DECISION MAKERS' EXPERIENCES OF COLLABORATING WITH RESEARCH TEAMS ON FEDERALLY FUNDED HEALTH RESEARCH INITIATIVES: AN INTERPRETIVE DESCRIPTIVE QUALITATIVE STUDY

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ABSTRACT

Within the current paradigm of evidence-informed decision making we assume that research findings will be used to guide health services practice and policy decisions. The gap between research findings and usual practice is concerning to decision-making and research communities. Collaborative research is a promising approach to facilitate the movement of research evidence into policy and practice, whereby researchers are encouraged to partner (with decision makers) to conduct research for the common goal of solving complex health issues. The purpose of my study was to explore and describe decision makers' experiences of participating on collaborative research teams executing a federally funded health research initiative. The principles of interpretive description were used to guide sampling, data collection, and analytic decisions. A purposeful sample of 27 decision makers, identified as collaborators on grants from the Canadian Institutes of Health Research (CIHR) Partnerships for Health System Improvement (PHSI) program, was invited to participate in two in-depth interviews. Conventional content analysis was used to identify concepts emerging from the data. The conceptual framework was developed inductively from the descriptive data and provided a structure for interpreting decision maker perspectives of collaboration. The framework posits an explanation leading to contextual understanding of their experiences. This research contributes new knowledge about factors affecting PHSI engagement, including availability of new funding; positive history with the researcher; prospect of tangible benefits to constituents of decision makers; the desire to contribute to research that informs health services programs and policies; capacity building; and knowledge creation. Recommendations to facilitate the partnership process underscore the importance of fostering connections among partners; identifying required skills and competencies; maintaining a sustainable focus of inquiry; clarifying roles and responsibilities; and cultivating a nurturing, learning environment. The study findings will inform decision makers, researchers, and funding agencies about the experience and legacy of collaborative research partnerships.

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I would like to dedicate this thesis to my exceptional family: Gerard, Gerard Junior, Melanie, Conor James, and Aoife. Your unfaltering love and support have guided me throughout this experience.

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DECLARATION OF ACADEMIC ACHIEVEMENT

I, Anne Moore-Cox, declare this thesis to be my own work. I am the sole author of this document. No part of this work has been published or submitted for publication or for a higher degree at another institution.

To the best of my knowledge, the content of this document does not infringe on anyone's copyright.

My supervisor, Dr Susan Jack, and the members of my supervisory committee, Dr Lisa Schwartz and Dr Don Willison, have provided guidance and support at all stages of this project. I completed all of the research work.

CHAPTER 1: INTRODUCTION

Within the current paradigm of evidence-informed decision making, the assumption is that the findings emerging from health services research will have a key role in informing practice and policy decisions in Canada. The gap between research findings and usual practice is cause for concern to members of the decision-making and research communities. To increase the impact of health research and the utilization of findings at all levels of decision making, researchers are being actively encouraged by funding agencies and governments to find ways to facilitate the movement of research evidence into health policy and practice (Canadian Institutes of Health Research [CIHR], 2013; Graham & Tetroe, 2007; Martens & Roos, 2005).

One strategy for doing so, is the utilization of collaborative research approaches. In this process, researchers are encouraged to partner with decision makers and policy makers to conduct research for the common goal of solving complex health issues. A collaborative research approach has the potential to enhance the health of communities due to its focus on building trust, developing relationships with partners, and using study findings to help bring about program, practice, and policy changes that have the potential to improve health outcomes (Golden-Biddle et al., 2003; Israel, Schulz, Parker, & Becker, 1998; Kothari & Wathen, 2013; Minkler, Blackwell, Thompson, & Tamir, 2003; Minkler & Wallerstein, 2002; Viswanathan et al., 2004). However, it is essential to involve decision makers early on in the development of the research study and continue to engage them throughout the entire research process. This strategy has resulted in researchers thinking critically not only about knowledge translation (KT) but also about developing and sustaining partnerships.

To facilitate the integration of research evidence into the complex process of decision making, funding agencies have recognized the importance of including decision makers within the research process. Thus, several Canadian agencies have developed collaborative partnership funding opportunities for health research, with an emphasis on translating research findings into practice. In June 2000, the Canadian Institutes of Health Research (CIHR) issued a mandate encompassing health research and KT, the objectives being to excel in the creation of new knowledge and its translation for more effective health services, an improved health care system, and better population health outcomes. The CIHR supports these concepts and recently coined the term *integrated knowledge translation* (IKT) to mean a complex collaborative process engaging all partners in the entire research initiative, working together to shape the research question. The goal of these multidisciplinary partnerships is to promote a two-way knowledge exchange between researchers (knowledge creators) and decision makers (knowledge users) to meet the unique needs of decision makers while at the same time producing relevant research evidence. The benefits of partnership and collaborative research endeavours include the ability to affect policy development, diversity of skills, and the knowledge that various partners bring to the collaboration (CIHR, 2013; Flicker, 2008; Golden-Biddle et al., 2003).

This thesis will offer a qualitative exploration of decision makers’ perspectives of this strategy within a federally funded health research initiative. Qualitative methods were selected to guide this study to gain a contextual understanding of experiences of decision makers in an IKT partnership program for health system improvement. Interpretive description was the qualitative approach chosen to guide all sampling, data collection, and analytic decisions. To shed light on their experiences in the research process, interviews were conducted with primary decision makers who have received federal health research funding, notably from the CIHR Partnerships for Health System Improvement (PHSI) program. Conventional content analysis was used to code data, create categories, develop a framework, and identify overarching themes and patterns.

The PHSI program supports teams of researchers and decision makers interested in conducting applied and policy-relevant health systems and services research that responds to the needs of health care decision makers and strengthens the Canadian health care system. My research is within the realm of IKT, whereby research findings are used to inform decisions related to health care practice and policy. Although there are many models of KT, most models emphasize the importance of the development and maintenance of decision maker–researcher partnership to support the translation of research findings into practice. Through exploration of the experiences of decision and policy-making partners, my research study will inform us how to support and improve collaborative health research, which should subsequently strengthen the impact of Canadian health research.

Collaborative Research

There has been a resurgence of interest in collaborative research. Under this framework, researchers are encouraged to actively and equitably partner with decision makers at the clinical, managerial, or policy levels (CIHR 2008, 2013; Flicker, Savan, Mildenberger, & Kolenda, 2008). Collaborative research is a participatory, democratic approach to the design and completion of research as well as the dissemination of the findings. The novel elements of collaborative research centre on equal partner participation in describing the research problem, defining the research design, and developing KT activities. In effective collaborations, each member plays a vital role, contributing to the development and sharing of knowledge (Himmelman, 1996). Partners are actively involved in the area under study, with the common goal of addressing and solving complex health issues (Bowen & Martens, 2005; Graham & Tetroe, 2009; Lomas, 2000). Subsequently, collaborative research provides a vehicle for the dissemination of findings. Research findings should be utilized to inform health policy and accomplish long-term systems change objectives.

Ideally, all partners will benefit from a collaborative research approach. These benefits can create goodwill and lay the foundation for subsequent alliances and partnerships (Bowen & Martens, 2005; Israel et al., 1998; Minkler, 2000; Minkler & Wallerstein, 2002; Minkler et al., 2003; Schensul, 1999; Seifer, 2006; Viswanathan et al., 2004).

Why Collaborate?

Health care reform driven by the present political and economic realities will change our health care system. These changes will likely affect the manner in which health care policy is developed and health care is delivered. Health services research focuses on answering questions pertaining to the organization, management, financing, and impact of public health care services. Ongoing health services research is required if decision makers and researchers are to address the challenges of the future. This need is recognized by many, evidenced by the number of researchers exploring medical health care delivery and the cost-effectiveness and utilization of health care services and programs (Davies & Nutley, 2008; Graham & Tetroe, 2007; Minkler, 2000; Minkler & Wallerstein, 2002; Walter, Davies, & Nutley, 2003).

Developing strong, mutually beneficial collaborations is key to strengthening health services research (Sullivan et al., 2001). Bringing together and focusing the energy of decision makers and researchers alike on shared goals and collaborative endeavours should allow more rapid development of health services research. Collaboration provides opportunity for partners to share responsibilities and resources and may occur between individual researchers, decision makers, or other organizations or disciplines.

Engagement in an equitable research partnership means that the inquiry and development of the research questions arise from both practical and scientific perspectives, often those of the decision maker and the academic researcher. Collaborative research can be a demanding and difficult process as it requires a shared interest and a common commitment (Bickel & Hattrup, 1991). Among the key components of this cooperative relationship is the promotion of relevant research, capacity building, and co-learning. Green (2006) identifies a collaborative approach to inquiry as a very effective way to enhance the significance of and value to health services research and practice.

Viswanathan et al. (2004) report that working collaboratively with diverse communities, in both research and practice, is key to the success of public health. When included in policy deliberations, the voices of leaders can help bring about innovation and sustain change while ensuring that the dialogue addresses root causes and broader health policy changes. One expectation of collaborative efforts is to increase the relevance and availability of findings to multiple stakeholders. For example, evidence of the effectiveness of health care services and efficiencies associated with the delivery of health care is considered vital to policy makers as they develop, adapt, and implement the programs they offer.

Collaborations involving organizations in a community context are becoming more prevalent. There is evidence that university-community initiatives can be effective, and the literature reports positive outcomes from these collaborations (Mayfield, 2001; Pew Partnership for Civic Change, 2003; Seifer and Maurana, 1999). Several funding agencies (for example, the CIHR, the Canadian Health Services Research Foundation [CHSRF], and the Social Sciences and Humanities Research Council [SSHRC]) promote collaborative research partnerships through the establishment criteria for funding opportunities. Application requirements stipulate that recipients of these funds join together to maximize their power to effect change through action. Furthermore, through these initiatives, it is anticipated that health services policy will be better informed by research evidence and findings (Bullock, Morris, & Atwell, 2012).

Benefits of Collaboration

Collaborative research may be regarded as an approach to inquiry; it is a joint process of knowledge production leading to new insights for researchers and decision makers. Experiences with partnership and collaborative research endeavours reveal many benefits, including the ability to affect policy development and effect change promptly, the development of skill diversities among partners, and the adoption and utilization of the specific professional or contextual knowledge that the various partners bring to the collaboration (Flicker, 2008; Golden-Biddle et al., 2003). Mayo, Tsey, and the Empowerment Research Team (2009) expand the benefits to include opportunities to develop skills and confidence within the community, the facilitation of recruitment initiatives, the enhancement of research quality, and the improvement of health outcomes. Parker et al. (2003) describe the valuable contributions community partners make to the design, planning, and implementation of research. However, according to Hanson (1988), it is advisable to involve decision makers early on in the development of the research study and to continue their engagement throughout the entire process.

Review of the literature suggests that successful collaboration is possible only when it is based on trusting, honest relationships characterized by commitment, openness, and active involvement. It seems apparent that successful collaboration is dependent on having buy-in from the decision makers, who provide essential access and experience.

Learning to share power and decision making, developing positive relationships, and understanding different agendas and timeframes may be challenging to researchers, who are used to making all the decisions independently. The research focus must match community priorities, so researchers who pursue collaborative research projects need to have a high degree of flexibility to accommodate the inherent variability and diversity of such work. They must be willing to spend considerable time investing in the process and seeking “win-win” solutions to the challenges they encounter (Israel et al., 1998; Sibbald, Kothari, & Wathen, 2010; Viswanathan et al., 2004).

Green et al. (1995) describe the benefits to decision makers working in collaboration with researchers and the development of knowledge that is applicable in other contexts. The authors recognize that the overlap between KT and collaborative research is an especially fertile area for enhancing the relevance of and adding value to health research. The successful implementation of new evidence in practice is more likely to occur when (1) the scientific evidence is viewed as robust and fitting with professional and patient beliefs; (2) the health care context is receptive to implementation in terms of supportive leadership, culture, and evaluative systems; and (3) the appropriate mechanisms are in place to facilitate implementation (Israel et al., 1998; Viswanathan et al., 2004). Rycroft-Malone et al. (2004) noted that the creation and implementation of research evidence are social processes; passively handing research evidence to practitioners is unlikely to promote its use. Lavis, Robertson, et al. (2003) propose that the key information and the delivery strategy must be “fine-tuned” (p.221) to the types of decisions and the environment in which the target audience works. Effective strategies for change include techniques such as educational outreach, audit and feedback, evidence-based guidelines, and the influence of key opinion leaders, with the most effective implementation strategies being multifaceted.

Challenges of Collaboration

Collaboration does not always evolve easily or lead to successful outcomes. An attitudinal shift may be required of the participants around issues such as shared power, ownership of the research process, roles and responsibilities, and commitment to partners' priorities. In addition, the collaborative research approach does not align with the usual perceptions of research, and there are reports in the literature of a lack of appreciation for the rigor and value of collaborative research. Furthermore, the slow pace of collaborative research processes may make it difficult for academic researchers to meet the scholarly requirements of their home institutions and result in delays for researchers achieving promotion and tenure (Ahmed, Beck, Maurana, & Newton, 2004; Denis, Lehoux, Hivon, & Champagne, 2003; Hall et al., 2006; Israel et al., 1998; Nyden, 2003; Nyden & Wiewel, 1992; Prins, 2005).

In the past, decision makers may have seen themselves as being on the periphery of the traditional research process. Collaborative research allows decision makers more control over the development of research questions and a greater role in using the research findings. Decision makers face challenges similar to those of researchers. They need to understand the research timelines and academic requirements of researchers. Determining what is required to build and sustain meaningful relationships is also challenging. To achieve success requires consideration of key elements, such as the investment of time, sharing of resources, and patience. Decision makers need to understand that, in collaborative research, an accepting attitude is required and that they, as decision makers, are expected to contribute to and participate equally in the research process (Ross, Lavis, Rodriguez, Woodside, & Denis, 2003; Savan, Flicker, Kolenda, & Mildenberger, 2009).

Due to their relatively long time scale, collaborative research endeavours face a particular vulnerability to change that arises from a variety of sources. Membership can be affected by changes in partners’ life situations (such as illness, career aspirations) and employment status. The external context can shift as a result of elections or changes in administrative structure or philosophy.

The Research Dimension of a Collaborative Approach

The research dimension of collaborative research approaches can involve a wide range of qualitative, quantitative, and mixed methods. The unique aspect of collaborative research is that no matter which methodology is chosen, the emphasis is always on the engagement and participation of stakeholders throughout the entire process, which should facilitate the study findings being used to bring about change. The principles of collaborative research and its themes of engagement and empowerment articulate how this approach differs from traditional “top-down” research practices.

When a traditional research approach is implemented, the relationship between the researcher and the researched is very clearly defined. In essence, there is no working relationship between the two parties; they function in distinct worlds that differ in focus, structure, and culture. Circumstances change dramatically with the implementation of a collaborative research approach, where the perspectives of all partners and their differences of opinion are important for the process of inquiry and reflection. To proceed systematically in the collaborative research process, partners need to understand the context and parameters within which the other operates.

Collaborative research allows the academic researcher to conduct research that meets the needs of the community as identified by the decision makers. In the process, both parties gain enhanced understanding of the relevance of the research and an appreciation of the role and value of each other's contributions (Kennedy, Vogel, Goldberg-Freeman, & Kass, 2009).

Background to the Research Study

In 2003–2007, I worked as a clinical research manager with an obesity specialist. My most satisfying and, indeed, most challenging experiences derived from preparing a funding proposal, in collaboration with a team of hospital administrators and decision makers, for an obesity clinical care and research program. The opportunity provided a platform to all partners to play a substantial role in the identification of the problem, the design of the intervention, and the implementation of findings. Furthermore, this opportunity to support the capacity of partners to work together with a shared vision on a common goal was rewarding. The ability to engage, participate, and problem solve was highly valued, as was the importance of recognizing the involvement of partners and their contributions. Acknowledging that all partners had much to contribute to the process was an interesting exercise in co-learning. The willingness of partners to share power and resources and to adopt the principles of collaboration created an exciting and satisfying experience. The combination of capacity building, innovation of methods, and support for the substantive involvement of all partners created a sense of synergy.

The current political and economic climates are such that researchers and decision makers are being encouraged to work together. To facilitate the integration of research evidence into the complex process of decision making, funding agencies have also recognized that the relevance and usefulness of the research are increased by including decision makers in the research process. With the encouragement of collaborative research approaches by funding agencies, there are a growing number of (funding) opportunities for health researchers that stipulate the use of collaborative partnership strategies. The objective of these funding initiatives is to produce knowledge through meaningful collaboration between researchers and partners, with the expectation of translating research findings into practice (Golden-Biddle et al., 2003; Green et al., 1995; Seifer, Shore, & Holmes, 2003; Minkler et al., 2003; Viswanathan et al., 2004).

Although the proposal we developed in 2006 for an obesity program was not funded, we found the experience rewarding. Upon reflection, it is clear that many of us were quite naïve about what the collaboration would entail and how events might evolve. There is now an accumulating literature on what factors are associated with successful outcomes in collaborative research, and much has been written on what researchers experience (for example, see Kennedy et al., 2009; Nyden & Wiewel, 1992; Sullivan et al., 2001). There is little information on the experiences and views of decision makers (Bullock et al., 2012; Denis et al., 2003; Ross et al., 2003).

In studying CIHR-funded Partnerships for Health System Improvement (PHSI) projects, my goal was to increase my knowledge of decision maker–academic researcher collaboration and, in the process, contribute to the existing knowledge base. Furthermore, I wanted to solicit advice from decision makers on how to develop and sustain relationships with researchers that would foster and sustain collaboration. My research work focuses on furthering understanding of collaborative research initiatives and how participation is experienced and given meaning by decision makers. By articulating the dimensions of the decision maker experience, the findings begin to reveal the essential components required for this type of collaboration. The findings of my work will be of interest to colleagues active in health services research, practice, and policy.

Context of Collaborative Research Initiatives

In June 2000, the CIHR issued a mandate encompassing health research and KT. The objectives were to (1) excel in the creation of new knowledge, (2) translate this new knowledge into more effective health services, and (3) develop an improved health care system leading to better population health outcomes (CIHR, 2000).

The CIHR uses the term IKT to mean a complex collaborative process of inquiry engaging all partners in the entire research initiative (Graham & Tetroe, 2007). The intention of these multidisciplinary partnerships is to undertake research with a high level of scientific rigor, to foster collaboration by building on each other’s strengths, and to promote a two-way knowledge exchange between researchers (knowledge creators) and decision makers (knowledge users) (CIHR, 2000). Research conducted in partnership is likely to be more meaningful and may lead to findings to meet the unique needs of decision makers that inform practice and have an impact on public health (Bartunek, Trullen, Bonet, & Sauquet, 2003; Bowen & Martens, 2005; CIHR, 2013; Graham & Tetroe, 2007; Rynes, Bartunek, & Daft, 2001).

Partnerships for Health System Improvement Initiatives

The CIHR's PHSI is Canada's premier health services and policy research funding opportunity—and with its strong emphasis on partnerships and KT, it is a major resource for decision makers who want relevant research to inform their decision making. The intent of the PHSI program is to support the development of research infrastructure through the creation of a research capacity–building initiative. The program provides an opportunity to bring decision makers and researchers together who are interested in conducting applied and policy-relevant health systems and services research on a broad range of projects.

In collaborative research, much time and effort are needed for the development of productive, meaningful partnerships. The PHSI provides financial support to help research teams build, foster, and sustain partner engagement. Allowing time for solid, trusting partnerships to develop and committing time to the planning of the research initiative have been shown to be indicators of project success (Kothari, MacLean, Edwards, & Hobbs, 2011; Viswanathan et al., 2004). Successful, productive partnerships may also provide for a reliable future research alliance.

The benefits of PHSI participation to researchers include the opportunity to direct research questions toward issues of community relevance and access to decision makers. The decision maker's unique expertise may guide researchers to refine the research question and add revisions to the study protocol. Decision makers have a special perspective on local issues. Through partnership with researchers, decision makers may use the study findings to launch new initiatives and receive endorsement of new policies, practices, and services that they designed and implemented. Dissemination of study findings should broaden the impact of the study to a wider audience. The benefits of collaborative research initiatives to the community include access to an outside perspective on local issues and access to research tools that may be used to analyze the impact and effectiveness of programs (Antil, Desrochers, Joubert, & Bouchard, 2003; Bartunek et al., 2003; Goering, Butterill, Jacobson, & Sturtevant, 2003; Krebbekx, Harting, & Stronks, 2012; Rynes et al., 2001).

Purpose of the Study

This study was initiated to learn about decision makers' perspectives on partnership with researchers, and the major focus was to present decision makers' voices and explore their perspectives on partnership on PHSI initiatives.

The purpose of this study was fourfold: to address a gap in the literature; to gain an understanding of decision makers' perspectives of collaboration within a federally funded health research initiative; to contribute useful new knowledge about strategies to support collaborative health services; and to encourage greater engagement, linkage, and exchange between decision makers and researchers. Collaborative research partnership is complex, raising important practical and ethical challenges. Through this study, I explored the development of decision maker–researcher relationships into functioning collaborations and the subsequent engagement of decision makers in the interpretation and dissemination of research findings. This topic merits further examination in the Canadian context, which was the intention in this study.

KT is about putting knowledge into practice. Bridging the gap between what we can be doing and what we actually do will yield a large health dividend, which can subsequently strengthen Canadian public health systems and services. According to Sir Muir Gray of the NHS National Knowledge Service, “In the nineteenth century health was transformed by clear, clean water. In the twenty-first century, health will be transformed by clean clear knowledge” (Gray, n.d.).

Significance of the Study

The study has significance for several reasons. First, previous studies have failed to capture decision makers’ perspectives on the experience of partnership with academic researchers. Thirty-five studies were funded during 2008 and 2009 under the auspices of the CIHR PHSI initiative. It is important to study these specialized PHSI partnerships and to explore, from the decision maker’s perspective, their evolution, development, and sustainability of these patnerships. This study will contribute to the field by increasing the depth of knowledge of decision makers' PHSI partnership experiences. It is anticipated that "improved application of what we already know will have a bigger impact on health and disease than any single drug or technology likely to be introduced in the next decade" (Gray, 2007, p. 4).

Second, collaborative research has evolved to become a popular research paradigm. Building formal decision maker–researcher partnerships are relatively new endeavours; research focusing on the decision maker's perspective is limited. Studies on decision maker–researcher partnerships typically focus on the (academic) researcher's perspective or approaches to partnership. PHSI decision maker–researcher partnerships were developed in response to a request for proposals from the CIHR. Through exploration of the experiences of decision- and policy-making partners, it is anticipated that the study findings will inform those entering into decision maker–researcher partnerships. Information about decision makers' experiences may be used by other partnerships working to sustain current efforts.

The research findings will (1) be a starting point for considering tangible ways of fostering connection and inclusion in the KT process; (2) contribute new knowledge in the form of strategies for engaging decision makers in collaborative public health systems and services research; (3) inform future decision makers, researchers, and funding bodies who are responsible for promoting health research of the highest quality about the benefits and costs associated with this involvement; and (4) develop understanding of the role and influence of decision makers in the transfer and uptake of research findings.

Thesis Roadmap

My thesis is composed of the following five chapters: Chapter 1, Introduction; Chapter 2, Review of the Literature; Chapter 3, Research Methodology; Chapter 4, Results; and Chapter 5, Discussion.

Chapter 1 sets the context for the study. It discusses the significance of research on collaboration and describes the focus of the dissertation. It provides an overview of decision maker–researcher collaboration, introduces the CIHR PHSI funding initiatives, and offers an explanation of the purpose and significance of the research study.

Chapter 2 is a literature review of the theoretical and empirical literature on collaboration. Relevant collaboration theory is outlined. Previous research in the area of decision maker–researcher collaboration is critically examined. Empirical studies specific to decision maker–researcher collaboration are reviewed. The chapter concludes with a summary of the gaps in current knowledge.

Chapter 3 responds to the literature review and describes Freire’s Dialogical Framework. Freire’s ideas offer an interesting perspective for viewing the engagement of decision makers with researchers and the nature of this collaboration (Freire, 1970). First, a description of the PHSI projects and the paradigm chosen for the study is presented; then the main research question and its secondary questions are presented. A systematic data collection and analysis plan flows from the questions. Information including sample selection, analysis methods, ethical considerations, and limitations is discussed.

Chapter 4 reports the qualitative findings of the study. The chapter begins with a detailed description of the background and history of the decision maker–researcher PHSI collaboration. Next, the conceptual framework developed from the data is described and provides a structure for interpretation and contextual understanding. The chapter progresses to include the recurring themes matching my data from interview transcripts, observation notes, member check transcripts, and documentation collected during the study. By providing quotations directly from the data, I hope to engage the reader in his or her own analysis process and to ensure that the presentation of findings is connected to the data.

Chapter 5 provides a discussion of the study's findings in relation to literature specific to collaborative research and to the framework for collaboration that was examined. Relationships among themes that emerged from the study are discussed. The final chapter also includes further discussion on insights, recommendations, and implications from the study and then concludes with suggestions for further research.

CHAPTER 2: REVIEW OF THE LITERATURE

To describe the nature of decision maker–researcher collaboration, three areas of the literature will be reviewed. First, following definitions of key terms used throughout the study, a historical overview of collaborative partnerships is described. Second, the experience of collaborative partnerships in health research is outlined, and third, an explanation of the study questions, purpose, and rationale is provided. The intention of this chapter is to provide the conceptual context for the methodology, research questions, and purpose of my research.

Literature Search Methodology

With the recent emphasis by funding agencies on the necessity to further engage stakeholders in research, my review of the literature was limited to studies focusing on decision maker–researcher partnerships in the period from 1988 to 2013. The initial review was based on the areas of focus stated above, and a list of inclusion and exclusion criteria was developed. Although the literature derives predominantly from the last two decades, a number of early foundational articles were also included (see Freire, 1970; Gramsci, 1982; Lewin, 1946). These papers and systematic reviews describing the definitions and history of collaborative research were included to provide conceptual and operational understanding of the approach.

I excluded letters and editorials. Furthermore, articles addressing continuing education and career development initiatives were excluded from review. The literature review focused on interorganizational partnerships among decision makers, policy makers, knowledge users, and researchers. Organizations included public, private, or nongovernmental agencies with representatives from several disciplines and professions, including law, business, health care practice and policy, social work, and education.

The literature search included the following electronic databases: PubMed, MEDLINE, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Scholars Portal, and ProQuest. Key search terms or combinations thereof included *collaboration*, *research*, *action research*, *collaborative inquiry*, *community-based research*, *community-based participatory research*, *cooperative behaviour*, *partnership(s)*, *integrated knowledge transfer*, *knowledge transfer*, and *knowledge exchange*, and *knowledge linkage*. After a review of the abstracts, 215 articles were selected for their relevance to the topic. Unpublished manuscripts and dissertations were excluded from the review.

Hand searching of references in exemplar publications provided a further 47 articles of relevance for my purposes. These articles were chosen as exemplars because they discuss or reference issues related to community-based research and partnerships. I purposely searched special journal issues that focused on aspects of partnership in a collaborative research context.

Additional references for consideration were identified by examining the bibliographies of articles collected during the electronic and physical searches of electronic journal indexes, library materials, and abstracts. This practice, commonly referred to as reference mining and citation snowballing, yielded some additional informative source materials. General concepts explored throughout all literature searching phases included types of partnership (e.g., decision maker's involvement in..., policy maker's involvement in..., decision maker driven versus researcher driven) and specific types of outcomes envisioned for these relationships (e.g., facilitators, barriers, changes in attitudes, practices, productivity).

Throughout the process, I kept track of the terminology used to classify each article as identified in PubMed or journal databases. Saturation was reached during hand searching (i.e., when I began to see no new articles). My search focus was on health care and social sciences. The literature search yielded diverse conceptual literature and many collaborative research studies. Although the research dimension of collaborative research approaches encompasses a wide range of qualitative and quantitative research methods, the literature search identified predominantly qualitative studies. Validated critical appraisal review tools (systematic review: DiCenso, Guyatt, & Ciliska, 2005; qualitative inquiry: Letts et al., 2007; quantitative research: Thomas, Ciliska, Dobbins, & Micucci, 2004) were accessed to guide my review.

Health Services Research

Mays, Halverson, and Scutchfield (2003) describe health services research as the study of the funding, organization, and impact of health care delivery systems and services on the health of the public. The resulting knowledge and evidence can be utilized to inform health care practice and policy decisions (Straus, Tetroe, & Graham, 2009a). Typically, health services researchers examine issues such as the cost, utilization, and efficiency of programs in the context of health care delivery, reform, and change. Growth in health services research initiatives has resulted from the challenge of how to manage escalating costs while still providing high-quality health care (Scutchfield, Marks, Perez, & Mays, 2007). The timely introduction of the Partnership for Health System Improvement (PHSI) funding opportunity by the Canadian Institutes of Health Research (CIHR, 2008) shows a commitment to fostering collaborative models for applied and policy-relevant health services research.

Within models of evidence-informed decision making, research evidence is an essential component of the decision-making process. Scholars have found that long-standing gaps exist between the production of research evidence and its utilization in practice and policy. This results in delays in the implementation of research findings and subsequent sustainability of quality health care programs and services. Collaborative research has been proposed as an innovative approach to support the translation of research findings into usable knowledge. Involving decision makers as collaborators in research may improve the overall quality and impact of research by increasing the potential for the translation of evidence-based research into sustainable change that can be broadly disseminated, enhance health policy, and improve the delivery of health care. It is anticipated that through collaborative processes, better informed research questions will be generated, more effective interventions will be developed, and the subsequent translation of research findings into practice will be enhanced (Golden-Biddle et al., 2003; Lavis, 2006; Lomas, 2000; Mitchell, Pirkis, Hall, & Haas, 2009; Ross, Lavis, Rodriguez, Woodside, & Denis, 2003).

Definition and Clarification of Key Terms

Collaboration is a relationship between two or more people, groups, or organizations that are working together cooperatively and equitably to achieve a common goal. The National Network for Collaboration Framework (1995) further describes this process as working together on the strengths of the community to achieve the desired results. Collective actions by people, groups, or organizations often result in greater progress and benefits than each could accomplish individually. Working collaboratively implies that the mutually beneficial relationship is based on trust and commitment. Collaboration is enacted through partnership, which comprises all forms of collaboration that bring people, groups, or organizations together.

A *partnership* is defined as a mutually respectful relationship where two or more parties, having common compatible goals, form an agreement to do something together. Partnerships provide an effective and practical approach to solving problems, seizing opportunities, and planning results. Furthermore, partnerships can empower people and systems to change for the better. There are many examples in the literature (Braun & Hocde, 1998; Jadad, 1999; Jones & Wells, 2007; King et al., 2010; Lasker, Weiss, & Miller, 2001; Zetlin & MacLeod, 1995) reporting successful partnership development, knowledge sharing, and the subsequent implementation of findings across a wide array of disciplines, including agriculture, nursing sciences, business, health care, information technology, and management.

Collaborative partnership is defined as an approach in which partnerships are formed among equals with complementary expertise (Downie et al., 2001). This approach is most often implemented in community-based partnerships where researchers and partners share resources, risks, and decision making. Researchers have recognized the need to reach out to community agencies who have the ability to reach vulnerable populations in ways that are not available to them. The study findings may then be used in ways that benefit the community and for the purposes of advocacy. Collaborative partnership is beginning to be established in some clinical specialties, for example, the development of acquired immuno-deficiency syndrome (AIDS) prevention strategies (Schensul, 1999).

An assortment of terms have been used to describe the phenomenon of involving groups of people in tackling issues of relevance to their local communities and doing these activities within a research framework. These terms include *collaborative research*, *community-based research*, *collaborative research*, *partnership research*, *participatory action research*, and *action research*. Differing views on which of these terms is most acceptable exist, each of which signifies a somewhat different meaning to the understanding of working with partners. Definitions of commonly applied forms of collaborative research are provided in Table 1.

Collaborative research is characterized by high levels of partner engagement throughout the complete research process. Those involved learn that each partner brings distinctive skills and experiences to the collaboration; for example, the decision maker will have unique knowledge of community perspectives and needs, whereas the researcher will have the "technical" expertise. There is equal participation in defining the research question and designing the study along with shared responsibility for decision making.

Table 1: Collaborative Research Partnerships

Partnership Approach to Research	*Participatory Research*	*Community-Based Participatory Research*
Israel et al. (1998) describe a partnership approach to research that "equitably involves, for example, community members, organizational representatives, and researchers in all aspects of the research process; with all partners contributing their expertise and sharing responsibility and ownership to enhance understanding of a given phenomenon, and to integrate the knowledge gained with interventions to improve the health and well being of community members" (p. 177).	Green et al. (2001) describe participatory research as a "systematic inquiry, with the collaboration of those affected by the issue being studied, for purposes of education and taking action or effecting social change" (p. 194).	Viswanathan et al. (2004) describe community-based participatory research as "a collaborative research approach that is designed to ensure and establish structures for participation by communities affected by the issue being studied, representatives of organizations, and researchers in all aspects of the research process to improve health and wellbeing through taking action, including social change" (p. 22).
The intention of a partnership approach is to increase knowledge and understanding of a given phenomenon and integrate the knowledge gained with interventions and policy change to improve the health and quality of life of community members.	Participatory research begins with a topic of importance to the community and has the aim of combining knowledge with action and achieving social change.	The significance of this approach is that it builds the capacity of communities to function as co-investigators with health agencies and academic institutions before, during and after the research process has re-emerged as the academic and public health communities struggle to address the persistent problem of disparities.

According to the literature, through ongoing dialogue, the research process and experience will be enhanced (Cargo & Mercer, 2008; Downie et al., 2001; Israel et al., 1998; Parker et al., 2003; Wallerstein & Duran, 2010).

Engaging community (nonacademic) partners means that researchers must create and develop linkages to facilitate collaborative and equitable decision making and to foster co-learning. The research focuses on local issues, and the partnership should plan how to disseminate study findings. Downie et al. (2001) describe a partnership between registered nurses and academics who conducted research to support clinical practice. This partnership resulted in changes in and innovations to current nursing practice and, importantly, dissemination of best practice outcomes that led to improved outcomes for the community.

Community-based participatory research (CBPR) is an umbrella term for several approaches (collaborative research, community-based research [i.e., research physically located in a community], action research, and participatory action research [PAR]) that share common core values of inclusivity and engagement throughout the entire research process. Cousins (1995) suggests that a participatory approach is understood as a means toward more information, improved decision making, and use of the knowledge. The term *community-based participatory research* is most often used in the field of public health, in the context of collaborative, multidisciplinary initiatives. Certain characteristics are common to collaborative research and CBPR, including the participation of those affected by the results of research at every step of the process (i.e., defining the problem, designing the study, analyzing results, disseminating findings), the equitable distribution of power among participants, and a solution-oriented outcome. Authors of reports on community-based research have discussed the importance of partnerships between communities and researchers (see, for example, Lasker & Weiss, 2003), the challenges they encounter (Parker et al., 2003), and the mutual benefits that can ensue (O'Brien & Whitaker, 2011).

For the purpose of this research study, I adopted Israel et al.'s (1998) definition of CBR. According to the authors, CBR is a collaborative research approach with a community focus, which provides a mechanism for partnership and the continuous exchange of skills, resources, and knowledge. CBR promotes community engagement and begins with a research topic of importance to the community with the aim of combining knowledge with action for social change. A key component of this approach is that it brings members of the community together with researchers to identify the issues; collect, analyze, and interpret the results; and decide how to use these to inform policy, change practice, and have a sustained positive impact in the community (Israel et al., 1998).

Throughout this thesis, the term *decision maker* refers to individuals (knowledge users) with the authority to have an influence on, make decisions about, or implement health policies or the delivery of health care services. Decision makers can be clinician leaders, educators, policy makers, and health system managers from organizations (e.g., hospitals, community-based health institutions, ministries of health, regional health authorities) that are involved in the administration or development of policies or programs to improve the health of the population. They may work at the local community, municipal, provincial, or national level and are most likely to make use of research findings. In the context of the CIHR's PHSI funding opportunities, a decision maker is someone capable of making significant changes to policy and practice.

Knowledge translation (KT) activity is a dynamic and iterative process that encompasses the synthesis, dissemination, exchange, and application of research knowledge. KT has been described by a variety of terms: *knowledge action*, *knowledge mobilization*, and *knowledge exchange*. All of these terms have a common focus on ways in which research knowledge is shared so that practitioners can use research to inform and influence change in their practice (Graham et al., 2006; Lomas, 2000; Nutley, Walter, & Davies, 2007). For the purpose of this study, KT is defined as a linking process of moving research findings into action and practice for the benefit of the population.

KT communication activities incorporate three important components: (1) making knowledge users aware of new knowledge so that the use of knowledge to enhance health care systems and services is facilitated; (2) closing the gap between what we know and what we do; and (3) moving research knowledge into action. The process, which may include tailored dissemination, interaction, social influence, facilitation, reminders, and incentives (Nutley, Walter, & Davies, 2009), is about "getting the right information into the hands of the right people at the right time" (Dobbins, Rosenbaum, Plews, Law, & Fysh, 2007, p. 9).

The term *integrated knowledge translation* (IKT) is associated with collaborative research, CBPR, action research, and the co-production of knowledge (Gagnon, 2009). IKT is a complex process, a key priority being to ensure that research is easily accessible, timely, and understood by different audiences. Thus, a primary tenet of IKT is the requirement for the active partnership and exchange between researchers and knowledge users throughout the research process, leading to the co-production of knowledge, its exchange, and subsequent translation into action.

The focus of this literature review was primarily on partnership and collaboration between decision makers and researchers in health research. In this context, partnership is conceptualized as a democratic, inclusive approach, and the term *decision maker* may be substituted with the term *policy maker* or *end user*.

A Short History of Collaborative Research

The roots of collaborative research may be traced back to the 1940s with the action research school developed by social psychologist Kurt Lewin (Adelman, 1993). Lewin is credited with coining the term “action research,” and in his 1946 paper “Action Research and Minority Problems,” he described the cyclical process of research, action, and critical reflection. He emphasized the importance of “intergroup relations,” that is, the relations between researchers and those who are the subjects of their studies. Lewin believed that decisions are best implemented by those who help make them. He was an avid proponent of the use of research findings by community leaders, hopeful that the active participation of those involved in the research initiative would facilitate action research in social change endeavours.

Lewin’s characterization of utilization-focused action research relates to the northern, or traditional, convention. In contrast, the southern, or radical, form of action research originates primarily in the southern hemisphere, or the developing world. This tradition has its roots in Marxism, the distinguishing characteristic being an explicit challenge to the unequal distribution of socioeconomic and political power (Wallerstein & Duran, 2006). Well-known proponents of the southern tradition include the Colombian sociologist Orlando Fals Borda and the Brazilian educator Paulo Freire (Fals Borda & Rahman, 1991; Freire, 1970; Israel et al., 1998; Kemmis & McTaggart, 2000).

Freire taught adult literacy in the early 1960s in poor neighbourhoods in Recife, Brazil. This experience led him to further develop the action research models developed by Lewin. Freire had a unique view of education—one that saw the creation of knowledge through “teacher” and “student” partnership and dialogue. He believed that people had important knowledge that could stimulate change and communicated a process of conscientization or a course of action whereby people developed the skills necessary to know the roles they may take to initiate change in their social circumstances.

One of the cornerstones of Freire’s teachings is dialogue, where everyone willingly participates and engages as equals in the creation of social knowledge. Freire’s concept is based on purposeful engagement and co-learning, with the expectation that better conditions can be accomplished. He further defines dialogue as being an encounter with people and argues that in working for meaningful change, the objectives of collaborative initiatives must evolve from the self-identified needs of the people so that salient issues guide all action. The researcher does not try to teach science to the real-world practitioner; rather, the researcher attempts to understand the practitioner's context and accepts the practitioner as the expert on his or her organization and its problems. Dialogical action research recognizes that the practitioner's tacit knowledge, expertise, and experience are of equal importance to the expert knowledge of the researcher.

According to Freire, dialogical action offers the opportunity for reflective one-on-one dialogue between practitioner and researcher. In successive dialogues, they build a mutual understanding of the organization and its problems. This shapes how the practitioner understands what actions he or she needs to take to solve these problems. The more fully researchers appreciate the expertise of practitioners, the better the direction they provide to their collaborators (Freire, 1970).

Freire's teachings around creating knowledge for change laid the foundation for PAR theory and practice. Fals Borda further developed the methodology, describing PAR's twofold aims of action (to bring about change in the community or program) and research (to increase understanding of the researcher, the partner, or both). Flicker, Savan, Mildenberger, et al. (2008) explain that PAR is based on the idea that communities ought to be included as full partners in meaningful research initiatives, problem solving, and processes for social change. PAR is an umbrella term for a variety of approaches (including participatory research, critical action research, classroom action research, action learning, action science, community-based research, and industrial action research) that integrate Freire's philosophy of dialogue and active partnership. PAR has been shown to be an effective methodology to (1) develop research initiatives addressing salient community concerns and (2) examine reasons and complexities for the disenfranchisement of marginalized peoples (Choudhry et al., 2002; Chung & Lounsbury, 2006). PAR proceeds through repeated cycles, in which researchers and the community start with identifying major issues, initiate research, originate action, learn about this action, and proceed to a new research and action cycle. Through reflection, PAR participants learn from the actions and proceed to initiate new actions (Flicker, 2008; Freire, 1970).

