A Case Study of KM Development in the Health and Social Services of Quebec

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Abstract: In the Canadian province of Quebec, eleven affiliated university centers (AUCs) and university institutes (UIs) with a social vocation are bringing together practitioners, researchers and students who are mandated to develop innovative ways to improve the health and social services provided to the public in their respective territories. The innovative practices developed by the AUCs and UIs are based on both scientific and tacit knowledge. Initiated in November 2011 and led by the Center for Liaison on Intervention and Prevention in the Psychosocial Area (CLIPP), a non-profit organization specializing in knowledge mobilisation (KM), the project allowed four of these public organizations to develop knowledge mobilisation strategies in order to facilitate the implementation of their respective innovative practices in other institutions within the public health and social services network. These strategies were co-developed by four communities of practice (CoP), which were created as part of this project. Each CoP comprised the organization that had developed the innovative practice, as well as other Quebec institutions interested in implementing the practice in their respective territories. At the end of the project, in February 2015, four KM strategies had been developed. According to the communities of practice, the project's main outcome was the appropriation of four leading-edge or innovative practices. They have been able to help 19 institutions that would not have had access to these practices without the project. We produced one tool that was made available on a website (http://trasss.ca/en/). It was intended for organizations that have developed leading-edge or innovative practices and that would like to help other organizations apply them using a KM process. The tool should help these organizations to 1) verify whether they have the competencies required to do so, and 2) develop their KM process.

Keywords: knowledge mobilisation, community of practice, health and social services, innovative practices

1. Introduction

In the Canadian province of Quebec, public spending on health and social services accounts for 43.4% of the total costs of government programs (Gouvernement du Québec, 2014). This spending is rising faster than government revenues, creating a threat to the accessibility and quality of services. In 2010, the Ministère de la Santé et des Services sociaux (MSSS) and its network established the priority of reinforcing the accessibility, quality and integration of health and social service resources, as well as the sound use of resources. This priority was intended to be based on recognized standards and practice methods (Ministère de la santé et des services sociaux, 2010). The government has relied on Affiliated University Centres (AUCs) and University Institutes (UIs) to meet institutional needs for scientific expertise with a view developing practices. These organizations belonging to the public health and social services network were created in 1994 by the government of Quebec (Gouvernement du Québec, 2015). They are required to develop leading-edge and innovative practices. More specifically, innovative practices must meet several of the following criteria, while leading edge practices must meet all of them:

- Constitute specific and well-defined expertise.
- Represent an innovation compared to current practices.
- Undergo a development process that includes implementation and fine-tuning.
- Be associated with research and evaluation.
- Be subject to knowledge mobilisation within their home institutions.
- Be developed with a view to being transferred to other organizations.

Six AUCs and five UIs have a social vocation. Their services must meet a wide array of socio-economic and psychosocial needs. They generally serve vulnerable populations, with the ultimate aim of improving individual

and community well-being by promoting adaptation, rehabilitation, integration, and social involvement (Gouvernement du Québec, 2015). At the time of the project, they were located in 94 territories, grouped into the 18 regions comprising the Quebec health and social services network. Each territory was under the responsibility of a Centre de santé et services sociaux (health and social services center, or CSSS). The AUCs and UIs with a social vocation were located within one of the following major cities: Montreal (4 AUCs), Sherbrooke (1 AUC), Trois-Rivières (1 UI) and Quebec City (1 AUC and 2 UIs).

Each AUC and UI focuses on a specific issue. Working with people who have addictions, or on the accessibility of services in multi-ethnic contexts, would be two examples of such issues. The leading-edge or innovative practices they develop are implemented in their respective territories. Yet the fact is that institutions located in other Quebec territories of the health and social services network need these practices, and have limited access to them. As early as 2005, the report of the ad hoc committee on the university organization of social services recommended that AUCs and UIs be required to highlight the research findings and innovations developed by communities of practice. To enable them to do so, a partnership was strongly recommended with KM organizations (Comité sur l'organisation universitaire des services sociaux, 2005), and more specifically the Center for Liaison on Intervention and Prevention in the Psychosocial Area (CLIPP), a non-profit organization created in 2000. Our project was intended as a follow-up to this recommendation.

