic alignment and constant SW-LHIN oversight served to limit decision making flexibility within enactment settings. In effect, meaningful engagement in enactment processes associated with the shared practices of policy-decision making (e.g. negotiation or co-creation) appeared to have been constrained or mostly removed from formal practice settings, further shifting the balance of decision making to the lead organization rather than placing it within collaborative spaces.

4.5.4   Reconsidering power in context

Equity in power or power sharing is an ideal associated with deliberative practice; however, actors engaged in practices of local implementation policymaking are not likely to experience equitable distribution of power within knowledge enactment settings (36, 40). Instead, the experience of power in practice settings is more likely to emerge from power structures that are already in place within the context of the implementation initiative (15, 17, 18, 39). As one considers the challenges involved in balancing collaborative practices within the centralized, hierarchical and structured settings of a lead organization, it is useful to consider power in context as having more than one dimension and further, how each dimension might affect aspects of inclusion, meaningful engagement and the roles of both lead agency representatives and engaged policymaking actors in collaboration (21, 90, 91), and all of which were identified as important themes revealed within the experiences of actors engaged within the Health Links initiative. For example, Huxham and Vangen suggested that power may be considered as having three aspects – power over, power to and power for (92). 'Power over' is seen as representing social control, while 'power to' is conceptualized as concerned with collective or collaborative action and is related to the notions of shared understanding, common good and mutual benefit (92). 'Power for' reflects altruistic aspects of power and represents collaborative empowerment in which support may be provided, by a group or organization, to foster the capacity within another decision making group to help them set their own priorities

and control their own resources (92). By examining power in context through this dispersive lens, engaged policy actors might begin to identify existing and evolving power asymmetries within the practice setting, in order to find ways to create balance, support meaningful engagement and strengthen collaboration.

In multi-level implementation initiatives, like Health Links, that are structured around a dominant, lead agency, the authority of perceived ownership operationalized in accountability or partnership agreements exerts 'power over' (16, 32, 33). Further, 'power over' may be exerted via control of funding and resource distribution, discursive framing and management of the flow of information, control of the initiative's agenda and of the time and space allotted for collective sensemaking (6, 25, 33, 92). In the current case study, each of these factors was observed to be associated with perceived constraints on meaningful engagement and the dominance/power of the lead agency within the initiative (i.e. 'power over'). Although there are mandated, legal considerations around vertical accountabilities between the LHIN, as a crown agency, and the MOHLTC (88), this does not mean that accountability must necessarily translate into dominant expression of 'power over' and constraint of collaboration. Each one of the factors (i.e. control of funding, discursive framing, information management, and agenda setting) associated with the exertion of 'power over' also represents a potential point of intervention at which 'power over' might be re-distributed or shifted to support the collective 'power to'. For instance, to mitigate perceptions of dominance and begin to address power asymmetry through the disbursement of 'power over', initiative administration could be managed by an organization that is not also responsible for all funding and resource allocation (5). In addition, lead agencies and their representatives have the opportunity to engage other organizations and actors in influential roles within enactment spaces (e.g. chairpersons or facilitators). Actors in influential roles have the opportunity to support the meaningful engagement of participants by co-creating a practice setting with ample space for diverse voices bringing information and knowledge to be included (6). Supporting practice settings in which actors can be engaged in discursive processes of knowledge enactment facilitates the development of the collective 'power to' and promotes trust, particularly if the co-created knowledge outputs are applied to advance the initiative toward shared goals (4, 93). Similarly, 'power for' collective knowledge enactment could be supported

by the lead agency through open dissemination of information and diffusion of innovations between groups, and provision of assistance in bridging barriers between organizations and sectors or in building relationships (36).

Limitations. As a crown agency, each LHIN has a formal accountability agreement with the MOHLTC (88). Under that agreement, each LHIN agency must plan, fund and coordinate health services with a focus on the provision of high-quality care based on local, community-based needs (88, 94). Therefore, HLs initiatives are likely to have been operationalized within specific structures based on the regional characteristics and requirements within the catchment area of their own LHIN. Therefore, in consideration of transferability, it is important to acknowledge the potential uniqueness of Health Links implementation initiatives and governance within each LHIN's own jurisdiction. Although as an instrumental case study, the issue of interest was neither the LHINs nor HLs per se, the individual structure of each lead agency (e.g. the LHIN) should be taken into consideration when consideration the information presented here in other decision-making contexts. To assist the reader in evaluation of the transferability thick description was used based on data collected from multiple sources.

In multi-level governance, there are both formal and informal decision-making environments (7). Within the Health Links initiative, data gathering was limited to formal environments only. Planned, formal meetings provided a partial picture of the decision-making practice since informal processes, including dissenting conversations and negotiations were usually '*taken offline*' and, therefore, were hidden outside of the researcher's frame of study (7, 17). At all levels, my observation was confined to the decision-making groups identified by representatives of the lead organization within a limited timeframe.

4.6 Conclusion

The Knowledge Enactment in Practice Settings (KEPS) framework depicts collective processes of knowledge enactment, informed by embodied and inscribed knowledge, activated within shared practice settings (Figure 4-1). In the KEPS framework, two broad categories of

knowledge work are highlighted: 1) the co-creation of a practice context, and 2) co-creation of policy-relevant knowledge. In the previous paper (Chapter 3), the KEPS framework was used as an analytic tool to explore and describe the development of the practice setting for a regional level policymaking group within a multi-level implementation initiative called Health Links. In that study, it was demonstrated that co-creation of a practice context was constrained by the appointment of a dominant lead agency and the adoption of an existing institutional frame from that organization. The ways things worked, including the staging of practice settings and the selection and distribution of information was determined by the lead organization and its representatives. I identified dominance of the lead agency, flexibility of organizational structures and processes and the distribution of power as important factors associated with the development of collaborative practice settings. Keeping these factors in mind, in the present chapter, I applied the KEPS framework once again to an expanded study of the same multi-level, implementation initiative in order to explore the ways in which decision makers at both the regional and local levels practiced within the lead agency structures adopted by the initiative. In so doing, I attempted to find ways in which collaborative practices in knowledge enactment settings might be balanced with the bureaucratic, institutional frame of a dominant lead agency.

While the appointment of a strong, centralized lead organization and use of its existing organizational structures and processes contributed to the initiative in important ways (e.g. time, resources, efficiency), hierarchical imperatives, particularly around accountability requirements and strategic directions, often appeared to overshadow commitments to the deliberative/collaborative ethic valued by individual decision makers. The lead organization dominated, or provided some form of oversight, at all meetings. Information was curated, presentations given, strategies created by LHIN-based representatives and, often, decision makers felt like consultants, left out of generative discussion with few decisions left available to them. The dominant role of the lead agency, the perceived asymmetry of power in favour of that organization and the relative rigidity of institutional structures and hierarchies of accountability appeared to work against the co-creation of a knowledge enactment setting to support collaborative practices.

Is it possible to achieve a balance between a stable and dominant structure provided by a prominent lead organization and a collaborative mode of working for decision making groups situated within it? While stability has been associated with effective governance (20), the findings of this empirical work suggested that there should be more attention paid to the impact of hierarchical and accountability structures on the collaborative intent and function of the decision making groups within a multi-level initiative in order to promote meaningful stakeholder engagement and maintain enactment flexibility. The imposition of rigid structures and processes from a dominant and ever-present lead organization can function to obstruct negotiation or co-creation of new policy-relevant strategies or implementation solutions, removing collaborative and decision-making opportunities from enactment spaces. Collective enactment processes, such as sensemaking discussions, including those that challenge and seek to resolve feelings of uncertainty or dissent, should be encouraged within practice settings to promote the shared co-creation of new knowledge (e.g. solutions and strategies) (35, 49).

4.6.1 Contributions and Future Steps

In the study of local implementation policymaking, there have been relatively few studies that have attempted to explore the practices and practice settings based on the experiences of the engaged, decision making actors. 'Theoretically informative' research to address identified gaps, accumulate knowledge and advance understanding is required to contribute to the important processes of theorizing in this area of interest (26). The present study used the KEPS framework as an analytic tool to help guide an exploration of the ways in practitioners engaged with an implementation policy practice setting that is mostly adopted from a dominant, appointed lead agency, rather than co-created by decision makers themselves. Despite benefits associated with elements such as initiative efficiency, and knowledge dissemination, the control and presence of the lead agency with its often-rigid hierarchical structures and processes around accountability requirements, was also associated with a disruption of collaborative practices. Rather than been included in meaningful, collective sensemaking or negotiation, actors felt like consultants offering feedback on solutions already created by the lead agency and its representatives. If resources – including power – remain unequally distributed among engaged stakeholders, the

asymmetry of influence and control within the practice contexts can create or bolster existing barriers to the meaningful engagement of decision-makers from outside of the lead institution.

Use of the KEPS framework to explore local implementation policymaking and the engagement within the knowledge enactment spaces of a multi-level initiative has contributed to an improved understanding of collaborative practices that reflected the gap between the experiences of engaged actors and the expected or ideal collaborative practices described in the academic literature. By first highlighting the processes around development of context first (see Chapter 3), and then how actors engaged in context, the relationship between these two aspects of the knowledge enactment practice settings was clearer. The analysis revealed the importance of the lead organization, its adopted structures and processes, as well as the potentially obstructing influences associated with dominance and control of both staging and scripting activities. The effects of bureaucratic hierarchy and accountability structures on collaborative intent, as well as the asymmetry of power are key aspects of local implementation policy practices that should be addressed within future iterations of the KEPS framework.

4.7   References

1.   Hoppe R. Institutional constraints and practical problems in deliberative and participatory policy making. Policy & Politics. 2011;39(2):163-86.

2.   Dickinson H, Sullivan H. Towards a general theory of collaborative performance: The importance of efficacy and agency. Public Administration. 2014;92(1):161-77.

3.   Freeman R, Sturdy S. Knowledge, policy and coordinated action: mental health in Europe In: Freeman R, Sturdy S, editors. Knowledge in Policy: Embodied, inscribed, enacted Bristol, UK Policy Press; 2015. p. 61-75.

4.   Emerson K, Nabatchi T, Balogh S. An Integrative Framework for Collaborative Governance. Journal of Public Administration Research and Theory. 2012;22(1):1-29.

5.   Kania J, Kramer M. Collective Impact. Stanford Social Innovation Review. 2011;9(1):36-41.

6.   Fischer F. Participatory governance as deliberative empowerment: The cultural politics of discursive space. American Review of Public Administration. 2006;36(1):19-40.

7.   van Popering-Verkerk J, van Buuren A. Decision-Making Patterns in Multilevel Governance: The contribution of informal and procedural interactions to significant multilevel decisions. Public Management Review. 2016;18(7):951-71.

8.   Williams P. Collaboration in public policy and practice: perspectives on boundary spanners. Chicago, IL;Bristol, UK;: Policy Press; 2012.

9.   Sinclair S. Partnership or Presence? Exploring the Complexity of Community Planning. Local Government Studies. 2011;37(1):77-92.

10.   McKenzie B, Wharf B. Connecting Policy to Practice in the Human Services 3rd ed. Don Mills, Ontario, Canada: Oxford University Press 2010.

11.   Fischer F. Participatory Governance: From Theory To Practice. In: Levi-Faur D, editor. The Oxford Handbook of Governance. Oxford Handbooks Online: Oxford University Press 2012.

12.   Berkowitz B. The Policy Process. In: Mason DJ, Leavitt JK, Chaffee MW, editors. Policy & Politics in Nursing and Healthcare. 6th ed. Philadelphia, USA: Elsevier Saunders; 2012.

13.   Lemke AA, Harris-Wai JN. Stakeholder engagement in policy development: challenges and opportunities for human genomics. Genetics in Medicine. 2015;17(12):949-57.

14.   Doberstein C. Designing Collaborative Governance Decision-Making in Search of a 'Collaborative Advantage'. Public Management Review. 2016;18(6):819-41.

15.   Ansell C, Gash A. Collaborative Governance in Theory and Practice. Journal of Public Administration Research and Theory. 2008;18(4):543-71.

16.   Klijn EH, Skelcher C. Democracy and Governance Networks: Compatible or Not?. Public Administration. 2007;85(3):587-608.

17.   van der Arend S, Behagel J. What participants do. A practice based approach to public participation in two policy fields. Critical Policy Studies. 2011;5(2):169-86.

18.   Dandy N, Fiorini S, Davies AL. Agenda-setting and power in collaborative natural resource management. Environmental Conservation. 2014;41(4):311-20.

19.   van Kerkhoff LE, Lebel L. Coproductive capacities: rethinking science-governance relations in a diverse world. Ecology and Society. 2015;20(1).