Fals Borda's and Freire's work has been adapted in many fields, including education (Wallerstein & Bernstein, 1988) and agriculture (Braun & Hocde, 1998), and has been a catalyst worldwide for programs in community development. It has also been credited with improving the delivery of health services, for example, improving communication and efficiency in a hospital emergency room (Eisenberg, Baglia, & Pynes, 2006) and public health promotion (Kemmis & McTaggart, 2000). The increasing recognition of the role that social determinants play in establishing the health of populations has prompted a focus on engaging community members in collaborative efforts. This can be achieved through action research as it embraces a collaborative philosophy and focuses on raising awareness, empowerment, and partnership. It may be easier to promote lasting beneficial change through democratic participation rather than autocratic coercion (Adelman, 1993).

Traditional Research Methods versus Collaborative Research Approaches

Collaborative research's guiding principle of engaging partners and researchers equitably in all phases of the research process represents a process quite different from traditional research approaches. Table 2 highlights these differences. Collaborative research, integrating two clearly defined dimensions, social action and education with research, is increasingly favoured over traditional research approaches in applied health services research.

Traditional research approaches separate the researcher and the researched; a defining feature of a collaborative approach is the commitment to develop non-hierarchial partnerships that allow the partners to work cooperatively on issues of common concern. Collaborative research has the potential to build trust and respect between partners; however, this requires a significant investment of time. This is particularly important to consider when there is an imbalance of power between researchers and communities. The power imbalance may be equalized when stakeholders collaborate as full partners in the research initiative, guaranteeing maximum community benefit (Northway, 1998; Schensul, 1999).

The history of poor relationships between researchers and communities is well documented; for example, the Tuskegee Syphilis Study is regularly cited as a horrendous example of research implemented without regard for the basic principles of ethical conduct (Freimuth et al., 2001). Several authors recommend that for meaningful decision maker–researcher collaboration to occur, researchers must be aware of the

Table 2: Approaches to Research Inquiry

TRADITIONAL RESEARCH *"Expert-Subject"*	*COLLABORATIVE RESEARCH* *"Collaborative Inquiry"*
Researchers develop the research ideas and hypotheses based on epidemiologic data	The research ideas and questions are developed with equal contribution of researchers and partners in all phases of the research project Consideration given to acceptability/feasibility to implement in community
Research focuses on disease and health outcomes Study design, methods chosen by researcher based on scientific rigor	Research implemented within context of health care delivery, programs, and policies Full participation of partners in identifying issues of greatest relevance
Paternalistic paradigm Strong leadership and management skills required	Collaboration and relationship building Decision making by consensus
Grant application/funds → researcher	Co-sharing of funding
Dissemination of findings through presentation at meetings and publication (subject to peer review)	Researchers and partners work together interpreting findings Collaborative dissemination of findings Findings used to effect change and inform and enhance local practices
Project completed, researcher → new project, Capacity leaves with the researcher	Sustainability of collaboration Capacity is developed
Success defined by peers, publication record, and awarding of funding	Success may be assessed by sustained change in health care services and policies that impact population health

history of research initiatives in the community (Bastida, Tseng, McKeever, & Jack, 2010; Kone et al., 2000; Minkler, 2004). Furthermore, researchers must be open to addressing the history of negative research events and issues of distrust with the community.

Collaborative research focuses on the respectful treatment of partners and communities and is regarded as an ethical approach to inquiry, improving knowledge accountability and transforming the researched into researchers (Corbie-Smith, Thomas, & St. George, 2002; Flicker, Travers, Guta, McDonald, & Meagher, 2007; Foster & Stanek, 2007; Israel, Eng, Schulz, & Parker, 2005). Community members expect research to address their locally identified needs. Researchers report that they have found community input invaluable in the design and implementation of research. One major benefit of collaboration is the development of a deeper understanding of the community's specific circumstances and culture along with the co-production of knowledge and its dissemination and translation into action (Tetroe et al., 2008).

Collaborative Research Partnerships in Health Services Research

In my search of the literature, a diverse array of papers, descriptive reports, and evidence defining and describing types of collaboration, partnerships, and ensuing relationships between members was reviewed (Golden-Biddle et al., 2003; Kone et al., 2000; Kothari, Edwards, Brajtman, Campbell, & Hamel, 2005; Lencucha, Kothari, & Hamel, 2010; Lomas, 2000; Pivik & Hillel, 2011; Sibbald et al., 2010; Sullivan et al., 2001; Wells et al., 2006; Zetlin & MacLeod., 1995). The partnerships that were described included health care networks (McLeod, Dosman, Kulig, & Medves, 2007) and interprofessional (see, for example, Norman and Huerta's [2006] description of communities of practice), industry-research (Gelijns & Thier, 2002; West & Nightingale, 2009), and academia-community (Lantz, Viruell-Fuentes, Israel, Softley, & Guzman, 2001) collaborations.

The Process of Collaboration

One of the defining characteristics of collaborative research is the common focus on participation and engagement. Denis and Lomas (2003) explain that collaborative research is "a deliberative set of actions and processes designed specifically to bring together those who study society problems and issues (researchers) with those who act on or within those societal problems and issues (decision makers, practitioners, citizens)" (p. S2:1). Wallerstein et al. (2003) recommend that collaborative research partnerships be considered according to the circumstances, environment, history, and philosophy of stakeholders. The National Network for Collaboration Framework (1995) describes two groups of factors necessary for collaboration. Process factors stipulate the precise skills, actions, and elements necessary to develop and maintain collaboration. Decision making, communication, participation, and leadership are specific examples of these. Context factors are the elements of the collaborative environment that influence collaboration. According to Taylor-Powell (1999), context elements necessary for collaboration include community characteristics, connectedness, policy, and social capital.

Lasker et al. (2001) and Lasker and Weiss (2003) describe their experiences of collaborative research while engaged in community health work. They stress the importance of strong leadership, skillful process management, clear understanding of the collaborative research process, effective problem solving, and synergy as being critical to success. Lasker et al. (2001) define synergy as combining the perspectives, resources, and skills of a group of people to “create something new and valuable together – a whole that is greater than the sum of its individual parts” (p. 184). Applying this premise to collaborative research means that multidisciplinary partner collaboration enhances research findings beyond what could be accomplished by a single individual or organization working in isolation.

Characteristics of Collaborative Research

There have been several attempts by scholars to describe the characteristics of a collaborative research approach, which are summarized in Table 3 (Israel et al., 1998; Seifer et al., 2003). Concepts such as trust, understanding, respect, shared decision making, and clear, ongoing communication are the foundation of developing a successful, effective collaborative research partnership. A collaborative approach to inquiry gives voice to the experiences and perspectives of partners. Active and ongoing participation means that those who are most affected by the research and subsequent findings have the ability to jointly define with the researcher the research question and develop innovations. Advocates of collaborative research place great emphasis on the value that partners have to contribute to the initiative (Schensul, 1999).

Table 3: Characteristics of Collaborative Research (CR)

Principles of CR	*Characteristics of CR*
Collaborative partnerships	Stakeholders collectively decide on research focus Equitably involves all partners in the research process
Ethical review	Ensures protection for individuals who agree to participate in the research Consideration given to issues framing ethical conduct: 1. Building trust between partners 2. Maintaining mutual respect 3. Obtaining consent 4. Agreement on mechanisms for benefit sharing 5. Preventing exploitation of knowledge users
Rigorous methods	Stakeholders decide on methodology
Capacity building	Capacity is built internally
Community relevance	Team of stakeholders decides on research topics with community relevance related to health equity and social determinants of health
Social action outcomes	The outcome of research combines knowledge and action outcomes that 1. Inform policy 2. Support advocacy 3. Change practice 4. Improve community health 5. Eliminate health disparities Early buy-in from stakeholders increases impact

Note: Adapted from Israel et al. (1998) and Seifer et al. (2003).

Collaborative efforts can strengthen the links between knowledge producers and users while enhancing the sharing of information and ideas (Walter, Nutley, & Davies, 2003). Linkages between decision makers and researchers with diverse skills, expertise, and different frames of reference are cited in the literature as contributing to stronger relationships. Multidisciplinary collaborations facilitate access for researchers to study participants and data, while decision makers provide unique perspectives on issues of relevance to the community.

Israel et al. (1998) describe the process whereby the grounding of the research in local knowledge contributes to the overall improvement of the validity and quality of the research. An additional benefit that results from working collaboratively is the translation of research findings and the subsequent impact on practice and policy (Ross et al., 2003).

Schensul (1999) advises that when researchers collaborate with nonacademic partners, a long-term commitment to community development is needed. A significant investment of time is regarded as critical to the development of relationships, the negotiation of partnership requirements, and discussions on the design and selection of appropriate research methodologies to address the research question. Partners must be ready to provide a rationale to funding agencies and others who may question the relevance of their involvement in the research initiative (Northway, 1998; Schensul, 1990).

Abma (2006) asserts that a partnership approach allows the researcher an opportunity to gain valuable insights into the participants' world. The Agency for Healthcare Research and Quality (2003) highlights an important feature of the approach, partner accountability, whereby all partners are held accountable, share in the decision making, and contribute expertise during the complete life cycle of the study. As a result, the quality of the research is improved, community capacity is developed, and health outcomes are improved. The important benefits of improved recruitment and retention of research participants and attention to issues of equity, the needs of the local community, and social justice are also described.

The concept of developing and establishing open, mutually beneficial, respectful relationships between research partners is described by Bowen and Martens (2005). This is an active process requiring the involvement of all partners at all stages of the process. The authors advise that the collaboration must include partners with a vested interest in the specific research and a focus on the local relevance of study findings. Ross et al. (2003) describe the experiences of researchers in partnerships and propose that before the project starts, identification of the roles and responsibilities of all partners should be clarified. Capacity building and the early engagement of partners in the research process have been identified as required elements for successful partnerships (O'Brien & Whitaker, 2011).

The engagement of partners is facilitated by personal contact between decision makers and researchers, and this has been identified as a valuable element in research policy deliberations. Denis and Lomas (2003) suggest that close relationships and partner interactions throughout the research process are major predictors of success. They advise that partnerships at all phases of the research process may enhance the relevance and subsequent application of research findings (Lavis, Robertson, et al., 2003).

Some collaborative research projects require that all of the partners be included from the inception of the project in defining goals and objectives and contributing legitimate input relating to the project (Golden-Biddle et al., 2003; Kothari & Wathen, 2013; Lencucha et al., 2010). Partners can enhance the relevance of the research by focusing it on their requirements and help ensure that dissemination strategies to the community are appropriate and in place. In order to accomplish true mutuality of purpose, there must be power sharing among the research partners. It is through this level of "ongoing linkage and exchange" that the key outcome of collaboration may be achieved: research that is significant and has meaningful results (Lomas, 2000, p. 239).

Cargo and Mercer (2008) state that although the equal participation of partners is ideal, there are situations in which researchers define the goals, data collection strategies, and data analysis plans. Subsequently, community partners contribute to optimally convey study findings, offer guidance on dissemination activities, and determine the relevance and utility of the findings to their community. From the literature, the researchers believe that the key contribution by the partners is the dissemination of the study findings (Bullock et al., 2012).

Collaborative research approaches have been used in health services and public health research since the 1980s and in clinical research in HIV/AIDS since the mid-1990s (for example, see Schensul, 1999). However, within the time-pressured world of academia, there may be little enthusiasm for collaborative research for certain applications. Given the slow and rather deliberative nature of research planning processes, this approach has been perceived by some experienced practitioners as slowing the pace of research. The challenge for researchers lies in combining the same level of collaboration into multicentred, national clinical trials with scientific rigor. For example, in cancer treatment research, the time taken to develop a protocol and implement the trial using a collaborative research approach may significantly slow the pace of treatment innovation (Seifer, Michaels, & Collins, 2010).

The literature describes the need for clarification around the meaning of collaborative research approaches, the roles and responsibilities of partners, and the decision-making processes. Many partnerships require that a formal written commitment outlining expectations and commitments be signed by all partners at the beginning of the project. Creating a research advisory committee to develop internal procedures for the implementation of research has been shown to be a useful strategy for sustained collaboration. Such a committee may play a role in (1) deciding which research projects should be conducted in the community; (2) identifying salient research topics; and (3) accessing research findings. This is an important role as the relevance of study findings to the community is highlighted (Edwards, Lund, & Gibson, 2008; Flicker, 2008).

The roles and responsibilities of partners should be clearly defined at the beginning of the research project. Consideration must be given to the fact that these roles may change during the course of the project. Schensul (1999) reports that when no provision is made to accommodate changes in the direction of the project or assigned roles, tension and conflict ensue. Collaborative research teams are advised by Kone et al. (2000) to think carefully about the levels of partner involvement in the project. In particular, for decision maker partners, research activities are often an additional task to an already busy schedule. Achieving a balance between decision maker involvement in the research process and their work advocating for health policy change is key (Kone et al., 2000).

A guidance document for researchers interested in participating in IKT partnerships was developed by the Participatory Research team at McGill University (PRAM). The process of engagement and integration is clearly described in this document (Parry, Salsberg, & Macaulay, 2009). In the early stages of research development, partnering facilitates the inclusion of partners' perspectives on study design, choice of methodologies, data collection strategies, and analysis. The authors identify several advantages of implementing a collaborative approach: (1) research quality is enriched; (2) the knowledge, skills, and organizational practices of partners and researchers are developed; and (3) uptake of findings is facilitated. Advocates of collaborative research believe that by building on the skills and abilities of all partners, resources may be used more efficiently. The most significant benefit of this approach to inquiry is research findings that are relevant to and used by decision makers and end users (Lomas, 2000). In general, researcher-community relations are improved, the research process is enriched, and, through effective collaboration, the rate of knowledge production and research quality is enhanced (Flicker, 2008; Parry et al., 2009; Rynes et al., 2001).

The Importance of Collaborative Research

There has been a surge of activity and interest in collaborative research in the last few years (Israel et al., 2005; Minkler & Wallerstein, 2002; Schensul, 1999). In the 1980s, funding agencies began to promote researcher-community collaborations to work on addressing population health issues (e.g., substance abuse, HIV prevention). A shift occurred in the 1990s, with professional organizations, researchers, and funding agencies becoming more interested in collaborative approaches that draw on the capacities and assets of stakeholders (Minkler, 2000). Collaborative research affords a two-way exchange between decision makers and researchers, provides learning opportunities, facilitates the development of new skills, and encourages changes in practice patterns for decision makers and researchers (Denis et al., 2003; Fals Borda & Rahman, 1991; Flicker, Savan, McGrath, Kolenda, & Mildenberger, 2008; Rynes et al., 2001).

The literature demonstrates that when implemented with fidelity, a collaborative approach to research benefits both stakeholders and research partners. The combination of the perspectives, skills, and resources of the partners creates synergy, which then evolves the collaboration into a new entity that is greater than the individual components. Researchers have found that an important facet to policy-mandated partnerships was the shared view of processes and study outcomes. The likelihood of improving the research process may be related to how well the community feels it is represented and the level of collaboration experienced. Furthermore, the quality of the dialogue among stakeholders is critical to success (Golden-Biddle et al., 2003; Lavis, 2006; Macaulay et al., 1999; Martens & Roos, 2005; Ross et al., 2003).

One key KT strategy that has emerged to positively influence the uptake and utilization of research findings has been the promotion of developing relationships between decision makers and researchers, in the belief that when decision makers are engaged in the process, their motivation to use the applied research findings might increase. Communicating the relevance and value of the research findings in clinical practice is the researcher's responsibility. Decision makers assume the role of research champions advocating for research. These roles offer an opportunity for partner engagement (Lavis, Robertson, et al., 2003). The CIHR recommends this collaborative approach as a KT strategy to support practice-based research and to build capacity within public service organizations for knowledge utilization (CIHR 2008, 2013).

Establishing a cohesive group is reported as being an essential cornerstone for genuine collaboration (Montoya & Kent, 2011). Collaboration is enacted through multidisciplinary partnership (Sibbald et al., 2010). Mutual respect and trust support the development of other aspects, contributing to strong working relationships and successful partnerships. The literature highlights the importance of communication, cooperation, a willingness to accommodate the partners' objective, and a readiness to adapt to change (Bullock et al., 2012). Key success factors to the establishment of a cohesive group are nicely summarized by Gagnon (2009), who describes the importance of developing common understanding between partners about the research under study. Gagnon suggests that plans be devised outlining the ground rules necessary for collaboration and the specific roles and responsibilities for each partner. Furthermore, prompt identification and resolution of conflicts using context- and partner-specific strategies have been proposed as effective (Bowen & Martens, 2005; Denis et al., 2003).

Once the collaboration has created new knowledge, researchers recognize the importance of the timely publication and dissemination of research findings, whereas decision makers realize the necessity of implementing evidence-based improvements in practice. Lomas (2000) advises that the engagement of partners in the research process lends ownership to study findings, and it is anticipated that this approach will result in research findings that are relevant to and used by decision makers and end users alike.

In addition to creating new knowledge, one of the goals of collaborative research partnerships is to survive beyond the lifespan of the current study. According to Terlecki et al. (2010), focusing on collaboration enhances the likelihood of long-term impact and sustainability for all partners. Kothari et al. (2005) attribute continued success to increased and sustained interactions. However, the literature also provides examples of collaborations that are context specific. These may not need to be sustained beyond the lifespan of the study to be successful. Thus, longevity may not be essential to success (Bowen & Martens, 2005; Golden-Biddle et al., 2003; LeGris et al., 2000).

Successes and Challenges of Collaborative Research Partnerships

Successful partnerships and the ensuing advantages to partners have been described in the literature (Bartunek et al., 2003; Bowen & Martens, 2005; Denis & Lomas, 2003; Goering et al., 2003; Innvaer, Vist, Trommald, & Oxman, 2002; Lavis, Robertson, et al., 2003; Lomas, 2000; Ross et al., 2003). Factors contributing to the success of collaborative research are the time taken to develop a trusting relationship, to develop the ground rules, to foster trust, and to communicate honestly (Macaulay et al., 1999; Sullivan et al., 2001). Table 4 summarizes the advantages of a collaborative research approach. Through collaborative approaches, research becomes more accessible, the process is demystified, and research findings become more accessible to the community.

Table 4: Advantages of a Collaborative Research Approach

Understanding of decision-making environment for researchers
Enhanced process and relevance of research
Increased trust and mutual understanding among partners
Development of new skills and rewarding learning experiences for participants
Detailed information about local responses to interventions, programs, and policies
Access to resources and data
Common language and contextualization
Use of research findings: fresh insights should lead to services that are more acceptable to patients and communities than are available currently
Partners have a unique perspective to share
Advancing evidence-based decision making
Increased relevance of research findings for local decision-making environment

Denis and Lomas (2003) identify the increased awareness of researchers to the advantages of partnering with decision makers. Increasingly, communities are choosing to work with researchers and are proactively advocating for research that addresses their local needs. New multidisciplinary collaborations are developed within organizations and academic research centres. These collaborations bring together people with diverse backgrounds with different views, skills, and expertise and build community. Reasons cited for this willingness to partner include obtaining funding and additional community resources, access to state-of-the-art interventions, increasing research and program design, implementing knowledge, and the opportunity to work with respected researchers (Innvaer et al., 2002; Martens & Roos, 2005; McWilliam, Desai & Greig, 2007; Minkler et al., 2003).

Generally, partnership efforts are facilitated through the implementation of effective trust-building strategies and honest communication. Access to expertise and open dialogue when interpreting research findings is made possible. Study findings may provide information that can then be tailored for use by decision makers to develop best practices and relevant health care programs and policies. Furthermore, when decision makers and researchers rally together in this manner to forge strong relationships, the likelihood that the research findings will be relevant and implemented is increased (Denis & Lomas, 2003; Golden-Biddle et al., 2003; Innvaer et al., 2002; Lavis, 2006).

Successful collaborations rely on supportive and strategic leadership. Miller and Hafner (2008) describe how the commitment and support of senior leadership working with communities were key factors in the creation and sustainability of engagement. Equally important to the success of the research initiative was the daily oversight and skilled guidance of the collaboration. Cooperation can strengthen the relationship between partners while at the same time enhancing the flow of ideas and information between groups. Israel et al. (1998) suggest that collaboration unequivocally strengthens links between researchers and partners. The authors attribute this to the diverse skills and expertise each partner brings to the partnership.

However, collaboration is not always an easy process. Despite the advantages to working in partnership, significant obstacles have been described in the literature (Israel et al., 1998; Parry et al., 2009). The commonly cited challenges, not surprisingly, include the time required to invest in the partnership, poor communication between partners, uncertainty regarding the role of partners, lack of trust of researchers, power differentials, conflicts over research goals, uncertainty about the ownership and utilization of study data, and allocation of research funding (Bartunek et al., 2003; Bowen & Martens, 2005; Denis et al., 2003; Goering et al., 2003; Golden-Biddle et al., 2003; Lasker et al., 2001; Lomas 2000; O'Brien & Whitaker, 2011; Ross et al., 2003; Rynes et al., 2001; Schensul, 1999; Shoultz et al., 2006). Researchers and partners must identify strategies to address these conflicts early in the process or they will worsen, damaging relationships and affecting the research process.

Cargo and Mercer (2008) report that the lack of trust is commonly cited as a source of tension in collaborative partnerships. Trust is defined as reliance on the integrity or ability of a person or thing or having the confidence in one's partner to commit to collaboration without fear of exploitation. Building trust is encouraged (Macaulay et al., 1999), not only between partners; as Levin and Edelstein (2010) describe, trust must be developed in the research process and the integrity of research findings. Jack, Brooks, Furgal, and Dobbins (2010) remind readers that if the working relationship between partners is not built on a solid, trusting foundation, then the researcher risks losing access to communities and permission to collect data.

The literature describes mistrust of the research itself as another source of tension encountered during collaboration. The term *helicopter research* (Pontes Ferreira & Gendron, 2011) is often used by community members to describe the following: researchers come into the community, conduct the study, and leave without any accountability to the community or reporting of study findings. Pontes Ferreira and Gendron (2011) report that communities that experience this type of exploitation are less likely to participate in research initiatives in the future. Trust as to how the research findings are disseminated in the community is another important consideration. Findings must be presented to partners in plain language that meets their needs, with implications and next steps clearly described (Davies & Nutley, 2008; Dobbins et al., 2007; Goering et al., 2003). Partners need to have confidence in the research process and a common focus with the researchers as to how the research findings are shared. Partners may have special insights into and understanding of the study findings (which may be different from those of the researchers) and are well positioned to move these results into practice. Alternative ways to disseminate study findings should be considered, which would place the findings in the hands of decision makers and target audience. Such strategies may include articles in practitioner journals, online research summaries, and networking opportunities for partners to meet and exchange ideas. The subsequent uptake of research findings, produced from such a trusting partnership, is improved with decision maker involvement throughout the entire process (Cordingly, 2008; Lasker et al., 2001; Nutley et al., 2007; Nyden & Wiewel, 1992).

Many articles report that the collaborative process took more time than expected. It is necessary to acknowledge the time required for the development of relationships and mutual understanding in collaborative health research initiatives. Although collaboration may add value to research endeavours, this added value requires the investment of significant periods of time (Denis et al., 2003; Goering et al., 2003; Lomas, 2000; Ross et al., 2003). Those articles report that researchers recommended that when considering collaboration opportunities, one should think strategically with respect to which partners to invite to participate and be committed to building the partnership. Researchers found that when they were involved in collaborative research projects, they spent long periods of time working on relationship building compared to their usual research endeavours. However, as reported by McWilliam, Desai, and Greig (1997), this investment of time was worth the effort as the resulting partnership was strengthened when there was equal participation and partners felt joint ownership over research processes and subsequent outcomes.

Although the importance of partnerships between decision makers and researchers is being increasingly appreciated and recognized as an approach to bridge the gap between the two groups, there are frequent substantial delays in the implementation of health research findings into practice or policy. Anticipated improvements in health care have not occurred due to difficulties in translating research findings into clinical, policy, or administrative practice. Experience over the past 10 to 20 years has shown that knowledge translation is not easy, intuitive, or automatic. Straus, Tetroe, and Graham (2009b) note the consistent failure to use research evidence to inform decisions. They inform us that practice audits frequently reveal that high-quality evidence is not applied consistently in clinical practice. An example of a delayed uptake of innovation is thrombolytic treatment for myocardial infarction as there was a 13-year delay between the demonstration of effectiveness from meta-analysis of randomized controlled trials and the widespread implementation of the treatment (Laupacis et al., 1997). Arnold and Straus (2005) contrast this delay with the prompt intervention to reduce overprescribing of antibiotics to children experiencing upper respiratory tract infection symptoms. Researchers identified strategies to improve parents' knowledge about causes of respiratory tract infections and when to consult their doctor. These community-based strategies decreased the number of consultations and subsequent prescription of antibiotics (Andrews et al., 2012).

Over the last 20 years, knowledge regarding best medical management practices has increased considerably. Finding ways to deliver care based on the best possible evidence remains an ongoing challenge. Increasing awareness of these issues has resulted in efforts to effect practice change and bring the usual therapy more in line with the best evidence available. This will help health care professionals manage patients to their best potential and should lead to improved outcomes. There are many frameworks and theories (Graham et al., 2006; Lavis, Robertson, et al., 2003; Lomas, 2000; Mitton, Adair, McKenzie, Patten, & Perry, 2007) for achieving KT; however, it is not within the scope of this study to provide a detailed explanation of all KT strategies for dissemination of research findings into health policy.

One of the implications of decision maker–researcher collaborations is the overlapping of two worlds: science and practice. The diverse culture, values, language, and priorities of researchers and partners can cause tension, frustration, and delays. Tensions may impede progress on the research project if they are not acknowledged and addressed. Exploring the source of tension, rather than avoiding possible conflict, along with open discussion about everyday challenges, helps to foster the relationship and build trust, thereby facilitating the workings of the collaboration. The literature recommends that training of partners in the practice of collaboration is worthwhile in this regard (Mitton et al., 2009).

Collaborative research promotes change within communities, and, according to Edwards et al. (2008), part of the very nature of this approach is political. They suggest that study findings may be used to advance political purposes. As the research is implemented, unanticipated agendas and issues may be revealed. Staffing changes within the decision makers' group due to terms of elected positions can cause upset. The new appointee may not be supportive of the research endeavour, underscoring the importance of long-term decision maker commitment. In fact, Edwards et al. further propose that a lack of sustained involvement or consistent support threatens the success of the initiative.

The structuring of academic rewards is another challenge to collaborative research. The criteria for university promotion and career advancement do not typically recognize collaborative research initiatives. Researchers are usually evaluated by success in achieving peer review grant awards, the volume and quality of scholarly activity and teaching, and documentation of university service (Calleson, Jordan, & Seifer, 2005;

Seifer, 2006). A key component of the review process is the assessment of the academic researcher's source of funding and the amount and period of funding. The number of publications per year, position of authorship, and type of journal where the work has been published are also reviewed. Usually, work published in top-tier journals is cited very shortly after publication and by the greatest number of other researchers, indicating its high impact. Letters of reference that critique the quality and impact of the researcher's scholarly activities are usually solicited from academic peers for the promotion review process. Conversely, recommendations from decision makers and communities that implement findings based on the researcher's work are not included in usual promotion and tenure submissions.

Collaborative research is increasingly recognized as a feasible approach to implementing research that is meaningful to both communities and universities (Ahmed et al., 2004; Nyden, 2003; Wallerstein & Duran, 2010). Nyden (2003) reports the benefits of community engagement in the review of the impact of the research findings in the community. He advises that as a result of this involvement, community partners will develop new insights into the research process and feel a greater sense of ownership of the findings. The success of collaborative research initiatives is generally indicated by sustained change in policies that influence health outcomes positively. The achievements of community-engaged researchers are more difficult to measure. Given that the research approach is a collaborative effort, the review and evaluation of the approach should also be collaborative. To align collaborative research with mainstream academia, some institutions have already developed new tenure and promotion standards for the evaluation of community-engaged researchers. Scholars suggest that a revision of the system of awards, to include review of activities such as mentoring, promotion, and tenure requirements, is necessary.

Several explanations as to why research is not making its way into policy and program decision making have been described in the literature. The lack of partnerships between decision makers and researchers was regularly cited as a key barrier to KT. Researchers and decision makers are from two different environments; the differences in their perspectives, roles, and goals create a gap in understanding such that these groups may find it difficult or impossible to relate to each other. When decision makers perceive that the study methods and/or research findings are not pertinent to their communities, the expected health improvements may not be realized. The catalyst to forming the research collaboration may have been the availability of funding as opposed to deciding that partnership was the most appropriate way to address the research question. There is a concern that a number of these “forced” partnerships, developed to meet the requirements of funding agencies, may be partnerships on paper only and will fail to thrive (Lasker et al., 2001). Furthermore, Lasker et al. remind us that clarity pertaining to the scope of each partner’s role and how the common aspects of the research will be completed is an important consideration at the beginning of the study. Toward the end of the research collaboration, some partners may be interested in completing the study in a timely manner, whereas others may be interested in sustaining the collaboration (Lasker & Weiss, 2003).

Flicker, Savan, Mildenberger, et al. (2008) report that community participants in their study felt that they did not have adequate resources to implement the research. In addition, they believed that administrative support would have been a valuable support to their endeavour and recruitment would have been more successful if appropriate financial reimbursement was available. Furthermore, the project funding did not include community-relevant dissemination activities. Lack of control of resources and power struggles with respect to the administration of research funding were cited by participants as significant challenges that resulted in tension in the team (Flicker, Savan, Mildenberger, et al., 2008).

Concerns relating to funding are widely cited in the literature (Edwards et al., 2008; Flicker, Savan, McGrath, et al., 2008; Green & Mercer, 2001; Lasker & Weiss, 2003; Minkler et al., 2003). The duration of partnership, the allocation of resources, and the impact of funding on partnerships were cited as challenges to partnership. Flicker et al. (2007) identify the burden of completing funding application forms as being another challenge to contend with that took partners away from their work. Previously, the costs associated with developing partnerships were rarely considered by funding agencies. Researchers were funded, whereas resources necessary to develop and ensure community capacity were not provided. This has changed recently, with some funding agencies developing more equitable funding arrangements to (1) initiate, develop, and sustain more robust research partnerships and (2) assign a proportion of funds to support the decision maker’s role and function. Thus, research teams are now required to include research and action outcomes in their grant applications; these funds are necessary for ongoing partner engagement and dissemination activities.

It would be interesting to know how researcher–partner interaction during the course of collaborative research affects the implementation of study findings in policy and health services decision making. The literature proposes that ongoing dialogue is a key factor for research partnerships to be rewarding, fulfilling experiences as opposed to tokenistic (Straus et al., 2009a).

Sustaining research collaboration over the long term has historically been challenging (Israel et al; 1998; Lasker & Weiss, 2003; Rynes et al., 2001). Both decision makers and researchers must recognize interrelated needs that merit the long periods of time spent working together. Engagement in the research process suggests reciprocity, whereby both parties contribute to and benefit from the interaction. An environment of co-learning and shared decision making (combining real-world knowledge with scientific knowledge) develops as a result of partner engagement. Effective collaboration embraces a constantly evolving process to meet each new challenge. Successful decision maker–researcher collaborations requires the implementation of a number of measures (e.g., regular communication between partners) intended to result in cohesion among partners while sustaining the partnership (Israel et al., 1998; Lasker & Weiss, 2003; Rynes et al., 2001).

Experiences of Collaborative Research Partnerships

Many of the papers reviewed present their findings based on the researchers' perspective only (Shoultz et al., 2006). The researcher's role is to conduct research in such a way as to produce a mutually acceptable outcome for all partners. To achieve this, the researcher must perform many roles (including facilitator, leader, mentor, motivator) during the various stages of collaboration. It is important for the researcher to adopt a cooperative stance and engage and encourage partners so that they can participate equitably in the process. The shift from the position of an outside expert to that of a collaborator is a key element of the approach, and the increased level of involvement this entails may be new to those who are used to being in the role of outside expert.

The literature identifies the plethora of skills required of researchers to work respectfully and effectively in collaborative research endeavours (Ross et al., 2003). These skills include understanding the variety of strategies required to engage decision makers in research. Key to a successful collaboration is the a priori investment of time for all partners to get to know one another, learn from one another, and learn to trust one another's perspective, especially when these perspectives differ. Researchers need to understand the organizational structure where the decision maker works and must be able to articulate the full scope of decision maker activity within the research process. The abilities to work cooperatively on a team and to address potential challenges promptly have also been identified as germane (Flicker, Savan, Mildenberger, et al., 2008).

Sullivan et al. (2001) report that respondents in their study emphasized the importance of honest and open communication, mutual respect, and power sharing. The early inclusion of diverse partners ensured culturally relevant research. The authors highlighted the importance of the researchers' home institution as being instrumental in the effective implementation of the research effort. Ross et al. (2003) report that improved understanding of the research environment was cited by decision makers as being most significant to them and that researchers appreciated decision makers facilitating their access to pertinent information. Researchers especially valued decision makers' contributions to focusing the research on the (end) users' needs. Generally, researchers reported that they had not appropriately planned for the time it would take to develop relationships with stakeholders (Flicker et al., 2007). Specifically, researchers reported that they would have liked more time to be involved in developing processes, engaging partners, clarifying roles and responsibilities, and teaching.

The experience of collaborative research has proven stressful for some. Cunningham (2008) describes how some partners felt intimidated by researchers, whereas others experienced anxiety and emotional strain that was hard to deal with. Cunningham was unable to clarify whether these experiences were a result of working closely with researchers or working on a research study. Partners may be intimidated by the "expert" status of researchers. The terminology used to describe the research design, methodologies employed, and plans for statistical analyses created barriers to understanding. Having the confidence to collaborate with researchers requires support and the investment of time. Similarly, it is not acceptable to have decision makers in a token role where they are regularly ignored. The research team recognized that misunderstanding posed a challenge to the ongoing partnership, so strategies were developed to address these concerns promptly (Cunningham, 2008).

The literature demonstrates that effective collaborative research is more likely when partners are satisfied with their level of involvement. During the planning phase, it is necessary for all partners to demonstrate their commitment to the endeavour. Decision makers, although keen to contribute to the process, may not understand their role and function. Researchers agree that those involved in research should be trained in collaborative research methods, the protection of human rights, and issues pertaining to the confidentiality of data. Such training prepares partners so that they know what their role can be in the (research) process and enhances the subsequent implementation of the research findings. Furthermore, they (partners) can develop the skills to effectively provide comment on research proposals and study documents. Informal dialogue and interaction provide partners with the opportunity to characterize themselves and their issues of interest. Minkler (2000) suggests that this is necessary for instigating genuine collaboration, changing perceptions, and enhancing proficiencies.

There are many published accounts that describe the shift away from traditional research approaches wherein the researcher defines problems, designs and implements research studies, and publishes the results. Collaborative research offers decision makers the opportunity to learn about the inner workings of research and become more aware of the evidence gaps. Little is known about the formation and development of partnerships (Sibbald et al., 2010); most accounts are from the researchers’ point of view, making it difficult to determine the role and perspective of decision makers throughout the collaborative process. Some studies reported the decision makers’ perspectives at specific times during the research process. Few studies provide comprehensive insights or, indeed, mention the impact of decision maker involvement on collaborative research initiatives. Furthermore, to my knowledge, there is little evidence indicating the efficacy of collaborative research approaches to inquiry. This represents a significant gap given the current focus placed on collaborative research initiatives by funding agencies.

Ross et al.’s (2003) insightful article identifies four key factors that influence decision maker engagement: (1) the stage of development of the collaborative research process; (2) time requirements; (3) the fit between the decision maker’s expertise and the planned program of research; and (4) a pre-existing relationship with the researcher. Individual decision maker experiences may vary depending on the level and type of involvement in the research process; additionally, their interest in the program of research and the subsequent findings affects decision maker engagement (Ginsburg, Lewis, Zackheim, & Casebeer, 2007). Facilitating opportunities for decision makers to contribute to and shape the direction of the research is regarded as appropriate. Given this directive, it is ironic that there is a paucity of research regarding decision makers’ reactions to collaborative research initiatives.

Ethical Considerations

The basic premise of the ethics of research involving humans is to ensure protection for study participants. As collaborative research is implemented in real-world circumstances and requires close communication between partners, researchers must pay careful attention to the ethical considerations associated with the research work (Maurana & Goldenberg, 1996; Minkler, 2004). Richards and Schwartz's insightful article (2002) describes the unique ethical issues and challenges that present in the implementation of qualitative research. Table 5 outlines the main issues that may arise and identifies strategies for reducing the risk of harm to individual research participants. The authors identify four potential risks to participants: anxiety and distress, exploitation, misrepresentation, and possible identification of the participant. They advise us that research must comprise a delicate balance between the need for rigorous exploration and respect for the well-being of the participant. Previously, ethical codes focused on the rights and welfare of individual research participants. Increasingly, the collective benefits and potential harms of community participation in research are being recognized.

The literature highlights how collaborative research principles parallel core ethical values, particularly justice and respect for autonomy (Bastida et al., 2010; Buchanan, Miller, & Wallerstein, 2007; Goldberg-Freeman et al., 2010). Collaborative research initiatives require an expanded ethical discussion that includes informed consent of individuals or communal consent of the organization or community.

Communal consent is a particularly important consideration because of the potential impact of negative research results on "researched" communities or groups. This impact may expand positively beyond the scope of one study, that is, through additional research projects or, negatively, through marginalization and stigmatization resulting from publicizing negative findings. Mutually agreed mechanisms must be in place to prevent discrimination and inequalities.

Table 5: Ethical Issues for Individuals Participating in Qualitative Research

Ethical Issue	*Strategies to Address Ethical Issue*
Mandate to conduct ethically sensitive research	Time given to participant ✓ To consider involvement in research ✓ To develop and establish trusting relationship with researchers
Voluntary participation	Time given ✓ To review all study information ✓ To ask questions before signing informed consent ✓ To discuss risk/benefit assessments
Fair selection of research participants	Select participants who agree to participate and provide informed consent Reiterate importance of privacy and confidentiality of data
In-depth interviewing	Consider ✓ What is the impact on participants who share such information? ✓ Will participants who share information be placed in a vulnerable emotional position? ✓ What will the effect be on those participants who share such information? ✓ How will this situation be handled? Time given to participant to ✓ Develop/establish trusting relationship with researcher ✓ Avail of counselling resources if required
Second interviews	This may have potential to ✓ Cause unnecessary distress ✓ Reveal too much information ✓ Reiterate privacy and confidentiality of data
Findings represent a true reflection of people's experiences from their own perspective	Time taken to document in journal without judgment what was heard/observed during the study
Concern of coercion	Adequate time provided to participant to ✓ Establish trusting relationship with researcher ✓ Examine values/role and motivations for doing this study. ✓ Recognize/acknowledge individual's contribution

Khanlou and Peter (2005) explicitly describe the terms and conditions associated with mutual negotiation of consent. Clear explanations of the roles and responsibilities of partners may also be outlined. This ensures that all partners are aware of the scope of their activity throughout the process and are in agreement with these terms.

Badger (2000) informs the reader of the adoption in action research of a shared acceptance of an ethical approach that is acceptable to all partners. Research ethics training is encouraged for partners, and guidelines have been developed by the CIHR and others to address issues during the research design, start-up and implementation, data analysis, and KT activities (CIHR, 2009). These guidelines serve to (1) improve the science researchers engage in by incorporating the expertise and knowledge of partners; (2) ensure fairness, equity, and a deeper understanding of cultural differences; and (3) better serve communities in addressing health disparities. Winter (1996) reports key points to consider when implementing a collaborative research project. First, ensure that all relevant parties are aware and informed of the work and have agreed to the principles guiding the project. Second, all partners should feel free to influence and contribute to the work. Finally, it is the researcher's responsibility to maintain the confidentiality of the data. In a collaborative research partnership, O'Brien (1998) recommends that opportunities for the involvement of all parties should be created and decision making about the direction of the project should be shared. He further advises that personal agendas and biases be disclosed by all partners at the beginning of the collaboration. Partners create an environment that encourages equity, stimulates respectful dialogue, and facilitates the development of trust. Application of ethical principles of justice, respect, and beneficence ensures that (1) the research questions are relevant to the community (justice); (2) the community's decision to participate or not in the research is respected (respect for autonomy); and (3) the research benefits the community (beneficence).

The literature informs us of the history of unethical research practices that have resulted in reluctance on the part of some communities to participate in research. Harm from research findings reinforces negative stereotyping of a community and can lead to further stigmatization of the most vulnerable in our society (Maurana & Goldenberg, 1996; Minkler, 2004; Sullivan et al., 2001). Examples of community stigmatization include publications in which researchers named the study community as well as the adverse conditions that affected their quality of life ratings. Minkler and Wallerstein (2002) describe research initiatives that have burdened the community and provide examples when the community has not been appropriately compensated. Decision makers and researchers, therefore, must thoughtfully consider the potential negative consequences of their research efforts beyond the findings.

