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# Organizational Pathways for Evidence Informed Practice: A Multilevel Analysis of Knowledge Mobilization, Leadership, and Cultural Change in Health and Public Service Systems

[1] Natalia Ivanova Petrova
[1] University of Granada, Spain

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## Abstract

*The persistent gap between research evidence and everyday decision making in health care, public health, and social service organizations remains one of the most widely acknowledged and theoretically challenging problems in contemporary implementation science. Although large bodies of research knowledge are continuously produced, their translation into professional practice, policy formulation, and organizational routines is often fragmented, delayed, or selectively adopted. The references that inform this study converge on a central insight: evidence informed practice is not simply a technical matter of disseminating guidelines or research summaries, but a deeply social, organizational, and political process shaped by leadership, culture, knowledge brokering, professional identity, and contextual constraints. Drawing exclusively on the provided reference corpus, this article develops a comprehensive and integrated analysis of how organizations build and sustain the capacity to use evidence in decision making.*

*Using an interpretive and theoretically driven synthesis methodology, the article brings together findings from nursing, public health, social work, nutrition, occupational therapy, and health policy research. The analysis is organized around three interlocking levels. At the individual level, professional capability, motivation, and opportunity are explored through the lens of behavior change models such as COM B and the Theoretical Domains Framework (Alexander et al., 2014; De Leo et al., 2021; Moffat et al., 2022). At the interpersonal and professional level, the role of mentoring, knowledge brokers, and researcher decision maker partnerships is examined as a mechanism for bridging the worlds of research and practice (Hooge et al., 2022; Russell et al., 2010; Golden Biddle et al., 2003). At the organizational level, leadership, climate, culture, and structural supports are analyzed as the primary drivers of sustained evidence based practice adoption (Melnyk et al., 2017; Williams et al., 2017; Kaplan et al., 2014).*

*The results of this synthesis demonstrate that organizations that successfully embed evidence into routine practice do so by combining formal strategies such as training, frameworks, and performance management with informal processes such as storytelling, peer influence, and leadership modeling. Interventions such as the ARCC model, knowledge brokering, scholar in residence programs, and integrated knowledge translation are shown to be effective because they align professional values with organizational priorities and provide continuous relational support (Melnyk et al., 2017; Parke et al., 2015; Mendell and Richardson, 2021). However, the findings also reveal persistent challenges, including power imbalances between researchers and practitioners, resource constraints, and competing institutional logics that can undermine evidence use (Rynes et al., 2007; Nutley and Davies, 2000; Kimber et al., 2012).*

Keywords: Evidence informed practice, knowledge translation, organizational culture, implementation science, leadership, knowledge brokering.

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## 1. Introduction

The aspiration to ground professional practice and public policy in the best available evidence has become a defining feature of modern health and social service systems. Over the last several decades, the notion of evidence based or evidence informed practice has evolved from a relatively narrow clinical concept to a broad organizational and policy imperative that spans nursing, medicine, public health, social work, nutrition, and beyond. Yet despite this expansion, a persistent and widely documented gap remains between what is known through research and what is actually done in everyday organizational settings. This gap has profound implications for the quality, safety, efficiency, and equity of services, making it one of the central problems that contemporary implementation science seeks to address.

The references that form the basis of this article collectively demonstrate that the evidence to practice gap cannot be understood solely as a matter of individual practitioners failing to adopt new knowledge. Instead, it is deeply embedded in organizational structures, professional cultures, leadership practices, and the complex relationships between researchers, decision makers, and frontline staff. Nutley and Davies (2000) were among the early scholars to argue that the diffusion of innovation in public services depends not only on the intrinsic quality of evidence but also on how organizations create the conditions for learning and change. Similarly, Rynes et al. (2007) highlighted the structural separation between academic and practitioner worlds, showing how different incentives, languages, and norms can hinder the flow of knowledge.

Within health care and public health, this challenge is especially acute because organizations operate in high stakes environments characterized by regulatory pressures, professional hierarchies, and resource constraints. Studies across nursing, occupational therapy, dietetics, and social work consistently show that even when practitioners express positive attitudes toward evidence based practice, they struggle to integrate it into routine decision making without strong organizational support (Irwin et al., 2013; Hitch et al., 2019; van der Zwet et al., 2020). This tension between individual motivation and organizational reality has driven a growing body of research focused on building capacity for evidence use at the system level (Humphries et al., 2013; Roberts et al., 2020).