Accordingly, the project's primary goal was to ensure that AUCs and UIs with a social vocation would be equipped with KM strategies to help foster the appropriation of their practices within other organizations in the health and social services network, mainly those located in different territories of Quebec. By knowledge mobilisation, we mean "activities aimed at sharing research-based knowledge" (Davies, Powell, Nutley, 2015). The project's secondary goal was to create and disseminate tools intended for health and social services institutions, namely 1) a diagnostic tool enabling any institution interested in engaging in KM to verify whether it has the expertise and resources required to do so, and 2) a synthesis-based knowledge mobilisation tool drawing on strategies developed by CoP. The project's ultimate aim was to help improve services provided to the public.

2. Project development

The CLIPP sought to initially co-construct the project with the six AUCs with a social vocation. To do so, we wished to be invited to the Table des CSSS-CAU, which brought together the AUCs' scientific directors. The support of the MSSS representative who was sitting on the round table was an asset in this regard. In November 2011, we presented the following aspects to the round table: the mission and achievements of the CLIPP, the aim of the project, and the program that could likely fund the project. More specifically, the project would provide AUCs with the resources required to develop their KM strategies. We wished to submit a funding application under the promotion and transfer support program of the Ministère du Développement économique, de l'Innovation et de l'Exportation (MDEIE). The fact that the CLIPP receives funding from this ministry was an asset, given that we were familiar with its requirements.

The Table des CSSS-CAU agreed to appoint its representatives to a committee that would be tasked with writing the grant application. The CLIPP would be responsible for: 1) organizing committee meetings, 2) drafting several versions of the application pursuant to committee feedback, 3) finding financial partners since the grant program we were applying for required 20% of the budget to come from organizations other than applying organizations, and 4) submitting the MDEIE application.

The maximum budget per project offered by the MDEIE was $500,000 Canadian. The Application Drafting Committee agreed that most of this budget should be allocated to the AUCs, in order to create and sustain the communities of practice (CoP) that would be set up in these institutions.

The five UIs with a social vocation, represented by a special advisor from the Institut national d'excellence en santé et en services sociaux (INESSS), asked if they could join us. There were both advantages and risks in agreeing to this request. On one hand, our projects would make it possible to meet a need of UIs. In addition, including them would give more weight to our grant application. However, including UIs in the project would mean that part of the budget would have to be devoted to these institutions. We wondered if this might diminish the resources that would be allocated to the AUCs in the context of the grant. Although the AUCs had no collaborative relationships with the UIs, the former agreed that the latter could join the project.

The Application Drafting Committee was comprised of representatives of the CLIPP, the round table of AUCs, the UIs, the MSSS and the INESSS. These last two organizations agreed to act as financial partners for the project. The categories of the organizations that acted as project partners are shown in Table 1.

Table 1: Project partners

Organization name	Acronym	Mission
Affiliated University Centres with a social vocation	AUC	"To develop service excellence, develop knowledge, and aid clinical and management related decision-making, namely in the form of leading-edge practices, via research, education, knowledge transfer, innovation and evaluation" (Gouvernement du Québec, 2015; our translation).
Center for Liaison on Intervention and Prevention in the Psychosocial Area	CLIPP	"To make available the knowledge originating from research and practice communities in order to increase the use of knowledge, improve decision-making and practices, and foster social innovation initiatives aimed at improving the quality of life of individuals and communities" (CLIPP, 2016).
Institut national d'excellence en santé et en services sociaux (INESSS) [national institute for excellence in health and social services]	INESSS	"To promote clinical excellence and the efficient use of resources in the health and social services sector." (INESSS, 2016)
University Institutes with a social vocation	UI	Identical to AUCs but with additional responsibilities (Gouvernement du Québec, 2015)
Ministère de la Santé et des Services sociaux (MSSS) [ministry of health and social services]	MSSS	"To maintain, improve, and restore the health and well-being of Quebecers by providing access to a set of integrated and high-quality health services and social services, thereby contributing to the social and economic development of Québec" (MSSS, 2015).
Table des Centres de santé et services sociaux-Centres Affiliés Universitaires [Round table of health and social services centres-Affiliated University Centres]	Table des CSSS-CAU	To coordinate and showcase research activities and leading-edge and innovative practices originating from these institutions, and to promote partnerships between them.