There have been complaints of inadequacies in informed consent processes where communities lack understanding of the intervention and have not been advised appropriately of the risks and benefits. Silka, Cleghorn, Grullon, and Tellez (2008) describe situations in which communities reported feeling coerced into research and did not understand the concept of voluntary participation. Incomplete explanation during consenting procedures of dissemination of research findings, confidentiality of data, and special tissue sampling procedures may cause unintended social harm (Banks et al., 2013; Foster & Stanek, 2007; Quigley, 2006). One example of this is the long-running dispute between Arizona State University and the Havasupai Indians over allegedly improper use of deoxyribonucleic acid (DNA) samples from members of the tribe. The research began in 1990 to search for a genetic variant that might contribute to the high incidence of diabetes in the Havasupai community. The blood samples donated by tribe members and DNA extracted from these samples resulted in other studies, grants, and publications. It was this research suggesting likely ancestral origins of the tribe and theories relating to mental illness that led to legal action. The final settlement for damages was substantial because the rights of human subjects were violated when they were not fully informed about how their DNA might be used (Santos, 2008).

IKT studies involve partners with different backgrounds, divergent agendas, shared decision making and governance, co-ownership of knowledge, and joint responsibility for dissemination of knowledge findings. The research process and subsequent findings may affect many people, and for each research activity and decision made, there are complex ethical implications. Table 6 highlights the main ethical issues to consider.

Key challenges that may arise in the course of collaboration include how partners seek to balance power, resolve disagreements, integrate community knowledge, build capacity, and develop respectful partnerships. One must consider how these issues will frame ethical conduct between decision makers and research partners. Macaulay et al. (1999) advise partners and researchers that, a priori, research goals, objectives, and methods should be negotiated, reflecting local needs, interests, and culture.

Table 6: Ethical Issues to Consider When Collaborating on IKT Projects

Ethical Principles of Concern in IKT Projects	*Strategies to Address Ethical Issue*
Trust	Building trust among communities, decision makers, and researchers
Respect	Maintaining mutual respect among all parties
Consent	The process of obtaining communal consent must be openly discussed and jointly negotiated at the beginning of the study
Benefit sharing	Agreeing on mechanism for benefit sharing—must be openly discussed and jointly negotiated at the beginning of the study
Preventing exploitation	Preventing exploitation of researched community—the complexity of any agreement depends on the essence of the research being implemented

Partners should agree on roles and responsibilities, control of the use of data, and methods of disseminating study findings. Building trust, mutual respect, and understanding is encouraged through listening to and sharing each other’s values and contexts. Addressing ethical issues early on in the collaborative process fosters trusting relationships, promotes capacity building and improved infrastructure, and, according to Macaulay et al. (1999), adds to the cultural validity of the study findings. The authors assert that when community partners are engaged as meaningful members in mutually respectful ethical partnerships, there are significant positive outcomes for all stakeholders. These outcomes, which can precipitate change, include a stronger community voice in research design and planning and improved receptivity to meaningful partnership opportunities with researchers (Macaulay et al., 1999).

Decision makers and researchers must be aware of potential challenges associated with working in partnership. They should be prepared to discuss and address these challenges and seek to apply sound judgment and the ethical principles salient to a given situation. All partners in collaborative research have rights and responsibilities, and these are listed in Table 7.

Table 7: Rights and Responsibilities of Partners Engaged in IKT Partnerships

	Decision Makers	*Researchers*
Rights	To be consulted and involved in all phases of the IKT study	To conduct scientifically rigorous research
	To benefit from research findings To contribute to the interpretation of research findings	To publish jointly interpreted (positive or negative) research findings
Responsibilities	To meet regularly with researchers to discuss/provide feedback on study-related issues	To actively engage partners in the research initiative
	To disseminate study findings	To provide resources to partners to facilitate partnership
	To offer advice on research topics/question and interpretation of data	To provide scientific explanations in lay language if required
	To provide constructive input and work collaboratively with researchers	To recognize decision makers as co-owners of the data

Before the study starts, discussions of rights and responsibilities serve the important dual purpose of avoiding conflict and misunderstanding later on in the partnership and building trust. Consideration must be given to (1) the consequences of participation in collaborative research and the sharing of personal insights; (2) for whom the research is being undertaken and who will act and advocate for change; (3) the implications (both negative and positive) of the research findings; and (4) the ownership of the research findings and policies for the presentation and publication of those findings. Discussions between decision makers and researchers should address whether the content (of the research findings) is safe to share with the community. Ultimately, these findings potentially may be damaging to the community (Sullivan et al., 2001).

Kidd and Krall (2005) recommend that it is wise to advise decision makers and researchers of the importance of documenting the nature and outcomes of the collaboration throughout the research process. By emphasizing the concept of dual responsibility, both parties in the partnership are empowered to take an active role and engage in the IKT project. Collaborative research initiatives provide a unique opportunity for decision makers and researchers to engage in a meaningful dialogue and advocate for change relevant to significant issues in their communities. This approach, implementing research “with” as opposed to “on” communities, represents a philosophy of inclusion.

The Role of the Canadian Institutes of Health Research (CIHR)

The CIHR is Canada’s national health research funding agency with the mission to improve the health and health care of all Canadians (Canadian Institutes of Health

Research Act, 2000). The CIHR has developed a broad, inclusive approach to partnerships and encourages application of the principles of CBPR to collaboratively study health and disease, design interventions, educate future health practitioners, and address health disparities. Much has been written on knowledge creation and the uptake of research findings (Grimshaw et al., 2001; Lavis, 2006; Lomas, 2000; Straus et al., 2009b). There is little doubt that the interaction of decision makers and researchers appears to stimulate significant change compared to when individuals work alone on the same problem. The CIHR emphasizes the importance of translating research findings into practice; some funding programs require that a plan for the dissemination of findings be developed as a condition for funding (CIHR 2008, 2013).

The Partnerships for Health System Improvement (PHSI) Program

In the past, researchers dictated research agendas with little or no opportunity for community input. Increasing levels of concern with the lack of utilization of research findings and what is left in the community once research funding ends resulted in the establishment of the CIHR's PHSI program. The current study explored the experiences of those decision makers who participated in PHSI-funded health services research. To better situate the reader, the following provides an overview of the program.

The PHSI program is an exciting and unique opportunity that was developed to support researchers and decision makers interested in conducting applied and policy-relevant health systems and services research (CIHR, 2008). Health services research conducted under the auspices of the PHSI program requires collaboration between decision makers and researchers interested in working together to address health services challenges. Funding provides an opportunity to decision makers, with a broad base of information and support, to pursue policy change. Research findings from PHSI projects have the potential to contribute to enhancing practice, developing understanding, and informing policy making to improve the quality and delivery of health care programs.

There are two categories of decision maker applicant roles: principal knowledge user and knowledge user. These roles acknowledge that partners are experts in their specific domains with unique strengths, as well as different knowledge and experiences that are equally valuable. In addition, as a prerequisite for participation, decision makers should have enough authority to integrate knowledge into their environments. Within the context of the PHSI program, the research process is guided by the information needs of research users. They should have the authority to implement new findings as there is a greater expectation that the new knowledge will be acted upon for the benefit of the community. The objectives of the PHSI program are to improve the relevance and quality of funded research, to develop decision maker capacity to access and use research findings, and to encourage ongoing linkage and exchange (CIHR, 2008). Table 8 highlights these distinctive characteristics. Sustaining interventions and partnerships can increase the cost-effectiveness of research and are consistent with the CIHR's mandate of improving the health of populations (CIHR, 2008, 2013).

Table 8: Characteristics of the PHSI Program

This program requires that the research is conducted by, with, or for communities and is intended for decision makers and researchers to work together to
➢ Shape the research question and set goals and objectives. Research topics should have community relevance related to health equity and determinants of health.
➢ Foster collaboration and promote the equitable involvement of all partners from a variety of health disciplines in the research process
➢ Determine the methodology and be involved in data collection and tools development
➢ Interpret the research findings, develop conclusions, and determine the modes of knowledge management and transfer that are best suited to the particular community
➢ Disseminate research findings and move the research findings into practice ➢ Combine the knowledge and action outcomes to inform policy, change practice, and, ultimately, improve community health

Note: Adapted from CIHR (2008, 2013).

Integrated Knowledge Translation

Most agree that decision makers can improve the timely dissemination of new findings in the community. Encouragement of collaboration in the process and the inclusion of decision makers on the research team are recognized as fundamental components of IKT (Golden-Biddle et al., 2003; Graham et al., 2006; Lomas, 2000). The collaboration derives strength from the recognition of, and respect for, the different forms of expertise around the table. A key property of collaborative research and a feature of effective IKT is the long-term interaction between researchers and users of research (CIHR, 2013). Synthesis, dissemination, and exchange IKT activities (as displayed on Table 9) can take place before, during, and/or after completion of a research study and may take many forms.

Table 9: IKT Interactions

IKT Activities	*Examples of IKT Activities*
Synthesis, dissemination, and exchange activities	1. Development of collaborative networks 2. Multidisciplinary partnered research 3. Shared decision making 4. Consensus-building activities
Communication and outreach activities	1. Stakeholder engagement and education 2. Tool development 3. Involving stakeholders in the definition of KT activities 4. Communities of practice 5. Evidence-based community outreach programs
Policy and practice improvement activities	1. Development of interventions that contribute to evidence-informed policies and practices 2. Engaging stakeholders in contributing to partnerships 3. Stakeholder-informed guideline development 4. Stakeholder engagement in initiatives to disseminate and apply the findings

The CIHR emphasizes the importance of fostering the active engagement of researchers and decision makers in knowledge exchange processes. Two categories of KT are described to move research findings into practice: end-of-grant KT and IKT. In both, the goal is to ensure that new knowledge generates action to enhance health care services through the "Knowledge to Action Cycle" (Graham et al., 2006). This comprises (1) identifying the problem and selecting the relevant knowledge; (2) tailoring and adapting the knowledge to the local context; (3) assessing challenges to knowledge use; (4) selecting, tailoring, and implementing interventions; (5) monitoring knowledge use; (6) evaluating outcomes; and (7) sustaining knowledge use, which completes and reinitiates the cycle. Once the study has been completed, end-of-grant KT activities typically include discussing results with peers, presenting at conferences, and publishing research findings. This form of KT is valuable to researchers to disseminate their research results (Lavis, Robertson, et al., 2003) as generally these projects are designed to advance science, so the results are of particular interest to researchers' peers (CIHR, 2008, 2013).

IKT processes have developed as a result of recognizing that there are huge gaps between research production and its subsequent utilization (Lavis et al., 2003; Lavis, 2006; Lomas, 2000). IKT and collaborative research share the tenets to (1) undertake quality research with a high level of scientific rigor using appropriate methods; (2) provide benefit to decision makers and knowledge users; (3) support research capacity building; and (4) develop knowledge that is applicable to their settings (Graham & Tetroe, 2007). The principles guiding a collaborative research approach, that is, mutual benefit for partners, actionable knowledge, and social change, are becoming increasingly popular. Lavis, Robertson, et al. (2003) propose strategies to facilitate the movement of research findings into health care practice and policy. It is outside the scope of the current study to describe in detail strategies for the production and translation of knowledge into health care policy. However, since IKT depends on a partnered approach and was mandated by the CIHR to be integrated into PHSI funding applications, a discussion will be provided here (CIHR, 2008, 2010, 2013).

Potential Contributions of This Study

A considerable body of literature exists that describes the common dimensions, characteristics, benefits, and dilemmas of decision maker–researcher collaborations.

However, few studies have described the context and conditions necessary for engagement. The absence of research on how decision makers experience partnership planning, implementation, and maintenance suggests that decision makers are largely uninvolved in decision-making processes relating to research agendas; thus, a more in-depth exploration is warranted. The lack of significant published work on decision maker participation in collaborative research represents a major gap in the literature. Ideally, lessons learned from collaborative research initiatives should be described, explaining the factors for successes and the challenges of partnership. These publications would provide direction for future work. This study explores the development of decision maker–researcher relationships into functioning collaborations and the subsequent engagement of decision makers in the interpretation and dissemination of research findings. This topic merits examination in the Canadian context.

Conceptual Framework and Research Questions

I selected dialogical action (Freire, 1970) theory as a conceptual framework to guide the exploration of decision makers' experiences within a federally funded health research initiative. Freire's dialogical action approach is one in which everyone participates as equals and co-learners to create knowledge. According to Freire, collaborative efforts must emerge from the self-identified needs of the people. His ideas of dialogue offer an interesting perspective for viewing the work of decision makers within the context of PHSI partnerships. The basic principles of dialogical action, as highlighted in Table 10, are very similar to the guiding principles of the PHSI initiative:

to start from the problems of the community, to use active learning, and to engage partners in establishing their needs and main concerns.

Table 10: Linkage between PHSI Objectives and the Principles of Dialogical Action

Objectives of PHSI	*Principles of Dialogical Action*
Decision makers and researchers mandated to work together throughout research project	Promotion of active collaboration at every stage of the research process
Foster equitable involvement of all	Variety of disciplines in the research process
Research is conducted by, with, or for communities	Research projects driven by needs of partners
Foster co-learning	Opportunities for co-learning encouraged
Dissemination of research findings and moving the evidence into practice	Dissemination of research findings in plain language in a timely fashion in ways that are best suited to the particular situation

Note: Adapted from CIHR (2008), Freire, (1970) and Montoya & Kent (2011)

The concepts of establishing and building a relationship, knowledge sharing, and capacity building have been recognized as influencing collaborative research. Freire's ideas offer a three-step methodology on how to work with decision makers, which are often different from the researchers' culture. The first step is listening in equal partnership with decision makers to identify issues and develop priorities. Step 2 is participatory dialogue about the issues, and step 3 is the action or change that decision makers envision. Viewing PHSI collaboration between decision makers and researchers as engagements in Freirean dialogue can promote the mutual nature of collaboration and enhance the benefits for all partners. PHSI projects require the establishment of collaborative processes characterized by shared intentions and equality of actions, so, within the context of this study, the choice of the Freirean framework to guide my research was appropriate.

My research study was designed to answer the following question: what are decision makers' perceptions and experiences about the nature of their partnerships with research collaborators on federally funded health research projects? This was a unique opportunity to explore the dimensions of collaboration as experienced by decision makers in a variety of different contexts. My research was guided by four objectives:

1. To explore and describe the decision makers' experiences in the research process during the development and engagement stages of the partnership
2. To learn and describe, from the decision maker's point of view, the working relationship during the partnership
3. To identify the ethical implications for decision makers in participating in collaborative research projects
4. To explore from the decision maker's perspective how this partnership facilitated the dissemination and subsequent uptake of research knowledge

In addressing these objectives, the research findings will (1) contribute new knowledge in the form of strategies for facilitating and engaging decision makers in collaborative health services research; (2) inform future decision makers, researchers, and funding bodies who are responsible for promoting high-quality health research of the benefits and costs associated with this involvement; and (3) develop understanding of the role and influence of decision makers in the transfer and uptake of research findings. Of particular interest to me was exploring whether there were common key factors that were important for collaboration in PHSI projects across all contexts or different contexts and whether this influenced the decision makers' experience of partnership.

Chapter Summary

With the increased emphasis on decision maker involvement in research, collaborative research represents an alternative approach to inquiry. The literature includes a diverse array of papers describing the fundamental principles, common characteristics, ethical aspects, and processes involved with a collaborative research approach. Despite the growing awareness of the need for collaboration between decision makers and researchers, there is only a limited literature exploring how decision makers in such partnerships can best work together.

There is increased recognition that best research outcomes are achieved when researchers collaborate with decision makers and gain input from those who are knowledgeable of the phenomenon under study (Quine & Kendig, 1999). A collaborative approach is a fundamental component of the CIHR PHSI program, where decision maker input is sought in setting research priorities and in the interpretation and dissemination of research findings. Furthermore, researchers are becoming increasingly aware that including decision makers in their research initiatives will improve the quality and applicability of their research findings. Many decision makers recognize that their health policy recommendations to governments are more likely to be successful if these submissions are supported by research evidence (Quine & Kendig, 1999). However, there is agreement that collaborative research is not an easy process, particularly if stakeholder partnership is to be more than tokenistic.

Collaborative research is complex, raising important practical and ethical challenges. Some studies focused on accounts sharing “lessons learned” and perceived facilitators and barriers encountered by partners involved in collaboration. The articles were generally written from the researcher’s perspective; few reported the impact of including decision makers in health services research (Goldberg-Freeman et al., 2010; Kennedy et al., 2009; Nyden, 2003). There is a paucity of research regarding successful strategies that were implemented by decision makers and that were effective in enhancing their experience with the research partnership and in the acceleration in the adoption of new practices. Understanding how the individual decision makers involved in these partnerships experienced the process addresses a clear gap in the literature. The concept of collaboration between decision makers and researchers has received little attention, an area to which this research will contribute. It is necessary to consider that individual decision maker experiences may vary depending on the level and type of involvement in the research process and whether the partnership was dictated by the requirements of a funding opportunity. This study will provide meaningful knowledge to others interested in similar initiatives.

In my study, I applied Freire’s model of dialogue as a conceptual framework for exploring the nature of collaborative partnership and the processes employed during the planning, implementation, and maintenance phases of PHSI partnerships that were beneficial to decision makers. My interest in learning about how decision makers were able to establish and maintain collaborations, characterized by mutuality of intentions and equality of actions, made this an appropriate framework to use for my study.

The literature review in this chapter has identified the need for this study and described the conceptual framework and study questions. The appropriate methodology chosen to answer these questions is described in the following chapter.

CHAPTER 3: RESEARCH METHODOLOGY

It has been recognized that there is a considerable gap in the translation of knowledge from research into evidence-based decisional processes in health services. Much has been written about the causes and consequences of this gap. One way to improve the applicability of research and ensuring that new knowledge is utilized by users is to engage partners from outside academic settings in collaborative research initiatives (Bartunek et al., 2003; Kothari & Wathen, 2013; Levin, 2004; Levin & Edelstein, 2010). In contrast to the extensive documentation of researchers' perspectives, there are few reports of the perspectives of decision makers' personal experiences with, and the strategies for, successful collaborative research endeavours. My thesis is an exploration of the collaborations in decision maker–researcher partnerships and addresses this key knowledge gap. My findings will provide a better understanding of what factors are associated with productive collaborations from the decision maker's point of view and will support implementing research findings and informing health policy practices.

Evidence-based practice is an important foundation for health care, and interpretive description, with its focus on the development of clinical understanding, is an important approach to guide evidence-based decision making. Thorne (2008) advocates strongly for better sharing of research findings with others working in the field. Findings from my analysis will add to the evolving understanding of the determinants of success in specialized health research collaborations, dissemination efforts, and subsequent uptake of research knowledge.

In this chapter, first, an overview of the research methodology selected to implement my study is provided. The chapter proceeds with the rationale for selecting this research method and a description of data sources, sampling, data management, and analysis strategies. The chapter concludes with an account of consenting processes, ethics approval, reflexivity, and the strategies implemented to ensure methodological integrity.

Qualitative Inquiry

Creswell (2007b) states that the qualitative approach is conducive to the exploration of unknown, undefined phenomena that may not be explained by using quantitative research methods. A qualitative approach facilitates understanding, from the participant's perspective, of the meaning, context, and processes of the phenomenon under study (Miles & Huberman, 1994; Thorne, 2008; Thorne, Reimer Kirkham, & MacDonald-Emes, 1997). Accordingly, qualitative inquiry is the favoured methodology for my thesis, which focuses on understanding decision makers' perspectives of collaboration within a federally funded health research initiative.

Feldman and Aldrich (1990) attribute the origins of qualitative research to Thomas De Quincey, an English essayist who in 1821 published an autobiographical account of his opium and alcohol addiction and the subsequent impact this addiction had on his life. *Confessions of an English Opium Eater* provides interesting insights into De Quincey's role as an observer and participant among prominent addicts and documented his observations (De Quincey, 1821/2004).

Qualitative research methods have evolved significantly since De Quincey's time and have become more systematically defined. When applied appropriately, qualitative methodologies have the capacity to go beyond the mere reporting of facts to unravel "the nuanced, the subtle, the complex and the various" qualitative evidence (McPherson & Thorne, 2006, p. 10). The literature (Creswell, 2007a; Lincoln & Guba, 1985; Miles & Huberman, 1994; Patton, 2002) highlights general characteristics (see Table 11) that are common to qualitative inquiry.

Table 11: General Characteristics Common to Qualitative Inquiry

Qualitative data: Data are collected in the form of words rather than numbers.
Naturalistic inquiry: Information was collected from decision makers, with the researcher as the main research instrument.
Researcher as the key instrument: Researchers' personal experiences and insights are an important part of the inquiry.
Concerned with process: Researchers are interested in how things occur and assume that change is ongoing.
Inductive reasoning for data analysis: Researchers explore open questions rather than testing a hypothesis.
Context sensitivity: Research findings are placed in a social, historical, and temporal context.

Note: Adapted from Creswell (2007a), Lincoln and Guba (1985), and Miles and Huberman (1994).

My research relied on words (through interviews with decision makers, copies of CIHR-funded grant proposals, and other supporting documents) to collect, know, and learn about decision makers' perspectives. Qualitative inquiry is a flexible approach; as new data were collected during my study, new avenues for inquiry emerged. Finally, including description and context allowed me to better address the unique conditions that led to collaborative research partnerships between decision makers and academic researchers. The intellectual goals of qualitative research applicable to my study were to explore and provide an in-depth description of the decision makers' perspectives and unique insights of collaboration, noting varying degrees and dimensions of their experience and similarities and differences (Maxwell, 2005).

Interpretive Description Research Approach

Interpretive description (Thorne et al., 1997) was the qualitative tradition selected to guide all sampling, data collection, and analytic decisions for my study. Interpretive description was originally developed by nursing scholars out of the need for an alternative method of generating applied knowledge and facilitating improved understanding about human health and illness experiences (Hunt, 2009; Thorne, 2008; Thorne et al., 1997). Although interpretive description was initially designed for nursing research, Hunt (2009) proposes that the approach is well suited to the "why," "how," and "what about" questions pertinent to many other disciplines. Some interesting interpretive description studies include "Restorative Health: Lessening the Impact of Previous Abuse and Violence in the Lives of Vulnerable Girls" (Henderson & Jackson, 2004); "Interpretive Description: Advancing Qualitative Approaches in Tourism and Hospitality Research" (Buissink-Smith & McIntosh, 1999); and "The Experience of Capacity Building Among Health Education Workers in the Yukon" (Horton & MacLeod, 2008).

With similarities to traditional qualitative research methods (ethnography, phenomenology, and grounded theory), interpretive description is grounded in the individual's experience (Thorne et al., 1997). In this alternative approach, the researcher develops a description of the phenomenon under study, and through interpretation of the study findings, the researcher moves beyond this initial description to portray an accurate representation of the meanings that participants attribute to the studied phenomenon. The resulting narrative includes thematic patterns and commonalities thought to characterize the phenomenon under study and is dependent on the perceptions, sensitivities, and inclinations of the researcher (Thorne, 2008). For example, in my study, I wanted to explore and describe how decision makers experienced collaboration within the context of health services research. Exploration of this phenomenon facilitated my research purpose, “to search out and explore features of a common issue (and to) render an understanding of them that honors that inherent complexity” (Thorne, 2008, p. 75).

Initially, interpretive description centred on developing knowledge that would inform clinical practice and has been used by researchers in a variety of disciplines exploring numerous questions relevant to applied clinical practice (Bakitas, 2007; Kenny & Duckett, 2004; Reimer Kirkham, 1998). The methodology should be located within the existing knowledge so that research findings can be created on the basis of connections to the work of others in the field (Hunt, 2009). Of particular relevance for my study was that this approach to inquiry was congruent with identifying commonalities of (decision makers’) experience while maintaining awareness of individual (decision maker) differences in ways that can be meaningfully applied to individual PHSI projects. To better understand why this approach was chosen and its applicability to my domain of inquiry, the distinct characteristics of interpretive description are discussed below.

Interpretive description is associated with a constructivist and naturalistic orientation to inquiry (Sandelowski, 2000). Creswell (2007b) explains that constructivists try to understand and develop subjective meaning of their experiences within the world in which they live. The constructive research paradigm represents a new approach to health research whereby learners develop their own understanding and knowledge through "constructive" processes. With naturalistic inquiry, the researcher attempts to present the phenomenon of interest as if it was not under study. Researchers use constructivism to seek understanding of and gain insights into people's experiences of a particular issue (Creswell, 2007b). Proponents of this theory claim that people are better able to understand the information they have developed themselves: "the learner constructs new knowledge through a process of relating new information to prior knowledge and experience" (Olgren, 1998, p. 81). They also acknowledge that people's understanding of their lives and situations is multiple and complex (Lincoln & Guba, 1985). Constructivists propose that to appreciate how life experiences shape the individual's actions, researchers must work in partnership with the individual to discuss meanings and develop understanding (Hunt, 2009; Thorne, 2008).

According to Thorne (2008), if the researcher is considered the instrument of the research, with the quality of the process and the product being dependent on the integrity of the researcher, then the task of locating oneself within the research initiative is fundamental (Thorne, 2008, p. 108). A priori background knowledge and a critical analysis of the existing knowledge provide valuable scaffolding in the form of an "analytic framework" (Thorne et al., 1997, p. 173) to the phenomenon being studied. Thorne proposes that this framework represents an appropriate platform upon which to develop a qualitative study to "generate new insights that shape new inquiries as well as applications of ‘evidence’ to practice” (Thorne, 2008, p. 35). More recently, Thorne revised her thinking and now proposes that “theoretical scaffolding” (Thorne, 2008, p. 36) replace the term “analytic framework” (Thorne, Reimer Kirkham, & O’Flynn-Magee, 2004, p. 53). She suggests that the use of “framework” terminology misled readers into thinking that a conceptual structure guided data analysis. She proposes that “scaffolding” clarifies for the reader the importance of foregrounding the study while maintaining the focus on scholarly positioning (Thorne, 2008).

Scaffolding is a useful tool for guiding the researcher’s reflexive and critical appraisal of research and to assist him or her in developing a “strategic synthesis of new understanding” (Thorne, 2008, p. 141). Two elements were implemented to “scaffold” (Thorne, 2008, p. 35) my study: (1) a thorough literature review, which supports the need for this interpretive description study, and (2) a description (see Chapter 1) of what I bring to the study, specifically, how my thinking has evolved and played a role in shaping the study. Much of my work has involved trying to understand the participant’s experience of clinical research trials. My domain of inquiry has expanded to include an exploration of the decision maker’s experience of engagement in health services research with academic researchers. The practice goal was to provide a coherent, straightforward account of the decision maker’s perspective of partnerships.

Hunt (2009) asserts that as with all research methods, there are strengths and limitations to interpretive description as it is applied in a research setting. Interpretive description serves as a logic framework within which a wide range of available social science techniques can be adapted and applied to the particular context of health and health care inquiry. Interpretive description, according to Thorne (2008), is not amenable to a "cookbook" (p. 141) prescriptive method, with a rigid set of steps and rules to be followed in designing a research study. Consequently, many design decisions are flexible. Direction is provided on key elements for planning and implementing research while remaining true to the logic and goals of interpretive description. For example, different forms of data collection and sources may be included in the research design. Analytic procedures capitalize on synthesizing, theorizing, and recontextualizing as opposed to simply sorting and coding. These design decisions are very much driven by the research topic and its context. Guiding the research process toward the clinical context and subsequent application of practice-appropriate findings are evident strengths of interpretive description (Hunt, 2009; Thorne, 2008).

Limitations cited in the literature (Hunt, 2009; Thorne, 2008) include challenges utilizing a lesser known methodology. Uncertainty regarding the level of interpretation to search for during data analysis has been recognized by Hunt (2009) as a challenge. He cautions researchers to ensure that the interpretive element of the analysis is adequately developed and in keeping with the exploration of the phenomenon under study (Hunt, 2009). However, with the publication of Thorne's book (2008), there is now a comprehensive, practically oriented, and authoritative description of this methodological approach for everyone to access.

Following consideration of the advantages and drawbacks associated with other qualitative research methodologies, I decided that the constructivist and naturalistic orientation toward inquiry, which interpretive description offers, makes this the most appropriate approach to address the focus and range of my research question. As discussed previously, interpretive description is based on existing knowledge, thoughtful linkages to the work of others in the field, and researchers' experiences (Thorne, 2008). It is a useful approach to inquiry for many health care research questions, especially when one seeks to gain first-hand knowledge of individuals' experiences and identify commonalities of that experience while, at the same time, maintaining awareness of individual variation (Sandelowski, 2000). In the foreword to Thorne's 2008 textbook, Sandelowski notes that this methodology furnishes researchers with an alternative technique to employ when it best fits the research question and context of inquiry (Thorne, 2008, p. 12).

Despite the original design rationale for interpretive description (to address the needs of nurse researchers), this methodology, with its orientation toward applied health disciplines, is a good fit for the purpose of my inquiry, which was to explore the multifaceted nature of decision maker–researcher partnerships. Consequently, it was clear from the outset that I consider implementing a flexible methodology that could assist this exploration. Below I describe why this is the case.

Interpretive description research encompasses two key facets: a practice goal and an understanding of what is known and not known on the basis of empirical evidence (Thorne, 2008, p. 35). My study's practice goal was to provide direction for support and strategies that would subsequently facilitate partnership initiatives and strengthen evidence-informed policy making within public health services. Engaging decision makers in the research process is a welcome development in terms of health services research and practice because it recognizes the decision maker's innate sense of what works in practice while at the same time challenging this knowledge as new ideas about the field emerge (Hunt, 2009). A better understanding of what decision makers report as helpful to them in their (collaborative) endeavours seems critical to developing evidence-informed recommendations for best practices in partnership with researchers.

The development of the research purpose and early design decisions were informed by a number of sources: (1) my review of the literature of collaborative research initiatives and published accounts of the partnership experiences of researchers and partners; (2) discussions with colleagues with collaborative research partnership experience; and (3) my experience as a PhD student working on research projects. Presenting an accurate account of decision makers' perspectives (descriptive validity) and precise, truthful testimony of the meanings they attribute to their experiences (interpretive validity) fulfill the goals of descriptive and interpretive validity (Sandelowski, 2000; Thorne, 2008).

Applied research implies that study findings, "a strategic synthesis of new understanding" (Thorne, 2008, p. 142), are expected to be of interest and applicable to the issues and challenges facing the health care system (CIHR, 2008). It was anticipated that by integrating study findings with relevant literature, we would improve our understanding of the role and influence of decision makers in the creation of knowledge transfer and uptake of research findings. The findings will be a starting point for considering tangible ways of fostering connection and inclusion in the KT process. By looking at the ways decision makers cooperate with researchers, we expected to learn about the strategies and factors that contributed to successful KT and what strategies and factors contributed to failure to implement findings. In turn, these learnings might be used to guide best practices, for example, the efficient transfer of research findings into improvements in policy and practice.

This study provided an opportunity to make an important contribution to the literature on collaborative research, which has in the past focused on factors motivating the development of partnerships with researchers while neglecting the perspectives of decision makers. Interpretive description of decision makers' perspectives adds to our developing knowledge and understanding of the manner in which decision makers' experience partnership and how that knowledge can be meaningfully applied in practice. I will argue that the findings from this work could be very helpful to other partnerships formed to address research goals.

Although interpretive description is considered to be a relatively new approach to qualitative inquiry, it has already been implemented by researchers who seek meaningful, relevant answers to specific research questions. The wide applicability of this approach is evident in the diverse range of topics researched, including evidence-informed decision making (Jack et al., 2011), capacity building among education workers (Horton & MacLeod, 2008), health professional communication (Thorne, Con, McGuiness, McPherson, & Harris, 2004), the implications of organizational culture (Thorne, Kazanjian, & MacEntee, 2001), the client-nurse relationship as experienced by public health nurses (Paavilainen & Åstedt-Kurki, 2007), home care safety perspectives (Lang et al., 2009), and cultural influences on breastfeeding choices (Chen, 1998).

Data Sources and Sampling Strategy

Context

PHSI is a significant research funding opportunity, with a focus on translational research, offered by the CIHR that supports a collaborative approach to applied health systems and services research. Participants for this study were sampled from the decision makers, who were partners on successfully funded PHSI grants in the 2008 and 2009 funding cycles. Research teams comprising academic researchers and decision makers were geographically dispersed throughout Canada, employed by various health authorities, provincial health services authorities, and government ministries (CIHR, 2008).

As stated previously, for the purpose of this study, the term *decision maker* is used to describe participants who make decisions about or who influence health policies or practices. Decision makers (practitioners, educators, health care administrators, elected officials, and individuals within the media, health charities, patient user groups, or the private sector) could be employed in a variety of settings (the local community, municipal, provincial, or national level) throughout Canada and are most likely to make use of, as opposed to merely benefitting from, the research findings. The term *academic researcher* or *researcher* is used to describe anyone whose primary place of activity is an academic institution or university.

To achieve the study's purpose, answer the research question, and learn about and describe the experiences of decision makers who were involved in PHSI research initiatives in the 2008 and 2009 funding cycles, I interviewed decision makers with varying lengths and degrees of involvement in the PHSI program. This strategy ensured maximum distribution regarding decision makers' experiences and facilitated exploration of the strengths and weaknesses of such partnerships. I was also curious to learn about facilitators and barriers identified before, during, and after the partnership. During the study, I (1) explored whether knowledge creation and translation activities occurred (during the collaboration) and whether strategies were developed and implemented by decision makers to ensure the application of findings and (2) learned about the factors that influence and strengthen the ability of the decision maker–researcher collaboration to realize the full potential of partnership.

Sampling Procedures

Purposeful sampling was chosen to best represent the aims of my research study. Sampling is the process used to select participants for inclusion in a research study. Purposeful sampling (or those individuals who understand the research problem and the central phenomenon under study) is typically implemented in qualitative research to facilitate an in-depth contextual study of a specific group of participants' experiences (Creswell, 2007a; Thorne, 2008). In the current study, I was interested in learning about the experience of PHSI partnerships from the decision maker's point of view.

To garner a rich perspective of participants' experiences, a purposeful sample of decision makers who were involved in the PHSI program for at least 12 months at the time of entry into this study were invited to participate. Criteria were developed in the early stages of the research study, at which time I decided against including researchers.

The rationale for this decision was that on the basis of the literature review, there has been limited research on the decision maker's point of view of partnership. I was interested in exploring their (decision makers') perspectives of partnership in the PHSI program as a phenomenon separate from that of researchers.

An active effort was made in this study to include a diverse, heterogeneous sample with the intention of portraying a wide range of decision makers' experiences of partnerships. The basic principle behind maximum variation sampling is to gain greater insights into a phenomenon by looking at it from all angles (Patton, 2002); it is a purposive sampling technique and is implemented when researchers want to understand how a phenomenon is seen and understood among different people, from different backgrounds, in different settings, with different expertise, and at different times. Patton (2002) advises that by including individuals with such diverse experiences, the researcher has the opportunity to describe the variation in the group and to develop understanding of these distinct experiences. This can often help the researcher identify common themes that are evident across the sample (Patton, 2002).

I invited decision makers to participate in my study based on the following dimensions of interest: (a) the level of the decision maker's role (e.g., clinical, managerial, administrative) and (b) the type of health care setting (e.g., acute health care, public health, community-based organization). Study inclusion criteria were as follows:

1. Individuals who spoke and understood English

2. Individuals who were formally identified as decision makers on PHSI programs funded in 2008 or 2009

Thirty-five multidisciplinary teams (comprising physicians, public health scientists, administrators, and policy makers) were funded in the September 2008, December 2008, and October 2009 PHSI competitions. The decision makers interviewed were representative of the various perspectives affiliated with the PHSI program, including community leaders, administrators, and decision makers from various organizations. Patton (1990) supports the selection of a diverse study sample and advises that two categories of findings will be generated as a result: (1) "high-quality, detailed descriptions of each case, which are useful for documenting uniqueness" (p. 172), and (2) "important shared patterns that cut across cases and derive their significance from having emerged out of heterogeneity" (p. 172). To provide a comprehensive description of decision makers' experiences across different contexts, I estimated recruiting 45 study participants across 35 PHSI projects; sampling continued until data saturation was achieved.

The initial goal was to recruit and interview 15 decision makers from each of the three funding cycles in 2008 and 2009. Thus, 45 decision makers were invited to participate in my study. An information-rich group of 27 individuals, representing 16 PHSI projects, were willing to share openly their experience, concerns, motivations, and expectations relating to partnership on PHSI projects (Patton, 1990). Participant demographic data are reported based on the experience, gender, and education level of the participants and the number of years they have been working in health research and are presented in Chapter 4.

The final sample size was determined by the number of decision makers willing to participate in the study and the number of decision makers required to achieve data saturation (Sandelowski, 1995b). Ultimately, in discussion with my doctoral committee, I decided when data collection was complete based on the identification of no new concepts related to participants' experiences; further data collection would not significantly contribute to deepening understanding (Hunt, 2009) and the ability to answer the study questions. The sampling strategies selected best represented the aims of the study and allowed for verification of newly developed themes, data patterns, exploration of relationships, and data analyses.

Data Collection Procedures

Participant Recruitment, Informed Consent, and Ethics Approval

Recruitment began in February 2012 following study approval by the Hamilton Health Sciences-McMaster Faculty of Health Sciences Research Ethics Board (REB). Participants were recruited using an REB-approved recruitment email (see Appendix 1). The email of invitation to participate outlined the inclusion criteria, provided a brief description of the study, and emphasized that potential study participants must be willing to openly share their experiences of partnership in the PHSI program. The ethics-approved consent form for administration to decision makers (see Appendix 2) was sent to study participants with the recruitment email. This afforded potential participants the opportunity to review the study information prior to consenting to take part.

If there was no response from a potential participant within 10 business days of the initial email, I sent a reminder email. If there was no response to the second email within 5 business days and no "out of office" message was received, it was presumed that this decision maker was not interested in participating in the study.

Prior to data collection, the participant information and consent form was reviewed with potential participants who expressed an interest in being involved with the study. The consent outlined the purpose and intent of the study, strategies implemented to ensure confidentiality, and the participant's role throughout the process. Participants were then asked to email or fax the completed consent form back to the researcher. Once informed consent was obtained, telephone interviews were scheduled with decision makers. At the time of the interview, I reiterated that participation was voluntary, confidentiality would be maintained, and participants could withdraw their involvement in the study at any time.

Individual Semi-Structured Interviews

To gain an in-depth understanding and description of decision makers' experiences of engaging and collaborating with health researchers, focused in-depth, semi-structured interviews were the primary source of data for this study. The most common form of interview administered in qualitative research studies is the face-to-face semi-structured interview (Bryman, 2004). These interviews are helpful as they guide the interviewer to discover the who, what, and where of the experience under study (Sandelowski, 2000).

Participants were offered a choice of either interview by telephone or interview using Skype technology. The primary reason for offering these choices was the recognition that some participants may feel more comfortable with one interview format over another. The second reason was for logistical purposes because many of the decision makers were located throughout Canada. All decision makers chose to be interviewed over the telephone. Interviews were arranged at a mutually agreed upon convenient time; only the decision maker and I were present for the interview. Decision makers were requested to block off an hour to an hour and a half of their time to complete the interview.

I viewed gaining trust and establishing rapport as essential components of the interview process, which, according to the literature, may affect the quality of the information people may be willing to share (Benner, 1994; Robson, 2002). Rapport was established through email, telephone contact, and prompt responses to any questions the participants posed. The interview process started with a discussion of the intent and purpose of the study and the decision makers' professional background and current role. Field and Morse (1985) advise that discussions begin on a superficial level, and as the relationship develops, so, too, do the richness and quality of the discussions. Semi-structured interviewing provided a consistent framework for exploring decision makers' experiences as stated in their own words, facilitated discussion, and enabled understanding regarding details of the strategies implemented while partnering with researchers on health services research projects. This interview process provided an occasion to listen to and obtain a level of understanding of decision makers' points of view. To obtain detailed, rich, experiential accounts of partnership, I listened attentively to the words and how the story was told—a strategy recommended by Benner (1994).

I administered interviews to decision maker participants on two occasions during the study (see Appendices 4 and 5). Participants were given a copy of the interview questions in advance so that they had time to reflect and prepare for the interviews by jotting down their thoughts, insights, and perspectives. An opportunity was provided to decision makers to reflect on and share their perspectives during the interview. Probing and reflection are strongly advised to facilitate discussion. The flexibility to adapt questions (i.e., open-ended, broad questions define the initial area of interest to be explored) to suit the interview pace and mood of the interviewee is considered an important feature of semi-structured interviewing. This method assisted the exploration of collaborative research partnership from the decision maker's perspective and facilitated the discovery of ideas unknown to me at the beginning of this research study (Britten, 1995). Although scheduling telephone interviewing may be tedious, the advantage of this approach is that participants do not feel influenced to answer questions in a particular way (Baker, Wuest, & Stern, 1992), thus diminishing the propensity toward "socially desirable responses" (Robson, 1993, p. 282).

