**2019 Online KT Conference:**

**Innovative KT Strategies That Work**

*Knowledge Translation Collaboratives: A Novel Model for Building Capacity in Graduate Students and Consumers*

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>> DONNA MITRANI: Our second presentation is given by Dr. Susan Magasi, Shoma Webster and Linda Cassady. Dr. Magasi is professor from Disability Studies at the University of Illinois at Chicago. Her research team called the Program for Healthcare Justice for People with Disabilities is committed to identifying and eliminating barriers to healthcare access, quality and outcomes for People with Disabilities. She uses a community‑engaged participatory approach by partnering with People with Disabilities in all phases of research process from conceptualization through Knowledge Translation.

Ms. Webster is an occupational therapist and student at the University of Illinois Chicago. She's working on a culturally relevant curriculum design to further address the mental health needs of Chicago's diverse population.

Ms. Cassidy is a Chicago‑based entrepreneur, artist, graphic designer and she participated in the Knowledge Translation Collaborative as a community partner sharing her professional expertise and knowledge as a cancer survivor and a woman with a spinal cord injury.

Their presentation today is Knowledge Translation Collaboratives: A Novel Curriculum Model for Building Capacity in Graduate Students and Consumers. As a reminder, if you have questions during the presentation, ask them in the chat box and we'll address them as we can using questions from the chat box. I'll moderate a Q and A following the presentation. With that, Dr. Magasi, are you ready to begin?

>> SUSAN MAGASI: We're ready.

Thank you for that nice introduction. We're really happy to be here.

We're going to be quite a change of pace from that last fantastic presentation. We're excited to share our work about training models we have a used to train members of the disability community and graduate students in the principles and doing of Knowledge Translation. We'll share a curriculum overview, and then we'll try to exemplify how it works using a single‑case example.

To lay the foundation for the work, I teach the Foundation Research Method Class here at UIC to our occupational therapy students. We really try to emphasize the importance of evidence‑based practice. I realized that even teaching students those ‑‑ to be critical consumers of research, even how to conduct extensive literature reviews and synthesis, it does not in and of itself adequate lit prepare them to implement these changes at clinical, a systems level, although they're in the midst of this course now so don't share that information with them.

We recognized that it is increasingly important that evidence‑based practice is really based on effective Knowledge Translation. Indeed, Knowledge Translation has been described as an essential capacity for 21st Century practice in all healthcare disciplines.

We think it is important that KT be recognized as this shared responsibility, especially between clinical and research communities, but also the importance of investigation patient and consumers be a part of that KT process.

Unfortunately, Knowledge Translation, it is not routinely taught as part of graduate education in health and medicine. Students, and then ultimately practitioners are left to their own devices to figure this out or come to this knowledge on their own. To address this gap, we developed a graduate elective called Knowledge Translation for Disability and Rehabilitation Research. At the heart of that we use a model that we call KT collaboratives that seeks to mirror real world practices although admittedly in a compressed timeframe, a petri dish of the 15 ‑week-long semester.

That brings us to the goals of today's presentation. We'll describe the KT collaborative approach and throughout we'll talk about some of the strengths and challenges of using this model to try to do real world Knowledge Translation or at least elements of it. Then we'll share the case studies to show you how we have integrated existing KT frameworks and tried to put some of these elements in practice both in terminal KT but also integrated KT approaches.

I'm sure this model is familiar to many people on the group. The graduate elective that we do tries to draw on a couple of theoretical frameworks for Knowledge Translation. The first one that we use, it is the knowledge to action framework to help structure both the curriculum and many of our weeks in the syllabus mirrors steps in this action cycle. It also provides students in the class with a framework to apply directly to their own work as students in their cores work, in project and thesis work that they're doing and also if they're asked to implement new innovations and practices in their field work.

I'm sure that many of you are familiar with the KTI model, but in a nutshell is consists of two parts, in the center, we have the knowledge creation funnel, and then around the perimeter is the action cycle. Most graduate research classes focus on the top of that knowledge funnel. We expect students to come in the class to have that research foundation to be able to understand how research is done and conducted and evaluated for rigger. In the KT class, what we focus on, it is the bottom of the funnel, creating knowledge process products and then understanding and applying elements around the action cycle.