20.   Provan KG, Kenis P. Modes of Network Governance: Structure, Management, and Effectiveness. Journal of Public Administration Research and Theory. 2008;18(2):229-52.

21.   Koch P. Bringing Power Back In: Collective and Distributive Forms of Power in Public Participation. Urban Studies. 2013;50(14):2976-92.

22.   Colebatch HK. Policy analysis, policy practice and political science. Australian Journal of Public Administration. 2005;64(3):14-23.

23.   Oliver K, Innvar S, Lorenc T, Woodman J, Thomas J. A systematic review of barriers to and facilitators of the use of evidence by policymakers. BMC Health Services Research. 2014;14.

24.   Oliver K, Lorenc T, Innvaer S. New directions in evidence-based policy research: a critical analysis of the literature. Health Research Policy and Systems. 2014;12.

25.   Whitehead M. The architecture of partnerships: urban communities in the shadow of hierarchy. Policy and politics. 2007;35(1):3-23.

26.   Kislov R, Pope C, Martin GP, Wilson PM. Harnessing the power of theorising in implementation science. Implementation Science. 2019;14(1):103.

27.   Weick KE. Theory Construction as Disciplined Imagination. The Academy of Management Review. 1989;14(4):516-31.

28.   Colebatch HK. What work makes policy? Policy Sciences. 2006;39(4):309-21.

29. Hajer M, Wagenaar H. Introduction. In: Hajer M, Wagenaar H, editors. Deliberative Policy Analysis: Understanding governance in the network society. Cambridge, UK Cambridge University Press 2003. p. 1-30.

30. Scott C. A Case Study in Collaborative Governance: Health Care Law Reform in Georgia. Conflict Resolution Quarterly 2011;28(4):441-63.

31. Sabatier P, Shaw L, K. Are collaborative watershed management groups democratic? An analysis of California and Washington partnerships. . Journal of Soil and Water Conservation. 2009;64(2):61a-4a.

32. Tenbensel T. A successful mix of hierarchy and collaboration? Interpreting the 2001 reform of the governance of the New Zealand public health system Policy & Politics. 2011;39(2):239-55.

33. Fenwick J, Miller KJ, McTavish D. Co-governance or meta-bureaucracy? Perspectives of local governance 'partnership' in England and Scotland. Policy & Politics. 2012;40(3):405-22.

34. Pope C, Robert G, Bate P, Le May A, Gabbay J. Lost in Translation: A Multi-Level Case Study of the Metamorphosis of Meanings and Action in Public Sector Organizational Innovation. Public Administration. 2006;84(1):59-79.

35. Ansell C, Sorensen E, Torfing J. Improving policy implementation through collaborative policymaking. Policy and politics. 2017;45(3):467-86.

36. Fung A, Wright EO. Deepening Democracy: Innovations in Empowered Participatory Governance. Politics and Society. 2001;29(1):5-41.

37. Escobar O. Scripting Deliberative Policy-Making: Dramaturgic Policy Analysis and Engagement Know-How. Journal of Comparative Policy Analysis: Research and Practice. 2014:1-17.

38. Bickerstaff K, Walker G. Shared Visions, Unholy Alliances: Power, Governance and Deliberative Processes in Local Transport Planning. Urban Studies. 2005;42(12):2123-44.

39. Orr K, McAteer M. The modernisation of local decision making: Public participation and Scottish local government. Local Government Studies. 2004;30(2):131-55.

40. Lowndes V, Sullivan H. Like a horse and carriage or a fish on a bicycle: How well do local partnerships and public participatiion go together? Local Government Studies. 2004;30(1):51-73.

41. Freeman R, Griggs S, Boaz A. The practice of policymaking. Evidence & Policy. 2011;7(2):127-36.

42.   Freeman R, Sturdy S. Knowledge and policy in research and practice In: Freeman R, Sturdy S, editors. Knowledge in Policy: embodied, inscribed, enacted Bristol, UK: Policy Press; 2015. p. 201-18.

43.   Geels FW. Ontologies, socio-technical transitions (to sustainability), and the multi-level perspective. Research Policy. 2010;39(4):495-510.

44.   Guzman G. The grey textures of practice and knowledge: review and framework. European Business Review. 2013;25(5):429-52.

45.   Wesselink A, Gouldson A. Pathways to impact in local government: the mini-Stern review as evidence in policy making in the Leeds City Region. Policy sciences. 2014;47(4):403-24.

46.   Schatzki TR. Introduction: Practice theory. In: T.R. Schatzki KC, E. von Savigny, editor. The Practice Turn in Contemporary Theory. New York, NY, USA: Routledge Publishers/Taylor & Francis; 2001.

47.   Nicolini D. Practice as the Site of Knowing: Insights from the Field of Telemedicine. Organization Science. 2011;22(3):602-20.

48.   Nicolini D, Roe B. Surfacing the multiple: diffractive methods for rethinking professional practice and knowledge. In: Fenwick T, Nerland M, editors. Reconceptualising Professional Learning in Turbulent Times Changing knowledges, practices, and responsibilities. Abingdon, UK: Routledge; 2014. p. 67-81.

49.   Shotter J, Tsoukas H. Performing phronesis: On the way to engaged judgment. Management Learning. 2014;45(4):377-96.

50.   Cook SD, Wagenaar H. Navigating the Eternally Unfolding Present: Toward an Epistemology of Practice. The American Review of Public Administration. 2012;42(1):3-38.

51.   Salter KL, Kothari A. Knowledge 'Translation' as social learning: negotiating the uptake of research-based knowledge in practice. BMC Medical Education. 2016;16(1):76.

52.   Freeman R, Sturdy S. Introduction: knowledge in policy — embodied, inscribed, enacted. In: Freeman R, Sturdy S, editors. Knowledge in Policy: Embodied, inscribed, enacted. Bristol, UK: Policy Press 2015.

53.   Wagenaar H, Cook SDN. The push and pull of the world: How experience animates practice. Evidence and Policy. 2011;7(2):193-212.

54.   Freeman R. Reverb: Policy Making in Wave Form. Environment and Planning A: Economy and Space. 2012;44(1):13-20.

55.   Smith-Merry J, Gillespie J. Embodying policy-making in mental health: the implementation of Partners in Recovery. Health Sociology Review. 2016;25(2):187-201.

56.   Stone D. Policy Paradox: The Art of Political Decision Making. 3rd ed: W.W. Norton and Company Inc. ; 2012.

57.   Casey D, Houghton C. Clarifying case study research: examples from practice: Dympna Casey and Catherine Houghton explore the use of case studies with examples from their research. Nurse researcher. 2010;17:41+.

58.   Thomas G. Doing Case Study: Abduction Not Induction, Phronesis Not Theory. Qualitative Inquiry. 2010;16(7):575-82.

59.   Nutley S, Walter I, Davies H. Using Evidence: How research can inform public services. Bristol, UK: The Policy Press; 2007.

60.   Stake RE. Qualitative Case Studies. In: Denzin N, Lincoln Y, editors. Strategies of Qualitative Inquiry. 3rd edition ed. Thousand Oaks, CA, USA: Sage Publications 2008.

61.   Thomas G. A Typology for the Case Study in Social Science Following a Review of Definition, Discourse, and Structure. Qualitative Inquiry. 2011;17(6):511-21.

62.   Bueger C. Pathways to practice: praxiography and international politics. European Political Science Review. 2014;6(3):383-406.

63.   Miles MB, Huberman M. Focusing and Bounding the Collection of Data. An Expanded Sourcebook: Qualitative Data Analysis 2nd ed. ed. Thousand Oaks, California, USA: Sage Publications 1994.

64.   Ministry of Health and Long Term Care. Ontario's Action Plan for Health Care. Toronto, ON; 2012.

65.   Miettinen R, Samra-Fredericks D, Yanow D. Re-Turn to Practice: An Introductory Essay. Organization Studies. 2009;30(12):1309-27.

66.   Yanow D. Accessing local knowledge. In: Hajer M, Wagenaar H, editors. Deliberative Policy Analysis: Understanding governance in the network society. Cambridge, UK Cambridge University Press 2003. p. 228-46.

67.   Yanow D. Thinking Interpretively: Philosophical Presuppositions and the Human Sciences In: Yanow D, Schwartz-Shea P, editors. Interpretation and Method: Emprirical research methods and the interpretive turn 2nd Edition ed. New York, NY, USA: M.E. Sharpe Inc. ; 2014. p. 5-26.

68.   Cepeda G, Martin D. A review of case studies publishing in Decision Management 2003-2004: Guides and criteria for achieving quality in qualitative research. Management Decision. 2005;43(6):851-76.

69.   Pope C, Ziebland S, Mays N. Qualitative research in health care: analysing qualitative data. Br Med J. 2000;320:114 - 6.

70.   Stanley M. Qualitative Descriptive: A very good place to start. In: Nayar S, Stanley M, editors. Qualitative Research Methodologies for Occupational Science and Therapy. London, UK: Routledge; 2014. p. 37-52.

71.   Tracy SJ. Qualitative quality: Eight a"big-tent" criteria for excellent qualitative research. Qualitative Inquiry. 2010;16(10):837-51.

72.   Soss J. Talking our way to Meaningful Explanations: A practice-centred view of interviewing for interpretive research In: Yanow D, Schwartz-Shea P, editors. Interpretation and Method: Emprirical research methods and the interpretive turn 2nd edition ed. New York, NY, USA: M.E. Sharpe Inc. ; 2014. p. 161-82.

73.   Oliver K, De Vocht F, Money A, Everett M. Who runs public health? A mixed-methods study combining qualitative and network analyses. Journal of Public Health (United Kingdom). 2013;35(3):453-9.

74.   Boydell L, Haggett P, Rugkasa J, Cummins A-M. Intersectoral partnerships, the knowledge economy and intangible assets. Policy and Politics. 2008;36(2):209-24.

75.   Freeman R. Epistemological Bricolage: How Practitioners Make Sense of Learning. Administration & Society. 2007;39(4):476-96.

76.   Verweij S, Klijn EH, Edelenbos J, Van Buuren A. What Makes Governance Networks Work? A Fuzzy Set Qualitative Comparative Analysis of 14 Dutch Spatial Planning Projects. Public Administration. 2013;91(4):1035-55.

77.   Laws D, Rein M. Reframing practice. In: Hajer M, Wagenaar H, editors. Deliberative Policy Analysis: Understanding governance in the network society. Cambridge, UK Cambridge University Press 2003. p. 172-206.

78.   Ministry of Health and Long Term Care. Guide to the Advanced Health Links Model. 2015. [Available from: http://www.health.gov.on.ca/en/pro/programs/transformation/docs/Guide-to-the-Advanced-Health-Links-Model.pdf]

79.   Scharpf F. Games Real Actors Could Play. Journal of Theoretical Politics. 1994;6(1):27-53.

80.   Hajer M. Setting the Stage: A Dramaturgy of Policy Deliberation. Administration & Society. 2005;36(6):624-47.

81.   Freeman R. Learning by meeting. Critical policy analysis. 2008;2(1):1-24.

82.   Wagenaar H, Cook SDN. Understanding policy practices: action, dialectic and deliberation in policy analysis In: Hajer M, Wagenaar H, editors. Deliberative Policy Analysis: Understanding governance in the network society. Cambridge, UK: Cambridge University Press; 2003. p. 139-71.

83.   van Hulst M, Yanow D. From Policy "Frames" to "Framing": Theorizing a More Dynamic, Political Approach. The American Review of Public Administration. 2014;46(1):92-112.

84.   Innes JE, Booher DE. Collaborative policymaking: goverrnance through dialogue. In: Hajer M, Wagenaar H, editors. Deliberative Policy Analysis: Understanding governance in the network society Theories of Institutional Design. New York, NY: Cambridge University Press; 2003. p. 33-60.

85.   Matthews P. Being strategic in partnership – interpreting local knowledge of modern local government. Local Government Studies. 2014;40(3):451-72.

86.   Carey G, McLoughlin P, Crammond B. Implementing Joined-Up Government: Lessons from the Australian Social Inclusion Agenda. Australian Journal of Public Administration. 2015;74(2):176-86.

87.   Larsson O. A theoretical framework for analyzing institutionalized domination in network governance arrangements. Critical Policy Studies. 2017:1-20.

88.   Ministry of Health and Long Term Care. Ontario's LHINs: Queen's Printer for Ontario 2014 [Available from: http://www.lhins.on.ca/Pan-LHIN%20Content/LHINs%20Accountability.aspx.

89.   Vaughan S, Rafanell I. Interaction, consensus and unpredictability in development policy 'transfer' and practice. Critical policy studies. 2012;6(1):66-84.