Interview guides designed for administration in interpretive description studies are typically more structured than guides implemented in other qualitative studies (Thorne, 2008). Early interview questions and guides were initially developed in the spring of 2012 in collaboration with colleagues at the CIHR (Andrea Smith, Manager, PHSI; Kristina Harris, Senior KT Specialist; and Jacqueline Tetroe, Senior Advisor). Based on the original research objectives, expert knowledge, themes, and principles of collaborative research as identified in the literature (establishing a relationship, knowledge sharing, interpretation of study findings, messaging findings, and dissemination of results), concepts derived from the conceptual framework (described previously), the interview documents directing this study were created. The interview guide focused on question development in areas that are poorly understood and was modified and revised as themes emerged during data analysis (Israel et al., 1998; Macaulay et al., 1999; Minkler & Wallerstein, 2002).

Interview guides are an integral tool in data collection in qualitative research and may be used to help researchers engage participants in conversation about the topic under study (Creswell, 2007a). The use of the interview guide facilitated observance of the time limits and ensured that similar lines of inquiry were pursued with each decision maker. The questions and guides were piloted with a team member of a PHSI program to establish appropriateness for use in the field. The pilot case was chosen based on ease of access and convenience and, as recommended by Creswell (2007a), was administered to explore the feasibility of the guide, test the questions, assess whether observer bias existed, collect additional questions that may be relevant, and obtain an early sense of emerging concepts and themes. The interview guide provided a valuable link between the research question, the study topic, and the literature. The guide (a copy of which is provided in Appendix 3) changed slightly over the course of data collection and analysis to reflect developing themes and concepts.

The focus of the first interview (lasting approximately 60 to 90 minutes) was to explore (1) the structures and practices that assisted in the formation of the partnership; (2) how the partnership developed over time; (3) how success was defined and evaluated; (4) the factors that contributed to or detracted from the sustainability of the partnership; and (5) the dissemination and strategies implemented for uptake of the research findings.

Study participants were asked for consent to follow-up in the event that following the interview I needed to clarify interview responses (see Appendix 4). These interviews were performed for the purpose of (1) member checking, or assessing the credibility or "truth value" of the qualitative data by having the participants comment on the accuracy of my interpretation of their data (Thorne et al., 1997); (2) providing an opportunity to explore concepts and themes that emerged during the first interviews; and (3) collecting additional data to fully saturate the properties and dimensions of emerging concepts.

As a hallmark of qualitative research, data collection and analysis occurred concurrently, with each step informing the other in an iterative process. As such, following careful analysis of the first set of interviews, the interview questions were adapted so that the concepts' properties and dimensions could be further identified and defined within subsequent interviews. During the second interviews, additional information that helped fill gaps in the emerging themes and provide clarification was gathered. Prompts pertaining to specific aspects of the collaborative research experience included questions about the decision makers' role and contributions to the various stages of the partnership process, perceived facilitators, and factors affecting the success and influence of collaborative research on professional practice and policy.

Assigning numbers to each interview ensured confidentiality. A separate document was created linking each decision maker's name with his or her unique participant number. This document was stored in a separate locked file in my office and will be kept for 10 years as per the REB guidelines, after which time, the data will be destroyed. All interviews were recorded using a high-quality digital recorder and subsequently transferred as audio recordings through a USB port to a computer, where they were protected under password. Once the transcription files were received by the transcriptionist, they were erased through a secure, password-protected Internet file transfer protocol. Interviews were subsequently transcribed verbatim from these recordings by a transcriptionist bound by confidentiality (see Appendix 5). Transcripts were then checked against audio recordings for accuracy, and then each transcript was transported into the NVivo 9 Qualitative Systems Research (QSR) data management software program in preparation for analysis.

In addition to interview transcripts, I took short field notes during the interviews. These field notes were treated in the same manner as other collected data. The notes were uploaded onto my laptop; participant anonymity was maintained by developing a code and pseudonym for all participants, with the original codes stored in a locked filing cabinet in my office. Field notes included detailed information such as a description of the interview setting and the study participant, any issues encountered during the interview, the tone of the interview, and my feelings during and after the interview. These notes enabled me to review my thoughts, knowledge, and understanding and how these impacted the study (Lofland & Lofland, 1995). Creswell (2007a) advises that field note keeping is good practice, with notes serving as data backup in the event of a technological failure. It was anticipated that second interviews and additional forms of data collection would result in data saturation, with no new themes being identified.

To date, no study participants have requested to be withdrawn from the study or reported experiencing significant distress following the interview. Twenty-five of the 27 participants requested a copy of the study results when available.

Data Management

The NVivo 9 QSR software program was chosen to facilitate data management and the initial phases of data analysis (Qualitative Systems Research, 2010). This computer program was designed for qualitative researchers working with rich text–based information for which deep levels of analysis are required. Interview transcripts were imported into the software program to facilitate coding and concept building. Preliminary qualitative conventional content analysis occurred concurrently with the data collection. This dynamic, flexible method of summarizing text data proved to be valuable for identifying common themes in subsequent interviews.

The digitally recorded interviews are maintained as digital sound–encrypted files on my password-protected computer. The files on the digital recorder were transferred from the recorder through a secure Internet-based file transfer protocol as soon as possible after the interview, and all files were deleted upon completion of the transcription. Data received were encrypted and backed up on a password-secured external hard drive.

As mentioned previously, the anonymity of study participants was preserved by developing a code and pseudonym for all participants. Participant identification codes, study documents, and informed consent forms were stored in a locked filing cabinet in my office. Access to all study-related materials was restricted solely to the research team. The data will be stored for 10 years as required by the Hamilton Health Sciences-McMaster Faculty of Health Sciences REB.

Data Analysis and Interpretation

Analysis engaged rigorous cross-comparison in the context of emerging thematic synthesis, the purpose being to transform the data into research findings. Coffey and Atkinson (1996) describe the process of qualitative data analysis in which common themes are identified and organized. Special attention is paid to the relationship that exist among these themes. The analysis and interpretation for this study focused on themes pertinent to answering the stated research questions. A description of this process is provided in this section.

Interpretive description allows the researcher the freedom to select coding approaches from other qualitative research methods. Thorne, Reimer Kirkham, et al. (2004) strongly encourage the researcher to adopt a flexible approach to data analysis. Intellectual inquiry, as opposed to line-by-line transcript coding, is the preferred approach, with the researcher asking questions such as “What does this mean?” and “Why is this happening?” (Thorne, Reimer Kirkham, et al., 2004, p. 13).

The constant comparative method, as described by Lincoln and Guba (1985), was implemented in this study. Review of "what is known" formed the basis for the preliminary analysis. As data analysis progresses, the researcher moves away from the "scaffold" and focuses on broad questions in an effort to develop increased understanding and interpretation of the data. Thus, the analysis procedures selected for this study were in keeping with the overall philosophy and fall within the evaluative criteria of the study. The precise nature of each decision maker's unique view is captured and recalled; data are presented in a logical sequence in relation to the research questions addressed in the study (Thorne, Reimer Kirkham, et al., 2004).

Analysis was planned in three stages. First, the participant demographic data were examined and reported based on the experience, gender, and education level of the participants and the number of years they have been working in health services research. As mentioned previously, the demographic data are presented in Chapter 4.

Second, the interview data were read and reread. This initial stage of data analysis allowed me to reflect on and immerse myself in the data. Thorne et al. (1997) (1) propose that this approach be taken before any coding or categorizing of data takes place and (2) inform us that the intention of data analysis is to obtain an overall picture of what is happening before any formal analysis begins. Data analysis is an inductive process as the researcher seeks an understanding of the decision maker's perspective of a specialized partnership as opposed to proving a theory (Hsieh & Shannon, 2005; Miles & Huberman, 1994; Sandelowski, 1995a).

During the third stage of analysis, copies of the PHSI grant proposals and field notes were considered in conjunction with the interview data. Polkinghorne (1989) advocates gathering information from multiple sources so that a greater depth of information is obtained. Triangulation is a validation strategy recommended by Creswell (2007b) whereby different data sources and data collection methods are used to provide perspective on a topic. Thus, each decision maker was asked to share ahead of the interview a copy of the original funded PHSI grant proposal and other supporting documents (e.g., terms of reference, meeting minutes) relevant to this study. The inclusion of these documents is a valuable source of data triangulation and is encouraged for several reasons as this information adds further breadth to the inquiry and richness to the quality of the data. First, as recommended by Thorne et al. (2004), integrating information from interview data and other sources with experiential knowledge facilitates interpretation of the phenomenon of interest. Document review provided an opportunity for me to familiarize myself with a comprehensive overview of the decision maker's area of work, knowledge, and experience. A second reason for sampling these documents was to garner a description of the types of studies funded and to understand program goals and guiding principles. The inclusion of these documents added important contextual information that added strength to the data sources and served to corroborate data gleaned during the interview. Finally, these data allowed me to understand the initial expectations decision makers held of the collaborative PHSI program, which served to guide interview discussions and provide a testing ground for the insights that emerged during data analysis (Thorne et al., 1997).

Field notes were documented after each interview and considered simultaneously with the recorded interview. Data analysis also required referring to my reflective journal, debriefing, and discussing findings with study participants and peers familiar with interpretive description. Reflective journaling (whereby the researcher records thoughts and reflections on experiences) was completed daily. This journal included such items as questions and decisions made throughout the research process. As recommended by Thorne et al. (2004a), common themes and data patterns that evolve may be used as the basis for validation interviews.

Constant Comparative Data Analysis

Researchers implementing interpretive description studies must be very familiar with the data (Thorne et al., 1997). The “explicit awareness” of the researcher as interpreter (Thorne et al., 2004a, p. 12), careful review, and thoughtful analysis are required to abstract themes to form a persuasive, “coherent, defensible and data grounded” narrative (Thorne et al., 2004a, p. 12; see also Hunt, 2009).

Glaser and Strauss (cited in Lincoln & Guba, 1985, p. 339) describe the constant comparison method as following four distinct steps: (1) reduce, code, and display the emerging themes or patterns comparing incidents applicable to each category; (2) combine categories, comparing them to each other and the themes; (3) define and refine themes; and (4) provide examples from the data to show how the themes were derived.

Each interview recording was listened to several times and considered with the field notes. All notes from interview transcripts and field notes were coded and analyzed in the same way. Interview transcripts were read in their entirety as soon as possible after the interview was transcribed to check for accuracy and to ensure that the qualitative elements of the interaction were accurately recalled.

During the coding process, codes were generated from the data and attributed to sentences or paragraphs in each document. These codes represented themes with which the particular data are linked and were written alongside the specific text in the margins of each transcript. Codes and definitions were recorded in a separate file, which ensured that the use of each code was consistent and established an audit trail, which may be reviewed by others if required. I kept notes throughout the study documenting the development and process of the coding system and data management decisions. Data with similarities were grouped into categories. Groupings and further data analysis required making sense of the relationships that these data groupings had to one another.

The constant comparative data analysis process shown in Table 12 outlines the steps taken during analysis and enables understanding of how the analysis was conducted so that the study findings are represented accurately and truthfully. As described by Thorne et al. (2004a), interpretive description provides grounding for conceptual linkages with the subjectivity of the experience under study to create credible, meaningful knowledge.

Strauss and Corbin (1990) propose that although literature-based codes can guide the analysis process, this type of coding may also limit the development of new ideas. Repeated, systematic reviewing of the data and repeated coding allowed themes and patterns reflective of decision makers’ responses to emerge from the data.

Table 12: Steps in Constant Comparative Data Analysis

Steps Taken	*Actions*
Constant comparative data analysis: comprehending data, synthesizing meanings, theorizing relationships, contextualizing data into findings	Researcher is driving the interpretation Process of intellectual inquiry to develop a credible explanation of the phenomenon of community partners' experience of partnership
Identifying, exploring multiple relevant sources of data through careful, thorough review	Use highlighters to identify patterns, themes in the margins of the documents Easy to see highlighted commonalities in the documents
Identify key themes, name them, and code them on each document	Assists in understanding emerging themes
Compare codes to find consistencies and differences Categorize specific themes	Constant comparative process during analysis
Consistencies in meanings between codes reveal categories	Constant process to prevent drifting away from meaning
Memo on the comparisons and emerging categories Report decisions, practices regarding coding practices	Constructing theoretical relationships Making sense of/explaining generated themes, patterns Meaningful and applicable findings
Category saturates when no new codes related to it are formed	Data saturation
Certain categories become more central focus	Refine the emerging construct of participation Theoretical explanation emerges
Monitor, report analytic procedures honestly	Steps implemented to establish trustworthiness (i.e., credibility, transferability, confirmability, dependability)

Note: Adapted from Lincoln and Guba (1985, p. 339).

The process was repeated until no new codes were generated to review and no new insights were identified.

After an agreed-upon number of interview transcripts were analyzed, I met with my thesis supervisor and qualitative research experts on my committee to review the process of data analysis and discuss potential identified patterns. Expert guidance to novice researchers facilitates the interpretive process by helping the researcher work through earlier assumptions and make sense of the emerging concepts and themes (Thorne et al., 2004a). As noted by Marck et al. (2010), the rigor of study interpretations is strengthened with contributions from these experts.

I engaged in member checking with 25 decision makers (2 refused further follow-up). To elicit comment and feedback, I prepared and sent a summary of the findings from the data analysis to decision makers who had participated in my study. I shared my observations with the intention of confirming my initial reflections and finding out how these ideas resonated with decision makers' perspectives. Presenting summaries of preliminary findings has been cited as being more useful to study participants as opposed to providing copies of individual interview summaries (Patton, 2002). In addition, Thorne et al. (1997) advise that by providing an overall analysis of emerging findings to participants, this activity further supports confidence in the findings. The summary document outlined key themes identified during the study and may be used to develop guidance for decision makers new to the field of partnership research initiatives. Of the 25 decision makers who received the summary document, 16 agreed to further follow-up. Although decision makers identified different areas of my analysis as important to them and offered divergent interpretations in other areas, there was general consensus that I had captured their experiences in my analysis. The study findings are presented in Chapter 4.

The Dialogical Framework

Freire's (1970) ideas are comparable to the principles that guide collaborative research initiatives. He proposes a dialogue approach in which everyone participates as equals and co-learners to create knowledge. In the context of decision maker–researcher partnerships, the guiding premise for dialogical action as proposed by Freire (1970) is the understanding that decision makers possess knowledge of equal importance to researcher-generated expert knowledge. Freire's ideas offer an interesting perspective for viewing the engagement of decision makers with researchers and the nature of this collaboration. Understanding how individual decision makers involved in PHSI projects experience research planning, implementation, and dissemination activities addresses a clear gap in the literature regarding partnership and is both timely and warranted.

Freire offers a three-stage methodology (1970). In the context of my study, the listening stage is completed in equal partnership with decision makers and researchers to identify and assess health concerns relevant to the community. Stage 2 is the participatory dialogue that comprises the sharing of experiences, problem-posing dialogue, and planning for action. The third stage is the positive change or action that partners envision during their dialogue (Freire, 1970).

This study focuses on learning and describing how decision makers were able to establish and maintain collaborative research partnerships that were characterized by mutuality of intentions and equality of actions. The components of Freire’s (1970) dialogical framework were compared to the data. The purpose of this step in the analysis was to clarify and explain how the experience of partnership (from the decision maker’s perspective) was or was not a dialogical relationship. This will be addressed further in Chapter 4.

Methodological Integrity

A number of steps were implemented to promote rigor throughout my study (triangulation of data, member checking, looking for disconfirming cases, audit trail). In qualitative research, an important measure of rigor is trustworthiness. This refers to the believability of data (Creswell, 2007b) and, according to Lincoln and Guba (1985), means that the research is authentic and dependable. The trustworthiness of the findings is shown through the use of rich description and may be evaluated according to credibility, confirmability, transferability, and dependability. Rich description provides details about the rationale for selecting an interpretive descriptive approach, the research process, and data collection and analysis. The trustworthiness of the study began with purposeful sampling from a number of different PHSI projects. Subsequently, data were collected during interviews with decision makers (Thorne, 2008). During data analysis, as themes emerged and were identified, they were compared to current knowledge about the themes through literature review.

Credibility is demonstrated when research findings and interpretations are plausible to the participants (Creswell, 2007b; Lincoln & Guba, 1985). The credibility of the study findings was advanced through transparency in the description of the research process. Researcher bias can threaten the credibility of a study; therefore, an explanation of my beliefs and assumptions was provided at the outset of the study and re-examined throughout the process of data analysis. Thorne et al. (2004a) suggest that acknowledgement of the researcher's involvement in the findings is an essential element of interpretive description. This activity supports the credibility of the researcher. The credibility of the findings was enhanced by referring to several data sources, the original grant application, available literature, self-reflection, and field notes (Patton, 2002).

As mentioned previously in this chapter, triangulation is a validation strategy recommended by Creswell (2007a) whereby different data sources and data collection methods are used to provide perspective on a topic. Lincoln and Guba (1985) advise that when a theme or concept has been confirmed by two or more data sources, the ambiguity of its interpretation is minimized. In this study, triangulation occurred through the collection of data using multiple data sources, primarily interviews and document analysis.

Confirmability is the degree to which the data and interpretations are grounded in events rather than the researcher's own beliefs. To establish confirmability, Lincoln and Guba (1985) counsel that the data, interpretations, and recommendations be examined for internal consistency to ensure that the findings are supported by the data and are meaningful to the study participants, in this case, decision makers. To achieve this, I followed Thorne's (2008) advice by creating a "quotable quotes" file containing especially meaningful quotations that support the study's findings. Furthermore, a complete explanation of the process of data analysis has been described.

Transferability is used to determine the degree to which the research findings can be applied to other contexts (Thorne, 2008). Lincoln and Guba (1985) describe how the collection of detailed, rich, accounts of the research process allows readers to make decisions regarding transferability and the determination of the applicability of the identified patterns in this study to other contexts. To enhance transferability, data analysis methods are described and careful attention has been paid to the writing of research findings detailing the path followed to reach my study conclusions (Marck et al., 2010).

Dependability refers to consistency and is usually established through duplication (Creswell, 2007b; Marck et al., 2010). To assure dependability within my study, comparable questions were asked in numerous ways, allowing me to evaluate the consistency of participants' responses. Evidence of dependability is provided through the demonstration of systematically searching for meanings embedded in the data (Patton, 2002).

To ensure that my analysis reflects the perspectives of decision makers, study participants were asked for a second interview. During this time, participants were asked to review the summary of previous interviews. As Patton (2002) recommends, this validation technique ensures accuracy and is a key step to completeness of the analytic process. Sharing the analysis with participants offers them the opportunity to provide context, clarification, and, perhaps, alternative perspectives. Other verification strategies (concurrent data collection and analysis, constant comparative analysis) were implemented in this study in an effort to increase dependability.

Thorne (2008) reminds researchers of the requirements for research credibility and accompanying responsibilities and duties that result from the mandate of nursing and applied health disciplines. These obligations must be considered over and above the requirements of rigor applicable to qualitative research because the aim in most research endeavours is practice change. Thorne advocates for providing a strong rationale as to why this interpretive description research is being conducted, what will be done with the research findings, and the practical significance for advancing disciplinary knowledge.

Reflexivity

The "thoughtful self-aware analysis of the intersubjective dynamics between researcher and the researched" is how Finlay and Gough (2003, p. ix) describes reflexivity. Traditional research approaches support a detached, objective role for researchers. In contrast, emphasis is placed on the significance of a high level of critical self-reflection and self-awareness when implementing interpretive descriptive research. Reflexivity is regarded as an active reflective process whereby researchers examine their values, biases, motivations, and actions. Self-reflection and self-awareness, results in learning with the specific purpose of changing behaviours, perspectives, and practices (Cooney, 1999; Koch & Harrington, 1998).

Wilkinson (1988, p. 55) proposes three essential elements of reflexivity, personal, functional, and disciplinary, all of which are important to this study. Personal reflexivity refers to me as the researcher and my interests, values and uniqueness, which have shaped my life relative to the research process. This means accepting who I am, what I believe in, and what has drawn me to this research. My background and knowledge impact decisions made during the study, and this knowledge provides a setting to the study. Functional reflexivity refers to two key elements: first, how my knowledge guides the selection of methodology and, second, how successfully the research adheres to those epistemological principles. To address these issues, Wilkinson (1988) recommends that there be a frequent critical examination of the research process. Disciplinary knowledge may be defined as knowledge associated with a particular discipline or profession and is a term used to describe various types of knowledge, expertise, and research areas that are associated with areas of study or professional practice. Disciplinary reflexivity relates to the need to recognize the knowledge that supports the topic under study (Wilkinson, 1988).

The purpose of my thesis is to describe decision makers' experiences in collaborative research partnerships truthfully and accurately. Accordingly, limiting my influence on documenting these perspectives was important. Lincoln and Guba (1985) advise that when implementing a naturalistic philosophy to inquiry, interpretations are very reliant on researcher–participant interaction. Reflexivity was a way to acknowledge my feelings and experiences as they evolved throughout the course of the study. Reflective journaling, documenting key study insights and decisions regarding methodology, started at the beginning of the research process. This continual reflexive activity, which promotes quality within the research process, was important for several reasons. First, the journal serves as an audit trail by recording study decisions and the rationale for choices made. Journaling provides evidence of the evolution of concepts that are included in my review of the literature. As the study progressed, my thoughts and ideas on methods, ethical concerns, and consideration of emerging themes were documented. Second, Patton (2002) recommends that when implementing a naturalistic approach to inquiry, the researcher’s perspective must be made clear. Accordingly, my journal provides evidence of critical self-reflection throughout the research process.

Description of my thoughts and feelings revealed similarities and highlighted disconnections between my experiences and those of decision makers. I found the experience of reflexivity difficult at times as I had to question some of my own assumptions and acknowledge limitations to my knowledge. The journal permits the reader to see how preconceptions and assumptions influence study design and development. My reflective journal allowed me to review my research study and interpret and understand my findings and is a testimony that research is not only about findings but, rather, is a rich learning experience.

“Reflexive accounting,” as described by Thorne (2008, p. 102), demonstrates a serious attempt to ensure a measure of validity to the study findings. This enables readers to judge for themselves not only the validity of the study but also whether it was implemented in an ethical fashion (Mays & Pope, 1995).

Chapter Summary

Interpretive description has been described in this chapter and an overview is presented in Table 13 (Thorne et al., 1997).

Table 13: Overview of the Interpretive Descriptive Research Approach

Components of Interpretive Description	*Explanation*
Philosophy	Pragmatic philosophy of inquiry and research methodology
Methodology	Interpretive description is an inductive, reasoned approach whereby the researcher interprets meanings emerging from the descriptive account to render a full understanding of the phenomenon under study
Sampling	Purposeful and maximum variation sampling implemented in this study
Methods of data collection	Semi-structured interviews The researcher was interested in the who, what, where, and why of the decision makers' experiences Review of documents and pertinent materials
Analysis	Content analysis NVivo qualitative software and in vivo coding procedures used in this study
Assurance of quality	Establishment of trustworthiness
Outcome	Rich, in-depth, comprehensive description of the decision makers' experiences in easy to understand terms

Note: Adapted from Thorne (2008).

Of particular relevance for my study was that this approach to inquiry was congruent with identifying commonalities of (decision makers') experience while maintaining awareness of individual (decision maker) differences in ways that can be meaningfully applied to individual PHSI projects. To better understand why this approach was chosen and its applicability to my domain of inquiry, the distinct characteristics of interpretive description are presented and discussed in this chapter. The aim of this work was to "deconstruct the angle of vision upon which prior knowledge has been erected and to generate new insights that shape new inquiries as well as applications of 'evidence' to practice" (Thorne, 2008, p. 35).

The study findings are presented in Chapter 4. The chapter begins with a description of important contextual factors and changes that occurred during the study, which is followed by the characteristics of the decision maker participants and the findings presented through concepts relevant to collaborative research partnerships.

CHAPTER 4: RESULTS

Chapter 4 begins with a description of the decision maker demographic data, PHSI study characteristics, and a summary of study themes. Second, the conceptual framework developed from the data is described and provides a structure for interpretation and contextual understanding. Third, the research question is addressed with the presentation of findings for each objective and described using decision makers' quotations to highlight key points. Next, I describe decision makers' experiences of initiating and developing partnerships. Findings in the form of processes relevant to the implementation of, participation in, and outcome and maintenance of PHSI projects are then presented. The chapter closes with the decision makers' advice for future research and practice.

Decision Maker and PHSI Study Characteristics

Decision makers were recruited from among the 35 PHSI projects funded by the CIHR in 2008 and 2009. In the publicly available database of CIHR funding decision notifications for the PHSI initiatives, I identified a total of 51 decision maker partners who were listed as a principal investigator on successfully funded PHSI projects. This full population of decision makers was invited to participate in the study, with 27 consenting to be interviewed, 10 declining to participate, and 14 not responding to the study invitation following three contact attempts. The reasons for declining included a lack of time, personal reasons, concern about limited experience with the PHSI project, and being on an extended leave from work.

In total, 55% of the decision makers, who were identified as principal investigators on PHSI-funded projects in 2008 and 2009, participated in this study. Semi-structured interviews were conducted between February and October 2012. During that time, PHSI projects that had been funded in 2008 had been in progress for four years, and projects funded in 2009 had been in progress for three years. Primary interviews were conducted with 27 decision makers. Of these participants, 13 described themselves as health system planners and managers with influential positions within the health care system. This group included public health practitioners, hospital administrators, executives, and managers who worked with regional health authorities. Five decision makers were health care professionals (medical doctors, nurses, social workers) and nine were policy makers who reported having the power to influence or determine policies and practices at an international, national, regional, or local level. To report these findings, each respondent was assigned a code and a number (i.e., health system planner or manager – HSPM, health care professional – HP, and policy maker – PM).

Of the purposeful sample of 27 decision makers, 16 participants (nine health system planners and managers, two health care professionals, and five policy makers) completed a second interview. The purpose of this second interview was to collect additional data to further understand concepts emerging in the first interview and to confirm and validate emerging patterns of data from all interviews. This process of member checking contributed to the overall credibility of the findings. The primary interviews ranged from eight to 52 minutes in length, whereas the secondary interviews ranged from 12 to 25 minutes (the mean duration for the primary and secondary interviews was 49 minutes and 22 minutes, respectively). Eleven decision makers (four health system planners and managers, three health care professionals, and four policy makers) did not respond to my request for a second interview.

The majority of the study participants were female (*n* = 19, 70%). All of the participants had completed post-secondary education, with the majority having completed a professional or graduate-level degree (nine completed master's training and five participants were graduates of PhD programs). Respondents represented a range of health care agencies and service providers in relation to size, geography, type of service provided, and years and extent of involvement in research. Decision makers described their job functions as policy development, communication leads, knowledge broker, quality performance management, administration, project management, lawyer, health system planner, and teacher.

On average, decision makers had 20 years of experience working in health care and six years working in their current positions. Thus, they were well positioned to provide in-depth descriptions about collaborative research initiatives with researchers. The genesis of PHSI collaborations was wide-ranging; many were based on the decision maker's previous (working) experience with the researcher, whereas others were a result of working with the researcher while pursuing their education, and some resulted from networking at conferences. At the time of the interview, of the 27 decision makers, 20 (eight health system planners and managers, four health care professionals, and eight policy makers) indicated a previous history of working on various projects with the same researcher. A summary of participant characteristics is provided in Table 14.

Table 14: Decision Maker Attributes

	*Health System Planners/Managers (*n = *13)* n *(range)*	*Health Care Professionals (*n = *5)* n *(range)*	*Policy Makers (*n = *9)* n *(range)*	*Total Sample (*N = *27)* n *(range)*
Gender				
Female	11	3	5	19
Male	2	2	4	8
Education	*	*	*	
Bachelor's				1
Master's				10
Prof. degree				11
PhD				5
Mean years experience	12.2 (4–22)	27.3 (21–30)	26.1 (15–37)	20.0 (4–37)
Mean years experience in current role	4.1 (1–7)	4.8 (1–12)	8.7 (3–25)	5.8 (1–25)
History with researcher				
Yes	8	4	8	20
No	5	1	1	7
Interview 1				
Yes	13	5	9	27
No	0	0	0	0
Mean interview time in minutes	52.2 (8–73)	45.4 (30–53)	46 (13–64)	48.9 (8–73)
Interview 2				
Yes	9	2	5	16
No	4	3	4	11
Mean interview time in minutes	25.0 (13–48)	20.0 (20–20)	17.7 (12–21)	22.3 (12–48)

*Cells suppressed to reduce the risk of decision maker re-identification.

The PHSI program differs from traditional research programs in which the funding agency contributes financial support to the initiative, and the researcher designs and implements the research and subsequently provides the findings to the funding agency. One of the defining characteristics of the PHSI program is the emphasis on decision makers and researchers coming together and then contributing their expertise and knowledge to implement applied and policy-relevant health services research.

The PHSI initiative fostered collaboration from the beginning by strongly encouraging decision maker partners to submit a signed letter along with the grant application describing their role and degree of involvement in the research project, the amount of time they planned to commit to the project, and a description of how they (decision makers) intended to use the project findings. It was anticipated that as a result of (decision maker–researcher) collaboration, research findings would likely be more relevant to and used by decision makers.

Although decision makers from only 16 distinctly funded PHSI projects participated in my study, these projects covered a broad range of study topics and diverse health service contexts. PHSI research projects were conducted in a range of settings, including community care, public health, acute care, or education. Issues under study involved topics within the realms of workforce and the work environment; change management for improved practice and improved health, data, information, and knowledge management; value-based decision making and public engagement; patient-centred care; chronic disease prevention and management; emerging technologies and drugs; quality and patient safety; and linking population and public health to health services. As of May 2013, from among the PHSI projects sampled, 12 were still in progress (the CIHR expects that these projects will be completed in 2014) and four have been completed and the final reports received by the CIHR.

Summary of Study Themes

For the most part, decision makers described positive experiences related to collaborating with researchers on the PHSI projects, particularly when the resources and processes were in place to foster relationship development and maintenance. Table 15 provides an overview of study themes.

Decision makers described their experience of collaboration as a multi-step process. Each step built on the previous step in an iterative manner and included the following sequence of activities: (1) *Getting Started*, which begins with the selection of appropriately diverse team members in terms of educational and professional backgrounds and the acquisition of sufficient funding and resources—the essential components for building a collaborative research team; (2) *Working Together* to engage decision makers and researchers to proceed in the work of research; followed by (3) *Completing the PHSI Project* and implementing the study findings; and, finally, (4) *Sustaining the Collaboration* and planning next steps.

Table 15: Summary of Study Themes

The experience of collaboration was a four-stage process: *Getting Started*: involved selection of diverse team members *Working Together*: involved building a collaborative research team *Completing the PHSI Project*: included implementing the study findings *Sustaining the Collaboration*: comprised continued interaction and planning of future initiatives
Understanding the tensions between decision makers' priorities and researchers' activities
The importance of investing sufficient time to the development and maintenance of relationships
The value of a diverse, multidisciplinary team to optimize relevancy of study findings
Decision makers appreciated researchers' commitment to valuing and integrating their input
The strong commitment to a common vision and goals, maximum engagement of all partners, and opportunities to have an equal voice
Finding the balance between the research endeavour and the decision maker's responsibilities was difficult for some decision makers due to capacity constraints
The effectiveness of PHSI collaborations was attributable to four foundational themes: (1) building connections among partners, (2) fostering an ethical approach, (3) building capacity, and (4) implementing IKT processes
Valued PHSI project outcomes and anticipated impact Improved knowledge of research methodologies and enhanced working relationships

Decision makers reported a wide range of project foci, most of which had unique needs and expectations. Project requirements typically developed and changed over the course of the partnership, for example, the development of meaningful research questions that were tailored to meet specific decision maker needs. Differences of opinion were encountered, and according to a few interviewees, tensions surfaced when previously agreed-upon issues were revisited. This created the sense that the process of moving forward had stalled. Consequently, some decision makers were prompted to re-evaluate their participation. At this stage of engagement, these respondents reminded me that understanding the tensions between decision makers' priorities and researchers' activities was required.

Upon reflection, respondents identified the importance of investing sufficient time to attend to the development and maintenance of relationships. The amount of time needed was often not foreseen, but within the PHSI collaborations, this was integral to the process and the ultimate success of the initiatives. Collaboration fostered trusting, supportive environments, which made it easy for decision makers and researchers to work together on projects of mutual interest. The collaborative and solicitous nature of researchers enhanced the experience, and the results of the partnerships led to new opportunities for many decision makers and their organizations.

The investment of talent was identified as an essential element of successful collaborative research and is reflected in Green's (1989) contemplations that "investments in people" may be a more appropriate process outcome to "investments in the programs" (p. 44). Decision makers articulated the importance of bringing together a team that included members with diverse skills and competencies. This multidisciplinary approach ensured that multiple perspectives contributed to planning the research. Respondents described the importance of a diverse team with involvement of all partners throughout the process as necessary to optimize the relevancy of their research findings. Furthermore, the majority of decision makers reported that sharing their distinct perspectives resulted in common understanding and mutual action agendas.

Many interviewees told me that they appreciated researchers’ commitment to valuing and integrating their input when appropriate. The research environment was respectful; these decision makers felt that there was an appreciation of the perspectives and insights they shared during team interactions. The majority of interviewees expressed their strong commitment to a mutual common vision and the goals required to accomplish this vision. The inclusive nature of PHSI projects maximized their engagement and gave a voice to the parties in these collaborations. This unique mix of decision makers and researchers had an authority and a commitment that were recognized as vital to effect policy change at the local, regional, or national level.

A minority did not subscribe to this broadly positive experience. The expectations of these respondents were not met; they anticipated that “there would be much more collaboration” (PM01) and that their level of involvement would be dynamic, negotiated, and substantial. A few mentioned that, at the start of the PHSI projects, they expected explicit delineation of their roles and responsibilities and that this would be re-evaluated on a regular basis during the course of the project.

Finding the appropriate balance between the research endeavour and their usual responsibilities was difficult for a few decision makers who chose a more limited collaborative role due to capacity constraints. One health system planner remarked, “There’s times [sic] when you don’t really want to be an equal partner because … you’ve got many different things on the go” (HSPM02). Another interesting perspective shared was that because some respondents were not actively involved in the day-to-day operations of the projects, they did not have “a right to be demanding quite so much”

(HP20). They “took a back seat,” and because of their limited involvement, they “didn’t aspire to be” equal partners (HP20). In collaborations where researchers underestimated the decision maker’s research acumen or did not consider the decision maker’s contributions to be of value, a few respondents felt that such initiatives may not “lead to any significant collaboration at all” (PM09). They commented that these collaborations may not necessarily result in high-quality research; they may be short-lived and potentially difficult to manage.

Decision makers concurred that, ideally, collaborative teams should commit to a longer-term association and should be complementary in expertise, building upon known strengths and assets. They attributed the effectiveness of PHSI collaborations to a limited set of foundational themes. These themes were applied throughout the collaborations and were identified as building connections among decision makers and researchers; fostering an ethical approach characterized by respect, trust, and understanding; building capacity; and implementing IKT processes. Improved knowledge of research methodologies, working to ensure that research findings were translated to practice and policy, enhanced working relationships, and improved practice and policy were regularly cited as valued PHSI project outcomes. What became evident during the interviews was the hope that the impact of the judicious investment of time and the careful selection of talent would lead to findings that would inform policy and program development, strengthen the delivery of health care services, and, ultimately, improve the health of the communities.

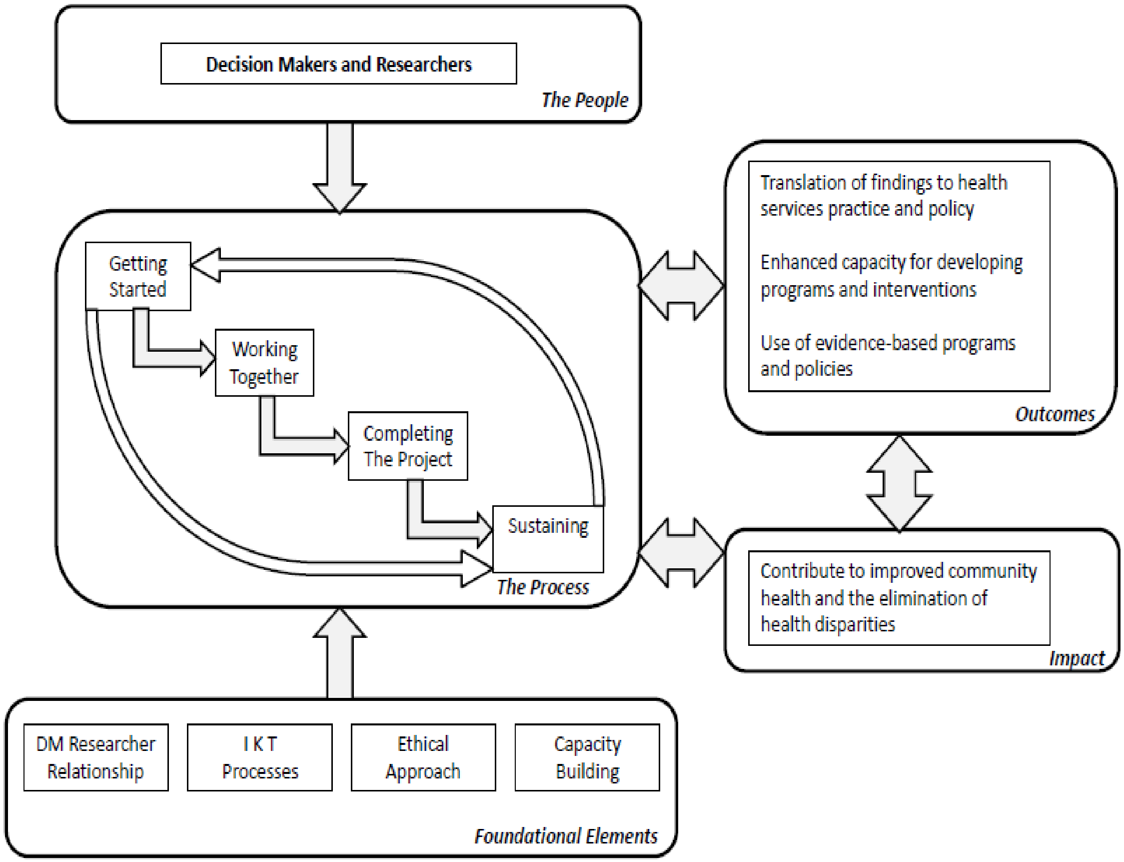
The Conceptual Framework of Collaborative Research

Interpretive description is the foundation for my research methodology framework and analysis. The three fundamental methodological elements of interpretive description are the objective, the mechanism, and the product (Thorne, 2008). Collaborative research is based on a constructivist approach that recognizes that knowledge is generated in both research and practice. In this study, the methodological objective was to develop a qualitative account of decision makers' perspectives of collaborative research and identify common patterns within those experiences. The mechanism used to achieve this objective was through informed questioning during interviews, reflective exploration, and careful analysis of the data. As described by Hunt (2009), the organization of study findings around an overarching conceptual sequenced organizing framework is the product. Thorne proposes that the organization of findings represents an appropriate platform upon which to "generate new insights that shape new inquiries as well as applications of 'evidence' to practice" (Thorne, 2008, p. 35).

PHSI projects were initiated to address national, regional, or local health priorities and health disparities within a partner community or a defined population. Each PHSI project team was co-led by a decision maker and a researcher who were expected to serve as equal partners in all stages of the collaborative initiative. All partners brought their professional and personal experiences to the collaboration and focused their research activities on the health issues of high priority to the community. By working together, decision makers and researchers identified what to study and determined the research agenda and what was feasible given the expertise of the team and partners' research priorities.

My conceptual framework of collaborative research is presented in Figure 1. It was developed inductively from the descriptive data collected and provided a structure for interpreting decision maker perspectives of collaborating with researchers. The framework posits an explanation leading to contextual understanding of the decision makers' experiences on PHSI projects.

Figure 1: The Conceptual Framework of Collaborative Research



The partners, the stages of engagement in the process, foundational elements, outcomes, and subsequent impacts common to all PHSI projects and the relationship between these components are illustrated in Figure 1. Although the boxes on the left are shown in a sequential fashion, the relationships among them are expected to be complex and iterative over time. The time required to achieve outcomes varied among PHSI projects and was dependent on many factors, such as the type of research implemented, the resources allocated, and contextual factors. Thus, the conceptual framework does not specify the time it may take to achieve outcomes.

The Process of Engagement

The framework consists of four unique but interdependent stages of partner (decision maker–researcher) engagement. As the process moves through the various stages of collaboration (*Getting Started, Working Together, Completing the PHSI Project*, and *Sustaining the Collaboration*), partners share responsibility for decision making and are mutually accountable for all aspects of the project. They work through an iterative cycle and are involved in activities such as guiding and developing the research inquiry, implementing the research, interpreting the data, and disseminating study findings. The framework figure displays linkages along the stages of engagement. The development of a vibrant partnership allows the group to take on new projects, which confers continuity.