The grant application was approved in October 2012. The CLIPP was required to sign a funding agreement prepared by the MDEIE. The project was undertaken in January 2013. It was expected to produce results within two years.

3. Project structure

3.1 Human resources

This section will introduce the CLIPP and describe the committees set up in order to carry out the project.

3.1.1 The CLIPP

The CLIPP assumed responsibility for carrying out the project. The CLIPP team was composed of individuals assigned the tasks and duties set out in Table 2.

Table 2: CLIPP team

Position at the CLIPP	Duties related to the project
President and CEO (2009-2014) Collaborator (2014-2015)	Project director
Assistant CEO	Write memorandums of understanding Follow up on the project budget
Director of Evaluation	Assist the Project Director by acting as project coordinator
Analysis and Evaluation Advisor	Design the tools produced in the context of the project Evaluate the implementation fidelity of the CoP
Four Project Directors	Provide guidance for one of the CoP

Position at the CLIPP	Duties related to the project
Information and Knowledge Management Department Head	Design the Wiki collaborative platform Act as the resource person for this platform
Marketing and Communications Director	Design the communications plan for the project
Marketing and Communications Advisor	Use the Wiki to write messages addressed to the public Oversee the website
Administrator	Handle accounting

The CLIPP disseminated two documents intended to help the project participants. The first (Berthelette, Briand-Lamarche, Dupuis, 2012) set out the logical model developed by the CLIPP in 2010, based on scientific publications on KM and the CLIPP's own experience in fostering the use of knowledge. The CLIPP has referred to this model for each of its KM projects. The second document (Boisvert, 2013) had to do with the running of CoP, and was designed based on a summary of scientific knowledge on the subject in particular on the works of Wenger, McDermott and Snyder (2002) and Langelier (2005).

3.1.2 The committees

The project was under the responsibility of a Steering Committee and a Coordination Committee. The Steering Committee was tasked with defining the strategic directions of the project and evaluating the feasibility of recommendations made by the Coordination Committee. The committee included a representative of each project's financial partner (AUC, UI, MSSS, INESSS). We designed and oversaw the adoption of a formal memorandum of understanding for these partners, who had to commit to MDEIE expectations regarding the project. The protocol was signed by each party.

The committee met nine times between November 13, 2012 and November 12, 2014. Minutes of these meetings were provided on the project Wiki.

The Coordination Committee was required to:

- Define project guideposts and coordinate project work and major steps.
- Define selection criteria for the practices addressed by the four pilot projects.
- Verify interest in implementing the practices in the health and social services network.
- Select the four projects and appraise the AUCs and UIs of the results of the selection.
- Stimulate, support and nurture the activities of the communities of practice established by the AUCs and UIs whose practices had been selected as pilot projects for knowledge mobilisation.
- As a content expert, each member could be called upon to respond to CoP requests.
- Based on available project resources, to decide on the nature of the support to offer CoP in response to their requests.
- Support facilitators in fulfilling their role.
- Develop a tool that would make these KM strategies known to the AUC and UI network.
- Choose indicators to be used in order to evaluate the scope and main anticipated outcomes of KM.
- Develop a tool to diagnose the ability of AUCs and UIs (the knowledge producers) to establish good knowledge mobilisation practices.