90.   Purdy JM. A Framework for Assessing Power in Collaborative Governance Processes. Public Administration Review. 2012;72(3):409-17.

91.   Vangen S, Huxham C. Enacting Leadership for Collaborative Advantage: Dilemmas of Ideology and Pragmatism in the Activities of Partnership Managers. British Journal of Management. 2003;14(si):S61-S76.

92.   Huxham C, Vangen S. Using Power. Managing to Collaborate: The theory and practice of collaborative advantage New York, USA: Routledge; 2005. p. 173-86.

93.   Fedele P, Brusati L, Ianniello M. Organizational underpinnings of interactive decision making: an empirical inquiry. International Journal of Public Sector Management 2016;29(4):310-26.

94.   Ministry of Health and Long Term Care. Local Health System Integration Act; Public Information 2006 [updated 31/03/2020. Available from: https://web.archive.org/web/20120625193650/http://www.health.gov.on.ca/english/public/legislation/lhins/hu_lhins.html.

4.1   Appendices to Chapter 4

4.1.1   Appendix 1. Brief Coding Summary

Aggregate Theme (parent node)	Sub-themes (child node)	Emerging concepts (open coding)
Finding Ways to Connect and Interconnect	It is about the relationships Making space for contributions that matter Leadership facilitates and models	-Including organizations; Crossing boundaries – multi-sector connections; Composing a group; Membership; Accessing the network; Supports and relationships -Staging access; bringing resources; ways to share; -Thinking about forward momentum; -Open style vs. closeted (showing v; Transparency; Consultative elite; strategy vs action
Looking up while looking out	Making sense of roles and responsibilities Whose project is it anyway?	-Defining roles; strategies and weighing strategic directions; funding structures and vertical accountabilities; HLLC responsibilities and expectations; situating local projects and local responsibilities -regional oversight and LHIN presence; perceived authority; sense of ownership
Going with the flow (of information & knowledge)	Your information vs my learning Share, Share, Share,	-expert input, knowledge, experience; pre-processed information; access to data; timing; administrative roles and inputs; scripting - no 're-inventing' -- standardizing knowledge products; knowledge sharing – movement of what we're learning; vertical supports;
Practice is voice-activated	Primed for agreement Making talk meaningful	-making meetings; reporting and presenting; framing; conditions for consensus; collective inscription; conditions for feedback; -Discussion; Dissent; Working things through – questions and answers; Making decisions together; Processes of consensus

Chapter 5

5 Discussion and Conclusion

Macro-level policy, once inscribed, is not likely to be implemented as written within regional or local settings (1). At regional or local levels, the creation of policies, including procedures, guidelines, directives, and tools intended to operationalize and support implementation may be created in multiple venues by actors engaged within a complex, and messy multi-level system (2, 3). Representatives of local authorities, organizations, community stakeholders or citizens may collaborate to construct solutions to the problems of operationalization and implementation, often within structures of distributed local governance (1, 4). Devolution of authority to regional and local decision-making groups may work to connect processes of implementation policymaking more directly and effectively to the sites of initiative implementation (5-7). However, expectations of collaborative working co-exist alongside established institutional structures and the often hierarchically-administered responsibilities for meeting vertical accountability criteria.

To engage with the messy, collective, experience of local policymaking, this dissertation focused attention on the practices of actors engaged in processes of initiative implementation at regional and local levels. By adopting a practice-based lens, each study included here focused attention on the experience of engaged policy actors, prompting consideration of context structure, process and agency within local implementation contexts — of how the practice setting was structured and how the policy actors then functioned within it. In this final chapter, I will provide a brief summary of the most significant findings of each of the studies undertaken (Chapters 2 - 4). A discussion of the practical challenges for local policy decision makers arising from this work, particularly around power, balance and meaningful engagement in practice settings, and limitations of the research will follow. Considerations for future work are presented.

5.1   Summary of Findings

5.1.1   Chapter Two: Evidence, Information and the Practice of Local Policymaking

In Chapter 2, I reported the results of an interpretive review and synthesis that examined practices of policymaking at the local level. Taking a practice-based approach, I was able to query the results of identified studies to create a synthesized representation of the various types and sources of knowledge and information that were reported to be valued and used by local level policymakers. I was also able to identify important knowledge enactment processes reported. Based on those reports, I described a relationship between practice, knowledge and context such that actors were depicted as practicing within two broad categories of knowledge work corresponding to a) the negotiation of practice contexts and b) the negotiation of policy-relevant knowledge. The Knowledge Enactment in Practice Settings (KEPS) framework, through which one might view collective policymaking practices, was developed based on these synthesized observations and informed by the phenomenology proposed by Freeman and Sturdy (8) and the work on practice theory of Cook and Wagenaar (9). The KEPS framework (see Figure1) represents an important contribution in understanding engaged actor experience, and the practice of policymaking. The work of the synthesis revealed that engaged actors work collectively to both shape their practice context and to enact knowledge within that context. Actors bring information and knowledge and enact, through largely discursive processes, a shared understanding of what the group is doing, how it can be defined or operationalized, what the goals or outcomes for the group actions are, how communication will be accomplished, what the rules for engagement and communication will be, where they will practice together, and what information will be accepted and distributed and by whom. Supporting the enactment processes (or knowledge work) of policymaking, in this view, requires an awareness of the practice context — how it was co-created and defined, how it is understood, and operationalized by the local actors themselves who bring knowledge, experience, and information with them to the new practice space. The proposed framework is a valuable tool insomuch as it both highlights the

importance of the co-created practice context and facilitates consideration of the ways in which actors collectively function to enact knowledge within it.
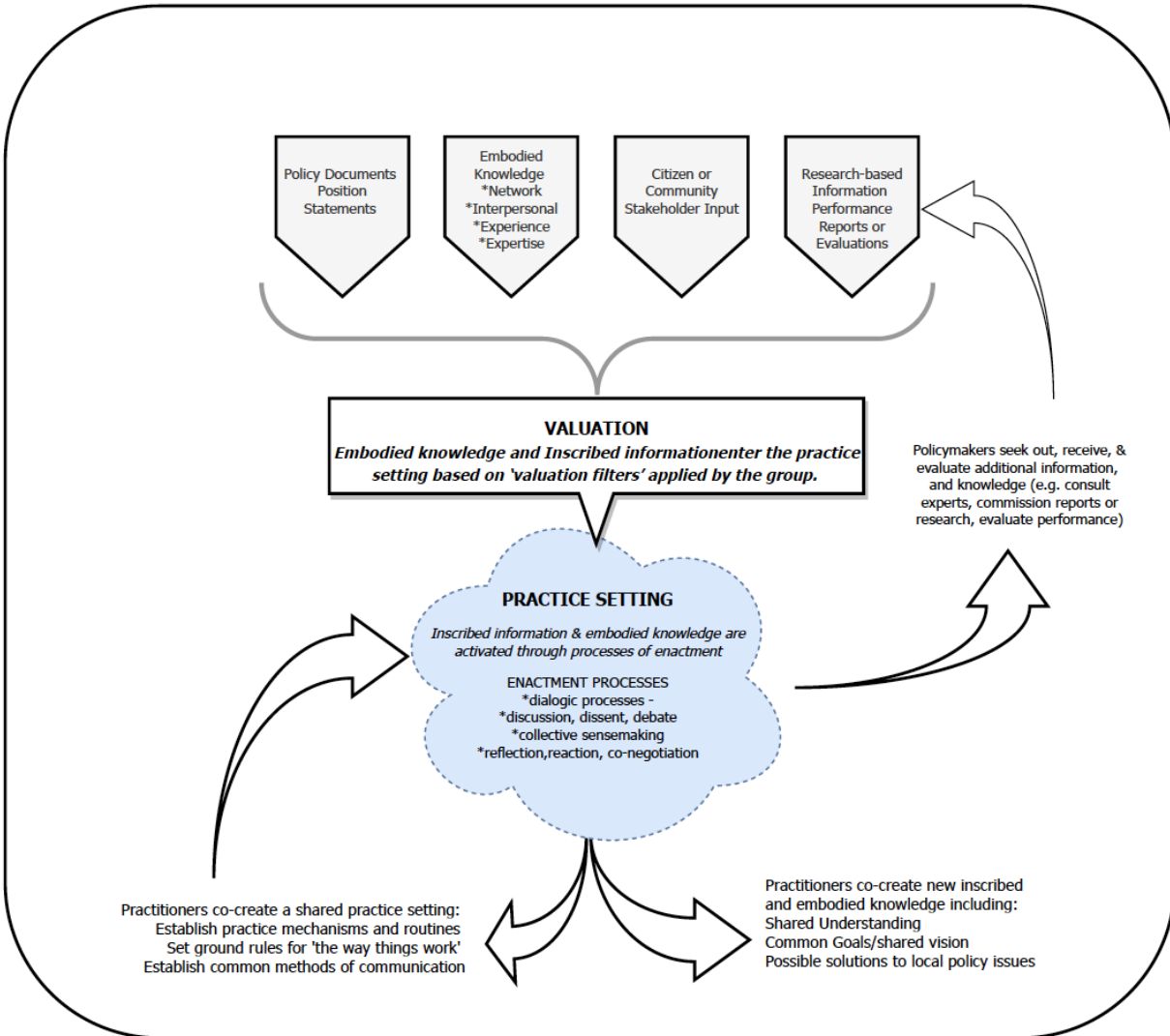
Figure 5-1. Knowledge Enactment in Practice Settings (KEPS) Framework

Embodied knowledge and inscribed information enter the local policy practice setting via 'valuation filters' applied by engaged actors. Inscribed information and embodied knowledge are activated through processes of enactment that facilitate co-creation of a) the shared practice setting and b) new knowledge.

5.1.2   Chapter Three: Enacting Shared Practice Contexts

There has been relatively little written in the research literature around the collective work of establishing a shared practice context as experienced by practicing local policymakers themselves (10, 11). In Chapters 3 and 4 of this thesis, a multi-level policy implementation initiative was identified as a (nested) case study. Using the framework described in Chapter 2 as a guide, the evolution of the regional-level practice setting was described in chapter 3, grounded in the experience of engaged actors. Descriptions were further contextualized against a backdrop of expectations around deliberative practices in collaborative contexts derived from information available in the research literature.

A multi-level implementation initiation, like the one identified for study here, that brings together a collaborative group represents an opportunity for engaged actors to co-create a shared and accommodative practice setting that enables meaningful engagement in collective action toward a common goal. This particular implementation initiative appointed a regional health authority, or LHIN, to function as the lead agency and invited individual actors to form a regional level leadership 'collaborative' to provide guidance and ensure strategic alignment at a systems level. In Chapter 3, I observed that individual actors, all experienced decision makers, did not identify as policymakers, but rather as stakeholders. However, they still brought expectations for collaboration with them, and this included opportunities to contribute to the negotiation of the practice setting for the implementation initiative. However, the degree to which engaged actors contributed to the co-creation of context, and the areas in which they had influence, was affected by the immediate adoption of existing, institutional structures and processes from the lead agency. Administrative structures, processes and resources were provided by the prominent, and familiar SW-LHIN institution. This structure was created by the SW-LHIN and presented to participants at the time the group formed. They were shown, by example, how the new initiative would fit within the SW-LHIN and be supported by existing structures and mechanisms. The adoption of existing structures represented an opportunity for engaged local actors to take a significant shortcut in creating an efficient practice context. Use of familiar, well-resourced and available structures of bureaucratic administration provided stability

to the new initiative, and aligned within the framework of the SW-LHIN organization, while the use of template documents to support the development of project specific guidelines for engagement (e.g. terms of reference and accountability agreements) helped to encourage forward momentum. However, at the same time, it limited the opportunity for actors to negotiate processes, discover ways to do things differently and co-create a shared understanding of what they were doing and how they would work together over time. The LHIN-based process also retained control over significant aspects of the practice context including roles such as coordinator and chair of the leadership collaboration, staging of enactment settings, agenda setting, and the ways in which information would move into and out of enactment spaces. Overall, the initiative was perceived by engaged actors as owned and driven by the lead agency. The perceived authority that is associated with ownership exacerbates existing power asymmetries within the initiative context that can work against inclusive and meaningful engagement in collaborative practices. While stability, efficiency and legitimacy have been associated with the adoption of existing bureaucratic structures, and may be beneficial in terms of efficient governance (12, 13), careful attention should be paid to the impact of these structures and processes on the collaborative intent and knowledge enactment occurring within the initiative contexts.