During the *Getting Started* stage of engagement, decision makers and researchers discover information about each other and establish the scope of work of the potential

PHSI collaboration. Critical questions partners ask at this stage include Who should be involved? What do we want to do? and Why is this research important? Before implementing research projects, the decision maker–researcher collaborative team must have adequate resources and capacities; the right people involved, with characteristics that are favourable to collaboration; clear organizing processes and structures; a focused purpose; and a supportive environment. These capacities are brought to the team by all partners and include expertise in the key areas of research, collaboration, and communication as well as other skills, such as grant writing and awareness of the tenets of ethical conduct to protect research participants. Resources include the facilities in which to work, an infrastructure comprising financial resources, administrative capacity, and support from the decision maker's organization and the researcher's academic institution (Minkler, 2004). Other key resources include relationships with decision makers, experience in community-based research and public health practice, knowledge of the values and cultural norms of the community, and access to the community. The "initial approach to engage people, the initial conference call to talk through the project, the milestones, the plan, and to introduce the committee members to one another" were key during this early stage of engagement (PM24). There were regular communiqués about the status of work, which was appreciated by many decision makers.

As the process of engagement moved beyond the *Getting Started* stage to the *Working Together* stage, decision makers recognized that health services research is complex and requires an extensive variety of skills and competencies. It could be argued that no one person possesses all the knowledge and expertise that might be needed for successful completion of a PHSI project—hence the motivation to work in collaboration. There is a high likelihood that people working in partnership will among them possess the required skill sets. Respect for and appreciation of each others' contributions and potential were regarded as fundamental to an effective collaboration. As one participant emphasized, "slowly developing groups of people who can support one another," sharing knowledge, skills, and competencies, ensured "a good focus on the study" (HP15).

During the *Completing the PHSI Project* stage of engagement, decision makers remarked that dissemination of findings through knowledge translation is both an ethical responsibility and a fundamental element of PHSI initiatives. They advised that when the PHSI projects are complete, researchers must ensure that the findings are transmitted back into the community. A commonly expressed opinion was that when decision makers are engaged in this stage, they must be influencers. They need to be a change agent or knowledge translator, "able to get the right information to the right people at the right time to make the right policy changes" (PM05). They need to be versatile and recognize when there is an issue that needs change and be able to translate that into the most appropriate policy change. They can then maximize efforts to bring political support and leverage resources to the partnership and make a sustainable impact on public health.

Decision makers considered sustainability in two domains: (1) the sustainability of their relationships with researchers and (2) the sustainability of the intervention (i.e., the program or policy change arising from the collaboration). For decision makers, working with researchers required a continual effort to balance costs and benefits to sustain cooperation and accountability. A key element of sustainability is the extent and manner to which relationships between decision makers and researchers are continued over time.

The Foundational Elements

Building connections between decision makers and researchers, maintaining an ethical approach, capacity building, and implementing IKT processes may be considered foundational elements of the conceptual framework. Furthermore, they may be viewed as inputs as they were introduced into the collaborative process during the initial (*Getting Started*) stage of the PHSI project and are applicable throughout each subsequent stage. As the collaborations progressed, these foundational elements were strengthened and so may also be regarded as outcomes of PHSI initiatives.

Outcomes and Impact

The first box on the right-hand side of Figure 1 includes the outcomes, or the intended effects, of PHSI projects. Expected outcomes relate to the translation of research findings to the development of health care policies and the use of evidence to guide practice. Over time, these outcomes may be disseminated beyond a decision maker's defined community and gain widespread use. Capacity building is a key outcome as it relates to the personal development of decision makers and researchers. Collaborative efforts facilitate co-learning and the acquisition of skills necessary to achieve PHSI project objectives. They require time, talents, and resources, individually and collectively, to produce findings decision makers and researchers care about (CIHR, 2008). Therefore, an expected outcome is improved community capacity for health promotion and disease prevention. Enhanced capacity includes an increased ability to implement and make thoughtful decisions about effective health care programs and services. This capacity combines the decision maker's commitment, resources, and skills to respond to public health needs and priorities. Recognition and dissemination of the PHSI findings can lead to increased support for the program and research overall (CIHR, 2008).

Effective PHSI initiatives are based on building connections with decision makers and researchers, fostering trust, and having appropriate resources in place. Engagement, explained by this policy maker as "making the link, the connections, the bridges to bring those other partners to the table and be part of a conversation" (PM07), throughout PHSI projects was perceived as vital for research outcomes to be relevant. The second box on the right-hand side of Figure 1, impact, was explained at interview by many respondents, as the future long-term changes that decision maker–researcher collaborative teams are working to create. There was agreement among interviewees that "it's the whole process that's an interest to us, and how it might impact on services, policies, programs we currently have in place, how it might impact both in the present and just as much as to how it might impact in the future" (PM07).

Research Findings

My study was initiated to learn about decision makers' experiences of partnerships with health services research teams. The research was guided by four objectives: (1) to explore decision makers' experiences of participation in PHSI collaborative research; (2) to describe, from the decision maker's point of view, the working relationship during the partnership; (3) to identify the ethical implications for decision makers in participating in collaborative research projects; and (4) to examine, from the decision maker's perspective, how this partnership facilitated the dissemination and subsequent uptake of research knowledge. Appendix 6 presents a summary of the key themes for the research question and each objective. The overarching goal of this study was to present decision makers' voices and to represent their perceptions of the phenomenon under study; to contribute useful new knowledge about strategies to support collaborative health services research; and to encourage greater engagement between decision makers and researchers.

Decision Makers' Experiences of Participation in PHSI Projects

PHSI funding supported the formation of teams of decision makers and researchers to conduct applied health services and policy research. For the most part, working collaboratively ensured that the research fulfilled the funding priorities and was scientifically sound and academically relevant. At the outset, it was anticipated that as a result of decision maker–researcher collaboration, research findings would be more relevant to and therefore used by decision makers. This point was explained by one health system manager, who said, “If you’re going to spend all that time and money to do something, let’s make sure we’re going to do something that we’ll be able to use in the real world, in the clinical setting” (HSPM14). The ability to ground the research into the clinical aspects of care and put “a reality lens” (HSPM14) on the development of the research was believed to be the major contribution of decision makers at this stage of engagement. As they shared a stake in the process and outcome of the PHSI projects, decision makers helped focus the research around its application for users and keep the work grounded in reality. Decision makers were aware that partnered research

> greatly increases the potential for knowledge dissemination later because it involves more people who have … more input into grounding the research problem to something that is truly applicable to the health care delivery. (HSPM19)

Open-ended questions gave respondents an opportunity to discuss their experiences of partnered research. When they described the positive aspects of PHSI collaborations, they spoke about the development of enhanced networks, co-learning between decision makers and researchers, gains in conceptual and practical understanding of research methodology, and linking findings to policy and action. Decision makers describe much of the context in which PHSI collaborative research has taken place as positive and, ultimately, satisfying. Such experiences appear to motivate decision makers to continue to collaborate with researchers as the majority of them reported that they would be interested in working with their respective partners again.

There was a wide range of opinions on the impetus for initiating PHSI decision maker–researcher collaborations. The PHSI program provided an incentive for decision makers and researchers to collaborate. Although either party could take the first step, most often researchers contacted decision makers; in a representative response, one policy maker (PM24) stated that the researcher "knew the work that [they] were doing" and invited them to participate. When initiating contact with decision makers, the researchers explained the research goals and expected outcomes, inviting decision makers to participate and enlisting their cooperation.

Frequently, researchers initiated the project in response to an external factor, such as a new funding opportunity. Evidence of collaboration was a prerequisite for applying for PHSI funding. Often the PHSI project represented a continuation of a previous collaboration or was a direct extension of a pilot project. As explained by one policy maker (PM16), the partnership and the research work that her team were involved in "would probably not have happened had [they] not developed a relationship" prior to being invited to join a PHSI project. This and the provision of dedicated funds for knowledge translation activities were mentioned by several decision makers as key factors that prompted their inclusion in collaboration. Several interviewees explained that the new source of funding and direction for including knowledge translation enabled research that otherwise would not have been feasible.

Building Connections. The Getting Started stage begins by selecting and bringing "all the different people who are involved from various clinical and research backgrounds" (HP20) together to pursue common research goals. One decision maker advised that the way to build a good project is having “a diverse view of things and lots of ideas” (HP21). The PHSI teams surveyed in my study were culturally diverse and heterogeneous in terms of professional and educational background and experience. From the start, decision makers and researchers shared a common understanding of the significance of their PHSI partnership. The basic working principles of collaborative research—participation, inclusiveness, partner relationships—were interwoven throughout the process of engagement. Decision makers were committed to the clear identification of issues, the setting of attainable goals, and the development of plans to achieve those goals.

A key dimension of collaboration is the manner in which relationships among decision makers and researchers evolved over the course of the project. Decision makers recounted that the “really good friendships” (HSPM26) created over time facilitated rapport with researchers. Each partner developed an understanding of the other’s needs and priorities; respondents reported that they felt that as the project progressed, the relationship increased in value. With some exceptions, decision makers noted that they felt appreciated and enjoyed working with researchers, whom they described as being “respected academics, very inclusive and very open to comment” (PM05).

Several decision makers spoke highly about what they learned about processes of collaboration. Through their engagement with researchers, they felt that they contributed to the democratization of knowledge production. This reflected a change from the traditional top-down or expert-driven process to one of cooperation, collaboration, and co-learning. Rather than researchers designing a study and asking decision makers to sign off, decision makers and researchers worked in a cooperative manner, integrating partner needs and priorities to shape the research initiative. Through this open dialogue, partners developed a very clear understanding of PHSI project processes.

One benefit, which many decision makers mentioned, was the opportunity to apply their expertise, knowledge, and skills to pressing real-world challenges. An insightful perspective was shared by one health system manager who realized that it was going to take a long time for the initiative to impact patient care. Subsequently, he decided that he would rather work in an area where change, improvement, and “some of the impact of the research” would be realized within a shorter time frame (HSPM08).

Getting Started was an important stage in the process of engagement and featured three essential components: (1) recognition of diverse and complementary skills; (2) the negotiation and agreement of a common purpose; and (3) the development of effective communication. Consideration of these components resulted in recognition of decision makers’ and researchers’ expertise and potential contributions, transparent understanding of the purpose and goals of the collaboration, and clarification of partners’ roles and responsibilities. Decision makers attributed the success of this stage of engagement to mutual respect, understanding, and trust.

Joint Efforts. During the Working Together stage, the PHSI collaborations built momentum. At this time, there was exploration of the pros and cons of various research approaches. The focus was on assigning roles and responsibilities according to the interests and strengths of the partners. For many, respect for roles and responsibilities was a key aspect of collaboration. Interviewees expressed relief that they were "not expected to be the researcher" and that researchers were not expected to be "the decision maker, the strategist, and the receiver of the results" (PM07). By moving research expertise to the decision maker's workplace and relaying everyday realities of community life into the researcher's world, access to information and other resources was facilitated.

Most PHSI collaborations functioned best when partners formed a structure, which helped them manage the work. Achieving these goals was best accomplished through regular verbal communication and face-to-face interactions; the use of written communication was not preferred at this stage. "If you truly want to have decision makers' input and them to be a part of the knowledge translation, to be a change agent, to drive policy," explained one policy maker, "then the group needs to determine clear roles to fit the structure and to implement the objectives of the PHSI project" (PM05). Respondents commented that the roles and responsibilities of each partner, the processes for guiding the collaboration, and the timelines to benchmark and evaluate the integrity of the partnership must be clearly defined. Consequently, with the full engagement of all partners, the partnership moved from a relationship between individuals to a partnership among decision makers and researchers focusing on the community's needs and not on the researcher's agenda. One policy maker described his engagement as follows:

> My own area of responsibility was very well delineated because, as I said, this is not the first project where I've participated as a principal decision maker. So I knew what they expected from me, and I assume that they knew what they were expecting from me. (PM17)

Interviewees concurred that the effectiveness of PHSI initiatives depended on the strength of the relationships, with each partner complementing the other. Decision makers and researchers cultivated and sustained their relationships through regular contact as they worked collaboratively and moved the projects forward.

Supportive Environment. Respondents emphasized how important it was to have strong leadership that created a supportive setting, "providing the ability, providing the facilities," as highlighted by one health professional (HP20). Fostering relationships was felt to be a worthy long-term strategy that justified significant investments of time, despite, as one policy maker said, "so many other things going on you just sort of shoehorn in when you can" (PM12). Interviewees felt that developing PHSI projects required building on trust and seeking mutual benefit. Being honest with one another about what each partner could and could not accomplish and an understanding of each partner's role were regarded as key. One of the positive outcomes of these close working relationships was that there was an opportunity for partners to reflect on the development of the PHSI project and how the findings would be used to inform practice and policy. Previous or developing personal relationships facilitated engagement, discussion, and understanding. These relationships directly influenced the quality of the experience and modulated the anticipated outcomes of PHSI projects, so there was greater awareness of how the findings could and would be used. Through improved understanding of each other's expectations, it was possible to better prepare for accommodating each other's agendas.

Challenges and Successes. Challenges emerged when decision makers were expected to participate in research activities that they were not trained to do. Respondents explained that they felt uncomfortable when they lacked the expertise required to contribute to certain phases of the project, such as data analysis. In other instances, the increasing complexity of the project raised the threat of overwhelming the decision maker. The constraints of time were mentioned frequently and identified by many respondents as a major source of tension. They felt conflicted when their involvement in a PHSI project took them away from their regular job. It was felt that these challenges could be mitigated by having clear lines of responsibility and regular communication among partners. Given the frequency with which I heard this issue raised, it is likely that some people did not engage in research because of time constraints.

Decision makers and researchers continued to negotiate on PHSI objectives and the implementation of projects during the *Working Together* stage of engagement. They made adjustments and improvements as the team learned about what works and what does not in the completion of projects. PHSI collaborative initiatives promoted two-way dialogue, and interviewees suggested that partners must continually ask themselves the questions from the *Getting Started* stage and put into commonly understood language the things upon which the PHSI team agreed. When issues arose, decision makers advised that “you just got to know the players” (HSPM14) and acknowledged that time was needed to resolve these issues cordially.

Overall, interviewees were very positive in their accounts of the *Working Together* stage of engagement. They suggested that as the PHSI projects progressed, it was wise to highlight the early successes to maintain morale. One compelling finding in my study was the respect decision makers held for research. As one health system manager advised, one must "think about research as living, breathing, and sort of something that's constantly informing how [one's] field is evolving" (HSPM19).

Completing PHSI projects. Respondents planned to use the findings to educate themselves and their constituents on the issue researched. During the Completing the PHSI Project stage, decision makers reported that they expected a role in knowledge transfer activities. They advised that how findings are presented can impact how readily the knowledge is understood and applied. They told me that when preparing a message, it is necessary to consider the information that will be most useful to the community and to package and present it in an optimal manner. Effective messages show the community the impact and the practical application of the knowledge. Descriptions in layman's terms were important to many decision makers as they served to amplify their familiarity with the findings and their confidence in communicating them.

The respondents said that they were interested in using the new knowledge to implement change and in specific decision-making situations. They wanted to base their policy and practice upon sound evidence, and a few decision makers told me that they would be more likely to be influenced by research findings from a collaborative multidisciplinary team than from an individual researcher. Some explained that comprehensive findings are particularly important when they make recommendations for change to senior policy makers and ministers.

Sustaining PHSI initiatives. The presence of strong partnerships was acknowledged by respondents as a critical component for sustaining successful PHSI initiatives. However, collaboration between decision makers and researchers required continued effort to balance the costs and benefits. A key element of sustainability is the extent to which relationships between decision makers and researchers are continued over time (Shediac-Rizkallah & Bone; 1998). Seven interviewees (four health system managers, one health professional, two policy makers), from the four completed PHSI projects, informed me that their collaborations resulted in sustained relationships with researchers. Decision makers reported another measure of sustained benefit from the PHSI collaborations: that their engagement in PHSI research enabled them to develop new competencies and skills, which increased their ability to address future issues in their roles.

The availability of funding was cited by decision makers as being centrally important to ongoing collaborations. Many anticipated that funding would be renewed, or new competitions would be held, because PHSI projects focused on health services research, improving the delivery of health care services, and the development of health care programs and policies. However, some interviewees did articulate a concern that funding opportunities stipulating involvement of decision makers would prompt formation of artificial partnerships. Also, the requirement for knowledge translation could lead to researchers either proposing activities they are not trained for or enlisting partners to provide legitimacy to the application. I heard from some respondents that “in some ways, they have to do a knowledge transfer plan because they have to, but they may not be fully committed to do that" (PM09). When present, this impression was a powerful negative influence that discouraged future engagement (i.e., the relationship would not be sustained). Related to this issue of the creation of artificial partnerships is the potential ethical concern that decision makers might join in an application for research funding even when the project goals would not align with priorities for their communities.

Many respondents commented that although PHSI funding did support the creation of new partnerships, the experience of the funding submission process was stressful. Decision makers found it difficult to manage the disappointments of unsuccessful applications for funding as the second time around they were faced with questions such as "Didn't we do this before?" It was difficult to go back to potential partners and prepare for resubmission. "The funding cycle is challenging for partners" because if the application is unsuccessful, the additional work preparing it represents a lost opportunity, or, as one health system manager described, "it's a lot of energy spent" (HSPM03).

Several decision makers expressed a desire to have access to additional funds to compensate existing staff for their work on the PHSI project or to hire additional staff. These concerns seemed to be more noticeable at the beginning of the research process, when researchers are "basically adding administrative burden on … teams, and it doesn't pay much" (PM09). Another challenge was maintaining enthusiasm and interest when funding was uncertain. Waiting for funding decisions was recognized as a vulnerable time in partnership development. At this stage, the research objectives have been agreed and plans are taking shape, but formal partnering is on hold until funding is secured.

Sustained interaction and communication are critical at this stage to ensure that the partnership maintains momentum and “stays alive” (HP11).

Advantages of PHSI collaborations. The strengths of PHSI collaborations include the breadth of perspectives and the different combinations of expertise that individuals contribute to research inquiry. A commonly cited challenge to long-term sustainability was that although the partnership may begin as a relationship between individuals who share common ideas, as the project evolves, there may be drift, leading to a misalignment between decision makers’ priorities and those of researchers. This can arise from changes at political, institutional, or personal levels. Also, when there are multiple shared goals, it is possible for one party to be less committed to the remaining outcomes if their own highest priorities have been met, as indicated by this respondent: “I’m not always satisfied by the lack of accountability” (HSPM22). For example, on one PHSI project that involved vulnerable members of the community, the researcher’s interest was study participants’ preference for different types of aid, whereas the decision makers were keen to identify which aids were effective—an outcome that took considerably longer and was more difficult to realize.

The majority of decision makers in my study were open to future collaborations with researchers even when the PHSI project did not continue. However, they suggested that for sustainability purposes, mechanisms should be considered during the *Getting Started* stage of engagement to strengthen the relationship between partners and throughout the project to maintain these relationships. Over the course of PHSI projects, new political contexts, new opportunities, or new challenges may develop. It is important for partners to regularly assess the effectiveness of their collaborations and to recommit or redirect in response to the external environment. Clear understanding of each partner's role and accountabilities and how the joint activities of the PHSI project will be completed were considered important elements from the early *Getting Started* stage to the *Completing the Project* and *Sustaining the Collaboration* stages.

Associated Difficulties. At times, PHSI collaborative research was as exacting as it was innovative, and interviewees identified a number of challenges that they encountered. One policy maker nicely described the initiative as a "function of time, treasure, and talent." She explained that she thought "the right people were involved [and that] the resources were in place"; however, "time was an enemy" (PM16). Clearly, many were "always juggling time" (PM24); time was the most pressing challenge. Respondents viewed time challenges from a variety of angles and indicated that time struggles were often linked to insufficient resources. They emphasized the considerable amount of time and effort needed to develop a meaningful (PHSI) partnership. Some decision makers thought that there had been an underestimation of the time needed to accomplish project objectives, and one respondent advised that "very few research projects—whether they're in the lab or in the clinic—go exactly as planned" (HP10), leading to unexpected delays and costs. A policy maker said that although partners must possess "the right expertise, for one thing," they must also show a willingness to attend regular meetings while at the same time fulfilling their work commitments. He felt that, eventually, some people may "take on more than they can comfortably handle because they like to be involved in things" (PM12).

Partners had to be adaptable and prepared for goals to change and “cannot be dogmatic about things” (HP10). Others commented that they thought that there was an underestimation of the time required to develop the kind of dialogue that would be most productive in collaborations. In this example, one policy maker nicely articulates this sentiment: “It takes time to get used to people’s language and perspective and trust them and also realize that they see the world differently” (PM07). One strategy proposed to address the issue of time was that the “decision maker would be removed from [his or her] normal work environment and be able to give full attention to the research”; however, as this health system manager observed, “Resources are always limited, and this is not often possible” (HSPM14).

A small number of interviewees were irritated with the length of time it took to see positive change and concrete benefits for their community. A few decision makers raised a concern about the lack of dissemination of the research findings as they thought that they should have received more timely feedback upon study completion. As one decision maker stated, she would be “interested in what the answers to those original research questions are” (HSPM06). Those decision makers without direct involvement with study participants felt that the findings should be provided directly to the communities. Another said that one challenging aspect of the partnership is to manage expectations of what exactly it is that “we’re going to be able to do with the results” (HSPM14).

Decision maker and researcher turnover posed a challenge to some PHSI groups as working collaboratively required particular skills and attitudes. Not all newly recruited staff would possess these, which proved to be problematic to some research teams and disrupted the smooth running of the PHSI project. Staff turnover caused delays while new personnel were appointed and oriented to the project. One health system planner illustrated his frustration with new employees' lack of expertise this way:

> People … came in with qualitative training who didn't necessarily understand some of the principles when we said we wanted to run a very inductive approach, line by line, low-level coding. They didn't necessarily understand, and repeated working with them … didn't necessarily get through, and it took quite some time, and then eventually those individuals were let go. (HSPM08)

Other challenges mentioned by several respondents relate to the structure of the research community as reflected in the emergence of university institutes, research departments, and research organizations that link researchers to national groups and limit their flexibility to address topics relevant to decision makers. This reflects trends of specialization within the research community. In addition, the reward structure within the research community can be viewed as a challenge to decision maker participation. Researchers like to work on projects that ensure scientific advancement, are likely to be published, and will secure academic acknowledgement. They are generally more attracted to career-enhancing opportunities than to projects dealing with topics that are relevant to the community. The pressure to achieve academically was perceived as a barrier to increasing researcher involvement in collaborative research.

My findings revealed that effective partnerships require an investment of time and attention by researchers. Neglected decision makers lost interest and became disenchanted with the collaborative process. It was regarded as the responsibility of the researcher to ensure that the project was beneficial to both parties; this was not seen as the job of the decision maker. Matching decision maker priorities with the scientific interest and expertise within the PHSI framework was frequently perceived as complex. One interviewee remarked that although “no single piece of research has ever resulted in changing the world overnight” (HSPM22), there was consensus that it was up to decision makers to ensure that “realism, not pessimism, … is always considered when embarking on collaborative projects” (PM07).

These challenges tended to be mitigated by the strength of the relationship between decision makers and researchers. In some instances, ownership was lacking, partner communication was poor, and the relationship never flourished. Conversely, many decision makers were intellectually committed to the research initiative and provided support and guidance to the team. They invested their time, talents, and knowledge to advance PHSI projects and recounted how much researchers valued their contributions. That they worked together so well is related to the partners experiencing joint ownership of the process and the study findings.

Despite the challenges encountered during the PHSI collaborations, most decision makers reported that, by and large, they did not find the process to be excessively onerous. It is encouraging that the majority of decision makers indicated that they would participate in PHSI projects again and that many are continuing some form of collaboration with their research partner.

The Working Relationship

The PHSI program promoted equitable partnership and influence between decision makers and researchers in all stages of engagement. Decision makers emphasized the importance of their group being involved in the project right from the beginning so that the research is respectful, accessible, and socially relevant. The role of the researcher was regarded as ensuring that the research was academically relevant, advanced academic goals, and had rigor. Decision makers appreciated when they felt that their contributions were listened to and, when applicable, integrated into the research. The following quotation exemplifies this, in which the researcher is described as being "very good at making sure everyone's voice is heard" and as doing "a really good job of having sort of distinctive roles for people" (HSPM06). Another common response linked to a positive experience during engagement was that decision makers "were consulted throughout the whole process in a very non-intimidating, non-threatening way so that there was an equal partnership" (HSPM02).

Table 16 displays the activities and level of involvement in each of the stages of engagement as described by respondents. They reported that their level of involvement varied across the four stages of engagement in PHSI collaborations, ranging from token participation to real power "equally vested" in decision makers (HSPM02). Using information gathered from decision makers during interviews, I defined three levels to describe the various ways that decision makers were involved: (1) minimal involvement when decision makers were not actively involved in the research process; (2) partial involvement when decision makers were new to the project and were gradually assimilated into the research team; and (3) full involvement when decision makers were actively engaged in the research process as equal partners and influenced the research process. Decision makers (eight health system managers, seven health professionals, and three policy makers) reported that they "played an incredibly big role" (HSPM06) from the conceptualization of the research to dissemination of PHSI project findings.

It was challenging at times to code the exact level of decision maker involvement at each of the four stages of engagement. This was a result of some decision makers not distinguishing the level of involvement and their specific activities by stage of engagement. Instead, they told me that their activities were primarily those of leadership, management, and operational matters (hiring, training, and supervising staff). In these cases, it may be that I overestimated their level of involvement (as I listed them as being engaged throughout the complete PHSI project).

The criteria for PHSI funding stipulated an extensive level of decision maker engagement and commitment throughout the project. Thus, it is not surprising that, under the auspices of the PHSI program, most decision makers felt they participated as equals with researchers in the development, implementation, and dissemination of research that was meaningful to the community. They felt that they learned from each other and respected each other's skills, competencies, and areas of expertise. They expected that partners would have a commitment to maintaining the collaboration in the long term.

Table 16: Decision Makers' Involvement in PHSI

Activities During Engagement	*Minimal Involvement*	*Partial Involvement*	*Full Involvement*
Getting Started Securing agreement/commitment to project Developing trusting relationships Defining/focusing the research inquiry Selecting study design Clarifying roles, expectations	HSPM04 PM01,05 HP20		HSPM02,03,06 08,14,19,22,26 PM07,09,12,16 17,24,25 HP10,11,15
Working Together Developing the data collection tools/study questionnaires Ensuring protocol training and recruitment strategies are in place Adhering to the tenets of relationship building, fostering ongoing dialogue Ensuing implementation of the research Being aware of the power dynamics that may hinder project process Developing strategies/evaluating processes to address issues e.g. disengagement	HSPM04 PM01,05 HP20	HSPM13,21, 28,29 HP18	HSPM02,03,06 08,14,19,22,26 PM07,09,12,16 17,24,25 HP10,11,15
Completing the PHSI Project Disseminating research findings Publicizing findings/results Reporting back to community Using findings to inform/make decisions about next steps Maintaining accountability	HSPM04 PM01,05 HP20	HSPM13,21, 28,29 HP18	HSPM02,03,06 08,14,19,22,26 PM07,09,12,16 17,24,25 HP10,11,15
Sustaining the Collaboration Planning next collaborative research projects Designing interventions Starting on submissions to granting agencies Developing long-term plan of action and ensuring that decision makers are still actively engaged	HSPM04 PM01,05 HP20	HSPM13,21, 28,29 HP18	HSPM02,03,06 08,14,19,22,26 PM07,09,12,16 17,24,25 HP10,11,15
13 Health System Planner/Managers - HSPM 9 Policy Makers - PM 5 Health Professionals - HP	1 HSPM 2 PM 1 HP	4 HSPM 1 HP	8 HSPM 7 PM 3 HP

Unique Contributions. There was a high level of agreement among decision makers that developing a mutually beneficial research agenda, participating in PHSI project planning, understanding decision makers' resource and capacity requirements, sharing control of the project, and ongoing assessment of collaborative processes were fundamental to successful PHSI collaborations. In this example, the policy maker nicely articulates the importance of choosing the right people for the type of project at hand. She said that having "an analyst or a worker-bee on a project is absolutely, totally appropriate" and vital to the exchange of knowledge, ideas, and experiences. Furthermore, she mentioned that strong working partnerships were possible only when time was taken to foster trusting relationships (PM05).

It was reported that some researchers were very good at working in consultation around the development of proposals. As emphasized by one decision maker, it was necessary to have a team member responsible for coordinating efforts:

> Making sure that someone is thinking ahead and scheduling those types of sessions and then producing the results, getting the team back together to verify them and then creating changes, and things like that. So continually refining and producing and being the person to … move all of that forward [are] really necessary in this type of project. (HSPM13)

Respondents spoke about their unique contributions in designing the research to be culturally sensitive and beneficial to potential study participants. Several PHSI project teams formed steering committees that met regularly to discuss such topics as the study design, development of the protocol, and project-related issues. Scientific and experiential knowledge were acknowledged as essential to this stage of the collaborative process.

Sharing of Responsibilities. Many respondents regarded sharing of responsibilities for managing the project as an important element of the collaborative process. They appreciated being involved in project activities such as hiring front-line staff, chairing meetings, and leading community activities. Interviewees felt that such involvement made them aware of the challenges associated with the implementation of the study; for example, one decision maker was concerned about the long-term employment status of project staff: “How are you going to sustain those interveners? They’re not part of the current system delivery” (PM25).

When asked why they chose to work with particular researchers, it was frequently mentioned that they were “thrilled to get this opportunity,” and it was like a “dream job falling into [their] lap” (HSPM13). There was agreement among decision makers on the importance of having accessible, aware researchers who were capable of providing strong leadership when necessary. As one respondent emphasized, one of the key things to negotiate early on is “the expectation around responsiveness” (HSPM29). The researcher should be “someone who is highly organized, who is forward thinking [and] consistently evaluating [his or her] place in the field” (HSPM02), and be receptive to trying different things and considering other people’s ideas. As one decision maker said, [The researcher is] “really good that way, about pulling people in and including them” (HSPM03).

Several respondents mentioned that they valued the researcher’s expertise and knowledge. Some chose to work with a particular researcher based on his or her publication record. Decision makers told me that they had the “confidence in the researcher’s ability” (HP10) to implement clinical research studies, particularly ones of a sensitive nature, where there would be direct contact with patients and their families. Generally, other positive attributes of researchers that were valued by respondents included being a nice person, the ability to bring people together and work in a collaborative way, and the ability to listen and facilitate change. Flexibility was identified by several interviewees as an important quality for both decision makers and researchers. “A trusting relationship, recognition for the value that each brings to the partnership, [and] willing to be flexible when necessary” is what one policy maker (PM07) told me when asked about the skills required for collaborative research.

Dynamic Communication. Effective collaborative research involves dynamic communication between partners. As one decision maker said, it is “pretty key to feel that there’s an open communication, especially on a project like this, where you just don’t want to let things drop” (HSPM13). The researcher was usually identified as the person responsible for orchestrating communications among PHSI team members. Decision makers expected to be kept informed and connected to the collaboration and thought that researchers would determine which information needed to be shared with them for their input and decisions on a regular basis. Although communication content varied with the phase of the project, decision makers reported that regularly scheduled communication was needed to maintain the working relationship, to ensure that partners stayed current regarding research progress and that information was shared in a timely fashion. Although regular communication via email was considered by many decision makers to be useful, meeting in person periodically was vital. Face-to-face meetings allowed partners to get to know one another better and exchange thoughts and ideas while at the same time facilitating discussions on future projects. However, as another interviewee commented, the “challenges are just ongoing involvement because of the fact that we’re now so dispersed across the country” (HP20). The ability of each partner to communicate his or her perspective, to confer with others when necessary, and to be open to problem-solving negotiations will determine the success or failure of the collaboration. Decision makers were expected to update researchers in real time on those issues that might impact the progress of the project, and researchers should inform decision makers of preliminary findings that could be used to inform strategic decisions.

Decision makers indicated that researchers’ typical style of decision making was a balance of majority rule and expert opinion. By and large, in their PHSI relationship experiences, decision making was based on the ability to obtain consensus, thereby providing every partner with an opportunity to speak. The ability to communicate clearly what the partners’ needs or objectives are, the ability to understand what the other partners are expressing as needs and objectives, and the ability to negotiate were described as being useful and “[putting] everyone in a win-win situation” (PM07). The communication needed for reaching agreement was time-consuming; said one respondent, “It required a lot more time and effort than I imagined it would” (PM16). However, decision makers felt that this input and working to achieve consensus were important to the success of the collaboration and the ultimate success of the project.

The Value of a Multidisciplinary Team. Leadership and accountability were widely regarded as key. The importance of a leader being a “strong, solid anchor” (HSPM22) who had good knowledge and was skilled in facilitating collaboration and managing conflict was emphasized frequently. Many spoke of the need for regular communication with partners to elicit comment and feedback. Several decision makers informed me that there were occasions throughout the process when it was really important to re-engage, to work through the issues, and follow through on resolving these problems.

Strong leadership facilitated brainstorming and problem-solving activities and was recognized as being critical to the collaboration. Many decision makers admired "a principal investigator who was completely aware of the methodology" (HSPM13). They believed that strong process leadership skills helped foster the collaboration and ensured its overall success and sustainability. The ability to provide "bang-on leadership" whenever it was required was appreciated despite the researcher being "incredibly busy" (HSPM13). "You should have a really strong project lead, who has a great grip on the project … someone that has a personal interest in it," advised one interviewee. Commonly mentioned attributes of an effective leader included being able to organize work, to adhere to a timeline, to follow through on commitments, and to motivate others to meet their responsibilities. Leaders should have respect for diverse contributions and honesty and display a willingness to listen. One health professional commented that she appreciated that her researcher colleague "did not hide anything from the team" (HP11).

Social and Management Skills. Decision makers proposed that collaborative research and the subsequent dissemination of knowledge required not only expert and local knowledge but also the social and management skills necessary to work in a team. Patience was one quality identified by more than a few decision makers, who explained that the collaborative process is slow due in part to the emphasis on the continued attention to the relationship. As one interviewee said,

> They would have patience for the process that's going to need to be followed. That's probably the biggest one for the decision maker. For the researcher, it's a flip of that, the patience to understand the decision maker ... how to engage the decision maker and how to keep [his or her] engagement throughout the process. (PM24)

A few decision makers reported their concerns that researchers did not value or appreciate their expertise and contributions to the PHSI project. Some decision makers were invited to participate on the team because of a unique expertise. This was highlighted by one respondent, who remarked that he was consulted when needed on specific matters, and although he "quite enjoyed" his interaction with the research team, he was not part of the inner circle on a day-to-day basis (PM01). Differences of opinion between decision makers and researchers were often resolved by using their relationship and goodwill to help find the "middle ground." Decision makers reported more challenging experiences such as conflicts in understanding the researcher's style of communication, differences in decision-making methods, and inadequate follow-through. Misunderstanding was often attributed to poor communication skills on the part of the researcher.

Decision Maker Engagement. During the four stages of engagement, the power dynamics within PHSI partnerships fluctuated, and, in general, decision makers felt increasingly empowered. The majority of decision makers were delighted that they were involved during the earliest part of the project, the research design phase. This was highlighted by several decision makers, who said that this was a time when "intelligent, thought-provoking conversations and discussions" took place and they got to feel as if they were contributing (PM12). It was an opportunity to be engaged as a significant partner in the conceptualization of research and share ideas. A number of respondents told me that they appreciated the willingness on the part of researchers to consider their input to the focus of the research. It was a positive experience when researchers were open to listening to decision makers' ideas on what approaches would work with a particular population.

It was apparent during the *Getting Started* stage that to implement PHSI projects, decision makers needed to be engaged as full partners in meaningful dialogue. Timely involvement of decision makers, with "a very experienced researcher, respecting the knowledge, insight, and contributions," was "hugely important" (HSPM03). At this stage of engagement, expectations around contributions were formalized, and as one health system manager pointed out, it was important to feel that "in fact, it is a true collaboration, that you're not just teaming up with them to grab the data or use them, but you truly want them to be a partner" (HSPM03). Early engagement made it easy for researchers to better understand how the community functioned and was organized. Clear decision-making processes and a sense of mutual accountability were two key elements to ensure that partners' expectations were aligned. As one health system planner explained, it was critical during these initial stages of the collaborative process to "really determine what the needs were and how everyone wanted to see things organized and then the format in which they wanted to see them organized" (HSPM02).

The majority of decision makers told me that they did not discuss how findings would be disseminated to the community during the *Getting Started* stage. When asked about key factors, respondents identified shared responsibility and accountability as important for advancing engagement. One policy maker promoted communication, listening, trust, and “knowing the political context that we work in, knowing the health services research community” (PM09), as necessary for effective collaborations.

The Investment of Time. Many decision makers believed that the formation of respectful, collegial relationships with researchers was necessary for “learning more about [researchers’] perspective on things and working together to move forward on specific projects” (HP20). Moreover, a supportive environment stimulated the exchange of knowledge and ideas. Respondents felt that the time spent with researchers during these early stages of PHSI projects was vital to the sense of ownership that decision makers developed. Strong connections were fostered, and decision makers gained valuable contextual knowledge of the researchers’ areas of interest and expertise during this period. Similarly, sharing this time gave researchers the opportunity to learn the decision makers’ domains of interest. The investment of time was regarded as necessary in the development of trust and the evolution of the decision maker–researcher relationship.

Previous relationships between decision makers and researchers were important catalysts for successful collaborations: “there was a basis of a good working relationship and understanding among ourselves and some common interests on common issues,” reported one policy maker (PM07). Frequently, challenges had already been identified and addressed during previous interactions. However, conflict was unavoidable in the course of PHSI collaborations. Most respondents were very experienced in working with researchers and were skilled at negotiating through conflicts to a mutually satisfactory resolution. When issues arose, decision makers and researchers needed to have “the complete comfort that [they] can pick up the phone or … can drop in and visit and … talk through the issues” (PM17). This health professional described how she felt that nothing of substance could be accomplished without discussion and debate. She explained the “sense of difficult perspectives, different perspectives, and trust” (HP20) that she experienced during the *Getting Started* stage of engagement. Subsequently, during the *Working Together* stage, these issues became “less problematic,” and anxieties were alleviated. The experience served to strengthen the partners’ commitments to the PHSI collaboration.

Many felt that a previous history of working together with the researcher reduced the time required to establish effective communication. Four new health system planners (HSPM13, 21, 28, 29) and one health professional (HP18) joined PHSI collaborative teams during the *Working Together* stage of engagement. The experiences of these individuals are interesting as they did not benefit from the advantage of a previous relationship with the researchers and did not participate in identification of mutually agreed project goals and so may not have felt as invested in the collaborations as others. Their roles and responsibilities were not clearly defined at the time they were invited to join the team; however, their roles evolved during the remaining three stages of engagement. A number of them indicated concern about handling conflicts because it was widely believed that it would be more likely that partners who were fully engaged in the process would remain committed to the collaboration. This concern could be addressed by orientation and discussion that would prepare partners to understand their new environment and confidently express their opinions in a large group. According to one, in dealing with conflict, it was important to be open and honest and to “be considerate of everybody’s opinion but [not] afraid to give [an opinion] in a polite, constructive manner” (PM07). Courteous, sincere communication helped ensure that decision makers felt informed, connected, and engaged. In fact, at the end of the PHSI projects, all five reported that they had become more confident in their skill levels and would like to work with their respective research partners again in the future.

For the whole group of seven decision makers (five health system managers, one health professional, and one policy maker) who did not know the researchers prior to embarking on a PHSI project, training and orientation were identified as essential strategies for forming effective collaborations. They told me that they felt supported by their new but heterogeneous partners, whom they described as helpful and professional. One interviewee mentioned that despite not having a previous relationship with the researcher, she became heavily involved in many aspects of the PHSI project and was treated like an equal partner. That she felt “very valued” (HSPM13) was a powerful factor, so her current experience contrasted sharply to previous experiences when there was no acknowledgement of the contributions, expertise, and skills that decision makers brought to the collaborative research process. Thus, it was possible to overcome the disadvantages of either not having a previous relationship with the research partners or joining a project after initiation.

Clarity of Roles and Responsibilities. There was a blending of roles within the PHSI collaboration, where partners acted as co-inquirers, facilitators, and co-learners. For example, a few health system managers became research champions and advocated for "early engagement" and "greater involvement" in research in their particular domains (HSPM28, HSPM29). There was respect for the different kinds of knowledge that each partner brought to the process. The linkage of like-minded partners working together as co-researchers enriched the quality and relevance of the work done. All 27 decision makers reported that their roles were defined at the outset of the collaboration. Despite this, there was role ambiguity. Three interviewees told me that delineation of roles "could have been better" (HSPM019); one said he "wanted more" (PM01), and another chose to "take a back seat role and was okay with that" (HP20) decision. A clearer articulation of how decision makers were expected to work with researchers throughout the project would have been welcome for these particular decision makers and may have facilitated achieving the PHSI project goals.