Even as we engage in understanding and applying the KT, I think we're always reminded of this quote from Masuda and colleagues that challenges us to acknowledge issues of power and competing interests as we go about preparing to engage in KT work.

So, we use Masuda and colleague’s equity focused Knowledge Translation framework throughout the course to start talking about and acknowledging power and power dynamics in Knowledge Translation. As all of you are, I'm sure well aware, talking about power, it is never easy. What this framework does, by using a combination of critical inquiry and reflective practices it provides us with a safe proactive but also slightly provocative forum to engage in this work and frank decision discussions about power. It is particularly challenging I find for students who are just beginning to learn this knowledge, and maybe have varying degrees of experience in the clinic about how power plays out. We have all members complete this framework and then we go back to it repeatedly, especially as the semester evolve and the work becomes more challenging in some of these competing interests start to emerge.

At the core of this graduate elective are what we call Knowledge Translation collaboratives. What these are is that we bring together members of the disability community with graduate students as co-learners and co-creators of knowledge products to promote healthcare products to People with Disabilities. It is important to recognize that the knowledge collaborative model is a little bit different than having members of the disability come in as periodic consultants or just to share their experience in a one and done kind of way. We have the members of the disability come in for the entire 15 weeks of the semester and it is integral, as team members.

This integration, we feel is critical. Then what we do, we actually immerse in an active area of research or program development, in addition to learning to the science behind Knowledge Translation, we're also emerging in an active area of research. When we select the members of the disability community to come in and partner, people that have a strong vested interest in this area, either as people that experienced the phenomena being studied or having a strong advocacy interest in that area. We also use elements of experiential, learn by doing and transformative learning. The teams then work together to create these knowledge products and think through very carefully how the knowledge product can be implemented to support a larger KT initiative.

We have done this by being able to leverage partial funding through a variety of grant mechanisms, some internal to our institution, but also with funding from the National Cancer Institutes.

Just like Knowledge Translation initiatives requires the bringing together of diverse stakeholders, so is this class. The KT collaboratives learn from and with a community of experts. This is included over the years, our local centers for independent living, policy experts, members of the clinical community as well as a professional film maker who has really helped us develop some novel knowledge products over the years.

Shoma will talk us through the next slides with some of the knowledge products we have created.

>> SHOMA WEBSTER: These are knowledge products that KT collaboratives have created over the years. The diversity of products, it is the different stakeholders, they have different preferences for how they use and consume information. We learn the importance of tailoring the message to each stakeholder. It is not only important to convey the information to stakeholders, but to also reinforce the action that needs to be taken. This is demonstrated with the use of policy briefs, which is a sense of available evidence to make recommendations for policymakers. Methods of visually displaying information and content, so students are able to design infographics based on the evidence and members of the disability community to create a product to educate consumers ‑‑ later on, Linda will talk more about her role in the development of infographics.

Educational videos where knowledge products were based on a collaborative process between the graduate student, members of the disability community and professional film maker. The results were a product that's both evidence, informed, emotionally evocative and also a way to drive that call to action piece. The film maker really challenged us to think about how we can use the power of film to get our message across.

Lastly, students and disability partners were able to culminate their efforts at the end of the year into posters to present at an academic Conference. So a photo on the bottom right hand corner, it was actually taken at a cancer research symposium early earlier this year where we informed Conference attendees of the work we were doing to increase the awareness of disparities that exist in higher education for Persons with Disabilities and our role in using the knowledge to okays a framework to adjust the issues that we encountered.

Here are my refractions. I'll let you take a moment to look at it briefly.