5.1.3   Chapter Four: Practitioner Engagement within a Structured, Multi-level Practice Context

The ways in which collaborative practice is structured and operationalized influence the ways in which policymaking is practiced (14). To understand the impact of the initiative context on the practice of local policymaking, one should seek to understand the shared experiences of engaged agents. Engaged actors may expect to be included in a collaborative process that represents an underlying ethic of deliberation and meaningful, equitable engagement (14, 15); however, the deliberative ethic is an ideal. Actual practices of local implementation policymaking are diverse, and the time and resources required for collaborative practice may not be considered suitable at all times, in all situations, for all things. While ideals associated with collaboration or deliberation are important, particularly within collective knowledge enactment

settings, these ideals may not hold up under the weight of complex multi-level accountability structures, rigid bureaucracies, or higher-level strategic planning (5, 10).

The tension between adopted structures, bureaucratic processes, mechanisms of accountability and the actors' connection with ideals or expectations that are associated with a deliberative practice ethic were illustrated in the case study described in Chapter 4. Based on the analysis of data presented in Chapter 4, I found that the expectations that individuals working at both the regional and local levels brought to their practice spaces were not vastly different from those one finds in the literature on collaborative or deliberative practice. Although they did not identify as policymakers, and could not easily identify decisions they had made, actors valued and expected open and inclusive deliberation, and opportunities to be engaged in discussions that were meaningful and useful to their shared goals. They understood the importance of relationship building, including the development of trust, and were looking for leadership that would facilitate an open and inclusive practice setting. While the actors engaged in the case study initiative accepted the appointment of the strong, dominant, centralized lead organization and acknowledged the advantages associated in engaging within that familiar structural frame, they also expressed the desire to participate as equal, collaborative and engaged partners. Actors were committed to involvement that included contribution of information and expertise to generative and meaningful knowledge enactment processes that helped to move the initiative toward shared goals. However, the needs for regional strategic alignment and vertical accountability, combined with the constant oversight by the authoritative and dominant owner of the initiative (i.e. the SW-LHIN) appeared to limit enactment flexibility and constrain meaningful engagement in decision making at all levels. The asymmetry of power present within the initiative was accentuated as the balance between the pressures and responsibilities placed on the lead institution by the frequently changing requirements of the macro-level policymaker and the equity-focused deliberative ideals held by individual decision makers shifted to favour LHIN-based priorities, emphasizing vertical accountabilities, strategic alignment and outcome deliverables. Actors who had been asked to join as contributing decision makers were often consigned to the role of consultant, participating in relatively few generative or influential discussions that could be linked to actionable decisions. Power sharing and equity were not

observed in practice and might be considered an ideal associated with the deliberative 'ethic'. In practice, power asymmetries should be identified, and consideration given to how one might address and re-balance power in knowledge enactment practices to support meaningful engagement and the development of trust.

5.2   Practical Implications

The practice of local implementation policymaking is often focused on tangible problems that must be solved on the ground (5). Collaborative governance, and other similar approaches, were intended to resolve issues around the implementation of policy in complex local contexts by facilitating the inclusion of expertise from multiple local sources and addressing the co-creation of implementation policy in ways that could not be done by a single organization or individual working on its own (16, 17). As an ideal, the literature suggests that deliberative modes of working can facilitate inclusion of a greater diversity of knowledge and information, and enhance capacities for collective problem-solving and shared learning, as well as promote improved transparency around funding, resources, timelines and accountability requirements (5, 6, 18-21). In initiatives, like the case studied here, viewing collaborative practices in policymaking as an important complement to established and familiar institutional structures creates the opportunity to bring diverse voices, and a broad range of information and knowledge to the development of more useful, applicable and productive solutions to the issues of local implementation (3). The process of balancing a stable and prominent administrative hierarchy with more inclusive and engaged modes of working for groups situated within that structure is likely to be met by a number of challenges including understanding and balancing or re-distributing power in knowledge enactment contexts, fostering conditions for inclusion and meaningful engagement, and understanding the roles and responsibilities of actors in co-creating collaborative practices.

Having identified power, and power asymmetries in local implementation policymaking settings as an important element that influences equity, inclusion and meaningful engagement in practice, it is vital that we consider alternative ways of thinking about power and practice. As

discussed in Chapter 4, by using a dispersive framing that considers power as a multi-dimensional resource, decision makers can consider not only 'power' as a single supraordinate construct, but also identify 'power over', 'power to' and 'power for' and begin to identify points of action where they might be able to change the way power is distributed, or used, in order to create a more balanced practice setting, facilitative openness and strengthen opportunities for meaningful engagement (22, 23). For example, in the present case, there was an established asymmetry of 'power over' that could be observed between the dominant lead organization, its representatives, and the rest of the decision makers involved in the implementation initiative. This 'power over' was observed as hierarchical and extended from the regional level to the local level implementation groups. Asymmetry of 'power over' might be addressed by examining some of the institutional or administrative processes adopted from the lead agency and consider their impact on power inequity in the group. Do they offer an opportunity to shift responsibility or authority in those areas in a way that would support inclusion or perceptions of shared ownership? For example, staging of meetings and control of the agenda can augment existing power asymmetry if these elements of the practice context are managed only by the lead agency and its representatives. Similarly, the way in which knowledge and information enters and leaves the practice environment can support asymmetry. Information that is curated or pre-processed through the lead agency perspective and presented as a shortcut to consensus, diminishes perceptions of meaningful engagement (24). Further, use of technology by the dominant lead to store, exchange, present or otherwise manage information by lead agency representatives can exclude some participants, or interrupt the potential for direct, sometimes disruptive dialogue, privileging selected framings with which actors are expected to agree (7). Supporting the engagement of other, non-lead agency actors in co-creating and acting on important aspects of practice context processes like these would enhance the development of the collective, and more inclusive, 'power to'. Well-resourced, prominent lead organizations, as they provide regional oversight and manage vertical accountabilities, could act on opportunities to invest in 'power for' by supporting the capacity of local decision-making groups to develop their 'power to' by helping to make important network connections (bringing people together), and supporting the open and transparent flow of knowledge and information to and between groups.

Establishing an inclusive and equitable environment that disburses 'power over' in support of 'power to' means seeking to promote safe and meaningful engagement in open deliberation within practice settings to co-create shared policy-relevant knowledge (19, 20, 25). If one accepts that shared, collaborative practices are beneficial to implementation policymaking and that deliberation represents an opportunity for discursive, knowledge enactment processes (like collective sensemaking) that are used to arrive at shared solutions that seem fair and applicable within the local context (21), then whose responsibility is it to examine and address power and to foster practices that support engagement in inclusive, local policymaking environments? As the perceived 'owner', with the most resources and the most 'power over', are the lead organization and its key visible representatives (e.g. administrators, managers, project team coordinators) responsible for framing an inclusive environment and insisting on collaborative practices? Although it might seem natural to place the burden of responsibility on the lead organization, relying on managers, project leads or coordinators to foster collaborative practice contexts, this strategy runs the risk of emphasizing the 'power over' experienced in context by upholding and extending existing administrative structures and mechanisms (7, 15). Instead, all engaged actors should share in the responsibility for contributing to the continuously evolving co-creation of the practice context.

Of course, constraints are placed on the actions of local policymakers based the pre-existing mandated accountabilities described by agreements held between the MOHLTC and the LHIN, as a crown agency (26, 27). While structures and processes adopted from the lead agency along with contingent documents, like the terms of reference or partnership and accountability agreements, inform the actions of the actors within the policymaking context, there remains a great deal of actor agency within the process of co-creating a practice environment (28, 29). Acknowledging the responsibilities conferred by legally mandated accountabilities, collaborative practices still do not have to remain within the acknowledged 'way things work' within LHIN-based (or lead agency centric) initiatives and the adopted organizational frame does not have to remain a rigid representation of how the group practice will progress. With a sense of balance, and by addressing power where possible, policymakers may fulfill the responsibilities associated with accountability and still work collectively within a collaborative practice setting.

Performance and accountability in implementation do not necessarily require conformance within a dominant and inflexible institutional frame (30). Engaged actors, including representatives of the lead organization, as members of collaborative policymaking groups functioning within multi-level implementation initiatives can choose to exercise their knowledge and voices where possible to challenge processes and framings, to find what is rigid and what can be flexed within the existing structure to support a more equitable and inclusive context that encourages the collaborative development of innovative courses of action that can still function to meet accountability criteria (11, 30). As observed in Chapter 4, representatives of the institution who are part of the designated project team are well-placed to contribute to this process as they often experience the tensions that arise between the structures and mechanisms of bureaucracy, the requirements of strategic alignment and vertical accountabilities and the pervasive expectations held by engaged actors regarding inclusive, meaningful engagement in collaborative decision-making environments (31, 32).

5.3   Limitations

To focus attention on the practices of engaged local actors, this dissertation has adopted a practice-based lens intended to enrich our understanding of the messy, collective experience of implementation policymaking. Studies of practice have been described as employing a strategy of looking down to understand the local by feeling around within the local contexts, observing the concepts, vocabularies and connections, for example, that are part of a particular time and place (33). However, in this, practice-based study has been criticized as being challenged in terms of scale (33, 34). If it is focused on the local in a particular time and space, is it also fixed in scale, of little relevance outside of the local context? Buegar suggested that the concept of practice is open in scale; that is, it is open to moving outward, or upward, from the site of study (33). Seeking to understand practices can help to understand the way in which connections are made between socially constructed levels (i.e. macro, meso, micro), as well as describe elements that may be transported beyond a specific site (34, 35). In this thesis, the case study was selected as an appropriate site-based strategy as case studies, in general, are intended to enhance understanding through experience (36-38). However, like practice-based studies, the case study

may also be criticized for being tied to a specific time and place. This perceived limitation was addressed in several ways.

First, careful attention was paid to the selection of the type of study strategy and the selection of a case. In instrumental cases, the study of the selected case helps the researcher to pursue an interest in a specific issue or area of interest that is not necessarily intrinsic to the case itself (36, 39). In this thesis, the issue of interest was identified as the practice of local policymaking within the context of a multi-level implementation initiative. While this issue is not necessarily tied to a specific site, careful and purposive selection of the case or cases to be included was considered to be extremely important, particularly in terms of the opportunity to learn about the experiences of engaged actors in context. Therefore, sampling strategy was focused on intensity – that is, the identification of an information rich case representing a significant learning opportunity within the specified area of interest (36, 40, 41) Based on information gathered from several formal and informal sources (e.g. searching government websites, conversations with advisors, attendance at a conference sponsored by the macro-level policymaker), Health Links was identified as an appropriate case based using an intensity strategy. Health Links, as a site for study, provided the opportunity to observe, firsthand, the translation of a macro-level policy initiative to local health service delivery via a multi-level implementation process within well-established regional system structures. The transition of Health Links from multiple pilot projects to initiatives situated within a system of LHIN governance contributed to the emergent, dynamic, decision-making environment. Engagement with decision makers situated within the SW-LHIN was facilitated by existing interpersonal connections. In addition, the openness, enthusiasm and commitment of engaged actors facilitated access to the numerous meetings, one-on-one interviews and documents circulated within the initiative over the extended period of observation. All of these factors contributed to an information-rich learning opportunity to enhance our understanding of the experience of local policy actors engaged in the work of local implementation policymaking.

Second, we recognized that, as in most qualitative work, the potential for the practice-based case study to have value across a variety of situations is determined, to some degree, by

the resonance felt by readers who connect with descriptions that overlap with their own experience (42). Readers determine whether the case, described as a representation of an issue of interest, is interpretable within their own experience, which is inclusive of their existing architecture of information and knowledge, from informal and formal sources (38). Resonance is facilitated by the use of thick description (42). This thesis presented thick description based on extended periods of observation, one-on-one interviews and documentation, and connected the experience of engaged agents within the cases to existing research-based knowledge as a means to enhance our understanding of local policymaking practices.

Lastly, in consideration of transferability, it is important to note that, in general, the overall shape and structure of the case study initiative was not unique. Within the healthcare sector, the use of a prominent, centralized organization that functions as the lead agency within a multi-level implementation initiative is not atypical (12, 15, 43). The structure of the Health Links initiative itself was similar to other initiatives, funded by the same macro-level policymaker and strategically situated within the SW-LHIN for the purposes of local implementation. As noted in Chapter 3, the initial framework for Health Links' structure, and terms of reference, were based on another project similarly situated within the LHIN and an invitation to sit on the HLLC was issued to a member involved with yet another project situated within the LHIN, for example. In the Province of Ontario, funding for local initiatives, like Health Links, flowed through and was administered by 14 LHINs or lead agencies. Given that the use of a central, lead agency is fairly common, and initiatives often adopt administrative structures from the lead agency, both of these features could contribute to the resonance of Health Links as an instrumental case study. However, Health Links in the SW-LHIN may also have been unique, as a specific setting for implementation, which is also important to acknowledge here. Each LHIN has a specific mandate focused around local, community need, as well as a separate accountability agreement between the LHIN and the MOHLTC (27). Therefore, the organizational structure of the SW-LHIN, and the governance structure of Health Links within the SW-LHIN may be unique to the region.