Eighteen decision makers (eight health system managers, three health professionals, and seven policy makers) described their specific activities during the *Getting Started* stage, including designing the study and preparing and reviewing the funding application. I expected that more decision makers would be involved in this activity and speculated that perhaps pressure to meet PHSI funding submission deadlines may have resulted in less substantial decision maker involvement. One health system manager explained that the contributions he and his team made to shape the research study design to the needs of the community were appreciated by the researcher. A significant benefit was that what the decision maker and his staff learned at the end of the study "impacted directly on [their] mandate in [their] jurisdiction around services and policies and programs" (HSPM26).

The *Working Together* stage was a very busy time for decision makers. They were involved in diverse activities such as hiring and training staff; developing study questionnaires and data collection tools; creating consenting materials; and facilitating access to and the subsequent recruitment of the full complement of research participants. For example, one interviewee (HSPM08) suggested constructs to measure in a PHSI project, and the researcher identified the appropriate measurement tool and explained the tool's psychometric properties and the rationale for its use. Many decision makers told me that they believed that their contributions at this stage of engagement were critical to the subsequent success of PHSI projects. On the other hand, there were stages of the research in which several decision makers did not expect to be involved. In particular, they did not see a need to be involved with certain aspects of the project that were outside their area of expertise, such as data analysis.

Messaging the Findings. Of the 12 PHSI projects nearing completion, several respondents expected that they would be involved in formulating and refining the KT messages, communicating the implications to governments, and coordinating the implementation of policy recommendations. Many of the research projects were still in progress at the time of this study; hence, there was limited opportunity to assess the extent of decision makers’ involvement during the *Completing the PHSI Project* and *Sustaining the Collaboration* stages. However, all decision makers who were fully involved throughout the first two stages of engagement planned to maintain their active participation. There was a fairly widespread expectation that decision makers would be heavily involved in the KT activities and that they would participate with researchers in an iterative manner to interpret findings. As explained by one respondent, decision makers have a sophisticated understanding of power relations and policy processes. “Policy happens in lots and lots of different ways,” she said. “The decision maker at the table” needs to be involved in interpreting the research findings and identifying their implications from a decision maker’s perspective. This was considered to be necessary to determine “what policy they’re hoping to drive and then figure out how best to go about it” (PM07).

Expectations of Partnerships. Four decision makers (one health system planner/manager, two policy makers, and one health professional) reported a less positive PHSI collaborative experience overall; Table 16 shows that they were not actively involved throughout the process. When reflecting on the expectations they had upon entering the partnership, they expressed disappointment with their level of involvement. When contrasting the PHSI collaborative experience with his involvement on another project, one policy maker remarked: “It reminded me how great it was to have a collaborative interdisciplinary team” (PM01). Another health professional commented that despite previous interactions with the research team, she was “just a co-investigator with very little, minimal involvement” (HP20). It was the expectation of these decision makers that the level of involvement would be dynamic, negotiated, and substantial. They mentioned that, at the start of the PHSI project, they expected explicit delineation of their roles and responsibilities and that this would be re-evaluated on a regular basis during the course of the project. They also expressed that they anticipated that their level of involvement would fluctuate during the course of the project. The following comment made during an interview highlights the disappointment experienced: “It didn’t really happen, and … I worked more in isolation.” Thus, this decision maker felt that in future, if presented with the opportunity to collaborate with researchers, he would first “clarify the ability to interact directly” (PM01).

An important motivation for some decision makers to become involved in collaborative research was the desire to learn new skills and knowledge that would help them improve outcomes in their sphere of activities. By partnering with skilled researchers, they were able to undertake research that “would bring about better outcomes” (PM07). Although expectations were met and exceeded in many cases, one policy maker had an interesting perspective to share: at the beginning, he anticipated that it would be “really hard” to work on partnered projects and expected there to be a “lot of hurdles” (PM12). At the time of the interview, he told me that his experience of the collaborative process was even more difficult than expected. Fortunately, the researcher played a key role in this situation by fostering the relationship. The shared work experience (e.g., identifying issues, proposing possible solutions, clarifying the research purpose) helped the decision maker and strengthened his commitment to the collaboration.

When I asked about the power to influence decision making within the partnership, there was a wide range of answers, which reflected decision makers' diverse experiences. "More than equal" was how one policy maker responded; she explained how she "felt listened to. Felt respected. Felt asked for advice on a constant and regular basis" (PM07). Another felt that "everybody had an equal opportunity to participate and influence the outcome of this study, but like anything, some people are going to be more keen to participate than others" (HSPM02). Conversely, although an equal partnership between decision makers and researchers is a key component of the PHSI program, differing opinions were expressed by half of the respondents. Sixteen decision makers reported that they felt that they were working in an equal partnership; 11 respondents (five health system planners and managers, three health professionals, and three policy makers) felt that the partnership was not equitable. An example of this was given by a policy maker who felt that because he held a position of influence in his community, he was approached for access to his community rather than for his potential to contribute as a researcher; because he was not a researcher, he did not see how he could be an equal partner. He candidly admitted that he did not have the proficiency "to challenge how they're going to measure something or what they should be measuring" (PM17). Like others who lacked certain specific research skills, he did not feel that he possessed the expertise to insist on being considered an equal partner.

On the other hand, some respondents did not think it was necessary to be, or to be seen as, equals with their research partners in skills or level of commitment. "I don't know if we need things to be as equal, as some people might say," said one health system manager. She added that she was uncertain as to whether an equal partnership was "needed in reality" (HSPM14). It was believed to be more important that partners trust each other and share a common purpose. Finding the appropriate balance between the research endeavour and advocacy efforts was difficult for decision makers. Thus, a few decision makers chose a more limited collaborative role due to capacity constraints. Others felt that because they were not actively involved in day-to-day operations, they did not have a right to be demanding quite so much. Thus, some decision makers chose not to be equal partners, and in some environments, this was accepted, so that one health professional said she never had a sense that she was "a second-class partner or a second-class citizen" (HP20).

Finding a Balance. Within the context of the PHSI program, it would seem that many decision makers were pleased with the process judging by the frequency of contact and the number of flourishing friendships. The majority of decision makers said that they would work with the same researcher in the future. They told me that as a result of their PHSI experiences, they learned about the processes for effective engagement and had a better understanding of when collaborative research initiatives could be effective. Clearly, a positive experience was a strong motivation to maintain commitment to the partnership. Decision makers experienced diverse benefits that motivated ongoing engagement. So, after working on collaborative research projects, many respondents could not "imagine doing projects … on [their] own" (PM12). Another respondent highlighted how she felt "highly satisfied" with her role and contributions during this stage of engagement and felt that "it's a partnership in the true sense of the word, where all partners involved have multiple opportunities to be engaged and provide direction and guidance" (PM07). Being consulted on project elements or strategies was widely appreciated by respondents, as typified by the response from someone who felt that her "opinion matters and voice counts" and appreciated that "the directions taken reflect input from partners" (HSPM06).

Associated Frustrations. Although a significant number of decision makers confirmed that experiences of collaboration were comparable to or, indeed, exceeded their expectations, there was, however, acknowledgement of the associated difficulties. PHSI collaborative research "wasn't without its frustrations in terms of some of the actual implementation," but the majority of decision makers were committed to "doing it, making it work, [and] adjusting it in midcourse if need be" (PM12). Revisiting collective decisions, reviewing areas of agreement, and allowing sufficient time for resolving conflicts were cited as key factors throughout all four stages of engagement.

Collaboration is greater than the sum of its parts, and the resulting benefits are likely to have the greatest impact when partners from different backgrounds and disciplines are included. However, the tensions in working effectively together may be amplified with greater diversity, which is one of the challenges of collaboration. Differences of opinion inevitably arise, as described by one decision maker, who said, "I mean the obstacles or the difficulties that I'm talking about, they're not … insurmountable." Mechanisms for their successful resolution must be developed, as this interviewee continued to explain: "We didn't have arguments or disagreements or squabbling. It was just that … things could've been a bit better if those aspects had been improved" (PM12). There may be conflict over reward systems and promotion criteria and general conflict over what is the most important research to pursue, how to implement it, and the ethical implications. The issue of varying agendas was described by one respondent, who told me that researchers “have a particular way they need to proceed, and they have a hypothesis that they want to see happen.” She explained that from a government perspective, it was necessary to “account for [their] time and things that [they] need to do and all the things that come before [them]” and establish “how [their] level of engagement in this project [is] actually helping … [their] service delivery system move forward” (HSPM24).

These differences need to be attended to in order to avoid serious issues developing that have the potential to disrupt the partnership. To address these possible sources of conflict, interviewees recommended engaging decision makers early and fully in the research process and accepting, valuing, and using decision makers’ expertise.

Sharing Research Knowledge. The engagement of decision makers in the research and the development of recommendations based on the findings are congruent with PHSI’s call for stronger linkages between research and health services. Translating research findings into practice by taking them from the bench to the bedside and into the community has become a recurring CIHR theme (CIHR, 2008, 2013). This principle is based on the idea of applying best research evidence with clinical experience to everyday practice (Sackett, Richardson, Rosenberg, & Haynes, 1997). According to Graham and Tetroe (2007), IKT at the CIHR “represents a different way of doing research and involves active collaboration between researchers and research users in all parts of the research process” (p. 57).

Establishing PHSI partnerships between decision makers and researchers was based on the principle that all partners are necessary to realize success. Collaboration facilitated opportunities for both parties to better understand the other's perspective. As mentioned previously, early involvement of decision makers in the process was considered key. Mutual accountability was promoted through evaluation of the collective rather than the individual performance. As a result, decision makers reported that they experienced a sense of ownership of the research and the findings. Engagement throughout the PHSI project allowed for the enhancement of understanding, increased uptake of information, and the willingness to integrate findings into health policy and practice.

Typically, in the PHSI program, knowledge translation begins as a collaborative process of knowledge sharing between decision makers and researchers throughout the entire project. Decision makers were most likely to be heavily engaged in activities such as the development of the research proposal and data collection. They expected to be involved in the sharing and dissemination of knowledge and advising researchers of strategies that could be employed to implement findings.

When respondents were asked why they chose to participate in PHSI projects, they informed me that they had little interest in being involved in the collaboration just for the sake of it. They became actively engaged and committed when they perceived that the findings could improve practice and outcomes. An indication of this increased commitment is the mobilization of community resources to support implementation of evidence-based interventions. Thus, it might be seen that the opportunity for knowledge translation was the most powerful motivation for decision makers to become engaged.

The Need for a Common Language. Decision maker–researcher collaboration was recognized as a way of transferring new knowledge. When decision makers talked about the way research knowledge is shared, they mentioned the need for a "common language." Several explained that within a multidisciplinary partnership, there was diversity of communication styles. Partners represented many different organizations and fields of specialization. Interviewees explained how the styles of communication vary among partners; researchers may communicate with one another using very specific scientific terminology, whereas decision makers may use a different lexicon suited to their daily work.

There was consensus that decision makers wanted comprehensible research findings written in simple terms with understandable implications and guidance on next steps or, as one busy health services manager informed me, "an executive summary because the reality is in this line of work, sometimes that's all you have time for." She explained how the "volume of demands on a daily basis is always more than ... can [be managed]" and told me that messages [must be given] in a comprehensible format so that [they can be absorbed]" (HSPM19).

Respondents proposed that plain language be used so that communication is clear. As described, "the ability to communicate" concisely and "in some non-research language for decision makers would be important" (HSPM22). According to some respondents, common understanding of partners' shared experience was needed early on in the *Getting Started* stage of engagement. They agreed that efforts must be made "to make sure those that are part of the equation are clear on the lingo, … what jargon means" (PM16). Some decision makers found finding a shared languageto be challenging, but, "at the end of the day, that turned into a benefit because it helped [them] all think about what is this shared language that [they] need to be developing together to understand to even have a conversation about what [they] are doing" (HSPM22). Working together, respecting each other's realities, and "knowledge and practice with community engagement" helped "find a shared language" (PM16).

Interviewees advised that regular discussion groups be established with the research team, where, in addition to discussing findings, they would outline what messages would be created. This process of sending out the materials in advance, scheduling a meeting to discuss project-related issues, and gathering input was identified as "the best way to do it" (HSPM24). Through these interactions, decision makers developed a clearer understanding of the research process and made valuable contributions in refining the implications of what had been learned. They found the process worthwhile as it afforded them an opportunity to reflect on the research activity, the PHSI project priorities, and the project outcomes. Furthermore, when decision makers had the opportunity to discuss findings (with researchers) within local contexts and their implications, they felt that they were more likely to support their implementation.

Strategies for Sharing Knowledge. Decision makers proposed a range of strategies for sharing the new knowledge that would be learned through the PHSI collaborations. There was broad agreement that an effective IKT program would be a capstone to their projects. Respondents advocated that both partners (decision makers and researchers) participate in presenting findings to various audiences. Decision makers foresaw their role as hosting educational courses, workshops, and public interactions. Researchers were typically involved in presenting background information on the research design, methodologies selected, and data analysis plans. One form of public interaction that many expected to provide was a community forum, where they would focus on reporting the findings in a manner that would be accessible to the public. These forums could be provided in person or through Internet technologies such as chat rooms, message boards, or web logs. In another instance, a PHSI team organized KT discussion days and invited the researchers to participate. The opportunity to sit and discuss the findings with the multidisciplinary team was especially valued. The team reported that the KT days were among the most positive experiences of partnership that motivated them to apply the findings in practice.

Many felt that one core component for a successful project is establishing procedures for writing up the findings, as in sharing the KT plans and giving people the opportunity to participate in the publication and be included as co-authors. This process became protracted when there was disagreement over findings, their interpretation, their significance, or who should be included among the authors. Although researchers would be expected to take the lead in preparing manuscripts for publication in the academic realm, all partners would seek opportunities for public presentation of the project results at conferences and meetings. Decision makers were acknowledged as powerful resources for policy advocacy because they are involved in making recommendations about responses to a public health issue. Within their organizations, decision makers identified their specific responsibility to promote utilization of their research findings to inform and mould future initiatives to improve health. In addition to being seen as championing research, they expected that they would also champion adopting and implementing the findings of their research. This was a commonly expressed opinion, typified by this response:

> I may be using the data that is produced as, for example, setting up contexts for what our future plans are for developing services. So I could be participating in disseminating some of the results. Or the results, once they are arrived at and … I become aware of [them], … could be used in helping us to plan different decisions that we're working on. (PM17)

Ongoing Dialogue. Dialogue can help decision makers and researchers produce an environment in which they can ask questions, solve problems, and come to understand why, for example, research findings are not as expected. Ongoing dialogue was highlighted by several respondents as necessary for continued success. They mentioned that it was imperative that they had strong organizational support for their endeavours on PHSI projects. Decision makers appreciated having a positive organizational culture that encouraged collaboration, valued learning, and promoted knowledge sharing. Furthermore, they felt there was great value when their organization was committed to using the PHSI project findings. One health professional explained that the study results were "very useful," are "going to allow [them] to identify" problems, and gave them "a benchmark" (HP10).

Lessons Learned. Of the 16 PHSI projects sampled, four are complete. In these projects, decision makers provided feedback on the analysis of the research and its implications. They highlighted the anticipated impact of collaborative research as the integration of findings into the policy directions, clinical practice guidelines, and health care service delivery programs. Thus, IKT was an integral part of the functioning of the partnership and occurred through the usual workings of the research group.

The implementation of a collaborative research approach has resulted in seven decision makers (four health system planners/managers, one health professional, and two policy makers) on the four completed PHSI projects being more knowledgeable, more confident, and more research aware. Working collaboratively facilitated researchers' access to resources, whereas the decision makers' "grounded" perspective contributed to research validity and applicability. These (seven) respondents reported high levels of partnership synergy, professional development, and capacity-building opportunities. Active engagement in research was reported during interviews to increase decision makers' ability to address important issues and develop new competencies and skills. Furthermore, these decision makers informed me that their collaborations resulted in sustained relationships with researchers and led to contributions to health care policy and programs. Some respondents introduced a cautionary tone when looking forward to future opportunities:

> If it's not something that I felt would benefit our patient population or would be a good use of my time, [that] influences our decision to participate in research unless we would consider it to be valuable. (HSPM14)

During these collaborations, respondents used study findings to inform program and policy agendas and researchers came to understand what type of research resonated with decision makers and would ultimately lead to improvements in the health of their communities. These decision makers provided some examples of constituents using the findings to inform policy and practice: federally, policy makers used it "within some backgrounders for looking at what's important in health systems strengthening" (PM24); First Nations colleagues used the information to improve health care delivery and services (PM25); and members of the nursing community developed a leadership syllabus and program to help strengthen that role (PM05). Furthermore, interviewees said that although they built their research skills through collaboration with researchers, they helped their organizations build capacity for applying the findings of the PHSI project. This was explained by understanding that "we all had something to contribute, but that we were all going to be learning from the process at the same time" (PM25). These respondents have an important ongoing role to play in influencing health services research policy and practice.

Although the majority of interviewees expected to be involved in sharing new knowledge, several advised that they foresaw having varying levels of involvement in IKT activities. Others described "the importance of a role within an organization" and described how the people who are actually implementing that role, directing that role, and participating in that role are approached rather than the individual decision maker. "I feel that given my position," said one decision maker, "people will come up to the ministry and come up to me for support or my participation [not] because of …who I am but because of the position, the responsibility that I hold at the government level" (PM17).

Staying Involved. Frequently, considerable time elapses before the knowledge gained through research appears in written form. This was succinctly articulated by one policy maker, who admitted to being "very impatient" and warned, "You will lose us if you say, 'Well, I'll get in touch 5 years down the road and I'll let you know what we found out'" (PM07). Knowledge translation requires skills that are often best learned on the job by engaging decision makers and researchers in collaborative efforts. A cross-fertilization of ideas may generate new insights that individuals working on their own may not have grasped. Many decision makers stressed that the act of partnership was a source of intellectual stimulation and creativity, but partners should be involved because "they decided to be there." One decision maker informed me that "you have to believe in the good of the research" and the anticipated impact the findings will "give to the system, the health system" (HSPM19).

PHSI partnerships were identified by interviewees as a way to help ensure that the findings maintain a focus of community relevance. PHSI projects were regarded as being more responsive to constituents' requirements, and the accessibility of findings was cited as an advantage over traditional dissemination approaches. It was acknowledged that decision makers may provide insights through guidance in the application of results in ways that researchers may not have considered. Since many of the projects I sampled have not been completed, it is premature to explore the impact of their findings, whether they have influenced policy, and how decision makers were involved. Sharing research knowledge and project findings will help fulfill the PHSI mandate of using collaborative research approaches as a standard for improving the delivery of health care services and the development of health care policies.

Fostering an Ethical Approach

The collaborative process is strengthened by decision makers and researchers sharing power and negotiating agreement from study design through to dissemination of study findings. Respectful dialogue was encouraged through listening to and sharing ideas on research interests and needs, ethical perspectives, and fundamental values. Core ethical principles of research, respect for autonomy, justice, and beneficence, were evident throughout the PHSI partnerships, as illustrated below.

Consideration of ethical matters was integrated into each of the four stages of engagement in PHSI initiatives. The thoughtful approach to invite decision makers to participate (core ethical principle of respect) was such that respondents perceived that they could decide freely whether to participate. Respondents were willing to participate because they trusted the judgment of reputable researchers. One health system manager explained that he recognized that some of his peers were “probably jealous” because they felt there was “not the same opportunity for academic research partnership” as there was for him (HSPM26). Respondents reported that they regarded this as an opportunity to strengthen common values, build their community, and, at the same time, address health inequities. They embraced the increased contact with researchers with the potential for capacity building and opportunities to achieve improvements in health programs and policy. This sentiment is nicely articulated as follows: "We were convinced that, first, we had a strong research team; second, we had a very important question; and, third, the results might contribute to new policies" (PM16).

The majority of respondents agreed that ensuring that research questions were relevant to their needs demonstrated the core ethical principle of justice. They spoke of working collaboratively for social justice and equity, "to make the necessary changes in our practices to provide the best care for patients" (PM09). The design of PHSI projects reflected this awareness. Decision makers highlighted the benefits of their involvement, which included similar values and visions, shared access to and greater representation of marginalized populations, reliable high-quality data, and opportunities for empowerment. Including scientific research activities to benefit the communities that decision makers serve was reported as important (core ethical principle of beneficence). In this example, the health professional explains the anticipated relevance of the project findings, which are going to be "extremely useful and practical in terms of trying to take corrective measures [and so] very important research" (HP10).

Equal Partners. Although the PHSI program was attractive because it offered new opportunities for learning (e.g., learning to adapt research methods to better fit with the realities of community practice and developing a stronger sense of the ways in which research contributed to reflective practice), decision makers felt that to be involved as equal partners in the process, they needed to be provided with training in research processes. They proposed educational forums that would promote the exchange of ideas and provide opportunities to "learn from each other" (PM16). Training in research ethics was also encouraged, in particular, sessions that focused on topics such as informed consent and building cultural competencies. Decision makers commented that such training would be helpful in facilitating understanding of the collective risks and benefits of research participation. They believed that they learned a significant amount that they could share simply from being a partner in the process.

Making the Link. Improved understanding of the researcher's perspective allowed decision makers to be more reflective of their activities and roles. Interviewees commented that learning was bidirectional and helped researchers "understand [the interviewees'] business a little bit." Decision makers have a highly developed understanding of power relations and policy processes; they can augment efforts to bring political support and leverage resources to make sustainable impacts on public health. "I can make the link, the connections, and the bridges to bring those other partners to the table and be part of a conversation," explained one senior policy maker (PM07). The majority of respondents articulated the significance of expanding and further developing knowledge. It was felt that this should take place throughout the entire research process so that researchers "are in tune with the ministry's agenda" and as a result have a much better understanding of the Canadian government system and "how government operates" (PM17). This policy maker commented that he noticed that researchers had modified "their research interests to fit in" with those of decision makers. Connections with decision makers working in public health were identified as an important resource for researchers. "We brought a lot to the table," remarked one health system manager, who added that his team was "able to bring insight into the real-life application of a theoretical care plan/intervention" (HSPM26). A few decision makers were critical of researchers who engaged partners in the initial stages of collaboration and did not sustain their interest in the initiative. They felt that this left people feeling disengaged and "disenfranchised" and, ultimately, undermined the collaboration (HSPM26).

Although the majority of respondents felt valued and did not feel that they were "there as a token decision maker" ("We'll just keep him happy, and we'll have his name on the grant form," said one policy maker [PM17]), some decision makers observed that sometimes their engagement amounted to input only, without any real capacity to influence projects. As one policy maker stated, "We sat there and nodded and made a few comments, but it really wasn't meaningful input" (PM24). One spoke of the hierarchy within academia, with researchers playing out their projects and partners not having the power to make decisions or make commitments to the community they served. From his perspective, this was an ethical question whereby researchers "do that because they have to"; however, "they may not be fully committed" to the project or the collaboration. He expressed his frustration:

> I'm looking at my cabinet here; I have a few thousand files, each corresponding to a given research project, and typically I was associated as decision maker, and many of these projects didn't lead to any significant collaboration at all because … once they [the researchers] got the grant they [ran] with it. (PM09)

Decision makers have a role to play in addressing the gap between the advances in research and the realities of real-world policy and practice patterns. Engaging them in the research process suggests that PHSI collaborations may increase the likelihood of framing how the findings may be collected and used to better inform policy and program activities. Knowledge transfer was described as follows: "We take what's learned from this research and … incorporate it through our provincial system and our provincial service delivery system" (PM25).

The Decision Maker's Role. The importance of the decision makers' responsibility in interpreting findings was a recurring theme. Decision makers are well placed to know the realities their constituents face; some expressed concern that information may be obtained during the course of the project that may expose the vulnerability of the community. A few respondents commented that to ensure the integration of multiple perspectives and avoid the potential of the over influencing of one group, partners must work together in a respectful manner. Respondents told me that personal contact with researchers led to a commitment to improve the way that study findings are shared with communities and policy planners. They reported that as a result of their interactions with researchers, it was more likely that the focus of inquiry would be more directed toward relevant health services research. Partnership enhanced dialogue, which encouraged discussions about the study findings and their subsequent applicability.

However, there was some level of concern among decision makers about the impact that the research findings could have on their local communities or agencies, particularly if the results were negative. Decision makers recognized this concern and explained that it is necessary for discussions to occur before the study starts so that partners can reflect on this possibility and plan how to act: whether to defer the publication of stigmatizing findings or to publish them as the expected product of the research activity. As the potential for prejudicial outcomes may not be obvious at the beginning, this should be monitored as the research endeavour evolves. Decision makers felt that they had particular responsibility in this domain as they have established connections with, and responsibilities to, the communities involved in the research. Respondents advised that a robust administrative structure for the research partnerships would ensure that decision makers and researchers have the opportunity to fully consider the implications of their findings before any publication or dissemination occurs.

The Impact of Research Findings. One policy maker clarified that although "the findings could be negative," to her, "that's not necessarily a non-success of the research" (PM07). She explained that she learned as much from not "necessarily accomplishing what [she] thought [she was] going to accomplish or making the difference [she] thought." She further advised that when projects reach this stage, returning to the questions initially asked in the Getting Started stage can help clarify the purpose of the project. For example, she said that the questions "'Why?' 'Why aren't the outcomes positive?' 'What could've been done differently?'" would prompt decision makers and researchers and provide an opportunity to revisit and re-evaluate "any service or program offering that [they] do" (PM07). This experience affords decision makers and researchers the occasion to reinvest in the collaboration, and as the policy maker suggests, sometimes from these challenges, new learnings and ideas emerge. Frequently, the decision maker–researcher relationship grows and is stronger as a result.

Ethical Challenges. Appendix 7 highlights examples of ethical challenges encountered during PHSI projects. "It's not exclusively … all rainbows and sunshine"

(HSPM02) is how one health system manager described the aggravation experienced in interactions with the process of ethics review. Whereas traditional research approaches focus on distributive justice with regard to the distribution of benefit and risk, community-based approaches focus on social justice concerns. At the interview, it was perceived by some respondents that members of ethics committees were out of touch, particularly when it came to reviewing community-based research. Effectiveness was described by interview participants as how well partners worked together and the types of health services change that they were able to achieve. Learning was not only about collaboration but also about community development, at the program level for the front-line workers as well as at the organizational level. Certain collaborative teams were working with marginalized groups of people. Respondents agreed that standardization of ethics committees' processes and review would be helpful. They commented that this would ensure that community-based collaborative research projects were reviewed using appropriate processes. A common perception was that without "the decision makers, the influencers, the people responsible for those services" (HSPM29), access to front-line interveners and marginalized groups of people "who are experiencing drug addiction, mental health issues, trauma" (HSPM22) would have been severely curtailed. The process of obtaining informed consent was challenging for decision makers involved in some PHSI projects. Several explained their concerns with respect to accessing members of vulnerable groups. Furthermore, some issues around confidentiality were reported. Decision makers recounted that they had worked collaboratively with researchers to address these concerns so that, ultimately, the cultural relevance of the projects was enhanced.

Rules of Engagement. Although one respondent confessed that he didn't "pay much attention to those things" and that "it would have to be pretty bad" (PM12) before he would go back to a memorandum of understanding, some decision makers recommended that rules of engagement be developed before any work is undertaken. Using the principles of PHSI collaborations as a guide, the memorandum prepared by all partners lays the groundwork for success. In such an agreement, clearly defined, thoughtful terms of reference defining partners' expectations, clarifying commitment levels, and documenting the terms of agreement are described, as in the provision of "clarity on role, clarity on perspective, clarity on the partner's role, clarity on everyone's role" (HP20). The agreement should clearly set realistic expectations with well-defined outcomes and identify mutual benefits.

Furthermore, it was also recommended that processes to ensure the ethical implementation of research be negotiated and transparent to all partners. Respondents commented that these agreed-upon terms should be reviewed on a regular basis. They emphasized the importance of having an agreement in place before the research starts. This interview participant recalled her recent frustrating experiences when she explained that people were involved in the early planning stages of their initiative but, in the last few years, "have essentially been ghosts." As the decision maker and researcher are now preparing to publish their findings, these people, who "had no commitment to the project," expected their names to be included as authors (HSPM22). The decision maker expressed her irritation and commented that this particular experience undermines the core values of PHSI collaborations. A few respondents voiced strong encouragement for agreements to be fine-tuned to meet the needs of individual PHSI projects. They recommended that statements on joint authorship, posters, papers, and presentations resulting from PHSI projects be included in these memorandums of understanding. Others suggested that memorandums of understanding and agreement should be signed off and shared with all parties during the *Getting Started* stage of engagement. These agreements were considered to be an important tool for developing and sustaining collaborations.

Respondents often reiterated the importance of paying attention to ensuring that research is respectful of the needs and priorities of all participants. This policy maker offered the following guidance:

> The partner needs to come to it knowing that they have something to contribute so they're not just a name on a piece of paper; they're just not keeping a seat warm. It really has to be active and interactive. So what's in it for the partner? Is there going to be ample room for the partner to influence both process and … outcomes? And the partner also needs to consider, and what am I prepared to do to advance the outcomes in this? I may see benefit for my organization or my clients or my own partners or my stakeholder groups, but what is the partner prepared to do to advance that? (PM16)

According to many respondents, integrating consideration of ethical issues across the four stages of engagement would promote respectful research and enable fuller realization of the potential of the PHSI projects.

Decision Makers' Advice for Future Engagement

Collaborations were fostered and established on the philosophy and principles of the PHSI program. When decision makers were asked to identify the main factors influencing their engagement in PHSI collaborations, the most common answers (see Appendix 8) included funding; the previous history with the primary researcher; tangible benefits to constituents represented by decision makers; the desire to contribute to and inform the development of health services programs and policies; capacity building; and the creation of knowledge, as in the "ongoing commitment to advance research in the community sector and then spread the word about those outcomes" (PM15). The salient factors that contribute to successful engagement in PHSI projects were nicely summarized by one policy maker:

> We know the service delivery system in a way that's very different from what academia might perceive our delivery system to be. We know what we can do within our policy and programs as opposed to what academia might perceive on paper … that our policies and programs are able to do. Our most valuable asset that we bring to the table is that we know the system … to which those research results are going to be presented. You do the research because you want to have some kind of an influence or impact on a policy or program. We want to make a positive difference in the end; that's the bottom line. (PM07)

The prestige of being supported by a federal funding agency while collaborating with reputable researchers, the potential value of the research, and the rich learning opportunities were cited by interviewees as significant considerations in the decision to participate and as benefits of partnership. As highlighted during the interviews, the risks of failure were reduced by the collaborative nature of the funding program. Decision makers made a number of recommendations to be considered when pursuing a collaborative approach with researchers. Their hope is that this advice will serve to "improve our relationship, our methods, our approaches, our delivery, our outreach" (HSPM02).

Commitment to a Shared Vision

Decision makers concurred that partners should have a shared vision, defined goals, and measurable outcomes for collaboration. Several interviewees commented on how it was important to have a clear understanding of their commitment, as typified by this quotation: "Be clear on how much time they're going to be needed for and what it is that they can contribute" (PM16). Interviewees said that researchers should be more direct and explicit about both the relevance of the inquiry or research and what it would entail. Many respondents emphasized the processes used to engage them in influencing policy and practice and how they were involved; said one policy maker, "It's a shared respect for those things that are going to guide practice on the ground" (PM16).

Respondents suggested that the careful selection of team members set the stage for future success: "It's really important to have the right decision maker for the type of project" (PM05). The "right" people were regarded as those individuals who shared the same goals, had the required skills and expertise, and had credibility in the community. They had a role to play in acting as an essential conduit between researchers and the communities they represented. As one policy maker said, "I don't feel that I'm there just because I'm a decision maker" (PM17). His perception was that he was invited to participate because researchers "felt that what [he has] to contribute is useful" (PM17). Interestingly, however, although more than a few interviewees indicated that not every project required the most senior decision maker, “whatever is being researched is pertinent to the level of decision making that the decision maker has” (PM17), and many considered the early engagement of a decision maker to be vital. Several interviewees pointed out that researchers are getting better at involvingdecision makers early on during the initial stages of the collaboration. Developing a plan before the research starts and ensuring that there are sufficient funds and resources were also acknowledged as key to successful engagements. One respondent suggested that to ensure the best outcomes possible, partners need to be engaged in the process and “see collaboration as in their self-interest” (PM24). Others proposed that engagement must be achieved in a way that is respectful of all partners and attentive to the ways in which research can contribute to decision makers’ and researchers’ agendas.

Foster Engagement

A few decision makers told me that unmet expectations can cause a loss of morale. They felt that there should always be ongoing evaluation of the collaboration to find out how the process is working. Evaluation might address what is working well, what is not working well, and what measures should be implemented to continuously improve and strengthen the collaboration.

There was consistent recommendation for appropriate communication between partners. “Everybody needs to know what’s going on, with whom, [and] when” advised one policy maker (PM16). There was agreement that ensuring that all partners are kept informed about the wider events that are taking place should be an ongoing priority. “Giving people the opportunity” to listen to each other and develop a common language was important during PHSI collaborations. Suggested communication strategies included telephone conferences and face-to-face discussions, and the occasional social event was regarded as valuable. Facilitated meetings focusing on specific issues were also recommended. Decision makers felt that these strategies are likely to generate more ownership and foster engagement in collaborative projects.

One recurring problem with decision maker–researcher collaborations that was highlighted was how to maintain involvement in and interest over the course of the project. Decision makers told me that it was not difficult to generate initial enthusiasm and excitement in the PHSI initiatives, but sustaining this involvement required particular attention. Much of the satisfaction experienced in decision maker–researcher collaborations derived from the quality relationships and the worthwhile nature of the PHSI projects. During interviews, decision makers suggested that the implementation of relationship-building activities would enhance enjoyment and subsequent engagement of partners in collaborative efforts.

Respondents recommend adopting a champion model because the value of PHSI collaborations was augmented through this approach. Champions promote collaboration and facilitate relationships among partners, resulting in sustained partnerships and “greater involvement of the front line and early engagement” (HSPM29). Another potential benefit to explore is the opportunity for experienced decision makers to serve as mentors to students and colleagues early in their career. “To have an opportunity to be invited to be on this team has been huge for my career" declared one (junior) health system planner (HSPM03). One seasoned health system manager said that one needed to "exhibit a little more Solomon-like wisdom" (HSPM26). In this model, junior colleagues can develop expertise, connect with others, and build relationships, which are the elements of capacity building.

Anticipate Challenges

Decision makers identified a number of potential challenges that should be anticipated and, preferably, avoided. One is the excessive time that collaborative research can require. At the outset, decision makers and researchers should be very clear about what will be required of each partner and the projected timelines. Second, partners must identify and agree on the question to be addressed. They need to be explicit about the goals and activities of the research project because they likely come to the project with different perspectives and motivations.

Related to these challenges is the issue of the decision makers' organizations supporting their involvement in research projects. One decision maker said that "your own home base giving you the time to be able to do it [and] recognition that it's important and that they will support you doing it" (PM24) were vital. A policy maker offered this observation:

> Optimally, a decision maker in a healthy entity brings to [his or her] role a balance of internal and external roles—and is supported in this way of work by [his or her]

> "sponsor," i.e., a board—and these together are enablers for sustaining commitment. The decision maker's network should view the partner role as legitimate and understand benefits accrued. (PM16)

Almost every respondent endorsed the value of sustained relationships and sustained research activity. For sustainability, mechanisms should be considered during the *Getting Started* stage of engagement to strengthen and maintain the relationship between partners. Over the course of collaborative projects, new political contexts, new opportunities, or new challenges may develop. Thus, it may become necessary to reassess the collaboration and either recommit or redirect in response to the external environment.

Under the auspices of the PHSI program, by facilitating a culture of inquiry, learning offered opportunities to decision makers and researchers alike for meaningful collaboration and cohesiveness of purpose.

Final Thoughts

In keeping with the key tenets and accepted practices of interpretive description (Thorne, 2008), decision makers were involved with approving my thematic interpretations. Direct quotations highlighting patterns and themes were shared with decision makers who engaged in validating and finalizing my early findings. I planned to integrate decision makers' further reflections into my final findings to ensure that all perspectives were fairly and truthfully represented. Ultimately, my expectation was that my research findings would advance decision maker collaborations and inform and guide decision makers in enhancing their practices. This expectation was supported in the findings; "there are comments that have been given by the interviewees in terms of how to solidify or improve that relationship" (HSPM06). Although no alternative interpretations were offered, one senior decision maker tendered the following:

> I've said most of what I had to mention. I think it's your responsibility, and I wouldn't interfere with that, to basically interpret this information knowing you know the context of your work and who you are reporting to and what you want to contribute, so … for ethical reasons I respect distance that has to exist … between my point of view and your interpretation of facts, and I would rather stop there. (PM09)

Chapter Summary

Study findings related to the research questions focusing on the exploration of the experiences of decision- and policy-making partners in the research process were presented in this chapter. It is interesting to consider the lessons learned during the course of my research; the honesty and candour of the decision makers were very much appreciated. A description of the context surrounding this study introduced the chapter, followed by a description of the conceptual framework. Findings were then presented, beginning with experiences during the development and engagement stages of the partnership; the working relationship; the ethical implications of collaboration; whether the anticipated efficient transfer of research findings into improvements in policy and practice occurred; and the strategies and factors that contributed to successful collaborative research partnerships.

CHAPTER 5: DISCUSSION

This chapter presents a discussion of the findings of my study of decision makers' experiences of partnering in PHSI collaborative research initiatives. First, the significance of the conceptual framework and interpretive description relative to understanding study findings is considered. Next, a reflection on the literature review presents the parallels between the findings and the literature. An account of the study's strengths and limitations is then provided. Based on the study findings, recommendations are offered for collaborative research endeavours and future research in IKT in health services research. The chapter concludes with a description of the dissemination of study findings and final thoughts.

I selected a qualitative research approach to examine information shared by the participants who took part in my study. Interpretive description was chosen because on the basis of analysis, it was possible to create a comprehensive narrative of the diversity and complexity of decision makers' experiences. Original features of my study include the exploration of collaborative research in the Canadian context. Furthermore, my focus on the experiences of decision makers complements published work in this field. Thus, a better understanding of what decision makers perceive as helpful to them in their collaborations with researchers is enabled.

The Relevance of the Conceptual Framework

From a methodological perspective, interpretive description facilitated exploration of the nature of participants' experiences with PHSI collaborative research initiatives. My analysis of these experiences was conducted in stages. First, I coded and categorized the data, and then the categories were organized into a novel conceptual framework. A more in-depth analysis of the data was completed by examining each of these elements within the framework and the relationships among them. My framework enhanced the analysis as this brought to light the multiple perspectives of decision makers and offered a contextual understanding of the experience of collaboration.

Collaborative Research Models and Frameworks

A number of collaborative research models and frameworks are described in the literature (Aubel & Niang, 1996; Bailey & Koney, 1995; Brinkerhoff, 2002; Bullock et al., 2012; Goering et al., 2003; Gronski & Pigg, 2000; Krebbekx et al., 2012; MacDuff & Netting, 2000; Masuda, Creighton, Nixon, & Frankish, 2011; Mitchell et al., 2009; LeGris, Weir, Browne, Gafni, Stewart & Easton, 2000; Ross et al., 2003; Thompson, Story, & Butler, 2003; Wallerstein & Bernstein, 1988). Hierarchical models are widespread in academic environments. Such models of collaboration are grounded in structure, driven by precise goals, and implemented by people conforming to clearly defined roles. Productivity and efficiency are the goals of such collaborations, in which multiple voices and shifting authority are seen as challenges (MacDuff & Netting, 2000).

Dialogic models are less common and are seen as alternative approaches to the more traditional research structures (Baumbusch et al., 2008; Freire, 1970; Miller & Haffner, 2008; Montoya & Kent, 2011; Wallerstein & Bernstein, 1988). MacDuff and Netting (2000) describe the dialogic collaborative model as being the "relationship between ideas, feelings, and action, which is seen and discussed" (p. 51). Dialogic collaboration requires the same talents and skills as traditional research approaches, with the emphasis on interpersonal relationships and mutual respect. Roles may change during the course of the collaboration based on need and on the progress of the project. In dialogic models, establishing goals is as important as the goals themselves, with all partners working together to develop a common agenda. Participants value the interactions created by their heterogeneity and varied perspectives. The benefits of a dialogic approach include partners being able to continue to "practice" while engaging in research and encouraging discussion among partners so that knowledge is more complete.

The Freirean Dialogical Lens

One way to consider decision makers' experiences of their collaborations in PHSI projects is through a Freirean dialogical lens. As discussed in Chapter 3, dialogical action was described in Paolo Freire's (1970) original discourse on the practices of teaching and learning. The philosophy of the PHSI program, as presented in Table 17, could have been inspired by Freire's ideas.