This committee was made up of representatives of the financial partners, but also of each AUC and UI with a social vocation, as well as the following associations and federations:

- The Quebec Association of Addiction Rehabilitation Centres (ACRDQ)
- The Quebec Association of Youth Centres (ACJQ)
- The Quebec Association of Health and Social Services Institutions (AQESSS)
- The Quebec Association of Intellectual Disability Rehabilitation Centres (FQCRDI)
- The Quebec Association of Physical Disability Rehabilitation Institutions (AERDPQ)

The mission of these organizations was essentially to gather together, represent and support their member organizations.

The Coordination Committee first met on February 19, 2013. This committee met seven times, with the last meeting dating to December 11, 2014. All meeting minutes were made available on the project Wiki.

3.2 Material resources

3.2.1 The collaborative platform

Given that our efforts were rooted in a collaborative approach, the project participants were required to interact, according to their technological proficiency and their availability. We were aware that they had very heavy workloads already and were spread out across different regions of Quebec. This is why we leveraged technological tools, embedded in a collaborative virtual platform, with the intent of optimizing the use of resources.

A collaborative platform is a virtual workspace that opens up access to many features that link together a given community in order to foster discussion and interaction (Fremont, 2011). We opted for a Wiki, on the advice of the Steering Committee members, given that this platform would be compatible with existing systems in the health and social services network. All the documents produced by the CLIPP, the committees and the CoP could be uploaded to the Wiki. Participant and project-related passwords were used to safeguard the confidentiality of information. Use of the collaborative platform addressed the following goals:

- Mapping out KM-related knowledge in order to be able to link together and mobilize such knowledge.
- Supporting the participants by continually monitoring the KM and CoP involved.
- Establishing a collaborative work method.
- Sharing expertise related to KM best practices and creating synergy between the participants.

3.2.2 The videoconference and Skype sessions

Given that the budget granted by the MDEIE did not provide for travel expenses, the committees and CoP used a MSSS videoconference system or Skype sessions to organize meetings that involved people from several Quebec regions. Use of this videoconference system is free for institutions belonging to the network, a fact that facilitated its use. This was certainly conducive to the participation of committee members and CoP members. This said, the system does have shortcomings, including frequent loss of connection. The greater the number of sites participating in the same meeting, the greater the chances of connection problems.

3.3 Financial resources

The project's total budget amounted to $380,554. The MDEIE supplied more than $280,000, while the INESSS and MSSS respectively contributed $24,000 and $75,000 Canadian. These sums do not include the time put in by the individuals involved in the project, except for the CoP coordinators.

4. Project completion

4.1 Call for and selection of the four pilot projects

The Project Director contacted the directors of the 11 AUCs and UIs with a social vocation in order to invite them to submit a leading-edge or innovative practice. Our letter informed them of the project's aim, process and completion, as well as the obligation for directors of the selected institutions to free up three individuals to devote 3 weekly hours of work, over a 19-month period, to participating in a community of practice. The project was intended to enable four of the institutions to create CoP. Moreover, the committees had agreed that the project should allow at least one AUC and one UI to be selected to create a CoP.

We designed a specific call and selection criteria for the practices. The committees agreed on the creation of a Peer Committee made up of a representative of each of the project's financial partners and of an external evaluator from the health and social services network, who would come from outside the AUCs and UIs, in order to avoid potential conflicts of interest. The evaluation involved two stages. First, the AUCs and UIs were asked

to submit a two-page letter of intent. Second, the AUCs and UIs whose practice had been selected subsequently had to submit a complete ten-page application. To ensure confidentiality, the letters and applications were submitted via the Wiki.

The Committee evaluated the letters of intent according to the five following criteria: 1) type of practice, with only leading-edge or innovative practices being accepted; 2) social relevance of the problem addressed by the practice; 3) precision and clarity of information on the practice's component parts; 4) scientific relevance; and 5) potential sustainability of the practice. The Committee also added the two following criteria to evaluate complete applications: feasibility of implementing the practice, and interest in the practice on the part of the health and social services network. To evaluate this last criterion, we asked the AUCs and UIs whose letters of intent had been selected to provide us with letters from institutions in the health and social services network indicating their interest in implementing the practice at hand.