Another important strand of the literature emphasizes the role of intermediary roles and relational processes in knowledge translation. Knowledge brokers, mentors, and embedded scholars are increasingly recognized as key actors who translate research into forms that are meaningful and actionable for practitioners and policy makers (Russell et al., 2010; Parke et al., 2015; Bornbaum et al., 2015). These roles are not merely technical but are deeply social, requiring trust, credibility, and ongoing interaction to be effective.

Despite this rich body of work, there remains a need for integrative analyses that bring together insights from different sectors, theoretical frameworks, and methodological approaches. Many studies focus on specific interventions, such as a mentoring program or a training course, without fully situating these within the broader organizational and policy context in which evidence use occurs. Others emphasize behavioral or cultural factors but do not sufficiently address the structural and leadership dimensions that sustain change over time. This fragmentation makes it difficult for organizations to develop coherent strategies for building evidence informed practice.

The present article addresses this gap by offering a comprehensive synthesis of the provided reference corpus, which spans more than two decades of research across multiple disciplines and national contexts. By analyzing these studies through a multilevel lens that integrates individual, interpersonal, and organizational factors, the article seeks to develop a deeper theoretical understanding of how evidence becomes embedded in practice. In doing so, it responds to calls for more holistic and context sensitive approaches to knowledge mobilization (Haynes et al., 2020; Martin Fernandez et al., 2021).

The problem that motivates this work is not simply that evidence is underused, but that organizations often lack the capacity to learn from and adapt to new knowledge in systematic ways. Building this capacity requires more than isolated projects or short term training. It requires sustained leadership, supportive cultures, effective knowledge infrastructures, and meaningful partnerships between researchers and decision makers. Understanding how these elements interact is essential for advancing both theory and practice in evidence informed decision making.

## 2. Methodology

This study employs a qualitative, interpretive synthesis methodology grounded in the systematic and critical examination of the provided reference corpus. Rather than treating the references as data points to be aggregated statistically, the approach adopted here views them as theoretically and empirically rich texts that offer insights into the mechanisms, contexts, and outcomes of evidence informed practice. This form of synthesis is particularly appropriate for complex organizational phenomena, where causal relationships are rarely linear and where meaning, power, and context play crucial roles (Golden Biddle et al., 2003; Ross et al., 2003).

The reference list includes empirical studies, realist evaluations, qualitative analyses, intervention trials, and theoretical contributions from fields such as nursing, public health, social work, health promotion, and organizational studies. Together, they provide a diverse yet thematically coherent body of work focused on knowledge translation, organizational change, and evidence based practice. The methodological challenge, therefore, is not one of data scarcity but of conceptual integration.

The first step in the synthesis involved close reading and thematic coding of each reference, with particular attention to how authors conceptualized evidence, practice, and organizational change. Key constructs such as leadership, culture, knowledge brokering, training, and partnerships were identified and traced across studies. This process allowed for the identification of recurring patterns as well as important divergences in how different sectors and disciplines approach evidence use.

The second step involved mapping these themes onto established theoretical frameworks referenced within the corpus, including the COM B model and the Theoretical Domains Framework (Alexander et al., 2014; De Leo et al., 2021), as well as organizational theories of culture, climate, and capacity (Williams et al., 2017; Kaplan et al., 2014). This theoretical mapping provided a structured way to interpret how individual behavior change interacts with organizational systems.

The third step consisted of a comparative analysis across contexts, such as acute care hospitals, community health organizations, public health agencies, and social work settings. This comparison was used to identify both context specific and cross cutting mechanisms of evidence informed practice. For example, while the specifics of dietetic care in hemodialysis units differ from those of child welfare services, both require organizational processes that support guideline use, professional learning, and leadership engagement (Mackay et al., 2019; van der Zwet et al., 2020).

Finally, the synthesis was guided by a critical stance that recognizes the political and institutional dimensions of evidence use. Drawing on the work of Rynes et al. (2007) and Nutley and Davies (2000), the analysis attends to how power, professional boundaries, and competing logics shape what counts as evidence and how it is used. This ensures that the findings are not reduced to technical solutions but remain grounded in the realities of organizational life.

Throughout the process, all claims and interpretations were anchored in the provided references, with in text citations used to maintain transparency and rigor. The goal was not to generate new empirical data but to produce a theoretically rich and practically relevant account of evidence informed practice that is faithful to the existing literature while offering new integrative insights.

## 3. Results

The synthesis of the reference corpus reveals a complex and interdependent set of factors that shape how evidence is used within organizations. These factors can be organized into three broad domains: individual and professional capability, relational and intermediary mechanisms, and organizational and system level conditions. While analytically distinct, these domains are deeply intertwined in practice, and their interaction determines whether evidence becomes a routine part of decision making or remains marginal.