Table 17: Core Principles of PHSI Collaborative Research Initiatives

PHSI Principle	*Philosophy*	*Examples*
Collaboration	Decision maker involvement and participation in planning and implementing PHSI projects	Fostering collaboration with decision makers who have an interest in health or health research Engaging a variety of partners with complementary research interests
Respect	Respect for partners from a variety of disciplines	Promoting the involvement and recognition of research partners
Mutual benefit	Working in collaboration with decision makers for mutually beneficial outcomes	Supporting research that reflects the emerging health needs of Canadians Supporting health policy decision making
IKT	Partners are engaged in the entire research process Partners work together to shape the research process Knowledge created can be applied to multiple regions and/or settings	Enabling the dissemination of knowledge and application of findings to improve the health of Canadians and strengthen the health care system

Note: Adapted from CIHR (2008, 2013).

Freire's philospohy embraces participation of decision makers as co-learners with researchers; value the decision makers' experiences that contribute expertise and knowledge to the research endeavour; endorse critical thinking about the research question and process; and encourage team dialogue to explore issues and engage in innovative actions to address issues of relevance to their communities. In this way, decision maker–researcher partnerships can be viewed as engagements in Freirean dialogue as they were shaped by the mutuality of PHSI initiatives and enhanced the growth of and benefits for both partners (Freire).

After preliminary findings were reviewed, emerging patterns and themes were compared to the components of Freire’s (1970) dialogical framework. The purpose of this step was to learn whether this collaboration could be viewed as a dialogical relationship consistent with Freire’s framework. My intention was to describe (from the decision makers’ perspectives) the nature of collaborative processes and explore how decision makers might enter into deeper forms of equitable engagement for mutual gain.

A guiding premise for dialogical action is that decision makers and researchers come together as equal partners. The first step in the process of engagement was to involve a variety of decision makers with complementary research interests in the planning of PHSI projects. Next, a research action agenda was developed, which, in this case, was stimulated by the availability of CIHR PHSI funding. According to Freirean tenets, this step involved the partners cooperating, assessing the community’s health concerns, negotiating, and shaping the direction of the research work (Freire, 1970).

Several PHSI projects focused on research priorities that were defined by decision makers and represented issues relevant to their communities. The combination of consultation and collaboration with equal participation was reported by decision makers. This is identified in the literature as an effective engagement strategy (Abma, 2006; Nyden & Wiewel, 1992; Wallerstein & Bernstein, 1988). Furthermore, in my study, deliberation among equals resulted in shared ownership of the research and its outcomes.

Building trust by establishing cohesiveness between PHSI partners was perceived in this study as an essential cornerstone for genuine collaboration. The importance of taking time and dedicating resources to processes for fostering and forging these relationships was obvious. In general, decision makers had easy access to their PHSI researcher colleagues. The creation of a comfortable, “safe” environment allowed an opportunity for people to share their opinions and explore the sources of and potential for tension. Engaging in dialogical action facilitated, in a respectful way, open discussion about the issues and challenges facing PHSI project partners.

Revealed within the findings is that diverse strengths, including knowledge, expertise, competence, and advocacy skills, were needed to complete scientifically rigorous research. During PHSI collaborations, many decision makers developed and enhanced their research skills. Through these partnerships on diverse projects in different communities, decision makers believed that they enabled researchers to learn about the complexities and political nuances of community-based research. The combining of lived experiences with expert knowledge, supported by a dialogical approach, resulted in a dynamic, synergistic collaboration that was expected to achieve more than the partners could accomplish working on their own (Freire, 1970; Lasker & Weiss, 2003; Lasker et al., 2001; Miller & Haffner, 2008; Montoya & Kent, 2011).

Engagement throughout the project provided a voice to all, not just those who were in senior positions in their organizations. Having a voice was considered by interviewees to be a cornerstone facet of collaborative research. Decision makers were motivated to participate in PHSI initiatives when they saw value in the research, believed that they could directly influence the process, and could foresee how the findings would be applied in health services practice. The PHSI process was perceived as one of mutual engagement to advance knowledge that would inform the field and improve the effectiveness and efficiency of practice.

Freire (1970) maintained that authentic dialogue is characterized by confidence in the capabilities of people to name and transform their realities. Faith in the researcher’s inherent abilities was mentioned frequently by decision makers in my study. Researchers were described as being particularly knowledgeable. Respondents’ motivations for and engagement in the research process were sustained by regular communication, acknowledgement, and respect for diverse contributions.

From the Freirean perspective, optimism gives rise to the belief that better conditions can be achieved (Freire, 1970). In the context of PHSI collaborations, a commitment to action inspired confidence and instilled hope in decision makers that research goals would be achieved. As many of the PHSI projects are still ongoing, decision makers described their anticipated roles and plans for dissemination of findings.

Several decision makers remarked that to help influence policy, they need to feel confident that PHSI project findings will stand up to careful scrutiny. They commented that working collaboratively with researchers increased their trust in the science and the likelihood that the findings would be pertinent to their constituents. They emphasized the importance of timely communication of study findings to all parties. Sharing research findings and interpretations across a range of socially and scientifically significant dimensions was highlighted by decision makers as important to patients and their families, members of the medical community, and local government officials.

The guiding principles of the PHSI program can be seen as congruent with Freire's philosophy of dialogical action. The study findings illustrate that many of the decision makers' intentions were aligned with Freirean tenets. The partners were highly motivated and committed to establishing collaborative research initiatives built on trust, mutual respect, and honesty.

Parallels to the Literature

Within the current paradigm of evidence-informed decision making, the findings emerging from health services research have a key role in informing practice and policy decisions in Canada (Sackett et al., 1997). There is increasing interest in implementing collaborative research approaches to facilitate the movement of research evidence into public health policy and practice. Thus, decision makers are encouraged to partner with researchers to conduct research for the common goal of solving complex health issues (Israel et al., 1998; Minkler et al., 2003; Viswanathan et al., 2004).

The Process of Decision Maker Engagement

The PHSI collaborative initiatives fit with Mayo et al.'s (2009) reflections on their experience with community-researcher partnerships for the purpose of community development and empowerment. They describe partnership as requiring trust and commitment from all involved and advocate for research that is relevant to community needs. This is facilitated by community consultation and reflection, which promote addressing community priorities, capacity building, and training. Interestingly, the same process factors that were fundamental to Mayo et al.'s collaboration were also considered by decision makers in my study to be critical to the success of PHSI collaborations.

My study findings are also comparable to those of Denis et al. (2003). Their self-administered survey to researchers and practitioners revealed core competencies and processes necessary for productive collaborations. Dynamic communication, problem-solving skills, and the ability to consider others' perspectives were regarded as elements critical to the success of the research endeavour. They explored the dimensions of collaborative research further and advised of the value of surveying respondents looking for factors of success. These included fostering a culture of inquiry, identification of mutual benefits, and the involvement of partners right from the beginning. The value of strong communication skills is highlighted in the literature (Denis et al., 2003; Kothari et al., 2011) and is linked to relationship building and enhancing partner commitment.

During the PHSI projects, decision makers reported devoting significant amounts of time and energy to developing a common understanding regarding the nature of their collaborative health services research activities. In an environment where everyone feels they are working harder and with fewer resources, time is a valuable commodity. To sustain collaborative efforts, communication must continue; this includes taking time to listen to all members and developing a common understanding (Bullock et al., 2012; Walter et al., 2003). “Clear, relevant, timely and respectful” (p. 207) communication was cited by Kothari et al. (2011) as necessary for successful collaboration.

Krebbekx et al. (2012) report that despite devoting a significant investment of time for getting to know each other, team members still encountered role ambiguity, which caused tension on the team. They advise that when considering participation in collaborative research, roles and responsibilities should be explicit. This was recognized by the interviewees in my study. However, decision makers also reported that flexibility in the research process was appreciated as health service managers, health care professionals, and policy makers assumed diverse responsibilities in PHSI projects, and so did the researchers. This flexibility validated the role of the researcher as a co-learner and co-worker and was evidence of the researchers’ willingness to share responsibilities and power. The flexibility can be productive only when there is an explicit description of partners’ roles and responsibilities.

O’Brien and Whitaker (2011) describe how collaboration starts as a dialogue between communities and researchers about an issue of shared interest and go on to say that maintaining effective collaborative research requires specific skills, including negotiation, reconciliation of incongruent agendas, time management, and the equitable allocation of resources. These same elements that were identified in the literature as being important for sustaining partnerships were also highlighted by decision makers in my study as being critical to the success of their projects.

Collaborative research has been described as research in which there is equal engagement and diverse partners are embraced in a long-term relationship (Khodyakov et al., 2011). When describing the use of a collaborative research approach in a study of family planning, Aubel and Niang (1996) inform us of the value of partner engagement throughout all phases of the research process; they explain that they had distinctive perspectives that were worthwhile to include when developing the study content, interpreting the results, and formulating recommendations. These themes were echoed by the decision makers interviewed in my study, who reported that their unique perspectives, coupled with effective dialogue, resulted in shared action agendas with mutual benefits. The majority of respondents reported being actively involved in all stages of their PHSI projects. They felt that their involvement should not simply be tokenistic; they expected and embraced opportunities to contribute real and meaningful input. Ideally, they wanted to be involved right from the beginning of the project, when the research proposal was being developed. This level of involvement facilitated a sense of ownership and encouraged engagement. For many of the PHSI projects sampled, at the time of the interview, work was still ongoing, so an accurate reflection of decision maker involvement in knowledge transfer and dissemination activities could not be realized.

Ross et al. (2003) describe the range of activities employed to foster decision maker engagement in collaborative research. They identified three models of involvement, each contributing significantly throughout the research endeavour: formal supporter, responsive audience, and integral partner. “Formal supporters” were defined as decision makers who “were not actively involved in the research process”; “responsive audiences” were those decision makers who were “actively involved” throughout and “responded to researchers’ approaches” with advice or ideas. “Integral partners” were those decision makers who were defined as being actively involved and “significant partners in helping to shape the research process” (p. 28). Four factors, the stage of the research process, the time commitment required, alignment between decision maker expertise and program needs, and an existing relationship between partners, were identified by the authors as influencing the role decision makers played in the process. The current study found that the majority of respondents were actively involved throughout the research process and could therefore be described as “integral partners.”

When decision makers engaged in the project, understood project goals and their responsibilities, and made valued contributions, the effectiveness of group dynamics was enhanced. The PHSI projects could not have been undertaken without the input of decision makers or the support of the organizations they represented. Active collaboration engendered a real sense of partnership and ownership, yielding research that was responsive and relevant to the range of needs of the decision makers’ communities.

Walter et al. (2003) reported that competing agendas and high levels of staff turnover can negatively impact a partnership. Staffing changes occurred over the course of some PHSI projects. Partnerships are established between people who have the right set of skills and a relationship with each other; therefore, a key ingredient of the relationship is lost when a particular person leaves, and a new person who comes, even if he or she has the skills, may have a hard time integrating into the team. As new staff were hired, the commitment to building the relationships could have been lost. This threat was avoided in most PHSI projects by providing orientation sessions that offered newcomers the opportunity to learn, to develop confidence, and to trust their project partners.

Ross et al. (2003) advise of the value of maintaining the partnership after the project is completed. This serves to keep the focus on research of local relevance, enhances capacity building, and advances social justice goals. Long-term collaborations have been acknowledged in the literature as important factors influencing capacity building and sustaining health benefits to the community (Kidd & Krall, 2005; Lavis, Robertson, et al., 2003; Lomas, 2000; Ross et al., 2003). In my study, 19 of 27 decision makers had collaborated with their research partners previously and the majority expressed the hope to continue working with them. These pre-existing relationships were powerful contributors to the success of PHSI collaborations.

Within this study, decision makers spoke of the profound effect research findings can have on a community. O'Brien and Whitaker (2011) inform us of the necessary steps to build an infrastructure for impacting health policy. This process is very similar to PHSI initiatives, which start with a dialogue between partners about a topic of shared concern and finish with the dissemination of findings and the mobilization of a community to action. Decision makers reported that they were pleased that outcomes-related research was being implemented in their communities. They recognized the importance of this work and its relevance to their organizations. They expressed interest in channelling such findings to produce long-term benefits for the community.

While recognizing the many positives aspects of collaborating on PHSI initiatives, decision makers reported a number of challenges that echo what is in the literature. Commonly cited challenges included time constraints (Lomas, 2000; Ross et al., 2003), inadequate communication (Golden-Biddle et al., 2003), cultural differences (Goering et al., 2003), lack of trust (Bowen & Martens, 2005), conflicts over the research goals of the collaboration (Nyden & Wiewel, 1992), and methodological concerns (Badger, 2002; Bartunek et al., 2003). Establishing an agreed and effective governance structure was often challenging (Israel et al., 1998; Rynes et al., 2001). For some, the research process and its associated methodologies proved to be daunting. It was unclear during the interviews whether these feelings were due to the complexity of the PHSI project or the lack of explanation by researchers.

Decision makers were concerned that their time might be wasted. For example, several respondents commented that over the course of the PHSI projects, they felt that the time spent at meetings could have been reduced. Several decision makers suggested that perhaps a segment of time at meetings be set aside to reinforcing the commitment of all partners to the research work and process. They felt that if partners were to recount what they contributed and how the PHSI collaboration benefitted from their involvement, it could improve the partnership as a whole. Ultimately, this would cultivate a nurturing environment.

The factors that I found to be necessary for successful implementation of PHSI initiatives as reported by decision makers are similar to what I found in the literature (Antil et al., 2003; Bowen & Martens, 2005; Golden-Biddle et al., 2003; Shoultz et al., 2006; Sibbald et al., 2010). Established relationships, understanding and trust, dynamic communication, development of roles and responsibilities, early engagement, positive experiences of the process, and a learning purpose were all considered important to effective PHSI collaborations (see Appendix 8). Time, talent, and treasure combined into a conceptualization of decision maker–researcher collaborations in PHSI projects. Time and talent were invested into the *Getting Started* stage and continued throughout the process of engagement to the *Sustaining the Collaboration* stage. As the research project progressed through each stage, “treasure” was accumulated in the form of data, knowledge, increased capacity, and ultimately, the anticipated application of findings into policy and practice.

Previous Literature and the Four Foundational Elements

The PHSI program was designed to ensure participation and cooperation throughout the research process. Using concept mapping, Antil et al. (2003) identified 10 factors for the successful implementation of a novel grant program to build partnerships between decision makers and researchers. These factors were grouped into a model comprising four dimensions: leadership and coherence, favourable political and social conjuncture, responsiveness to the needs of health and social services institutions, and responsiveness to the needs of the university. Their mention of well-defined and shared goals, effective coordination, and positive working relationships resonates with the findings of my study of the PHSI program.

The Decision Maker–Researcher Relationship

PHSI research teams were multidisciplinary and had representatives from academia, health services organizations, and government agencies; hence, the development of a common understanding was key. Decision makers reported that because of the diversity of partners with respect to skills, competencies, and backgrounds, there needed to be regular check-in with sharing of information and ideas.

Bullock et al. (2012) identified key factors in the development of good project team relationships: quality and relevance of the research, "commitment to equality and mutual respect" (p. 8), and appreciation of partners' input. One of the most powerful factors contributing to success in PHSI collaborations was the continuation of pre-existing, established relationships. A key attribute of such interactions was the ongoing development of mutual respect, trust, and understanding, which facilitated the workings of the partnership.

Decision makers commented during the interviews on the influential role the researcher plays in collaborative research. In addition to being competent to implement the study, researchers must modify their "traditional academic, theoretical approach" (Krebbekx et al., 2012, p. 222) and adopt a partnership approach. In my study, decision makers looked to the researchers to set the tone and outline the framework for developing the partnerships and the relationships. A common theme was the changing roles of PHSI team members. Many researchers were described as advocates, facilitators, and committed supporters of the research endeavour. According to some respondents, this shifting in roles (by researchers more used to the hierarchial model) strengthened and promoted trust in the engagement process. These high levels of involvement can be new to researchers, who are more familiar with the hierarchical model. This situation may cause tension during the course of the project (Walter et al., 2003) as was mentioned during interviews with respondents.

Lomas (1997) describes communication difficulties between decision makers and researchers, misunderstandings regarding the different needs of decision makers, the lack of incentives or rewards, and the distinction between research-driven and pragmatically driven decisions. These difficulties may impact how well researchers and decision makers work together, and all were mentioned by interviewees in my study.

Capacity Building

The potential for the creation of partnerships that enhance co-learning among decision makers and researchers is believed to be central to the PHSI program of health services research. Mutual ownership of research processes, shared decision making, and the transfer of expertise and knowledge were acknowledged by interviewees as integral values to PHSI initiatives.

Mentoring was identified by many respondents as an effective strategy for capacity building. Several decision makers in my study valued mentoring for those who come to the field with little or no experience of working with researchers. They suggested that through PHSI projects, they had access to experienced colleagues who were highly skilled in the practice of research. Mentoring facilitated the development of skills and individual capacity, which in turn enhanced the transfer of study findings into decision making (Khobzi & Flicker, 2010; Masuda et al., 2011). Individual capacity building was recognized by decision makers as an important benefit of PHSI participation. This was evidenced by the development of professional aspirations; for example, one interviewee is currently pursuing advanced credentials in health care and is interested in applying these newly developed competencies in her work as a decision maker.

Engaging students in PHSI projects was felt to benefit everyone. They learned about community health care services and programs from decision makers, whereas decision makers and researchers, through their interactions with students, enhanced their knowledge and competencies. Learning from one another and the opportunity to participate in intellectually stimulating research were cited by respondents as attractive factors.

Bowen and Martens (2005) identified characteristics of effective KT that also facilitate capacity building. These include communicating findings in a way that supports the making of decisions, successful working relationships, and research of relevance to intended users. The authors describe three types of learning experienced by community partners who were engaged in The “Need to Know” Project. Conceptual learning was identified as facilitating community team members to become “creative partners in research implementation” (p. 308). Such learning afforded these partners opportunities to reflect on and change how they perceived research. Changes in their way of thinking about research often resulted in an openness to new ideas and the potential use of study findings. Educating and training all partners in the skills and competencies required for high-quality research ultimately result in trusting, sustainable relationships that can lead to positive change. Additional skills and expertise empowered decision makers to become more effective advocates for their communities and constituents. Fostering a sense of mutual learning to enhance the common good is supported by the literature (Bartunek et al., 2003; Bowen & Martens, 2005; Denis & Lomas, 2003; Jacklin & Kinoshameg, 2008; Khodyakov et al., 2011; Ross et al., 2003; Rynes et al., 2001; Sibbald et al., 2010; Viswanathan et al., 2004).

The development of enhanced partnerships and acquiring new skills were described by decision makers in my study as added gains. Each decision maker–researcher team had individuals with expertise in specific domains, abilities to collaborate with one another, and skills to articulate their methods and goals. Mayo et al. (2009) describe partnerships as a process with the potential to develop skills and confidence within the community. Decision makers told me that co-learning and KT required significant investments of time, personal relationships, and resources. They identified trust, mutual respect, adequate time, shared commitment, clear communication, involvement in interpretation of the data, and dissemination of study findings as important for effective collaborations.

Decision makers reported that the diversity of perspectives on PHSI teams was valuable in adding different insights to and drawing on diverse experiences for shaping the research process. In my study, the professional backgrounds of the participant decision makers ranged from nursing to medicine, from policy consultation to legal counsel, and from public health to hospital administration. Interviewees felt that this diversity strengthened the research endeavour, enriched the process, and fostered a culture of research inquiry. Ultimately, this added to the potential to yield important relevant findings. Some decision makers reported a benefit from improved understanding of methodologies that motivated them to engage in future research activities. These findings are congruent with what is reported in the IKT literature (Bowen & Martens, 2005; Denis et al., 2003; Golden-Biddle et al., 2003; O'Brien & Whitaker, 2011; Ross et al., 2003).

Although it was acknowledged that diversity should be embraced when considering issues, this created the potential for discord among partners. Fortunately, most decision makers had a wealth of experience in conflict resolution and building and maintaining relationships. Although more than a few had leadership and management training, some lacked skills in these domains. A few respondents highlighted the need for specialized training (for example, to address research participants' questions regarding confidentiality and informed consent). Others asked about leadership and organizational development training. They reported the transformative effect of such educational opportunities on staff and the organizations they represented.

Access to funding and supportive organizational structures are identified in the literature as factors that are critical to capacity building (Antil et al., 2003; Blevins, Farmer, Edlund, Sullivan, & Kirchner, 2010; Denis et al., 2003; Golden-Biddle et al., 2003; Ross et al., 2003; Sibbald et al., 2010; Tetroe et al., 2008). Blevins et al. (2010) discuss the provision of funding as facilitating their research pursuit. During interviews, some decision makers explained that the mandate of many community-based organizations is to provide a range of robust health care programs and services. Research is not a priority for many organizations, and the lack of time and lack of money to devote to study activities were identified as substantial challenges. Health services agencies are bound by their organization's mission and agenda based on the operational needs of the organization. One decision maker explained to me that grassroots organizations are often more flexible in terms of tailoring their programs to the needs of the community and the goals of the funding organizations. Incompatibility with the research agenda and uncertainty in potential returns were acknowledged in my study as being difficult issues to address.

By the same token, decision makers advised me of benefits to their organization, which included an enhanced profile, the provision of greater resources to the public, and increased credibility to obtain new funding. These resulted from collaborating on a federally funded research initiative. Decision makers understood that they and their organization were accepted for their knowledge and experience in the field. This was identified as beneficial when setting the research agenda and selecting study methodologies. Decision makers were adamant that research relationships should not end when the funding ends; they said that they still had opportunities to assist with intervention and policy issues for years after the study's close. A few mentioned that they had received an increasing number of requests from researchers to partner in collaborative research, and being able to engage in these partnerships was seen as a positive outcome. Several decision makers mentioned that using the research findings of one project to bolster an application for funding of a subsequent project is a powerful tactic. Antil et al.

(2003) describe similar experiences in their examination of a grant program developed to encourage the building of decision maker–researcher partnerships in Quebec.

Integrated Knowledge Translation

As described by the CIHR (2013), the term *integrated knowledge translation* (IKT) means a complex collaborative process. Partners are engaged in the entire research initiative, working together to shape the research inquiry, make decisions about the methodology, develop tools and collect data, interpret findings, and disseminate and implement research findings. Typically, the questions posed are ones that decision makers deal with on a regular basis and so are relevant to their daily activities. The goal of these multidisciplinary partnerships is the co-production of knowledge and the promotion of a two-way knowledge exchange between researchers (knowledge creators) and decision makers (knowledge users) to meet the unique needs of decision makers while at the same time producing relevant research evidence. IKT relies on a partnered approach to research and is considered a suitable method to disseminate study findings. As highlighted in the literature and reported by decision makers in my study, the benefits of partnership and collaborative research endeavours include the integration of decision makers at every stage of the research process, the ability to affect policy development, and the diversity of skills and knowledge that the various partners bring to the collaboration (Bartunek et al., 2003; Goering et al., 2003; Golden-Biddle et al., 2003; Innvaer et al., 2002; Sibbald et al., 2010).

One advantage decision makers commonly emphasized during the interviews was accessing the diverse perspectives, skills, and unique insights of multidisciplinary team members. The decision makers reported that on several occasions, they had interesting insights to offer during discussions about the interpretation of study findings. Israel et al. (1998) explain how by integrating practitioner insights, research quality and validity are enhanced as the research is grounded in local knowledge. Ross et al. (2003) report that working collaboratively mobilizes knowledge and creates impact for implementing findings in practice.

Decision makers reported that they were actively involved in shaping the research inquiry during PHSI collaborations. They advised of setting realistic research goals based on what could be accomplished. A few mentioned that the driving force behind their studies was a result of identifying an issue of relevance in their community. They subsequently approached the researcher for help addressing this need. Other decision makers informed me of their contributions in setting the research agenda, discussing study methodologies, collecting data, interpreting findings, and, for some, implementing the findings. Many of the PHSI research projects in my study sample are still in progress; hence, there was limited opportunity to assess whether decision maker involvement influenced the final stages of the research process with respect to KT and uptake of findings.

Graham and Tetroe (2007) address the varying levels of involvement in IKT activities. They propose that dissemination of study findings should be targeted to the appropriate audience. In cases where there is strong evidence of significant benefit, these findings may require a more aggressive KT strategy. Lavis, Robertson, et al. (2003) propose that the key information and the delivery strategy must be adapted to the types of decisions and the environment in which the target audience work. Engaging in IKT can be challenging, particularly for researchers who are used to making all the decisions. They may need to learn how to work as a member of a team and to respect other perspectives. Sharing power and authority, developing strong relationships, and understanding different time frames and agendas are all areas that require discussion as the research findings are shared and implemented. In my study, decision makers reported that they encountered similar challenges, including misalignment between decision makers' priorities and those of researchers. They believed that knowledge translation would be sub-optimal if there were unresolved conflicts in values or in their research approaches. Similar to what was described by Ross et al., (2003), decision makers reported that attention to team building activities (for example, regular contact, joint sense making, and conflict resolution sessions) was important for the collaborative process.

The literature informs us that successful implementation of evidence into practice occurs when (1) the scientific evidence is viewed as robust and consistent with professional beliefs; (2) the health care context is receptive to implementation in terms of supportive leadership, culture, and evaluative systems; and (3) appropriate mechanisms are in place to facilitate implementation (Bartunek et al., 2003; Baumbusch et al., 2008; Bickel & Hattrup, 1991; Bowen & Martens 2005; Lavis, 2006; Lavis et al., 2003). Rycroft-Malone et al. (2004) noted that the creation and implementation of research evidence are social processes. Passively handing it to practitioners is unlikely to promote its use. As mentioned previously, a complete assessment of decision maker's experiences in this domain was not possible in the current study.

The Promotion of an Ethical Environment

Ethical research is characterized by work promoting social justice and equity by addressing relevant issues and producing knowledge that is shared and leads to community health improvements (Banks et al., 2013; Bastida et al., 2010; Baumann, Rodriguez, Parra-Cardona, 2011; Kennedy et al., 2009; Pontes Ferreira & Gendron, 2011). Jacklin and Kinoshameg's (2008) description of the ethical approach they implemented when developing a participatory research project examining Aboriginal health issues is an excellent example of ethical conduct of research. In my study, the decision makers aspired to conduct PHSI research projects in an ethical fashion and they reported being guided by principles identified by Jacklin and Kinoshameg. These included communication through discussion with community members, performing research that reflects the concerns of the community, and the intention to transfer research skills to community members.

An ethical environment is characterized by a number of qualities including trust and respect among partners (Banks et al., 2013; Buchanan, Miller & Wallerstein, 2007). In PHSI initiatives, decision makers affirmed that it was helpful to have worked with particular researchers in the past as a strong, trusting relationship was in place. The lack of trust was identified by some decision makers as a challenge to collaboration. Trust is not only an integral component of the partner's relationship but also an important element in the research process and development of findings.

Mistrust can arise from a number of sources, including conflicting agendas among partners, lack of agreement on the relevance of the research, and concern around opportunism by researchers. Decision makers and researchers should create a process whereby they can appreciate each other's point of view and judgment. For this to happen, researchers may need to relinquish some control. For the collaboration to work effectively, a process that integrates many points of view and ways of knowing will lead to improved understanding and communication between decision makers and researchers. Ultimately, the development of knowledge through engagement will guide research to the further advancement of research inquiry (Bastida et al., 2010; Cargo & Mercer, 2008; Davies & Nutley, 2008; Dobbins et al., 2007; Goering et al., 2003).

For many interviewees, their projects had excellent communication strategies so that study updates were provided to all in a timely fashion. For others, that information was provided at all was remarkable as this contrasted sharply with previous experiences of collaboration with researchers. In addition, some decision makers had experience with projects in which there was a failure to share study findings, let alone observance of the ethical imperative to use the findings to shape future policy decisions. Sharing findings with communities is an important responsibility for decision makers and researchers. For non-academic audiences, findings should be written in plain language, with clearly defined implications and next steps (Denis et al., 2003; Goering et al., 2003; Sibbald et al., 2010).

A number of decision makers described their motivation for becoming engaged in PHSI projects as related to their interests in promoting social justice and equity. In these projects, they saw a way to strengthen community values, to develop community programs, and to impact the greater good. PHSI projects provided empowerment of decision makers through development of additional skills to become more effective advocates. Since decision makers have direct involvement in the forces affecting the well-being of their community, they were invited by researchers to have influential roles in PHSI projects. Through this power sharing, decision makers could advocate more strongly for their constituents.

Lastly, it is worth discussing whether decision maker involvement is appropriate in all situations. Arguments against decision maker involvement include the fact that participation can be expensive and time consuming. It would be inappropriate for decision makers to engage in research that is not directly related to their area of activity. For each study, perhaps a balance should be found between excluding decision makers completely and encouraging their full participation. Ross et al., (2003) provide recommendations for making these determinations and in addition, potential partners should consider the relatedness of the study topic to decision makers' scope of activities and the expected relevance of the research findings to inform health care policy and program development. Additional discussion of these issues is provided by Caron-Flinterman, Broerse and Bunders (2007).

Strengths and Limitations of the Study

One strength of this research was the selection of interpretive description methodology, which was appropriate to and compatible with my research questions. An interpretive description approach highlighted the diversity and heterogeneity of decision makers' perspectives of PHSI collaborative research. The trustworthiness of my study was optimized by means of the following measures: confirmability, credibility, dependability, and transferability. Appendix 9 highlights the steps implemented throughout the study to establish trustworthiness and to promote rigor.

A hallmark feature of interpretive description is the use of multiple data collection methods (Marck et al., 2010; Thorne et al., 1997). In my study, I reviewed PHSI competition description details as provided by the CIHR and copies of the PHSI grant proposals as provided by the decision makers. To obtain a more comprehensive understanding of the PHSI competition process and principles, I spoke with members of CIHR staff (one manager representing the PHSI and Evidence on Tap programs, one senior KT specialist who works in the Knowledge Translation Branch, and one senior advisor who works in Knowledge Translation and Program Planning). In addition to completing interviews, I corresponded electronically with interviewees to expand on or clarify certain points. The value of implementing these data collection strategies enhanced the confirmability and subsequent trustworthiness of the study findings. Every effort was taken to "ground" the study in the voice of the interviewees. Interviews afforded decision makers the opportunity to reflect on their engagement in PHSI projects and discover the who, what, and where of that experience (Sandelowski, 2000). Interviewing facilitated the opportunity to probe deeper into initial responses to gain more detailed answers to questions. As a result, a rich, authentic description was created. This account served to illustrate the nuances, complexities, and subtleties of the decision maker's perspective of collaborative research.

Credibility was achieved by inviting decision makers to provide feedback on their interview transcript. With respect to dependability, meticulous consideration was given to the research methodology throughout the course of the study. Every aspect of the study was discussed regularly with members of my PhD committee. Consistent, enthusiastic involvement and sustained commitment of committee members further supported rigor.

Attention to rigor was reflected by maintaining a personal journal chronicling all decisions made during the study. An audit trail was created by clearly documenting information on data collection methods and processes from the start of data collection to the completion of the study (Creswell, 2007c).

Several limitations of this research are important to note. In my study, I expected to learn whether (1) the anticipated efficient transfer of research findings into improvements in policy and practice actually occurred; (2) what strategies and factors contributed to successful KT; and (3) what strategies and factors contributed to failure to implement findings. However, many of the PHSI research projects are still in progress; hence, there was limited opportunity to assess the timely movement of research findings into public health policy and practice.

Although interviewing is an effective way to garner information, providing respondents with control and freedom to share their stories as they choose, the richness of the descriptive account is entirely dependent on the skill of the interviewer. Thus, this may be seen as a limitation to the study. There were constraints to credibility in the form of the multiple accounts provided by decision makers of the different PHSI projects. Assembling all aspects of the shared perspectives into a set of recommendations for best practice has been difficult. It could be argued that constraints to dependability centre on the flexibility of qualitative research methodology. There were many opportunities to explore other aspects of decision maker involvement in my study; large amounts of data were collected, and synthesizing these data into meaningful, useful accounts was challenging.

In terms of transferability, it could be argued that because only 27 of 51 decision makers agreed to be interviewed, it is possible that the study sample is not entirely representative of all decision makers who are engaged in PHSI collaborative research projects. By the same token, the issues raised by interviewees in my study and those represented in the literature are congruent. An additional limitation of this analysis is that although 27 decision makers completed the first interview, approximately 60% completed a second interview.

I cannot make definitive generalizations about the larger community of decision makers as (a) a purposive sampling technique was implemented in my study and (b) the low response rate (53%) to the invitation to participate. Decision makers were predominantly female (19 of 27); hence, it may be said that I have described a limited perspective of the male experiences of partnership. Furthermore, it is likely that my study sample overrepresented decision makers who had a relatively positive experience of collaborating with researchers. During the interviews, responses from decision makers were mainly constructive. This leads me to wonder whether decision makers were concerned about affecting current relationships with researchers if they provided negative responses.

Related to this issue of incomplete recruitment, despite multiple attempts, perhaps those who chose to participate were the most engaged in the process. Although these could be considered to be integral to the partnership, making their experiences very valuable, more work could be done to understand the experiences of those who are less engaged. Knowing the attitudes of those who chose not to participate would reduce the threat of sampling bias.

Since it was a requirement of the PHSI program that decision makers collaborate with researchers, it could be argued that the partnerships did not develop “naturally”—they were mandated relationships. The catalyst for forming the collaboration was the availability of funding as opposed to choosing a partnership as the most appropriate approach to address a health services research issue. It may be that some decision makers in the 2008 and 2009 PHSI funding cycles felt compelled to partner for the sake of access to funds. When I reviewed the history of successful grantees, 19 decision makers were building on existing relationships, making this concern more theoretical than actual.

Furthermore, regarding my study design, my choice of English-only PHSI projects probably excluded some important perspectives. My study was designed to learn about decision makers' experiences on specific PHSI projects. Exploring how researchers experience their relationship with decision makers would have allowed me to compare those experiences and perspectives with what I did obtain. The inclusion of these projects may have provided a more complete description of the relationships between researchers and decision makers. Due to the descriptive nature of my research and the methodology selected, quantitative evaluation of the processes and outcome assessments of decision maker–researcher collaborations was not possible. Despite the acknowledged limitations of this study, my findings resonate with the research of others.

Future Research Directions

In Chapter 2, I reviewed published accounts of collaborative research initiatives. However, most of these accounts are from the researcher's perspective, whereas my study explored the decision maker's perspective.

One key element for effective collaboration is that the decision maker and the researcher fully understand one another. A future research study to explore how researchers experience their relationship with decision makers on PHSI initiatives would allow detailed comparison of the perspectives of researchers and decision makers and provide a more complete description of their relationships.

The next step could be an exploration of the contextual variables, for example, how personal characteristics, professional standing, and previous experience impact collaborative efforts. A handful of decision makers in my study reported a less than ideal relationship with researchers. It would be interesting to examine how these dynamics are related to project outcomes. If decision makers do not interact well with researchers during the course of the collaboration, does this impede project progress and the subsequent application of findings in decision making?

In my study, decision makers working on PHSI projects were highly skilled and represented many different disciplines. Nineteen decision makers had a previous history of working on various projects with the same researcher. Thus, they had the opportunity to develop shared values and a common vision. Jones and Wells (2007), in a commentary in the *Journal of the American Medical Association*, refer to the “vision, valley and victory” (p. 409) stages of participatory research. They explain how the existence of shared values is related to trust, which develops through partnership. Developing a common vision is facilitated when there are common values, and this may have been facilitated when these collaborations were pre-existing and decision makers came from a common value system and already had common perspectives. In my study, many (12 of 27) decision makers came from medical or nursing backgrounds. Perhaps the shared backgrounds contributed to their willingness to commit to PHSI partnerships. A future study could examine the professional and educational backgrounds of partners as they relate to the partnering for conduct of collaborative research. Such work would assist with understanding the key aspects of sustainability of decision maker–researcher partnerships that have been in place for many years. It would be interesting to study if and how these collaborations end. Exploration of these dimensions of partnerships could provide valuable insights and guidance.

During the interviews, the responses from decision makers were mainly positive. This leads me to wonder if there was sampling bias, if experiences of collaboration are always successful, or if the PHSI collaboration was unique. Furthermore, the degree to which collaborative research initiatives are perceived to be effective would be interesting to explore. There are many reports in the literature of effective research initiatives; however, further work focusing on collaborations that were not so successful may be informative. Study findings may be helpful in developing guidelines for success in future collaborations.

IKT is a comparatively new approach to the mobilization of knowledge into health policy and practice. In the literature, authors have discussed the need for research evaluating the outcomes and impact of IKT processes (Kothari et al., 2005; Lavis, 2006; Lavis, Ross, McLeod, & Gildiner, 2003). Kothari et al. (2011) developed a set of practice-based indicators that can be used to assess the performance of a researcher-practitioner partnership. They recommend that these indicators provide a method to “monitor processes” (p. 212) and “provide guidance” (p. 212) for those engaging in collaborative efforts.

Since the majority of PHSI projects are not yet complete, there was little information on the effects of the research findings on outcomes. Future work should include consideration of the themes necessary for successful IKT structures, processes, and strategies. Learning whether the anticipated efficient transfer of research findings into improvements in policy and practice actually occurs, the strategies and factors that contribute to successful KT, and the strategies and factors that contribute to failure to implement findings is an exciting prospect. An additional consideration would be that it may be worthwhile to ask decision makers how collaborative efforts worked at enhancing the policy environment and how successful the collaboration was with respect to taking steps toward policy change.

Recommendations for Practice

One of the objectives of the PHSI program is to promote research appropriate to decision maker priorities. In this study, I focused on decision makers' perspectives, and the study findings have implications for practice and future research. Understanding that collaborative research is a contextual, multidimensional phenomenon raises questions about how decision makers can facilitate the partnership process. Some ground rules can be set to avoid tensions and enrich the experience of partnership. The following recommendations, based on insights gained during interviews with decision makers, underscore the importance of fostering connections among partners; identifying required skills, competencies and commitment; maintaining a sustainable focus of inquiry; clarifying roles and responsibilities; and cultivating a nurturing, learning environment. Strategies for each key recommendation that may be used to develop guidance documents and training materials for interested parties are illustrated in Table 18.

Table 18: Recommendations for Practice

Fostering relationships between partners ➢ Get to know each other, be patient and respectful, and embrace diversity. ➢ Plan time for communication; this affords partners an opportunity to discuss study-related research processes. ➢ Implement relationship-building activities such as social gatherings and satellite meetings at conventions. ➢ Accept that compromise may be required.
The assessment of skills, competencies and commitment ➢ Secure appropriate project resources and support. ➢ Invite skilled individuals who recognize the contribution to science and practical knowledge. ➢ Choose partners carefully to ensure alignment and establishment of mutually beneficial goals. ➢ Be open to learning, expect partner turnover, and develop orientation packages.
A sustainable focus of inquiry ➢ Schedule a briefing meeting to orient partners, discuss the focus of the research inquiry, and create ground rules. ➢ Establish buy-in, input, and ownership of the project. ➢ Have a clear sense of how findings will be used.
Clarity of roles/responsibilities ➢ Develop a written partnership agreement to provide clarity and build trust between partners. ➢ Define roles, responsibilities, and processes for making study-related decisions and addressing conflicts when they arise. ➢ Negotiate how and when partners will be included in the different project phases. ➢ To avoid misunderstanding, schedule regular discussions throughout the project.
Cultivating a nurturing environment ➢ Facilitate training to allow partner involvement in all stages of engagement. ➢ Plan dissemination strategies and present findings in a respectful way.

Fostering Relationships between Partners

The importance of investing sufficient time to attend to the development, implementation, and maintenance of relationships within the PHSI collaboration was identified as integral to the ultimate success of the initiative. Developing personal connections is very important for partners to work well together. Promoting communication and dialogue is necessary for developing and fostering connection among partners. Issues of trust and influence and a regular review of processes should be continually observed. A supportive environment helps to cultivate respectful relationships in which partners are treated as equals.

Connectivity was strengthened by regularly meeting one another and working together. These contacts served to build and sustain personal trusting relationships. The cooperative and considerate nature of researchers enhanced the decision makers' experience. As a result, the partnership led to new opportunities for many decision makers and their organizations. Decision makers should explore their relationships with researchers and reflect on these experiences in comparison with previous collaborative experiences. These reflective activities may help decision makers in their daily work. Cultivating strong and strategic links between partners through open communication further expands and strengthens the relationship.

The Assessment of Skills, Competencies and Commitment

First, during the *Getting Started* stage of engagement, it is vital to select appropriately skilled partners drawn from multiple disciplines involved in the field of inquiry. In the PHSI collaborations sampled, partners brought to the table a wealth of relevant experience. The skills and competencies of the decision makers and researchers were complementary. Linking with like-minded partners who are sufficiently senior in their organizations to make decisions and being open and flexible to different styles and ways of working are important considerations. Skilled members who recognize the project's potential contribution to science and utility to improve practice should be involved early and engaged throughout the research process. Equally important is the recognition of partners' contributions, which should be solicited regularly throughout the course of the collaboration.

Second, an assessment of each partner's commitment to the collaborative research initiative should be made, followed by an assessment of partners' interests and research priorities. In my study, many interviewees commented on underestimation of the time requirements of the project, as evidenced by the fact that, to date, only four projects are complete. Some felt inadequately prepared and overwhelmed by the complexity of the tasks at hand. With this in mind, developing realistic timelines is critical.