We received seven letters of intent. The six selected projects were then required complete applications. The directors were notified of the results on July 2, 2013.

4.2 The communities of practice

Table 3 presents the selected practices, which came from two AUCs and two UIs located in three cities (Montreal, Quebec City and Sherbrooke).

Table 3: Selected practices

Cases	Name of the practice	Main goals of the practice
A	Parenthood and Addiction	Improve the medium-and long-term prognosis for 6-12 year old children affected by parental addiction
B	Collaborative Mental Healthcare for Youths in Multiethnic Contexts	Devise an interdisciplinary and interinstitutional approach that re-empowers clinicians and professionals working with young clienteles in the mental health sector
C	An organizational strategy to support team guidance in order to foster interprofessional cooperation	Equip and support clinicians from various professional backgrounds in making decisions and providing health services, in close partnership with patients and their family/friends
D	Neighbourhood intervention: the CSSS and its partners join their efforts in a disadvantaged area	Support practitioners' integration into inhabitants' living environment in order to identify their individual and community resources and thus help them resolve their difficulties

In accordance with the CLIPP's KM logical model, the mandate of the CoP was to define the knowledge to be shared regarding the leading-edge or innovative practice, as well as the context in which the practice could be implemented. This knowledge and the form in which it was to be disseminated had to be adapted to the institutions interested in implementing the practice. The Cop also had to determine whether the user communities would benefit from guidance and if so, in what form. Finally, the CoP was expected to help create the tools anticipated in the context of the project.

Each CoP was facilitated by a person appointed by the Executive Director of the AUC or UI responsible for developing the leading-edge or innovative practice. The facilitators helped convince the managers of the institutions interested in the practices to free their staff to participate in the CoP.

Each CoP was coordinated by a contractual half-time coordinator hired by his or her AUC or UI, thanks to the budget allocated for this resource person under the project. Each coordinator worked under the Scientific Director of the AUC or UI. The coordinator's roles were to directly support and facilitate the work of the CoP. This individual's duties were geared toward motivating members and mobilizing and uniting them around a common project in order to foster their commitment and mutual trust. The coordinator's duties were as follows:

- To inform members of the characteristics and functioning of a CoP.
- To lead meetings, take meeting minutes and coordinate the work of the CoP.
- To be attentive to member needs and communicate them to the Coordination Committee.
- To follow up on requests addressed to the Coordination Committee by their CoP.

- To implement the KM strategies developed by the CoP, and more specifically to interact with consultants and specialized resource persons from the institutions in order to adapt the form and content of the knowledge to be transferred regarding the leading-edge or innovative practices.

Each CoP coordinator was supported by a CLIPP project director, who was responsible for making sure the coordinator had access to all required resources. The project directors were required to present the coordinators with two documents disseminated by the CLIPP, as well as a memorandum of understanding between the CLIPP and the CoP. This protocol mainly presented the obligations set out by the MDEIE. According to this ministry, the CLIPP was responsible for enforcing these obligations, and we wished to increase the likelihood that they would be followed by all project partners. One of the clauses had to do with the intellectual property of the documents produced under the project. The ministry wished for these documents to belong to the CLIPP, which was rightfully very problematic for our partners. After some discussion on this subject in the committees, we agreed to add the following amendment to the memorandum:

- "The CLIPP undertakes to give all Project Partners, without territorial or temporal limitations, a non-exclusive and non-transferable license enabling them, for non-commercial purposes, to reproduce, communicate, and disseminate, whether by electronic or telecommunicational means, the reports, documents or other property produced over the course of the Project.
- The Parties shall mutually ensure that the name and logo of all Parties named in this agreement appear on all reports, documents or other property produced over the course of or resulting from the Project.
- The parties shall mutually ensure that no changes are made to the reports, documents or property produced over the course of or resulting from the Project without the prior agreement of the Steering Committee before the dissolution of said committee.
- This article shall remain in effect even in the event of the termination of this agreement."