It is worth noting that, at the time of writing, the LHIN structure within the healthcare system in Ontario is in the process of evolving into a new system of Ontario Health Teams (OHTs). The future of initiatives such as Health Links within the new system is uncertain. However, this thesis was not intended as an intrinsic case study. That is, it was not about Health Links specifically; rather, it was intended to advance our understanding of the practice of local policymaking through the experience of the case.

5.4   Looking to the Future

The Knowledge Enactment in Practice Settings (KEPS) framework developed and used in this thesis provided a lens through which the practice context could be ordered for the purpose of study. In the simplest, and most general of terms, use of the framework facilitated consideration of the collective knowledge enactment processes in which policy agents engage as they co-create both their practice contexts and knowledge products including local implementation policy, guidelines or procedures. The framework also depicted processes, labelled collectively as valuation, that are more specific to the ways in which knowledge and information are selected for use within the practice context. It is this third area that explores the ways in which knowledge and information moves into, within and out of the practice context, as well as how it is valued and used in processes of knowledge enactment by engaged policy actors. At the present time, work is proceeding on a study that focuses on valuation and use of knowledge and information within the Health Links case study. This continuing work seeks to identify what kinds of knowledge and information were used most often within the formal decision-making practice setting and will seek to identify the value placed on various types of knowledge and information used. In addition, the influence of the initiative structure and existing power relationships on the valuation of knowledge and information in enactment contexts will be explored. This study will represent a completed, initial examination of the three primary components of the KEPS framework as proposed at the end of Chapter 2.

Within a local context, policymaking can be messy, unruly and complex. However, it is not necessary to study all of the potential complexity within a context simultaneously (33). It is

important to acknowledge that the framework offered does not seek to incorporate all the complexity of all possible practices within the implementation policymaking setting, but rather provides a starting frame from which to begin to describe policy actor experience. Looking ahead, additional work should be done to examine the applicability of the KEPS framework across a variety of policymaking contexts, not to assess generalizability, but rather, to determine whether or not the framework itself can function as an exemplar for use in understanding collaborative, policymaking practices. That is, can the representation of practice as described here, within the context of this researcher's experience of Health Links, be used to described practices of local policymaking within the context of someone else's experience? The more often that the KEPS framework is used, in various contexts, the closer we will come to understanding its value and ways that it might be improved and expanded. For instance, based on the results of the observations made here, one element of complexity that future work should address is how to incorporate power, and different types of power, into the practice framework.

5.5   Conclusion

There have been relatively few studies that have focused on the experiences in practice of actors engaged in processes of local policymaking. Practice-based study helps to ground our insights into policymaking practices within the everyday ambiguity and complexity of actor experience. By adopting a practice-based lens, this dissertation focused attention on the practices of actors engaged in processes of initiative implementation. First, a review and synthesis of existing literature that described practices of local policymaking facilitated the development of the Knowledge Enactment in Practice Settings (KEPS) framework depicting the collective processes of knowledge enactment. The framework was then used to reflect different aspects of the collective knowledge work of local policymakers — the co-creation of the practice context, and how the engaged actors functioned within it. By using this framework to study and reflect on the co-creation of context separately from the knowledge enactment processes within the practice setting highlighted how important the engagement of actors in the ongoing co-creation of context is to collaborative knowledge enactment in the practice of policymaking. Surfacing the key themes connected to working within co-created and adopted contexts, such as those related to

inclusiveness, deliberation, and meaningful engagement, for example, served to locate where and how important aspects of collaborative practices may be constrained or facilitated.

It has been suggested that collective knowledge enactment works best when the practice context is co-created (32); however, this does not mean that all context development must start from scratch or that adopted contexts cannot be re-created or co-adapted by engaged actors. In practical terms, the proposed framework and the accompanying case study functions to encourage an increased awareness of the ongoing negotiation of the practice context that supports and sustains collaboration within knowledge enactment environments. Understanding actor experience of 'the way things work', perceptions of power and initiative ownership within the adopted or co-created context improves opportunities to identify strategic points where the practice setting might be re-negotiated to support re-distribution of power, or foster inclusion and meaningful engagement, for instance. While power may never be shared equally among all collaborators, power can be shifted to support the collective 'power to' or used as resource to support the decision-making capacity of others.

Meaningful engagement and inclusion in knowledge enactment also refer to those practices wherein the practice context is negotiated. This means that initiative administration, structures and mechanisms are not just the responsibility of actors in management roles — even when those context structures and mechanisms are mostly adopted from a lead organization or agency. While administrative rules, bureaucratic processes and vertical accountabilities can frame or even restrict collaborative processes, there remains a great deal of actor agency in context. Engaged actors can identify and challenge established organizational structures that constrain collaboration, while representatives of the lead organization or agency are well positioned to contribute to the process of finding a balance between structural requirements and collaborative knowledge practices.

5.6   References

1.   Graham A. Pressman/Wildavsky and Bardach: Implementation in the public sector, past, present and future. Canadian Public Administration. 2005;48(2):268-73.

2.   Freeman R. Care, policy, knowledge: Translating between worlds. The Sociological review (Keele). 2017;65(2_suppl):193-200.

3.   Cairney P, Oliver K. Evidence-based policymaking is not like evidence-based medicine, so how far should you go to bridge the divide between evidence and policy? Health Research Policy and Systems. 2017;15(1):35.

4.   Greenhalgh T. What is this knowledge that we seek to "exchange"? The Milbank quarterly. 2010;88(4):492-9.

5.   Fung A, Wright EO. Deepening Democracy: Innovations in Empowered Participatory Governance. Politics and Society. 2001;29(1):5-41.

6.   Rusch L, Swarts H. Practices of Engagement: Comparing and Integrating Deliberation and Organizing. Journal of Community Practice. 2015;23(1):5-26.

7.   Crompton A. Inside co-production: Stakeholder meaning and situated practice. Social Policy & Administration. 2019;53(2):219-32.

8.   Freeman R, Sturdy S. Introduction: knowledge in policy — embodied, inscribed, enacted. In: Freeman R, Sturdy S, editors. Knowledge in Policy: Embodied, inscribed, enacted. Bristol, UK: Policy Press 2015.

9.   Cook SD, Wagenaar H. Navigating the Eternally Unfolding Present: Toward an Epistemology of Practice. The American Review of Public Administration. 2012;42(1):3-38.

10.   Carey G, McLoughlin P, Crammond B. Implementing Joined-Up Government: Lessons from the Australian Social Inclusion Agenda. Australian Journal of Public Administration. 2015;74(2):176-86.

11.   Purdy JM. A Framework for Assessing Power in Collaborative Governance Processes. Public Administration Review. 2012;72(3):409-17.

12.   Provan KG, Kenis P. Modes of Network Governance: Structure, Management, and Effectiveness. Journal of Public Administration Research and Theory. 2008;18(2):229-52.

13.   Fedele P, Brusati L, Ianniello M. Organizational underpinnings of interactive decision making: an empirical inquiry. International Journal of Public Sector Management 2016;29(4):310-26.

14.   Whitehead M. The architecture of partnerships: urban communities in the shadow of hierarchy. Policy and politics. 2007;35(1):3-23.

15.   Fenwick J, Miller KJ, McTavish D. Co-governance or meta-bureaucracy? Perspectives of local governance 'partnership' in England and Scotland. Policy & Politics. 2012;40(3):405-22.

16.   Doberstein C. Designing Collaborative Governance Decision-Making in Search of a 'Collaborative Advantage'. Public Management Review. 2016;18(6):819-41.

17.   Vangen S, Hayes J, Cornforth C. Governing Cross Sector Interr-organizational Collaborations. Public Management Review. 2014:1-24.

18.   Zimmermann K. Changing governance - Evolving knowledgeScapes: How we might think of a planning-relevant politics of local knowledge. DISP. 2009;178(3):56-66.

19.   Larrick RP. The Social Context of Decisions. Annual Review of Organizational Psychology and Organizational Behavior. 2016;3:441-67.

20.   Topp L, Mair D, Smillie L, Cairney P. Knowledge management for policy impact: the case of the European Commission's Joint Research Centre. Palgrave Communications. 2018;4(1):87.

21.   Williams O, Fullagar S. Lifestyle drift and the phenomenon of 'citizen shift' in contemporary UK health policy. Sociology of health & illness. 2019;41(1):20-35.

22.   Shepherd S. Managerialism: an ideal type. Studies in Higher Education. 2018;43(9):1668-78.

23.   Huxham C, Vangen S. Using Power. Managing to Collaborate: The theory and practice of collaborative advantage New York, USA: Routledge; 2005. p. 173-86.

24.   Koch P. Bringing Power Back In: Collective and Distributive Forms of Power in Public Participation. Urban Studies. 2013;50(14):2976-92.

25.   Emerson K, Nabatchi T, Balogh S. An Integrative Framework for Collaborative Governance. Journal of Public Administration Research and Theory. 2012;22(1):1-29.

26.   Ministry of Health and Long Term Care. Ontaio's LHINs: Queen's Printer for Ontario 2014 [Available from: http://www.lhins.on.ca/Pan-LHIN%20Content/LHINs%20Accountability.aspx.

27.   Ministry of Health and Long Term Care. Local Health System Integration Act; Public Information 2006 [updated 31/03/2020. Available from: https://web.archive.org/web/20120625193650/http://www.health.gov.on.ca/english/public/legislation/lhins/hu_lhins.html.

28.   Cairney P, Kwiatkowski R. How to communicate effectively with policymakers: combine insights from psychology and policy studies. Palgrave Communications. 2017;3(1):37.

29.   Feldman MS, Khademian AM, Ingram H, Schneider AS. Ways of Knowing and Inclusive Management Practices. Public Administration Review. 2006;66 (Special Issue: Collaborative Public Management):89-99.

30.   Barrett SM. Implementation Studies: Time for a Revival? Personal Reflections on 20 Years of Implementation Studies. Public Administration. 2004;82(2):249-62.

31.   Skelcher C, Mathur N, Smith M. The Public Governance of Collaborative Spaces: Discourse, design and democracy Public Administration. 2005;83(3):573-96.

32.   Addleson M. Will the real story of collaboration please stand up so we can see it properly? Knowledge Management Research & Practice. 2013;11(1):32-40.

33.   Bueger C. Pathways to practice: praxiography and international politics. European Political Science Review. 2014;6(3):383-406.

34.   Birtchnell T. Elites, elements and events: Practice theory and scale. Journal of Transport Geography. 2012;24:497-502.

35.   Miettinen R, Samra-Fredericks D, Yanow D. Re-Turn to Practice: An Introductory Essay. Organization Studies. 2009;30(12):1309-27.

36.   Stake RE. Qualitative Case Studies. In: Denzin N, Lincoln Y, editors. Strategies of Qualitative Inquiry. 3rd edition ed. Thousand Oaks, CA, USA: Sage Publications 2008.

37.   Merriam SB. Qualitative research and case study applications in education. 2nd ed. San Francisco, USA: Jossey-Bass Publishers; 1998.

38.   Thomas G. Doing Case Study: Abduction Not Induction, Phronesis Not Theory. Qualitative Inquiry. 2010;16(7):575-82.

39.   Casey D, Houghton C. Clarifying case study research: examples from practice: Dympna Casey and Catherine Houghton explore the use of case studies with examples from their research. Nurse researcher. 2010;17:41+.

40.   Huberman M, Miles MB. Theories and Analysis The Qualitative Researcher's Companion. London, UK: Sage Publications 2002. p. 1-36.

41.   Miles MB, Huberman M. Focusing and Bounding the Collection of Data. An Expanded Sourcebook: Qualitative Data Analysis 2nd ed. ed. Thousand Oaks, California, USA: Sage Publications 1994.

42.   Tracy SJ. Qualitative quality: Eight a"big-tent" criteria for excellent qualitative research. Qualitative Inquiry. 2010;16(10):837-51.

43.   Larsson O. A theoretical framework for analyzing institutionalized domination in network governance arrangements. Critical Policy Studies. 2017:1-20.