The knowledge products that we created in class were a great way to drive home the concepts that we learned, and there were quality products we could use in the immediate future. After completing the Knowledge Translation class that was taught by Dr. Magasi, I was able to apply what I had learned about the Knowledge Translation process and the knowledge to action goal to facilitate a similar process in my own research. As a result of working on the film in a more directive role, I acquired knowledge on a filming process and terminology, but also I learned about some of the ways that students with disabilities may encounter situations in higher education, and I ultimately hope that the film would be a starting ground to not only highlight the Fellowship we'll talk about later, but also have it be a conversation starter for discussing these issues. Behind the scenes, it was clear how much a project like this meant to the end users.

>> SUSAN MAGASI: Thank you, Shoma.

Linda, you participated with us as one of our consumer participants. I was wondering if you could share how your expertise as a disabled woman and a cancer survivor added to the class the year that we were focusing on cancer screening disparities for Women with Disabilities.

>> LINDA CASSADY: I was relatively extemporaneously going through the process of screening and then cancer treatment, whatnot, when the class was going on. One of the things that I never ‑‑ I live in an urban area, I have access to a large hospital where my primary dare happens, it is the experience of just the literal accessibility to mammograms, which is what we were kind of focusing on in terms of, that I didn't realize until participating in the class just how much other members of the community, the disabled community have screening issues in terms of whether they can actually get into a facility that does the screening to working with techs that know how to work with you in the machine. There are things that you wouldn't think about until you're confronted with the situation of how do you get a mammogram seated? How to go through treatment seated? It is all ‑‑ I'm not answering the question properly.

Direct me, please, Susan, on how you would like me to add more to that.

>> SUSAN MAGASI: A thing I valued about your participation in the class, your ability to be a good reality checker for us, to make sure that the students who many of whom didn't have lived experiences of disability or going through cancer treatment, to provide some guidance and ways that we could strengthen our products. I was wondering if you had any thoughts on how you felt you were able to guide that process as well? It.

>> LINDA CASSADY: As I said, about the learning, being involving, being involved with the conversations, people that are not in urban center, such as we're located in Chicago, many didn't have a local facility that allows for people that are in wheelchairs to get mammograms in the first place. That was ‑‑ I hadn't even thought about that. That was interesting for me, because I come from a small town to think of, well, I wonder how people in that community would go through what I went through when I was lucky enough to just be able to as a consumer with a little bit of direction with the techs at Northwestern, to go where you have to guide them in terms of how to treat you. The that's not an easy thing to figure out how to communicate. Everyone is kind of at new ground. With the discussions that we had in class, for instance, I found those valuable in terms of what I could add from the hey, this is what happened to me in terms of talking to a tech and how do you position yourself or guide someone to help you position yourself if that's what needs to happen when people in the class spoke up about various locations where maybe we have an embarrassment of riches in terms of facilities. It is ‑‑ one of the things that I learned, and hopefully contributed to was just how many ways there are to have the dialogue with various players and then the benefits to approaching it X way versus Y way. I learned from you guys as well as being able to say, like, hey, when I dealt with this person this way, I felt, you know, like ‑‑ I feel like one of the other disability participants had issues when she experienced stuff that I hadn't in terms of where she felt a little disempowered I think by the process versus where I have always ‑‑ I have been involved in exams, stuff like that, I felt like a member of the team versus being talked to or at.

>> SUSAN MAGASI: Those experiences were really important when making decisions especially for the video about tone and wanting to make sure that we established a collaborative tone with our target audience versus an adversarial tone. We actually spent several weeks of discussion about how do we sort of temper our outrage of what we were finding with some of the disabling barriers and attitudinal barriers in our focus group, data check, then wanting to make sure that we ‑‑ our video was well received by the people in whom we were trying to advocate for change.

>> LINDA CASSADY: Exactly. You want to make sure it is a fine line to walk in terms of you want to empower the patient to ask questions and advocate for themselves, but then any added discussion where often you feel that you can't because it is a power play when you're in the medical community.

I apologize, my dog is barking.

You kind of are there like a pupil teaching dynamics. That's not appropriate when it is your own health. You feel like you're being told what to do in a way that's not respectful. I don't know. Versus the we want to make sure when talking to the caregivers and the providers that hey, there's benefit to making changes to how you deal with people.