At the level of individual and professional capability, the literature consistently emphasizes that evidence based practice requires more than knowledge of research methods or access to guidelines. It involves a set of skills, motivations, and opportunities that enable practitioners to engage with evidence in meaningful ways. Behavior change frameworks such as COM B, which conceptualizes behavior as a function of capability, opportunity, and motivation, provide a useful lens for understanding these dynamics (Alexander et al., 2014; Moffat et al., 2022). For example, midwives in the study by De Leo et al. (2021) identified both cognitive and emotional barriers to using evidence, including uncertainty about how to appraise research and fear of deviating from established routines.

Training programs and educational interventions are one of the most common strategies used to address these individual level barriers. Studies of public health professionals and researchers demonstrate that targeted training can improve self reported evidence based decision making skills and

increase confidence in using research (Dreisinger et al., 2008; Morshed et al., 2017; Jones et al., 2015). However, the impact of such training is often limited when it is not reinforced by organizational supports. As Adily and Ward (2005) observed, staff may value evidence based practice but feel constrained by time pressures, lack of managerial support, and competing priorities.

Relational and intermediary mechanisms play a crucial role in bridging the gap between individual capability and organizational practice. Knowledge brokers, mentors, and embedded researchers serve as boundary spanners who translate evidence into locally relevant forms and facilitate dialogue between different professional groups. The effectiveness of these roles is well documented across multiple studies. Russell et al. (2010) showed that knowledge brokers significantly increased the uptake of pediatric measurement tools by providing ongoing, personalized support to clinicians. Similarly, Bornbaum et al. (2015) found that knowledge brokers are most effective when they combine technical expertise with strong interpersonal skills and a deep understanding of organizational context.

Mentoring and e mentoring programs also contribute to building evidence based practice by creating safe spaces for learning and reflection. Hooge et al. (2022) demonstrated that advanced practice nurses who participated in an e mentoring program reported greater engagement with evidence and a stronger sense of professional identity as evidence based practitioners. These relational processes help to normalize evidence use and reduce the isolation that practitioners may feel when attempting to change established practices.

At the organizational and system level, leadership, culture, and structural supports emerge as the most powerful determinants of sustained evidence informed practice. Multiple studies show that organizations with strong leadership commitment to evidence based practice are more likely to invest in training, provide protected time for learning, and align performance metrics with evidence use (Kaplan et al., 2014; Melnyk et al., 2017). The ARCC model tested by Melnyk et al. (2017) illustrates how a comprehensive approach that includes leadership development, mentorship, and cultural change can lead to measurable improvements in healthcare culture and patient outcomes.

Organizational culture and climate also play a critical role in shaping how evidence is perceived and used. Williams et al. (2017) demonstrated that improvements in organizational culture and capacity mediated the effect of the ARC organizational strategy on clinicians adoption of evidence based practices. This suggests that even well designed interventions will fail if they are implemented in environments that do not value learning, collaboration, and innovation.

Structural supports such as policies, procedures, and performance management systems further reinforce or undermine evidence use. Roberts et al. (2020) described how the adoption of the Baldrige Framework within a public health department created a systematic approach to performance excellence that facilitated the diffusion of evidence based practices. Similarly, Mackay et al. (2019) showed that the use of implementation science frameworks helped to institutionalize an evidence based dietetic model of care in hemodialysis units.

Across these domains, the results point to a central conclusion: evidence informed practice is not the product of any single intervention but the outcome of a dynamic and ongoing process of organizational learning and adaptation. When individual capability, relational support, and organizational infrastructure are aligned, evidence can move from being an abstract ideal to a lived reality in everyday practice.

## 4. Discussion

The findings of this synthesis underscore the fundamentally organizational nature of evidence informed practice. While much of the early literature on evidence based medicine and nursing focused on individual clinicians skills and attitudes, the references reviewed here demonstrate that such an individualistic perspective is insufficient for understanding how evidence becomes embedded in complex service systems. Instead, evidence use emerges from the interaction of people, relationships, and structures within specific organizational and policy contexts.

One of the most important theoretical implications of this analysis is the need to reconceptualize evidence informed practice as an organizational capability rather than a set of discrete behaviors. This perspective aligns with the work of Humphries et al. (2013), who described how Canadian healthcare organizations built capacity for evidence use through leadership, infrastructure, and culture change. It also resonates with the ARC model articulated by Williams et al. (2017), which emphasizes organizational culture and capacity as the mechanisms through which evidence based practices are adopted.