Appendices

Appendix A. Notices of Ethics Approval

Western Research

Research Ethics

Western University Health Science Research Ethics Board
HSREB Delegated Initial Approval Notice

Principal Investigator: Dr. Anita Kothari
Department & Institution: Health Sciences\School of Health Studies, Western University

HSREB File Number: 105852
Study Title: The Practice of Policymaking: Decision-maker or stakeholder roles and agency in the context of locally referenced policymaking
Sponsor:

HSREB Initial Approval Date: December 19, 2014
HSREB Expiry Date: December 19, 2015

Documents Approved and/or Received for Information:

Document Name	Comments	Version Date
Other	Confidentiality Agreement	2014/09/19
Other	Consent Log/I.D. assignment	2014/09/19
Recruitment Items	recruitment email (external informants)	2014/09/22
Other	preliminary interview guides	2014/09/22
Other	Sensitizing questions to guide direct observation	2014/09/22
Recruitment Items	Invitation to participate (committee members) - pdf version	2014/11/26
Letter of Information & Consent	External Informants	2014/12/18
Letter of Information & Consent	Committee/Working Group Members	2014/12/18
Other	(received Dec.19/14) Verbal Consent script	
Revised Western University Protocol	clean copy in PDF format	2014/11/26

The Western University Health Science Research Ethics Board (HSREB) has reviewed and approved the above named study, as of the HSREB Initial Approval Datenoted above.

HSREB approval for this study remains valid until the HSREB Expiry Date noted above, conditional to timely submission and acceptance of HSREB ContinuingEthics Review. If an Updated Approval Notice is required prior to the HSREB Expiry Date, the Principal Investigator is responsible for completing andsubmitting an HSREB Updated Approval Form in a timely fashion.

The Western University HSREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), theInternational Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use Guideline for Good Clinical PracticePractices (ICH E6 R1), the Ontario Personal Health Information Protection Act (PHIPA, 2004), Part 4 of the Natural Health Product Regulations, Health CanadaMedical Device Regulations and Part C, Division 5, of the Food and Drug Regulations of Health Canada.

Members of the HSREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when theyare presented to the REB.

The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940

Ethics Officer to Contact for Further Information

Erika Basile ebasile@uwo.ca	Grace Kelly grace.kelly@uwo.ca	Mina Mekhail mmekhail@uwo.ca	Vikki Tran vikki.tran@uwo.ca

This is an official document. Please retain the original in your files.

Western Research

Western University Health Science Research Ethics Board
HSREB Amendment Approval Notice

Principal Investigator: Dr. Anita Kothari
Department & Institution: Health Sciences\School of Health Studies,Western University

Review Type: Expedited
HSREB File Number: 105852
Study Title: The Practice of Policymaking: Decision-maker or stakeholder roles and agency in the context of locally referenced policymaking
Sponsor:

HSREB Amendment Approval Date: December 18, 2015
HSREB Expiry Date: December 19, 2016

Documents Approved and/or Received for Information:

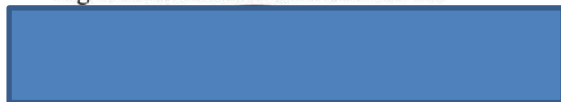| Document Name	Comments	Version Date
Revised Western University Protocol		2015/11/30

The Western University Health Science Research Ethics Board (HSREB) has reviewed and approved the amendment to the above named study, as of the HSREB Initial Approval Date noted above.

HSREB approval for this study remains valid until the HSREB Expiry Date noted above, conditional to timely submission and acceptance of HSREB Continuing Ethics Review.

The Western University HSREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use Guideline for Good Clinical Practice Practices (ICH E6 R1), the Ontario Personal Health Information Protection Act (PHIPA, 2004), Part 4 of the Natural Health Product Regulations, Health Canada Medical Device Regulations and Part C, Division 5, of the Food and Drug Regulations of Health Canada.

Members of the HSREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB.

The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.

Chair

Ethics Officer to Contact for Further Information: Erika Basile ___ Nicole Kaniki ___ Grace Kelly ___ Mina Mekhail ___ Vikki Tran ___

This is an official document. Please retain the original in your files

Western Research

Western University Health Science Research Ethics Board
HSREB Annual Continuing Ethics Approval Notice

Date: November 30, 2015
Principal Investigator: Dr. Anita Kothari
Department & Institution: Health Sciences\School of Health Studies, Western University

Review Type: Expedited
HSREB File Number: 105852
Study Title: The Practice of Policymaking: Decision-maker or stakeholder roles and agency in the context of locally referenced policymaking
Sponsor:

HSREB Renewal Due Date & HSREB Expiry Date:
Renewal Due -2016/11/30
Expiry Date -2016/12/19

The Western University Health Science Research Ethics Board (HSREB) has reviewed the Continuing Ethics Review (CER) Form and is re-issuing approval for the above noted study.

The Western University HSREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use Guideline for Good Clinical Practice (ICH E6 R1), the Ontario Freedom of Information and Protection of Privacy Act (FIPPA, 1990), the Ontario Personal Health Information Protection Act (PHIPA, 2004), Part 4 of the Natural Health Product Regulations, Health Canada Medical Device Regulations and Part C, Division 5, of the Food and Drug Regulations of Health Canada.

Members of the HSREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB.

The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.

t, HSREB Chair

Ethics Officer to Contact for Further Information: Erika Basile ___ Nicole Kaniki ___ Grace Kelly ___ Mina Mekhail ___ Vikki Tran ✓

This is an official document. Please retain the original in your files

From: <<u>romeo-notifications@uwo.ca</u>>

Date: 10 November 2016 at 16:28

Subject: 105852 Ethics Approval Notice

Ethics File #: 105852

Study Title: The Practice of Policymaking: Decision-maker or stakeholder roles and agency in the context of locally referenced policymaking

Hello,

The Approval Notice for the above mentioned study is now available in ROMEO.

**** **Please note**: The original will **not** be sent in the mail, it is available for download in Romeo ****

 To access the Approval Notice:

1. Log in to ROMEO

2. Click on 'Applications Submitted Post Review'.

3. Click on 'View' to open the file.

4. Under the 'Attachments' tab, you can download the Approval Notice.

Kind regards,

Office of Human Research Ethics

Western University

Support Services Building

Date: 30 November 2017

To: Anita Kothari

Project ID: 105852

Study Title: The Practice of Policymaking: Decision-maker or stakeholder roles and agency in the context of locally referenced policymaking

Application Type: Continuing Ethics Review (CER) Form

Review Type: Delegated

Full Board Reporting Date: December 5, 2017

Date Approval Issued: 30/Nov/2017

REB Approval Expiry Date: 19/Dec/2018

_____

Dear Anita Kothari ,

The Western University Research Ethics Board has reviewed the application. This study, including all currently approved documents, has been re-approved until the expiry date noted above.

REB members involved in the research project do not participate in the review, discussion or decision.

Western University REB operates in compliance with, and is constituted in accordance with, the requirements of the TriCouncil Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2); the International Conference on Harmonisation Good Clinical Practice Consolidated Guideline (ICH GCP); Part C, Division 5 of the Food and Drug Regulations; Part 4 of the Natural Health Products Regulations; Part 3 of the Medical Devices Regulations and the provisions of the Ontario Personal Health Information Protection Act (PHIPA 2004) and its applicable regulations. The REB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.

Please do not hesitate to contact us if you have any questions.

Sincerely,

REB Chair

validation and approval via an online system that is compliant with all regulations).

Date: 10 December 2018

To: Anita Kothari

Project ID: 105852

Study Title: The Practice of Policymaking: Decision-maker or stakeholder roles and agency in the context of locally referenced policymaking

Application Type: Continuing Ethics Review (CER) Form

Review Type: Delegated

REB Meeting Date: 15/Jan/2019

Date Approval Issued: 10/Dec/2018

REB Approval Expiry Date: 19/Dec/2019

Dear Anita Kothari,

The Western University Research Ethics Board has reviewed the application. This study, including all currently approved documents, has been re-approved until the expiry date noted above.

REB members involved in the research project do not participate in the review, discussion or decision.

Western University REB operates in compliance with, and is constituted in accordance with, the requirements of the TriCouncil Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2); the International Conference on Harmonisation Good Clinical Practice Consolidated Guideline (ICH GCP); Part C, Division 5 of the Food and Drug Regulations; Part 4 of the Natural Health Products Regulations; Part 3 of the Medical Devices Regulations and the provisions of the Ontario Personal Health Information Protection Act (PHIPA 2004) and its applicable regulations. The REB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.

Please do not hesitate to contact us if you have any questions.

Sincerely,

seph Gilbert, HSREB Chair

validation and approval via an online system that is compliant with all regulations).

Western Research

Date: 10 December 2019

To: Anita Kothari

Project ID: 105852

Study Title: The Practice of Policymaking: Decision-maker or stakeholder roles and agency in the context of locally referenced policymaking

Application Type: Continuing Ethics Review (CER) Form

Review Type: Delegated

REB Meeting Date: 17/Dec/2019

Date Approval Issued: 10/Dec/2019

REB Approval Expiry Date: 19/Dec/2020

Dear Anita Kothari,

The Western University Research Ethics Board has reviewed the application. This study, including all currently approved documents, has been re-approved until the expiry date noted above.

REB members involved in the research project do not participate in the review, discussion or decision.

Western University REB operates in compliance with, and is constituted in accordance with, the requirements of the TriCouncil Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2); the International Conference on Harmonisation Good Clinical Practice Consolidated Guideline (ICH GCP); Part C, Division 5 of the Food and Drug Regulations; Part 4 of the Natural Health Products Regulations; Part 3 of the Medical Devices Regulations and the provisions of the Ontario Personal Health Information Protection Act (PHIPA 2004) and its applicable regulations. The REB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.

Please do not hesitate to contact us if you have any questions.

Sincerely,

h Gilbert, HSREB Chair

lidation and approval via an online system that is compliant with all regulations).

Appendix B. Summary of Data Collection

Document data collected

Type of Document	Number of documents collected
Regional Level: Health Links Leadership Collaborative	
• Background information - Includes policy reports and updates from macro-level policymaker, reports from other LHINs, organizational bodies or projects used to inform HLLC development; Health Links conference proceedings	26
• Foundational Materials - Includes documents provided to support the early development of the initiative, LHIN templates and reporting documents, terms of reference	26
• Meeting Materials - Includes agendas, materials forwarded to participants in advance of meetings, copies of presentations, meeting minutes	56
• Executive Committee Materials - Includes all of the materials produced by the Executive Committee and forwarded to me by the LHIN representative	71
• Total	179
Local Level: Steering Committees of Local Health Links Implementation Projects	

• Foundational/ informing materials
  - HL1: 17
  - HL2: 29
  - HL3: 10
	56

• Meeting materials
  - HL1: 19
  - HL2: 17
  - HL3: 22
	58

• Communiques
  - HL1: 5
  - HL2: 1
  - HL3: 5
	11

• Total	115

Participant Observation

Group	# of meetings observed	Period of Observaton
HLLC	12	01/15 - 01/16
HL1	6	07/15 – 01/16
HL2	6	03/15 - 12/15
HL3	6	03/15 - 12/16

Interview Participants

Primary Committee Affiliation	Other Committee Membership	Role within home organization	Length of participation in Health Links Initiative at time of interview
HLLC	None	Volunteer	14 months
HLLC	All	Project staff	18 months
HL3	HLLC	Executive director	8 months
HL2	None	Chief executive officer	From inception of project
HL2	HL2 working group	Care coordinator	9 months
HL3	HLLC	Chief executive officer	From inception of project
HLLC	None	Portfolio lead	8 months
HLLC	All	Vice-president	>2 years
HL2	HLLC	Project manager	10 months
HL-O	HLLC	Executive director	16 months
HL1	None	Medical Officer of Health	>2 years
HL1	HLLC	Executive director	>3 years
HL3	HLLC	Vice-president	Approximately 2 years
HL3	None	Integrated care manager	6-8 months
HL2	HLLC	Executive director	>2 years
HLLC	None	Senior director	3 years
HL2	None	Executive director	8 months
HL3	HLLC	Executive director	10 months
HL1	HLLC	Executive director	>2 years
HL1	HLLC	Executive director	>2 years
HL1	None	Director	>2 years
HL2	None	Director	>2 years
None	None	Manager, HQO	Approximately 9 months
Total Interviews conducted: 23			
Total Interviews with HLLC participants: 15			
Total Interviews with actors engaged in local level committees: 17			
Total Interviews with actors engaged in both: 12			
Total Interviews with external actor (macro-level): 1			

Appendix C. Interview Guides

Note: These interview sessions will begin with an informed consent process. The researcher will invite questions and respond to all requests for clarification with regard to the research.

A. Interview Guide – Internal Key Participant (Health Links Leadership Collaborative member)

Now that I have had the opportunity to observe 'a number' of committee meetings over the past year and become more familiar with some of the background for the project, I would like to learn more about your own experience in being involved in this kind of process and talk more directly with you about some information issues related to making decisions.