To provide the CoP with the flexibility required in the context of their variable respective contexts, we accepted the amendments requested by the scientific management of the AUCs and UIs, to the extent that they did not contravene the MDEIE's requirements of the CLIPP. Once all the parties had reached agreement, i.e. four to six months after the submission of the memorandum, we drew up a summary of the amendments, which we distributed to all the CoP out of a concern for transparency. Discussions on the memorandums' content were lengthy and fraught with tension, in one case requiring a direct meeting between, on one hand, the General Project Director and a Steering Committee member, and on the other, the members of an AUC's management team. This said, these discussions provided an opportunity to clarify the responsibilities of all parties involved. After the memorandum was signed, relationships between the parties were cordial.

The composition and operations of these CoP varied, but in all cases, the participants focused on the sharing of scientific and tacit knowledge. As agreed, each CoP was made up of members of the AUC or UI that had developed the leading-edge or innovative practice, or who were involved in services provided in the context of this practice. Each CoP also included representatives of other institutions in the health and social services network (Table 4). This said, recruiting such representatives sometimes proved challenging, given that participation in a CoP did not generate direct, short-term services for the public. In light of this fact and budget constraints, some institutions were unable to free staff to participate in the project.

The institutions that took part in the project were from 19 different territories belonging to 8 different regions. They were mainly CSSS centers: 6 in cases B and D and 4 in case C. Three addiction rehabilitation centres participated in CoP A. The mission of these organizations was to offer specialized adaptation, rehabilitation, integration and social reintegration services to individuals with alcohol, drug, gambling and money abuse or addiction problems, as well as support services to provide individuals in these situations with encouragement (Gouvernement du Québec, 2015). The practice addressed by this CoP was central to this mission. In case C, a health and social services agency and an inter-regional consortium joined the CoP. The mission of the agency was to oversee and maximize the performance of its regions' health and social services system. The consortium, made up of the Institut national de santé publique, a university, and the health and social services management for three Quebec regions, was in charge of scientific knowledge sharing for frontline services in the context of institutions in more remote regions.

Table 4: CoP functioning and composition

Cases	Main goals	Knowledge components to transfer regarding the practice	Knowledge sharing and diffusion methods	Number of regions and territories (n;n)
A	To make the practice and the knowledge required for its implementation accessible throughout Quebec.	Relevance and costs of the targeted problem. Development history. Components. Scientific foundations. Clinical content. Conditions for implementation. Partnership.	WordPress	3 ; 3
B	To create a network of youth professionals from various CSSS and disciplines. To offer a space conducive to their interaction and mutual support.	Adaptive, defined according to the needs expressed by CoP members. Themes focused on practitioners' clinical realities.	Monthly lunch discussions by videoconference. Biannual half-days for face-to-face knowledge sharing and transfer. Web platform containing a member directory, discussion forums, written documents and audio. E-newsletter for members.	1 ; 6
C	To facilitate the practice's implementation and its continuation in eastern Quebec.	Factors that contribute to implementing and continuing the practice. Organizational strategy components in order to implement and continue the practice.	Questionnaire to support the organizational strategy. Descriptive document. Recommendation of measures for supporting and guiding implementation of the practice.	4 ; 4
D	To make the practice known. To improve managers' and practitioners' understanding of the practice. To foster recognition of the practice.	Understanding the territory and citizens' experiences. Intervening locally. Managing an intervention. Offering clinical support and developing the competencies of local practitioners.	Website containing strategies, illustrative examples, means of action, and anticipated benefits.	4 ; 6

The choice of knowledge sharing and diffusion methods took into account the context of the health and social services network, particularly the broad area it covers (1.7 million km^2)(Gouvernement du Québec, 2016) and the significant financial restrictions it faces, with the government elected in April 2014 striving to achieve budgetary balance. The knowledge diffusion methods generated by the CoP thus had to be accessible and inexpensive to implement, which was the case. This said, the network's structural and financial context at the end of the project threatened medium-and long-term accessibility to the generated knowledge, given that the participants did not know whether human and financial resources would be available to update documents and host websites.