A Sustainable Focus of Inquiry

Decision makers and researchers starting a collaborative research project together need to pay attention early on to the establishment of a mutual vision representative of common needs. Interim goals to achieve that vision should be developed and shared by all team members. It is practical to use goals as a way of exploring common ground. Although partners come together in the anticipation of effecting change, it is a concern that this expectation may result in overly ambitious projects. Achieving project goals is likely to be successful only if they are feasible and within the team's identified capacity. The researcher provides dynamic leadership, whereas the decision maker provides the pragmatic focus.

As reported herein, the blending of decision makers' priorities with researchers' interests led to enthusiasm and created project momentum. Appropriate time should be allocated for discussions on the development of the focus of inquiry and the design of the research project. A briefing meeting should be arranged during the *Getting Started* stage of engagement to orient staff and set ground rules. How and when partners will be included in the different stages of engagement and processes for orientation of new staff members should also be planned at this time. Partners should have ample opportunity and be encouraged to provide feedback so that decisions are made by mutual agreement. These strategies are vital for facilitating "buy-in" and ownership of the project and maintaining momentum. The researchers can facilitate the success of the collaboration by ensuring that decision makers are engaged and appreciated as equal partners.

When collaborative projects are completed, partners' attention turns to sharing findings and mobilizing resources for change in the communities. Understanding the local environment guides decision makers and researchers as they plan studies and contextualize findings to advocate for change.

The Clarity of Roles and Responsibilities

Role clarity is an important feature of collaborative research that is founded on mutuality and equality. Effective collaboration requires clear understanding of individual responsibilities and working closely together to better understand the work context and culture.

In my study, decision makers reported that they did not encounter any major personal or professional difficulties that they could not overcome; however, it is probable that this is not always the case in collaborations. There will be times when difficulties impede partnership efforts, so when participating in collaborative projects, ground rules should be set to avoid tensions, address conflict, and enrich the experience of partnership. Written partnership agreements can provide transparency and serve to build trust between partners. It is wise to develop such an agreement before the work of the collaborative initiatives begins. This strategy ensures that the likelihood of uncertainty within the process, power struggles, and partner dissatisfaction is diminished.

Shared decision making is facilitated when there is mutual respect, strong links between partners, and effective communication strategies. All partners should be continually mindful of the principles of collaborative research and aware of project goals.

Ongoing negotiation and feedback help maintain “buy-in” and a sense of equal ownership. As a result, partners can feel optimistic that their contributions will improve the quality of the research performed.

With respect to the research findings, these should be discussed with all partners. The joint interpretation of the data enhances the cultural and contextual validity of the conclusions and reduces the potential for the results to cause harm. An internal review process could be set up to determine the applicability of the findings and assess how these findings may be disseminated and subsequently applied in practice. Findings need to be described in a way that is informative and respectful to constituents. Ideally, decision makers who have a role in policy and program development should also have a strong role in KT activities. They should be actively involved in determining where these findings best fit with existing policies and programs.

Cultivating a Nurturing Environment

Collaborative research initiatives require environments that nurture creative thinking. The PHSI program provided an opportunity to build research capacity, learn from practice, and create new knowledge. The supportive environment helped to foster respectful relationships and to enhance mutual appreciation of partners’ contributions. On some PHSI teams, it was perceived to be the researchers’ responsibility to create a co-learning environment, often through open communication, relationship-building activities, and encouragement of reflection.

It is anticipated that these recommendations will provide guidance for decision makers as they reflect on their roles, responsibilities, and functions as they embark on collaborative research initiatives. When a productive experience is facilitated, it provides a strong foundation upon which to engage decision makers and researchers in effective and mutually fulfilling research.

Conclusion

This interpretive description of the decision maker's perspective adds to our evolving knowledge. It provides an understanding of which elements underlie decision makers' positive experiences in collaborative research. Several conclusions can be drawn from this research. Decision makers' experiences of collaborating on successfully federally funded partnership grants were described. Insights into the experiences of partners as to what constitutes the main conditions, the shared interactions, and influences for a productive relationship with researchers have been shared.

My findings are largely congruent with published work reporting challenges to engagement in collaborative research. Limited resources, including time, funding, and knowledge, as well as structural and cultural factors are possible challenges to effective involvement. Structural barriers refer to institutionalization, which inhibits engagement in collaboration and reduces flexibility. Cultural factors refer to the values, norms, and attitudes of researchers that deter successful collaborations.

One merit of this study has been to illustrate how collaborative research partnerships among governmental, social service, and university organizations develop and function. In attempting to determine the important factors, I found that PHSI initiatives worked well for several reasons, and these can be organized around four foundational elements: the decision maker–researcher relationship, the promotion of an ethical environment, capacity building, and IKT processes. Effective collaboration must attend to the fostering and forging of relationships throughout the engagement process. My study reveals that concepts such as mutual benefit, trust, respect, and communication are the foundation of the development and maintenance of successful partnerships. These could be the essential facets that contribute to success in other collaborative initiatives. Dedicating time, investing talent, and promoting an ethical approach advanced a positive, trusting environment in which PHSI partnerships developed and flourished.

My research contributes to the health services research knowledge base by exploring collaboration in the context of a community-university initiative and proposing an original conceptualization to illustrate the important themes. Detailed knowledge and an in-depth understanding of decision makers' experiences may be of interest to other health policy makers, decision makers, and researchers. The study findings may serve as a guide in supporting relationship building with partners. This information will help us better understand the dynamics of effective partnerships and may influence decision makers and researchers who are considering collaborative research projects. Taking this knowledge and applying it to future research endeavours, using it practically to guide those working in partnership, and providing feedback to funding agencies will help ensure that collaborative processes will continue to evolve.

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Appendix 1: Email of Invitation to Decision Makers to Participate in the Study

Dear [insert name]:

As a graduate student at McMaster University I am conducting a research study to fulfill requirements for the Health Research Methodology PhD program. My supervisor is Dr. Susan Jack, School of Nursing & Clinical Epidemiology, McMaster University. Please consider participating in this study exploring your experiences of partnering on a Canadian Institutes of Health Research (CIHR) Partnerships for Health System Improvement (PHSI) grant. Your participation is voluntary. The information collected during the interviews will not be discussed in any way or at any time with your research partners. The information obtained is purely to gain data to help to further understand the phenomenon of collaborating with research teams on CIHR PHSI grants.

At the start of the study, I will ask you for some demographic data such as your experience, education level, and the number of years you have been working in health research. Participation will involve talking about your experiences, during an interview that will take 60–90 minutes and will be scheduled at a time convenient to you. Should a follow-up interview be required, this will take 30–45 minutes and will be scheduled at your convenience. The interviews will be digitally recorded. We would also like a copy of the original PHSI grant as review of these documents should add important contextual information and serve to corroborate data gleaned during the interview.

There will be a written consent form with further information about the study provided to you. Participation in the study is voluntary, and should you wish to withdraw from the study, you may do so at any time. Your digitally recorded interviews will be typed to paper copy. Once transcribed, the recordings will be deleted. All information will be kept completely confidential and all identifying information will be removed from quotes and stories. Your privacy will be protected as no real names will be used in the study. Electronic files will be password protected and stored on a password-protected computer. All information will be kept for ten years post study and after that time will be destroyed. The only people with access to the data, including myself, will be members of my thesis committee.

If you are interested in participating in the study, please email your response to me at coxp@mcmaster.ca.

Thank you for considering participating in this research study.

Yours sincerely,

Name: ___________________________ Telephone Number: _________________

Email address

When is the best time to call? _____Morning, _____Afternoon, _____Evening

Appendix 2: Letter of Information/Consent

Decision makers' experiences of collaborating with research teams on federally funded health research initiatives: An interpretive descriptive qualitative study.

Investigators:

Local Principal Investigator:
Susan Jack, RN, PhD
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Student Investigator:
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T:289-237-7748
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Purpose of the Study

I am a graduate student at Mc Master University and I am conducting this research study in partial fulfillment of the requirements for the Health Research Methodology PhD program.

You are invited to take part in this study because I am interested in learning about your experiences of partnership on Canadian Institutes of Health Research (CIHR) Partnerships for Health System Improvement (PHSI) Grants.
This is a study in which I will interview you in order to learn and understand your perspective on partnership with researchers.

I also hope to find out what strategies you used through all stages of the partnership to foster engagement and fair, sustainable working relationships, and what factors might have hindered these.

Procedures Involved in the Research

Should you decide to take part in the study, you will be asked to

1) Provide some demographic/background information such as your level of education and number of years you have been working in health research.

2) Participate in two telephone interviews at a time of your choosing. With your permission, all interviews will be digitally recorded.

3) Provide a copy of the original PHSI grant.The inclusion of these documents will add richness to the quality of the data and integrating this information with your knowledge makes it easier to interpret your experiences of partnership on PHSI grant.

Participation in the study is voluntary and should you wish to stop (withdraw) from the study you may do so at any time.

Your recorded interviews will be typed to paper copy (transcribed). Once transcribed, the digital recording will be deleted. All information will be kept completely confidential and all identifying information will be removed from the transcripts. Your privacy will be protected, as no real names will be used in the study. Electronic files will be password protected and stored on a password protected computer.

I plan to publish some of the study findings in peer reviewed publications, however, identifying information will be deleted and your privacy will be protected. At the end of the study, all information will be kept for ten years, after that time, the information will be destroyed. The only people with access to the data, including myself, will be members of my thesis committee.

You will be asked questions about
1) Strategies you used to develop relationships with researchers.
2) Strategies you used to maintain the relationship during the research project.
3) How you shared and used the research findings.

How will my information be used?

Your information will be used to inform decision makers and researchers of strategies which have been useful in developing researcher engagement and making partnerships better.

Potential Harms, Risks, or Discomforts:

There are no known risks to participating in this study. While every effort will be made to protect (guarantee) your confidentiality and privacy. I will not use your name or any information that would allow you to be identified. However, it may be possible, given the cohesive nature of the research community, that some of the researchers may be able to tell who you are from your responses. Please keep this in mind in deciding what to tell me.

There are no benefits to you for participation in the study, but the study results may help to inform your own work with researchers.

Potential Benefits

The research will not benefit you directly. However, what is learned as a result of this study will contribute new knowledge and help us to better understand decision makers' experiences of working with federally funded research teams..

Confidentiality

Every effort will be made to protect (guarantee) your confidentiality and privacy. I will not use your name or any information that would allow you to be identified. All identifying information will be removed from the transcripts. Your privacy will be protected, as no real names will be used in the study.

Your interview will be recorded on a digital recording device. Your name will not appear on any of the digital media that are used for recording or storing your interview. The file with your interview on it will be uploaded to the secure server at the researcher's office as soon as possible after the interview has been completed. The digital file will then be transcribed and any identifying information about you will be removed from the transcript.

The study findings will be presented in themes and quotes which will be anonymised. However, limitations to confidentiality include the fact that the number of people being interviewed is small enough that you may be recognizable to members of the research team, based on your responses to some questions. Please keep this in mind in deciding what to tell me.

The information/data you provide will be kept in a locked desk/cabinet, in a locked office, where only I will have access to it. All information will be kept for ten years and after that time will be destroyed.

What if I change my mind about being in the study?

Your participation in this study is voluntary, It is your choice to be part of the study or not. If you decide to be part of the study, you can decide to stop (withdraw), at any time, even after signing the consent form or part-way through the study.

You are free to choose to not answer certain questions or to stop the interview at any time. If you do not want to answer some of the questions you do not have to, but you can still be in the study.

Should you decide at any point during the study that you would no longer want to participate, you can simply inform the interviewer that you want to withdraw from the study. If you decide to withdraw, there will be no consequences to you and you have a choice as to whether you would like to withdraw and allow the interviewer to use the information you have already provided for the study, or withdrawing all of the information you've provided up to that point.

Information about the Study Results

I expect to have this study completed by approximately August 2012. If you would like a brief summary of the results, please let me know how you would like it sent to you.

Questions about the Study

Should you have any questions or need more information about the study itself, please contact me at: coxp@mcmaster.ca , Telephone # 289-237-7748
This study has been reviewed by the Hamilton Health Sciences/McMaster Faculty of Health Sciences Research Ethics Board (HHS/FHS REB). The REB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call The Office of the Chair, HHS/FHS REB at 905.521.2100 x 42013

CONSENT

I have read the information presented in the information letter about a study being conducted by Anne Moore-Cox, of McMaster University.

I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.

I understand that if I agree to participate in this study, I may withdraw from the study at any time. I have been given a copy of this form. I agree to participate in the study.

Permission to Quote

I hereby give permission for Anne Moore-Cox to quote responses given by me during the interviews conducted on ________ and ________ 2012, as part of Ms. Moore-Cox's PhD thesis research as signed below.

I understand there will be no information used that would in any way identify me as the person who provided the information.

I agree that the interview can be digitally recorded. Yes No

I would like to receive a summary of the study's results. Yes No
If yes, where would you like the results sent:

Email: ___________________________________

Mailing address: ___________________________

I agree to be contacted about future research and
I understand that I can always decline the request. Yes No

Please contact me at:

Telephone # __________________

______________________________ ___________________________________
Name of Participant (Printed) Signature Date

Consent form explained in person by:

______________________________ ___________________________________
Name and Role (Printed) Signature Date

Appendix 3: Decision Makers' Interview Guide

Decision makers' experiences of collaborating with research teams on federally funded health research initiatives: An interpretive descriptive qualitative study.

Phone call to set up the first interview

Hello, my name is Anne Moore-Cox and I am a graduate student at McMaster University.

Thank you for allowing me to contact you so that I can describe the study to you.

Is this a good time for you to talk?

(If it is not a good time to talk, arrange another time for contact with the participant.)

The purpose of this study is to answer the following research question: What are decision makers' perceptions and experiences about the nature of their partnerships with research collaborators on federally funded health research projects? Specifically, I am interested in understanding the key dimensions of decision maker partnerships and exploring the influence of decision maker engagement on the outcomes of collaborative research teams.

In this study, I am asking individuals who have been identified as decision maker partners on a Canadian Institutes of Health Research (CIHR) Partnerships for Health System Improvement (PHSI) grant to complete two telephone interviews.

In these interviews, I am interested in

1) Understanding your experiences in the research process during the development and engagement stages of the partnership
2) Describing your working relationship during the partnership

3) Identifying the ethical implications for decision makers in participating in collaborative research projects
4) Exploring, from your perspective, how this partnership facilitated the dissemination and subsequent uptake of research knowledge

The first interview will last approximately 90 minutes. A copy of the interview guide will be emailed to you prior to the interview. Each interview will be conducted by telephone.

Your participation in this study is completely voluntary. All the information you share with me will be kept confidential and will not be shared with anyone outside of the research team.

Would you like to be involved?

If "Yes," proceed to informed consent process.

End by setting a date for the baseline interview and completing the information form for reminder contact and the second interview (if required).

Preliminary Procedures

Prior to interviews: Review decision makers' information (i.e., description of the PHSI grant the decision maker is working on) prior to the interview.

During the interview: (After initial conversation and settling in…)

Obtain/Review informed consent and ask the study participant to sign two copies.

While chatting, set up the tape recorder and microphone and test the tape.

Introductory comments to include

- ✓ Purpose of interview
- ✓ Confidentiality/anonymity measures
- ✓ Reason for tape recording
- ✓ Nature of questions

Purpose: You are being invited to participate in a research study from McMaster University.

This study is led by Anne Moore-Cox, and it is hoped that the findings will facilitate our understanding of the experience of collaboration on successfully funded CIHR PHSI health research initiatives from the perspective of decision makers.

Procedures: If you agree to be in the study, there may be two interviews.

The first interview will be 60–90 minutes. You will be asked questions regarding your experiences as a decision maker.

The interviewer will ask to tape record the meeting to make sure that everything said is accurately captured. No identifying information will be recorded, or if it is, it will be deleted from the tapes and any transcripts made from the tapes. You may request to review the tape if you wish.

Approximately 4 months later there may be a short follow-up telephone interview of about 45 minutes. In the second interview, the interviewer will share with you a summary of the first interview and ask you to comment on the accuracy of the information collected and summarized.

Confidentiality: Any information you give during this interview will be kept confidential.

Study materials will be kept in a locked file or a computer with a secret password. Information will not be shared with anyone else outside of the research team.

All study tapes will be kept in a locked drawer.

Your name will not be on the tape. When the study is over, all tapes will be destroyed. If the results of the study are published, neither you nor any other person will be identified in any way.

Risks/Benefits: There are no known physical or psychological risks associated with asking the questions or the interview process.

Approximately 45 people will take part in this study.

Your participation in this study is voluntary. You may refuse to participate, refuse to answer any questions, or withdraw from the study at any time with no effect on you.

Decision makers' experiences of collaborating with research teams on federally funded health research initiatives: An interpretive descriptive qualitative study.

Thank you for responding to my interview request. I have developed these interview questions to learn more about partnerships inherent to and required by specific Canadian Institutes of Health Research (CIHR) funding competitions. I am particularly interested in learning about your experiences of collaborating as a decision maker partner on the CIHR Partnerships for Health System Improvement (PHSI) grants.

Your participation is voluntary. The information you provide will be treated in the strictest of confidence and will be administered in accordance with the Privacy Act and other applicable privacy laws.

Thank you in advance for your participation. The interview will take approximately 90 minutes to complete.

Interview Questions

1. Professional background and current role

As a decision maker partner on the PHSI grant, can you describe to me what your position and level of decision making are in your organization?

For the purposes of this project, decision makers are categorized as follows:

- **Health system managers and planners.** Health care managers and leaders with influential positions within the health system, including public health practitioners, hospital administrators, executives, and managers who work with regional health authorities.
- **Health professionals.** Medical doctors, nurses, and other certified, registered, or licensed health professionals.
- **Policy makers.** A person with power to influence or determine policies and practices at an international, national, regional, or local level.
- **Community knowledge users.** Community stakeholders who understand the unique health needs of a particular community as well as how research can lead to useful practical outcomes for the community and who can facilitate the involvement of that community in the research process.

Which best describes your role?

At what jurisdictional level do you work?

National ______

Provincial ______

Regional (RHA, LHIN) ______

Local (Municipal, District Health Authority) ______

Other (please specify) ______

Current number of years with organization ______

Number of years in current position ______

2. Partnership information during the initial stages of PHSI partnership development

1. What did you see as your role on the project?
2. Can you please tell me about your work on this project?
3. Please explain what the impetus or driving force was behind applying for this type of funding.
4. Can you describe to me how the idea to apply for a PHSI grant emerged and developed?
5. How and why did you choose to work with this researcher/research team? (Probe for: history with research team, how they came to know of each other, past working relationships, completely new relationship, how the relationship developed.)

6. Please tell me about the process of forming this partnership. How was the partnership nurtured/maintained?

7. Can you take me through the steps you and your partner(s) went through to create your research project?

Specifically, during the development of the PHSI grant proposal, what was your role (for example, writing the research proposal, defining the problem, deciding methodologies) in the process?

8. Would you please briefly describe the objectives of the PHSI grant?

9. In what ways did you feel that you were contributing to the partnership?

How satisfied were you about your role and contributions to the partnership?

Could you please describe this?

10. During this time, what were your expectations of what the partnership would be like during the PHSI project? How does that compare to what has really happened?

3. Required partnership and PHSI partnership processes

1. What was your experience working with the research team on this grant—particularly the partnership aspect?

2. Can you please describe the benefits/most positive experiences of this partnership?

What factors influenced engagement in the partnership?

3. What were the most challenging experiences of being involved in this partnership?

Was there any staff turnover during the partnership? If yes, was there a process for project handover?

4. What strategies did you use to foster and maintain the partnership throughout the course of the study?

5. As challenges arose, what strategies were used to address the challenges?

Did you help overcome these challenges? How?

If not, why? How do you think these challenges could have been better managed?

6. The literature we examined prior to conducting the survey indicated that the following barriers existed for partnerships between researchers and decision makers:

a. Adequate resources
b. Concerns about the quality of the research
c. Compatibility of problem-solving styles among team members
d. Level of trust among team members
e. Amount of turnover among team members
f. Power/status imbalances among team members
g. Knowledge/skill imbalances among team members
h. Competing agendas among team members
i. Differences in availability/contribution among team members
j. Lack of financial or personal incentives for conducting this type of research for team members (researchers or knowledge users)

Our data indicate that these barriers were not an issue for the majority of our respondents.

Why do you think this is the case?

Is it something to do with the required nature of the partnership?

7. How was this partnership different from non-partnered research that you have participated in?
8. From your experience, do these required partnerships increase impact compared to grants not requiring a partner?
9. Would the research have been successfully implemented if decision makers had not been part of the team?

10. Would the team have benefitted from additional expertise? (Was there any key research or decision maker expertise missing?)

4. Partnership processes during the PHSI collaboration

1. To what extent did your partnership help you to consider the perspective of researchers when designing your research?

To what extent do you feel that the partnership helped the researchers better understand the perspective of the decision makers?

2. What skills are required for an effective productive partnership?
3. It has been recommended that the involvement of decision makers in the design and implementation of the research project enhances the quality of the process and study results. What are your experiences in this regard?

5. PHSI partnership outcomes

1. As a result of participating in the PHSI grant, what have been the most significant outcomes to emerge from this project?

   a. For the decision maker at an individual level (e.g., increase knowledge about research)?
   b. For the decision makers' organization?
   c. Patient/client outcomes?
   d. Cultural changes at the organization?
   e. Increased uptake of the research findings into practice and policy?

2. Could you please comment on the influence of collaborative research on professional practice and policy implications?

6. Ethical issues

1. Who benefitted from engaging in this research and how?
2. Did you feel like an equal partner in the project?

Did you feel you had more or less power to influence the project than other members of the partnership? In what ways?

3. Describe for me how you felt being a decision maker in partnership with academic researchers.
4. How did the partnership facilitate dissemination and subsequent uptake of research knowledge?
5. Who participated in analyzing the study findings, developing the presentations, and messaging these findings?
6. How did the study findings get presented, and who participated in the presentation delivery?

Were the findings presented in an accessible and meaningful way?

7. Did the study findings reinforce negative stereotypes?

If yes, how were the findings presented?

8. Would it do more harm to the community to report such findings?

9. How were the study findings received by the community?

10. Have study findings been taken up or applied in your community?

Have study findings been taken up or applied in other communities?

11. How did you share and use the findings?

7. Next Steps

1. Have you had correspondence or meetings with your research partner since the end of the study? If yes, please elaborate.
2. Are you still working with your research partner? If yes, please elaborate.
3. Do you intend to work with that partner again in the future? If yes, please elaborate.
4. What characteristics would you seek when collaborating with researchers that would contribute to developing effective productive partnerships?
5. What, if anything, would you change or do differently if you had another chance at a partnership of this sort?
6. Can you highlight issues decision makers should consider when planning to undertake involvement in partnered research?
7. Can you identify/describe factors that would facilitate decision maker involvement in partnered research?

8. Can you please suggest names of other decision makers we should interview about their experiences with researchers on successfully funded CIHR PHSI grants?

8. Further contact

1. May we contact you later this year for a follow-up interview?

Yes ☐

No ☐

If yes, where/how is the best place to reach you?

through this email address ___________________

at this telephone number ___________________

2. When is a good time to get in touch with you?

time of day ___________________

I will not be in the office from ___________________

3. Is there anything else you would like to add?

Appendix 4: Follow-Up Interview Questions

Thank you for the information you shared with me during the first interview. I would like to let you know the common themes which emerged during that conversation and ask you to comment on my interpretations and provide any additional feedback.

Following review of the transcript and early findings:

1. What current strategies are followed to involve decision makers in research?
2. To what extent can these strategies be considered effective in terms of ensuring decision maker influence?
3. In cases of suboptimal effectiveness of PHSI partnership strategies, what obstacles hamper effective decision maker participation in collaborative research?
4. What additional strategies could contribute to overcoming obstacles?
5. How satisified were you about your role in the partnership?
6. In what ways did you feel that you were contributing to the partnership?

Appendix 5: Confidentiality Agreement for Transcription Services

I, __________________________, transcriptionist, agree to maintain full confidentiality in regards to any and all digital recordings and documentation received from Anne Moore-Cox (Researcher) related to her research study, **Decision makers' experiences of collaborating with research teams on federally funded health research initiatives: An interpretive descriptive qualitative study.**

Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of digitally recorded interviews or in any associated documents;
2. To not make copies of any digital recordings or computerized files of the transcribed interview texts, unless specifically requested to do so by Anne Moore-Cox (Researcher);
3. To store all study-related digital recordings and materials in a safe, secure location as long as they are in my possession;
4. To return all digital recordings and study-related documents to Anne Moore-Cox (Researcher) in a complete and timely manner;
5. To delete all electronic files containing study-related documents from my computer hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the digital recordings and/or files to which I will have access.

Transcriber's name: Printed _____________________Signature ____________________

Date ___________________

Appendix 6: Summary of Key Patterns and Themes Related to the Research Question

"What are the experiences of decision makers of collaborating with research teams on federally funded health research initiatives?"

Objective #1: Decision Makers' Experiences

Patterns	*Themes*
Building a Collaborative Research Team	Prestige of being associated with CIHR PHSI initiative
Motivations for partnership	Interesting research question, opportunity for co-learning, validation that the research could add Previous relationship with researcher Growth in interest in interdisciplinary research Need to address gap between research and practice, teaching and practice Science is a social institution that grows with interaction of many individuals Sharing knowledge/skills/expertise ensures a more effective use of partner's talents Use available means to effect positive social change
Expectations of partnership	Cited clear expectations that (1) participation would help decision makers understand/implement change in the health care system; (2) assist them in changing the culture of their organization; and (3) bring expertise in the area of change Implement research "with" rather than "on" decision makers Decision makers reported that the research was

	helpful in validating their expectations about the effectiveness of their work
Characteristics of PHSI partnership success	Formed to address genuine issue Builds on trust, solid process structures, and leadership Involves decision makers and researchers as partners Skill-building and mentorship opportunities Appropriately funded
Objective #2: The Working Relationship	
Patterns	*Themes*
Decision maker's role in/work on the project	Level of decision maker involvement varied across and within programs Ross et al. (2003) have categorized decision makers as either • Supporters—for research goals/objectives • Responsive audience—listen to/provide ideas, advice Identification of expected role for decision makers in KT Envisioned active role in defining program and clinical application of findings Unique, important role Focus on long-term relationships
Impetus behind applying for PHSI funding	Common vision lends itself to the exploration of important variables

	Integral partner—engaged, helps shape the research question and process, involved in the messaging of the study findings Alignment between decision maker’s expertise and needs and those of researcher
Contributions to the partnership	Decision makers and researchers have complementary skills and perspectives that need to be used to enhance sustainability of research and partnership Decision makers have a closer connection to the lived experience of the constituents they represent Decsion makers have unique organizational experience and good understanding of cultural contexts
Level of satisfaction with role and contributions	Decision makers felt appreciated and valued; contributions acknowledged and taken seriously Level of involvement agreed upon per each PHSI project Ability to effect change Recognition of the merits of the decision maker’s contributions Satisfied and committed decision makers likely to more fully participate in partnerships
Partnership nurtured/maintained	Collaborated to develop and continuously refine actions Engaging and seeking input from decision makers Decision makers and researchers have complementary skills and perspectives that need to be used to enhance sustainability of research and partnership Decision makers felt appreciated and valued;

	contributions acknowledged and taken seriously
Why work with this researcher?	Pre-existing trusting relationships, resulting in more active involvement Respect and admiration for researcher and quality of his/her work Decision makers an excellent source of stimulating questions and unique insights; coupled with researchers' acumen may result in new discoveries Decision makers seek partnerships with researchers when faced with complex health research questions Trust, respect, shared values formed foundation for key partnerships Decision makers and researchers committed to common goal Researchers have a broad range of experience, methodological expertise, research infrastructure
Initiation of PHSI Project Process of forming partnership	Existing relationship with academic researchersstrengthened through frequent meetings between interdisciplinary team of decision makers and researchers
Decision maker engagement	Positive experiences of partnership Personal contact, interactive processes, setting priorities, research agendas fostered realistic expectations for decision makers Foster goodwill, lay groundwork for future collaborations
Positive experiences	Opportunities for decision makers to develop or create knowledge/use the findings PHSI program—formal support—confers legitimacy on the research program, facilitates access to resources

	Valuable learning experiences, enhancement of skills and knowledge Decision maker involvement in shaping the research process Access to academic community, perspectives of multiple and varied disciplines enhance collaborative research process Decision makers well situated to address gaps in knowledge about health care program and service delivery
Challenging experiences	Time commitment was challenging Decision-making processes sometimes difficult. Decision makers reported that they would have liked more opportunity to shape the process and provide input in the decisions being made by researchers. Staff turnover/process for project handover Changes in personnel due to political changes may be challenging Decision maker turnover—lack of subsequent decision maker involvement Difficulty with consensus on what issues are important/relevant to decision makers Overcoming competing agendas and priorities Limited resources Tight timelines and other pressures
Factors influencing engagement	Decision makers involved from the beginning Opportunities for decision makers to develop or

	create knowledge/use the findings PHSI program—formal support—confers legitimacy on the research program, facilitates access to resources Clear articulation of purpose and goals of PHSI project
Strategies to foster partnership	Trust based on communication, collaboration involving shared responsibilities, excellence in science Clear, common, shared commitment, vision, and goals Invest energy in building relationships and infrastructure Processes facilitating engagement time, resource support, immersion within research, shared activities on research design, data collection and analyses, dissemination, respect, and trust Plan/budget for sufficient time for decision maker and researcher communication Engage and maintain decision maker involvement by establishing trusting, respectful, equitable relationships Work with decision makers to identify best ways to translate findings into practice and policy Recognize expertise of partners, shared decision making, shared control Staff PHSI project appropriately Develop a staffing transition plan in the event of staff turnover during the PHSI project Know the potential partners, recognize and respect

	the culture Successful collaborations require sustained, long-term commitment Expectations managed, roles clearly defined early on in the partnership Within the context of PHSI grant, attention already paid to possible barriers, design, and setup of these awards to overcome these barriers Regular and frequent communication Understanding of ongoing collaboration to achieve the same end. As a result, researchers better understand the perspective of the decision makers. The application of the principles of participatory action–based research make collaboration a success Pilot work—foundation for development of trust and establishment of key partners
Skills required for partnership	Effective communication strategies Ethical people with integrity Respects and values strengths each partner brings to the collaboration Collaboration skills Interpersonal and facilitation skills Committed to collaborative intitiative and issues being addressed by the PHSI project <u>Researchers</u> Energetic team leader with strong partnership facilitation skills Leader—engaged, competent, excellent researcher;

	relationship builder; organized, dependable, accessible, skilled negotiator Be clear about who to engage in PHSI project, be prepared to relinquish control Understand diverse perspectives of decision makers Appreciate range of solutions to address issues Dynamic communicators, transparency in communications Good listeners, supervisory abilities Know when to consult others when required Flexible to meet needs of decision makers Open to problem solving Appreciate the role, respect, and value of decision makers <u>Decision Makers</u> Skilled in policy analysis, strategic planning, developing initiatives Knowledgeable about the community, commitments and connections to the community
PHSI Participation Benefits of partnership	Enhanced commitment to sharing of knowledge and skills and implementing findings into practice Opportunity to network with others working in the field Access to information and resources Researchers dream big, decision makers grounded Impact breaks down boundaries between researchers

	and decision makers Increase knowledge about research, clinically relevant grounded research Focus research question so that it is relevant to practice Ownership accountability/obligation to research results Joint desire to influence practice and structural change Decision makers involved from the beginning—likely buy in from the beginning Key decision makers high in their respective organizations have a better chance to make an impact
Costs of partnership	Challenging, frustrating experience at times Resource- and labour-intensive activity Costs—time, challenges, financial costs Benefits of collaboration reported as outweighing the costs
Strategies to foster/maintain effective partnership	Facilitate honest transparent discussions about challenges and strengths Adequate funding for project and decision maker time/involvement Establish strategies that guide interactions with partners Build and sustain formal and informal networks to maintain relationships, communicate messages, and leverage resources

	History of relationship and trust Work with experienced researchers Upfront dealing with tensions and challenges important Value in researcher thinking whether project of interest to decision makers and the expected level of involvement
Significant outcomes	Decision maker involvement enhances quality of process/findings Opportunity for researchers to gain access to contexts and knowledge that may not otherwise be accessible Increased visibility for decision makers and their organizations Collaborative research approach helps partners better understand/address health issues Effective, culturally appropriate program of research and robust findings
Sustaining PHSI Collaboration Skills required	Effective communication processes—ability to communicate his/her perspective and to appreciate the other's perspective Ability to consult others when required, open to problem solving Willing and committed to PHSI project Establish governance
Required nature/impact of required partnerships	Nothing to do with the required nature of the partnership

	More to do with the overall positive experience of collaboration with these researchers Thoughtful selection of partners—consider what both partners can bring and how the partners can best complement the collaboration fo rthe PHSI project to succeed
Objective #3: The Ethical Implications of Participation in Collaborative Research	
Patterns	*Themes*
Ethical Implications	Decision maker engagement creates opportunity to improve the research process, identify ethical pitfalls, and create processes for resolving ethical issues Ethical considerations when engaging—transparent and equitable decision-making mechanisms in place Contemplate the consequences of findings, open writing/publishing processes Power to influence the project, facilitate ongoing research to improve health of community Accountability, commitment to stakeholders Respect for decision maker knowledge Interpret findings, identify implications from the decision maker's perspective, commitment to acting on the findings Shared culture that supports knowledge sharing Agreement on handling confidential information
Capacity Building	Capacity building is a significant element of decision maker engagement, necessary for

	effectively addressing problems within the decision maker's organization or community Development of skills and capacity contributes to the longer-term legacy of the project Fostering shared knowledge, leadership skills, and ability to represent the interests of the decision maker's organization Teaching activities—decision makers reported that students had experiences they would never have otherwise had Support for personnel (i.e., facilities/office equipment) Requires people skilled/trained in relationship building For decision makers to be involved as equal partners, they must equipped with training for engaging in research Training may include study methodology
Objective #4: The Dissemination of Research Knowledge	
Patterns	*Themes*
IKT	PHSI—new impetus toward collaborative research, focuses on knowledge translation KT—reciprocal exchange of knowledge, method of integrating context into evidence and moving evidence into policy and practice Complex process of developing locally informed, scientifically accessible knowledge Important to recognize the active role that decision makers can play in the process

	Network to share meaningful findings across a range of socially and scientifically significant dimensions Senior decision maker involvement can make things happen Decision maker involvement from start to finish results in increased impact of study findings to a wider audience Success from decision maker's perspective improved access. Decision makers anticipated that the research findings would subsequently impact policy
Challenges	Daunting task of sifting through a long document to isolate key information Presentation of findings in a way that is compelling to the target audience
Benefits	Skilled interpretation and judgment required; enable translation of best practice knowledge into health policies and programs that results in evidence-based practice Findings presented in an accessible and meaningful way Findings actively interpreted by decision makers for their own context Findings taken up or applied in decision makers'/other communities Fosters a culture that shares and uses the findings Study findings did not reinforce negative stereotypes

Development/presentation of findings	Use of plain language. Attention to context was identified during interview as an integral aspect of effective KT Decision makers saw themselves as messengers bringing the findings to target audiences Interactive forums to engage decision makers in research-related activities, site visits Increased uptake of the research findings into practice and policy The influence of collaborative research on professional practice/policy implications Target communications and resources, develop/deliver messages across formal/informal communication channels Decision makers recognized as necessary for translating research findings to implement/sustain health policy/programming
Recommendations for Future Collaborative Endeavours	
	Pilot work—foundation for development of trust and establishment of key partners Increased uptake of the research findings into practice and policy The influence of collaborative research on professional practice/policy implications

Appendix 7: Examples of Ethical Challenges Encountered During PHSI Projects

Ethical Challenges	*Proposed Action and Resolution*
The process of ethics review "The rigidity of the university ethics review really limits that freedom of exploration." (HSPM22)	"It just would be nice if the ethics boards across the country could get together and standardize their decision making." (PM12)
Maintenance of research participant's privacy and confidentiality Confidential information being discussed in a clinic waiting area	"What we put in place was that the manager would approach" the potential research participant and invite him or her to consider participating in a clinical research trial. The "research assistant actually sat in a private area, and so if people … came forward and said, 'Yes, I'd like to be interviewed,' they would approach this research assistant and then set up a time, and it would be done in a private way." (HSPM14)
Accessing/working with marginalized groups of people "We're not studying someone's response to a new vaccine where we can have one test group receiving it and the other not receiving it. We can't do that to people's lives who are really, quite frankly, in a life or death situation." (HSPM22)	Work with a community research ethics committee that has expertise with CBR projects and a focus on social justice concerns
Inclusion of minority populations and their unique needs	The PHSI researchers and decision makers "worked that into a next stage of another aspect of the research."

“We’re a bilingual province, and this was only an English project.” “Consideration of First Nation needs and priorities” (PM25)	They “tried as a research group to listen to the issues” and recognize that this is reflective of the “milieu of our province.” (PM25)
Issues regarding “clarity on role, clarity on perspective, clarity on the partner’s role, clarity on everyone’s role” (HP20) and authorship	A memorandum of understanding documenting terms of reference, including defining partners’ roles, expectations, and commitment levels developed before the PHSI project starts

Appendix 8: Factors Affecting Decision Maker Engagement

CIHR PHSI funding Understanding of the terms of the funding provides a level of structure and focus to the research process and on building partnerships, setting the stage for the current PHSI project *Funding provided "a pretty good jumping-off point to set up that kind of a collaboration" (HP15).* *"If these people hadn't partnered with us … we'd never have been able to do the study" (HSPM03).* *Funding opportunity contrasted to other awards where partners did not "get the time to foster the teams and really think through how everybody's going to provide contributions to a project" (HP15).*
Previous history with the researcher renowned for high-quality work of relevance to the decision maker's community. *Respondents felt that due to a historical relationship that "advice and input was going to be respected" (PM16)* *The relationships allowed one to "foster deep relations with one another" and build genuine partnership (HP15).*
The appreciation of decision makers' contributions The two arms of a true partnership are based on mutual respect and trust PHSI project partners took time to consistently demonstrate respect throughout the project Trust was established and maintained through courteous communication and served to keep decision makers informed, connected, and engaged. *"I felt listened to, I felt involved, and I felt appreciated. But I'm a guy, so I don't really have that many feelings" (HSPM26).* *The advice and suggestions provided ("received full consideration") were greatly appreciated by decision makers (PM17).*
The importance of ongoing two-way communication, clearly defined roles; acknowledgement of each other's opportunities and issues; understanding the researchers' point of view and each partner's work culture; caring about mutual research goals *Communication to obtain "shared clarity on role (as per the graduated roles – supportive, responsive and integral), feedback on decision maker contributions, and group check ins – "how are we doing" – together with the partners" (PM16)*
Opportunities for co-learning and sharing knowledge Feeling that the research was meaningful, interesting; the sheer enjoyment of working in diverse multidisciplinary teams. *Important to "be considerate of everybody's opinion but don't be afraid to give your own in a polite, constructive manner" (PM07)*

Enjoyed the “importance of the research in the sector” (HSPM19)
Informing policy and program development Respondents enjoyed the team work and the creativity in terms of designing the research and applying the knowledge that they were developing *“We know each other is hearing the message that we’re intending to deliver… we want to make a positive difference in the end; that’s the bottom line” (PM07).*

Appendix 9: Strategies Implemented to Promote Rigor

Trustworthiness	*Verification Strategies*	*Examples*
Confirmability The extent to which the data and interpretations are grounded in events	To establish confirmability, the data and interpretations are examined for internal coherency to ensure that the findings were supported by the data Findings are supported by decision makers' quotations Full explanation of the analysis and identification of the patterns that led to an interpretive description are provided	Semi-structured interview guide developed Semi-structured interviews conducted Audit trail for study designs and decisions
Credibility Demonstrated when findings were credible to the participants	Decision makers invited to comment on their interview transcripts Advanced through transparency in the description of the research process	Member checking Personal journaling
Dependability Consistency, typically demonstrated through replication	To ensure dependability, similar questions were asked in multiple ways, allowing assessment of the consistency of responses The original interview transcripts were re-read several times Concurrent data collection and analysis, making field notes; attentive to potential biases Constant comparative analysis used to increase dependability	Semi-structured interview guide Coding guide Audit trail for study designs and decisions Findings reviewed with PhD committee
Transferability The extent to which the findings can be applied to other contexts	Rich descriptions allow readers to make decisions regarding transferability and to judge the applicability of the identified patterns to other contexts Presentation of the patterns that explain decision makers' experiences accompanied by quotations provides the information necessary to determine applicability in the practice setting	Detailed descriptions of study methods and the conceptual framework provided

Note: Adapted from Creswell (2007c); Lincoln and Guba (1985); Patton (2002); Marck et al., 2010 and Mays and Pope (1995).