I would like to begin by getting to know a little bit more about you, your background and how you see yourself within this group.

1) *To begin, would you please tell me a little bit about*

   i. *your professional history,*

   ii. *your educational background –*

   iii. *and what your organizational affiliation is.*

2) How did you become involved with the Leadership Collaborative?

   i. How long have you been involved with this group?

3) In general, how would you describe your own role within the collaborative?
   Provide cues as necessary, giving possible examples of roles (e.g. the person who tries to clarify issues, organizes discussion, finds common ground, plays devil's advocate, etc.)

   i. As it relates to information or knowledge?
   Pursue the discussion of roles as it pertains to knowledge-based activities (possible cues include seeking out knowledge, bringing new information/knowledge to the group, initiating discussion, questioning, interpreting, or summarizing, for example)

4) What kinds of information or knowledge sources do you use most often for your work with the leadership collaborative?

If clarification of "information or knowledge sources" is required, the following possible cues may be used: personal experience, anecdotal narratives, evaluation studies, surveys, organizational reports, government documents, research or academic studies, etc.

    i.   In your role, what kinds of information or knowledge do you feel are the most valuable or influential to the work of the Health Links Leadership Collaborative?

    ii.   Why are these types of information or knowledge important to you (personally)?

    iii.   In your opinion, what kinds of information does the group (collectively) consider most important?

    iv.   What kinds of information do you feel tend to be highlighted most frequently (in presentations, documentation, at meetings)? Why?

5) Where (or to whom) would you go to seek out new information, knowledge (or insights) to bring to the Leadership Collaborative?

Thinking about the information-related roles we talked about earlier, are there individuals in the group whose role is to search for and identify information; or individuals whose role it is to make sense of or interpret information for the group?

6) In general, what do you consider to be the key resources necessary for the success of any initiative that is charged with implementing policy at the local level? (not specific to Health Links)

7) Thinking specifically about the current Health Links initiative, what kinds of information or knowledge resources do you feel are necessary to support the group in creating implementation policy within the framework provided by the Province?

8) Are there any specific information or knowledge gaps associated with Health Links that you feel have made the decision-making process more difficult for the Leadership group?

    i.   In what way? Can you identify barriers or constraints? *(around knowledge or information gaps)*
    ii.   How might these *(identified constraints)* be improved or resolved?

9) How important is timeliness of information?

This question is intended to access two features of timeliness. That is, how important it is that the information required can a) be accessed/provided in a timely fashion and b) has been produced relatively recently? E.g. in the past months, year, 2 years, 5 years?

10) Now, I would like to ask you to think a little bit about the structure of the Leadership group.

     i.   Do you think that, in terms of representativeness, the group is well constructed? *(think about organizations, community groups/sectors, etc.)* Is there any area that is lacking? (*Is anyone missing?*)

     ii.   Do you think that, in terms of what each member is able to contribute to the process, that it is well constructed? Do you have all the skills available within the group that you need to address task at hand?

     iii.   What do you perceive to be the strengths of the group?

     iv.   What do you perceive to be the groups' challenges?

11) How would you describe the overall approach or strategy used by the group to make decisions as part of the policymaking (*or decision making*) process?

12) Is there anything else that you would like to add before we end this interview?

B. Interview Guide – Internal Key Participant (Local HL Steering Committee Member)

Now that I have had the opportunity to observe 'a number' of committee meetings over the past year and become more familiar with some of the background for the project, I would like to learn more about your own experience in being involved in this kind of process and talk more directly with you about some information issues related to making decisions.

I would like to begin by getting to know a little bit more about you, your background and how you see yourself within this group.

1) *To begin, would you please tell me a little bit about*

     i.   *your professional history,*

     ii.   *your educational background –*

     iii.   *and what your organizational affiliation is.*

2) So, how did you become involved with this committee (*name of local steering committee*)? How long have you been involved with this group (*name of local steering committee*)?

3) In general, how would you describe your own role within the group? *Provide cues as necessary, giving possible examples of roles (e.g. the person who tries to clarify issues, organizes discussion, finds common ground, plays devil's advocate, etc.)*

     i.   As it relates to information or knowledge?

Pursue the discussion of roles as it pertains to knowledge-based activities (possible cues include seeking out knowledge, bringing new information/knowledge to the group, discussing, interpreting, or summarizing, for example)

4) What kinds of information or knowledge sources do you use most often for your work with (insert name of local steering committee)?

If clarification of "information or knowledge sources" is required, the following possible cues may be used: personal experience, anecdotal narratives, evaluation studies, surveys, organizational reports, government documents, research or academic studies, etc.

   i.   In your role, what kinds of information or knowledge do you feel are the most valuable or influential to the work of the group **(HL steering committees/working groups)**?

   ii. Why are these types of information or knowledge important to you (personally)?

   iii. In your opinion, what kinds of information does the group (collectively) consider most important? What kinds of information tend to be highlighted most frequently? Why?

5) Where (or to whom) would you go to seek out new information to bring to (HL steering committee)?

Thinking about the information-related roles we talked about earlier, are there individuals in the group whose role is to search for and identify information; or individuals whose role it is to make sense of or interpret information for the group?

6) In general, what do you consider to be the key resources necessary for the success of any initiative that is charged with implementing policy at the local level? (not specific to Health Links)

7) Thinking specifically about the current Health Links initiative, what kinds of information or knowledge resources do you feel are necessary to support the (*insert steering committee*) in creating policy to support local implementation within the provincial framework?

8) Are there any specific information or knowledge gaps associated with Health Links that you feel have made the decision-making process more difficult?

   i.   In what way? Can you identify barriers or constraints? *(around knowledge or information gaps)*

   ii. How might these *(identified constraints)* be improved or resolved?

9) How important is timeliness of information?

This question is intended to access two features of timeliness. That is, how important it is that the information required can a) be accessed in a timely fashion and b) has been produced relatively recently? E.g. in the past months, year, 2 years, 5 years?

10) I would like to ask you to think a little bit about the structure of your steering committee, overall.

    i.   Do you think that, in terms of representativeness, the group is well constructed? Is there any area that is lacking? *(think about organizations, community groups/sectors, etc.)*

    ii.   Do you think that, in terms of what each member is able to contribute to the process, that it is well constructed? Do you have all the skills available within the group that you need to address task at hand?

    iii.   What do you perceive to be the strengths of the group?

    iv.   What do you perceive to be the groups' most significant challenge(s)?

11) How would you describe the overall approach or strategy used by the steering committee to make decisions?

12) Is there anything else that you would like to add before we end this interview?

C. **Interview Guide – Internal Key Participant (Dual Membership – HLLC and Local Steering Committee)**

Now that I have had the opportunity to observe 'a number' of committee meetings over the past year and become more familiar with some of the background for the project, I would like to learn more about your own experience in being involved in this kind of process and talk more directly with you about some information issues related to making decisions.

I would like to begin by getting to know a little bit more about you, your background and how you see yourself within this group.

1) *To begin, would you please tell me a little bit about*

    i.   *your professional history,*

    ii.   *your educational background –*

    iii.   *and what your organizational affiliation is.*

2) So, how did you become involved with the Health Links initiative in the southwest? How long have you been involved with the Leadership Collaborative? With the (insert local steering committee)?

  iv. *What is your role at the Leadership level? (e.g. as a representative of...)*

3) In general, how would you describe the role you perform within each group? What sort of a member are you? Do you...

  Provide cues as necessary, giving possible examples of roles (e.g. the person who tries to clarify issues, organizes discussion, finds common ground, plays devil's advocate, etc.)

4) What role(s) do you take that relate specifically to information or knowledge within each group (as them to think about each group separately – prompt for comparisons in the knowledge roles they fill)

  Pursue the discussion of roles as it pertains to knowledge-based activities (possible cues include seeking out knowledge, bringing new information/knowledge to the group, discussing, interpreting, or summarizing, for example)

5) What kinds of information or knowledge sources do you use most often for your work with a) the Leadership Collaborative and b) the local steering committee? Are they different?

  If clarification of "information or knowledge sources" is required, the following possible cues may be used: personal experience, anecdotal narratives, evaluation studies, surveys, organizational reports, government documents, research or academic studies, etc.

  i. What kinds of information or knowledge do you feel are the most valuable or influential to the work of the group **(a) Leadership collaborative and b) HL steering committees/working groups)**?

  ii. Why are these types of information or knowledge important to you?

  iii. In your opinion, what kinds of information does each group (collectively) consider most important? What kinds of information tend to be highlighted most frequently? A) by the Leadership Collaborative? B) within the (*local steering committee*)?

6) Where (or to whom) would you go to seek out new information to bring to either the Leadership Collaborative or to (one of the Health Links Steering Committees)?

  i. *Thinking about the information-related roles we talked about earlier, are there individuals in the group whose role is to search for and identify information; or individuals whose role it is to make sense of or interpret information for the group?*

7) In general, what do you consider to be the key resources necessary for the success of any initiative that is charged with implementing policy at the local level? (not specific to Health Links)

8) Thinking specifically about the context of the current Health Links initiative, what kinds of information or knowledge resources do you feel are necessary to support the a) leadership collaborative and b) (local steering group) in creating policy needed to support the implementation initiative within the provincial framework? Are they different?

9) Are there any specific information or knowledge gaps associated with Health Links that you feel have made the decision-making process more difficult? **(at the Leadership Collaborative Level? – at the Steering Committee Level?)**

   i.   In what way? Can you identify barriers or constraints? Challenges? *(around knowledge or information gaps)*

   ii. How might these *(identified constraints)* be improved or resolved?

10) How important is timeliness of information?

This question is intended to access two features of timeliness. That is, how important it is that the information required can a) be accessed in a timely fashion and b) has been produced relatively recently? E.g. in the past months, year, 2 years, 5 years?

11) I would like to ask you to think a little bit about the structure of the groups with which you are involved, overall. (*Start with the Leadership Collaborative, then ask again for the local committee*)

   i.   Do you think that, in terms of representativeness, the group is well constructed? Is there any area that is lacking? *(think about organizations, community groups/sectors, etc.)*

   ii. Do you think that, in terms of what each member is able to contribute to the process, that it is well constructed? Do you have all the skills available within the group that you need?

   iii. What do you perceive to be the strengths of the group?

   iv. What do you perceive to be the groups' greatest challenge(s)?

12) How would you describe the overall approach or strategy used by the a) the HLLC and b) the local steering committee to make decisions?

13) Is there anything else that you would like to add before we end this interview?

D. **Semi-Structured Interviews (External key informants)**

Hello. I've invited you to speak with me today because of your involvement with the (x committee) that is currently working to (state mandate of group). I would like to learn a bit more about your experiences or involvement with this local initiative and talk a bit about information and knowledge related issues in this context.

1) *To begin, would you please tell me a little bit about*

    i. *your professional history,*

    ii. *your educational background –*

    iii. *and what your organizational affiliation is*

2) What is your position relative to the -- Provincial Health Links framework that is being addressed by (*the local policymaking group of interest -- insert name of group*).

    i. What is your role/position in Health Links? How and when did you become involved with Health Links?

    ii. Does your agency/role contribute to the knowledge/information exchange with LHIN-based groups that have been tasked with implementation of Health Links?

3) How would you describe your involvement with groups working on implementation at the regional or local levels?

    i. Could you describe your involvement/connection to the Health Links initiative within the southwest LHIN, specifically?

4) Broadly speaking, what do you consider to be key resources necessary for the success of initiatives, tasked with implementing provincial policy and programs in local communities?

5) What types of information or knowledge sources do you consider important for groups working to create local policy to guide implementation of Health Links locally?

    What kinds of information and knowledge, do you think they might need to support decision-making processes?

6) In your opinion, does the Health Links initiative in the southwest have access to all the information and knowledge (*and other important resources – refer to answers provided to questions 4*) required?

    i. What constraints do local groups experience? (in terms of information/knowledge?) Are there gaps in knowledge and information available?

    ii. Does your agency/position have a role in addressing identified knowledge/information gaps? If so, how?

7) How important is timeliness of information?

This question is intended to access two features of timeliness. That is, how important it is that the information required can a) be accessed in a timely fashion and b) has been produced relatively recently? E.g. in the past months, year, 2 years, 5 years?

8) Is there anything else that you would like to add before we end this interview?