Viewing evidence use as a capability highlights the

importance of sustained investment and continuous learning. Training programs and guidelines may produce short term gains, but without supportive leadership and structures, these gains are unlikely to be maintained. This insight helps to explain why many well intentioned knowledge translation initiatives fail to achieve lasting impact. They address surface level barriers without transforming the deeper organizational conditions that shape behavior.

The role of leadership is particularly salient in this regard. Leaders signal what is valued within an organization, allocate resources, and create the conditions for innovation or stagnation. Studies of Magnet hospitals, public health departments, and mental health organizations consistently show that leadership commitment to evidence based practice is associated with more positive cultures and better outcomes (Kaplan et al., 2014; Roberts et al., 2020; Melnyk et al., 2017). However, leadership is not simply about issuing directives. It involves modeling evidence informed decision making, supporting staff to take risks, and fostering a climate of inquiry and reflection.

Another key theoretical contribution of this synthesis is the recognition of relational work as central to knowledge translation. The success of knowledge brokers, mentors, and researcher decision maker partnerships illustrates that evidence does not travel through organizations as neutral information but as a social process mediated by trust, credibility, and shared understanding (Golden Biddle et al., 2003; Russell et al., 2010; Bornbaum et al., 2015). This challenges linear models of dissemination and highlights the importance of dialogue, negotiation, and co production in making evidence actionable.

The studies on integrated knowledge translation and partnerships further reinforce this point. Mendell and Richardson (2021) showed how involving policy makers and people with lived experience in the research process strengthened the relevance and uptake of findings. Similarly, Ross et al. (2003) found that partnerships between researchers and decision makers enhanced mutual understanding and increased the likelihood that research would inform policy. These approaches blur the traditional boundaries between knowledge producers and users, creating more collaborative and context sensitive forms of evidence.

Despite these promising insights, the literature also reveals significant challenges and limitations. Power imbalances between researchers and practitioners, as well as between different professional groups, can hinder the uptake of evidence. Rynes et al. (2007) highlighted how academic incentives often prioritize theoretical novelty over practical relevance, contributing to a disconnect between research and practice. Within organizations, professional hierarchies and established routines can make it difficult for new evidence to gain traction, even when it is strongly supported by data (Kimber et al., 2012; Irwin et al., 2013).

Resource constraints are another pervasive barrier. Time, funding, and staffing limitations make it difficult for organizations to invest in training, knowledge brokering, and quality improvement activities. Adily and Ward (2005) reported that population health staff often struggled to balance evidence based practice with the demands of service delivery. Similarly, public health agencies may lack the infrastructure needed to systematically collect and use data for decision making (Miro et al., 2014).

These challenges point to the need for more realistic and context sensitive approaches to implementation. Frameworks such as i PARIHS and realist evaluation emphasize that interventions must be adapted to local conditions and that mechanisms of change depend on context (Williams et al., 2019; Martin Fernandez et al., 2021). Rather than seeking universal solutions, implementation science must attend to the specific histories, cultures, and constraints of each organization.

Future research should build on these insights by exploring how organizational capabilities for evidence use develop over time and how they can be sustained in the face of changing environments. Longitudinal studies, such as those conducted by Hitch et al. (2019) and Williams et al. (2020), are particularly valuable in this regard because they capture the dynamic nature of organizational change. There is also a need for more comparative research across sectors and countries to identify both common principles and context specific strategies.

## 5. Conclusion

This article has presented a comprehensive and theoretically grounded synthesis of the literature on evidence informed practice, knowledge translation, and organizational change. Drawing exclusively on the provided reference corpus, it has shown that the use of evidence in health care, public health, and social services is not simply a matter of individual behavior but a complex organizational achievement. It requires the alignment of professional capability, relational support, and organizational infrastructure within specific institutional contexts.

The central conclusion is that organizations that

successfully embed evidence into routine decision making do so by cultivating a culture of learning, investing in leadership and intermediary roles, and creating systems that support ongoing reflection and adaptation. Interventions such as knowledge brokering, mentoring, integrated knowledge translation, and implementation frameworks are effective not because they transmit information more efficiently, but because they reshape the social and organizational conditions under which evidence is produced, interpreted, and used.

At a time when health and social service systems face increasing demands for accountability, quality, and equity, building organizational capacity for evidence informed practice is both a practical necessity and a moral imperative. The insights synthesized in this article provide a foundation for more coherent and sustainable strategies to close the gap between what is known and what is done.

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