The number of face-to-face, videoconference and Skype meetings varied significantly, from 6 to 12. In case A, it is worth noting that an initial face-to-face meeting was an asset to forging relationships between participants and clarifying their roles. Two of the CoP regularly used the Wiki. The other two preferred to create their own Wiki. A hyperlink to their Wiki was provided on our own Wiki, providing access to these communities' documents. Each of the CoP presented its work to the Steering Committee and Coordination Committee on two subsequent occasions, and at the end of the project, each produced a document describing their respective KM plans (http://trasss.ca/en/).

4.3 The KM tool

We grouped together the two tools that we developed in the context of this project into one single tool that should help organizations to 1) verify whether they have the competencies required to do so, and 2) develop their KM process.

Before developing this tool, we began by cataloging the available KM tools. Then, we analyzed these tools' content and selected various dimensions. Our goal was to develop a tool that would be relevant, exhaustive and user-friendly, and to avoid duplicating an existing tool.

Based on the concept of "competencies," our tool highlights knowledge, know-how and knowing-how-to-be (attitudes) in the area of KM (Durand, 2008). Once integrated, these skills determine an organization's ability (or inability) to engage in a KM process. Each of these elements must be evaluated taking into account the context of each organization. The elements are addressed in the form of questions to be answered by organizational managers and staff who are interested in facilitating other institutions' use of their practice. Examples drawn from the CoP are provided for illustration purposes.

The tool was submitted to the Steering Committee and Coordination Committee several times for feedback. Finally, in May 2015, the tool was incorporated into the website devoted to the project (http://trasss.ca/en/). This site, hosted by the CLIPP, is mainly intended to facilitate access to the knowledge generated in the context of the project. At the end of February 2016, the site had been visited 1,415 times.

5. In conclusion

Thirty-five institutions in the Quebec health and social services network took part in the project. The participants, i.e. more than 200 individuals, demonstrated that institutions with distinct missions and located in a number of different regions and territories of Quebec can work together to achieve a common goal. This was the first such project of its size in Quebec.

Our outcomes are consistent with Davies et al (2015) conclusion that "knowledge mobilisation could be enhanced by providing support to enable cross-sector and interagency learning". Most of the institutions did not have access to knowledge originating from AUC and UI research activities. Some of the participants even mentioned that they distrusted researchers at the outset of the project. At the end of the project, the members of the CoP mentioned that their participation had allowed them to demystify scientific research and to question their practices. Moreover, participants credited the project with promoting collaboration and reinforcing ties between the members of CoP (Kimvi, Berthelette, Dutil and Masse-Jolicoeur, 2015). In this context, an evaluative study should be conducted in order to explore how implementing CoP can influence knowledge use in such a network.

In the final year of the project, the government of Quebec announced its firm intention to carry out a wide-scale reform of the network. One of the reform's keystones would be to replace the 94 CSSS with 13 Centres intégrés de santé et de services sociaux (CISSS) and 9 Centres intégrés universitaires de santé et de services sociaux (CIUSSS). The impact of such institutional mergers on the continuation of CoP is unknown. Our hope is that our project will have paved the way for institutions to carry out KM activities that are adapted to the needs of end users.

Acknowledgements

The authors share the credit of their work with the TRASSS Group and the other participants to the project. Our work was partially supported by the Ministère du Développement économique, de l'Innovation et de l'Exportation, the Ministère de la Santé et des Services sociaux and the Institut national d'excellence en santé et en services sociaux.

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