Curriculum Vitae

Name	Katherine L. Salter
Post-secondary Education and Degrees	1981-1984, B.A. (Psychology), Huron University College, University of Western Ontario, London, Ontario, Canada *Dean's Honours List & Tony DuMoulin Scholarship* 2010-2012, M.Sc. Rehabilitation Science, Faculty of Health and Rehabilitation Science, University of Western Ontario, London, Ontario, Canada 2012-2020, PhD., Health Promotion, Faculty of Health and Rehabilitation Science, University of Western Ontario, London, Ontario, Canada
Honours and awards	Dean's Honours List & Tony DuMoulin Scholarship 1981-1984 Mary Horney Research Fellowship SJHC/Parkwood Healthcare Foundation 2012-2013 Integrated Knowledge Translation Research Network, CIHR Post-doctoral research fellowship TBD
Related Work Experience	Research Assistant, Community Capacity Building Literature Synthesis and Review Department of Geriatric Medicine, Parkwood Hospital, St. Joseph's Health Centre, London, Ontario, Canada 2002-2003 Research Associate, Stroke Rehabilitation Evidence-based Review Aging, Rehabilitation and Geriatric Care, Stroke Rehabilitation and the Collaboration of Rehabilitation Research Evidence (CORRE) Research Group, Lawson Health Research Institute, Parkwood Hospital site, London, Ontario, Canada 2003-2013 Research Assistant, Musculoskeletal Evidence-based Review Schulich School of Medicine, University of Western Ontario, London, Ontario, Canada 2013-2014 Research Assistant, Locally-Driven Collaborative Projects, Develop and Test Indicators of Ontario Local Public Health Agency Work to Address the Social Determinants of Health to Reduce Health Inequities Public Health Ontario/UWO partnership project, London, Ontario May 2014 – August 2016 Research Assistant, VEGA project (Violence, Evidence, Guidance and Action), Faculty of Health and Information Science, University of Western Ontario, London 2016-2017

	Research Assistant, Socio-Cultural and Environmental Health Risks and Resilience among Street-Based Women and Transgender Sex Workers, Faculty of Health Sciences, University of Western Ontario, London, ON 2018-2019 Graduate Research Assistant, SSHRC Mobilizing Narratives project Department of Nursing, Western University, London, ON 2018 – present Partner, WorkHORSE Consultants (Health Outcomes, Research and Service Evaluation); Current Projects: SouthWest Frail Senior Strategy – needs-based capacity planning; London, Ontario, Canada March 2019 – March 2020
Publications: reports	Pellizzari R, Kothari A, Cohen B, LeBer M, **Salter K**, LeMieux S, Moran K, Antonello D, Robson J, Wai C et al. Develop and Test Indicators of Ontario Local Public Health Agency Work to Address the Social Determinants of Health to Reduce Health Inequities: Phase 1 Report: Review of the Literature. Locally Driven Collaborative Project, PHO, July 2015. Pellizzari R, Kothari A, Cohen B, LeBer M, **Salter K**, LeMieux S, Moran K, Antonello D, Robson J, Wai C et al., Develop and Test Indicators of Ontario Local Public Health Agency Work to Address the Social Determinants of Health to Reduce Health Inequities: Phase 2 Report: A case study approach to pilot test indicators. Locally Driven Collaborative Project, PHO, March 2016 Pellizzari R, Kothari A, Cohen B, LeBer M, **Salter K**, LeMieux S, Moran K, Antonello D, Robson J, Wai C et al., Develop and Test Indicators of Ontario Local Public Health Agency Work to Address the Social Determinants of Health to Reduce Health Inequities: Health Equity Indicators for Ontario Local Public Health Agencies – User Guide, Locally Driven Collaborative Project, PHO, April 2016. MacGregor, J. C. D., **Salter, K**., Wathen, C. N. for the VEGA Project. Responding to family violence in specific groups: Brief overviews. London, Canada. 2016. MacGregor, J. C. D., **Salter, K**., Wathen, C. N. for the VEGA Project. Interventions for Adult Perpetrators of IPV: Systematic Review**.** London, Canada. 2016. McTavish J, **Salter K**. for the VEGA Project. Interventions that address maltreatment recurrence: A systematic review. London, Canada. 2017.
Publication: refereed journal articles	**Salter K**, McClure JA, Mahon H, Foley N, Teasell R. Adherence to Canadian Best Practice Recommendations for Stroke Care: Assessment and management of poststroke depression in an Ontario rehabilitation facility. *Top Stroke Rehabil* 2012;92(2):132-140. **Salter K**, Foley N, Zhu L, Jutai JW, Teasell R. Prevention of Post-Stroke Depression: Does prophylactic pharmacotherapy work? *Journal of Stroke and Cerebrovascular Diseases*. 2013 Nov;22(8):1243-51. Foley N**,** Pereira S, **Salter K**, Fernandez M., Speechley M, Sequeira K, Miller T, Teasell R. Treatment with Botulinum Toxin improves upper extremity function post stroke: a systematic review and meta-analysis. *Archives of Physical Medicine and Rehabilitation* 2013 94(5): 977-989. Eskes, G. A., Lanctôt, K. L., Herrmann, N., Lindsay, P., Bayley, M., Bouvier, L., Dawson, D., Egi, S., Gilchrist, E., Green, T., Gubitz, G., Hill, M. D., Hopper, T., Khan, A., King,

	A., Kirton, A., Moorhouse, P., Smith, E. E., Green, J., Foley, N., **Salter, K**., Swartz, R. H. and Heart Stroke Foundation Canada Canadian Stroke Best Practices Committees (2015), *Canadian Stroke Best Practice Recommendations*: *Mood, Cognition and Fatigue Following Stroke* practice guidelines, update 2015. International Journal of Stroke. doi: 10.1111/ijs.12557 **Salter K,** Kothari A. Using Realist Evaluation to Open the Black Box of Knowledge Translation: A state-of-the-art review. *Implementation Science.* 2014 Sep 5;9:115 **Salter K**, McClure JA, Foley N, Sequeira K, Teasell R. Pharmacotherapy for depression post traumatic brain injury: a meta-analysis. *Journal of Head Trauma Rehabilitation*. 2016, 31(4) E21-E32. **Salter K,** Kothari A. Knowledge 'Translation' as social learning: negotiating the uptake of research-based knowledge in practice. *BMC Medical Education.* 2016: 16:76 Helen Butlin, **Katherine L. Salter**, Amanda Williams, Carla Garcia, PracticeCALM: Coaching Anxiety Lessening Methods for Radiation Therapists: A Pilot Study of a Skills-Based Training Program in Radiation Oncology, Journal of Medical Imaging and Radiation Sciences, Volume 47, Issue 2, June 2016, Pages 147-154.e2, ISSN 1939-8654, http://dx.doi.org/10.1016/j.jmir.2015.12.002. Cameron J, O'Connell C, Booth R, Lindsay P, Boyle R, Cheung D, Cooper N, Corriveau H, Dulude A, Flaherty P, Holzmann J, Hurteau P, Lamy E, LeClaire S, McMillan T, Murray J, Scarfone D, Shum, V, Taylor K, Taylor T, Yanchula C, Foley N, **Salter K**, and Swartz, RH *on behalf of the Heart and Stroke Foundation Canada Canadian Stroke Best Practices Committees; Canadian Stroke Best Practice Recommendations*: Managing Transitions of Care following Stroke, Guidelines Update 2016, *International Journal of Stroke*, 11(7), 807-822. **Salter, K**, Salvaterra RP, Antonello D, Cohen BE, Le Ber MJ, Kothari A, Lemieux S, Moran K, Rizzi K, Robson J, Wai C. Organizational Level Indicators to Address Health Equity Work in Local Public Health Agencies: A Scoping Review, Canadian Journal of Public Health, 2017, 108(3), Cohen B., **Salter K**, Kothari A, Janzen LeBer M, LeMieux S, Moran K, Wai C, Antonello D, Robson J, Salvaterra R. Indicators to Guide Health Equity Work in Local Public Health Agencies: A Locally Driven Collaborative Project in Ontario**.** *Journal of Health Promotion and Chronic Disease Prevention*, 2018, 38 (7-8), 277-285. Orchard T, Murie A, **Salter K**, Elash H-L, Bunch M, Middleton C, Benoit C. Balance, Capacity and The Contingencies of Everyday Life: Narrative Etiologies of Health Among Women in Street-Based Sex Work. Qualitative Health Research 2019, https://doi.org/10.1177/1049732319855967
Conference Proceedings	**Salter K**, McClure JA, Foley N, Teasell R. Treatment of post-stroke insomnia during inpatient rehabilitation: the use of sedating antidepressants. 3rd Canadian Stroke Congress, Calgary Alberta. September 29-October 2, 2012, Stroke, 2012; 43 (11); e140. **Salter KL**, McClure JA, Foley N, Orange JB, Teasell R. Adherence to Canadian best practice recommendations for post-stroke depression: who are we treating anyway? 3rd Canadian Stroke Congress, Calgary Alberta. September 29-October 2, 2012, Stroke, 2012; 43 (11); e140.

	Salter KL, McClure JA, Sequeira K, Foley NC, Teasell RW. Pharmacotherapy for depression post traumatic brain injury: a meta-analysis. <u>2012 Joint Annual ACRM-ASNR Conference</u>, Vancouver, British Columbia, Canada, October 9-13. Archives of Physical Medicine and Rehabilitation. October 2012, Poster 43, e26. Macaluso S, **Salter K.** Does Imaging Guidance Improve Patient Outcome Following Corticosteroid Injections of the Shoulder? Presented at the <u>62nd annual scientific meeting of the CAPMR</u>, St. John's Newfoundland, Canada, June 18-21, 2014. Macaluso S, **Salter K**, Manocha R, Batey C. Nutritional Supplementation for Knee Osteoarthritis. Presented at the <u>62nd annual scientific meeting of the CAPMR</u>, St. John's Newfoundland, Canada, June 18-21, 2014. (Poster award winner) Macaluso S, Manocha R. **Salter K**, Batey C. Clinical review of acupuncture for Non-traumatic shoulder pain. Presented at the <u>62nd annual scientific meeting of the CAPMR</u>, St. John's Newfoundland, Canada, June 18-21, 2014. Meyer, M. J., Sooley, D., Tee, A., Morrison, K., McConnachie, S., Gallardi, A., Plewes, S., O'Callaghan, C., Kelloway, L., McClure, A., **Salter, K.,** Foley, N., Moher, C., Developing a Decision-Making Model for Investment in Outpatient and Community-Based Rehabilitation for Stroke Patients in North Simcoe Muskoka , <u>Canadian Stroke Congress</u>, Oct 04-07, 2014, Vancouver, CANADA; Stroke 45(12): E276. **Salter K**, Kothari A. Using Realist Evaluation to Open the Black Box of Knowledge Translation: A state-of-the-art review**.** <u>Faculty of Health Science Research Day. Western University</u>, London, ON, Canada, March 25, 2015. Chawla, K., **Salter, K**, Meyer, M. Experience-based design in healthcare evaluations. <u>Canadian Evaluation Society Conference</u>, May 2017, Vancouver, BC.
Invited Presentations	Teasell R, **Salter K**. Screening for Depression Following Stroke: Why Bother? <u>3rd Canadian Stroke Congress</u>, Calgary Alberta, September 29th, 2012. Invited Workshop Presentation. **Salter K**. Invited Panelist: Outcome Measurement Resources for Clinicians. A symposium presentation. Session Chair: Dr. A. Heinemann. <u>Joint ACRM-ASNR Annual Conference</u>, Vancouver BC, October 9-13, 2012. **Salter K. I**nvited speaker and instructor: Scoping Review workshop – <u>Public Health Ontario</u>, Toronto, Ontario January 2016: Develop and Test Indicators of Ontario Local Public Health Agency Work to Address the Social Determinants of Health to Reduce Health Inequities – Phase 1a: A Scoping Review Case Study T. Lambert, S. Lemieux, K. Moran, R. Salvaterra, **K. Salter**, C. Wai. *A Wicked Problem: Developing and Testing Indicators to Guide Health Equity Work in Public Health*. Workshop presentation at the <u>TOPHC Conference</u>, Toronto Ontario, April 2016. R. Salvaterra, C. Wai. **K Salter**. Invited presentation to the <u>Health Equity Office at the Ministry of Health and Long-term Care</u>. May 5, 2016, Toronto Ontario *A Wicked Problem: Developing and Testing Indicators to Guide Health Equity Work in Public Health*

	R. Salvaterra, A. Kothari, **K. Salter**, C. Wai. Invited presentation to the <u>Standards Branch of Public Health Ontario</u>, May 31, 2016, Toronto, Ontario. *A Wicked Problem: Developing and Testing Indicators to Guide Health Equity Work in Public Health*
	K Salter, D. Antonella. Invited presentation to <u>Ontario Public Health Nurses Network</u>. September 29, 2016. Recorded online webinar. *Health Equity Indicators for Ontario Local Public Health Agencies*.