There is going to be good outcomes across the board for everybody involved. You're getting a better exam than what people are actually going to tell you, various things they deal with, whether it is pain or finding a lump or whatever the case may be. You feel comfortable speaking to the provider and then the provider feels like there is benefit and reward to them putting the effort forth to communicate in a way that allows for that kind of thing to happen.

>> SUSAN MAGASI: When I first invited you to participate in the class, I knew about your disability experience, a little bit about your cancer experience, what I didn't know was your professional background as a graphic designer and a set stylist. I was wondering if you could say a little bit about how you think these strengths or skills of yours emerged over time and contributed to student learning.

>> LINDA CASSADY: When one area, the video, the set building, the set design background, it helped just in terms of approach, more of a technical kind of situation. I think I was useful there as a hey, how about this, or we don't want to see that.

Where I found I made possibly even more value of a difference or contribution, it was when I was working with the students on the infographics, and ‑‑ they were seen a couple of slides ago on the upper right happened corner ‑‑ it was great to kind of get them to think outside the box in terms of ‑‑ and learn ‑‑ we were all learning stats and things together based on information that they had called, but it was fun for me to see them expand their horizons in terms of hey, how can we really demonstrate this in a way that's visually engaging, in then ‑‑ versus just bullet points, we're trying to ‑‑ so it engages the viewer to read more. They really got into it once they felt allowed to get a little creative in terms of what I think one of my charts, we had a pie chart that we had, it was glued to the loudspeaker, things like that, they got a kick of how to take the data, that collaboration, it was fun, how to turn the data into something that's visually engaging as well as really valuable and interesting information from the directive standpoint.

>> SUSAN MAGASI: I think again, only if we had had Linda come in as a collaborator, the disability/cancer expert students would have had a different level of engagement. I think what this model of KT collaboratives allow the teams to do, it is really to work together, to see people from their full range of scopes and abilities and potential contributions. It is not all roses and sunshine. Some of what they learn is that tension it is emerge and that these competing interests do come into play, but it is in this safe environment to allow those issues to play out.

Thank you, Linda. What we'll do now is shift over to a case study from last semester's KT collaborative, and how the work they do figuring out in a larger initiative, in which we were trying to create a cancer research Fellowship for undergraduate students with disabilities and that's called the CanResearch Fellowship.

So, we use this model again to guide the class and the work. Our first issue came up when we identified a problem or really an opportunity. My it collaborator David Chum, who used to be at the national cancer I wanted institute, he's now here, he recognized there is pipeline programs for underrepresented students and they exist in three categories, racially and ethnic minorities, people that experience disadvantages, like low socioeconomic status and category three, it was disability, People with Disabilities. He noticed that very few programs, if any, were applying for the category C, people with disability opportunity. We found that was a unique opportunity to create a program, but also introduced many implement takings barriers, not the least of which are inertia, if it is such a great idea, why hasn't it been done before? We had to overcome that.

We started out with a team of two. We had this lone visionary in the cancer center that didn't know a lot about disability and the disability experience and he partnered with me as an academic researcher who understands and is passionate about capacity building within disability that maybe didn't have the connections and infrastructure to create a Fellowship within the cancer center.

So what we did, we saw an opportunity to use this existing framework of the KT collaborative to help us build that infrastructure and bring in stakeholders who could help support and launch this Fellowship, and this is the group of the KT collaborative from last year's class.

We started with our KT collaborative and we recognized that there was a diverse group of stakeholders that we needed to bring in the fold to make sure that the project or the program could launch. We needed funders; we did this with private funding initially. We needed to get buy in from administration, and then we also wanted to make sure that we had a strong set of mentors and guides who could really support development amongst our Fellows.

Our goal was to bring them altogether.

What we did, it was we expanded from having identified this problem and opportunity to go back to the existing literature to try to understand what really are best practices in evidence‑informed evidence pipelines that mentor different under‑represented students, how can we make sure that we're meeting unique needs of students with disabilities? So why aren't students with disabilities participating as cancer researchers for example? Then also, how can we use this to support future funding? So Shoma will guide you to the work that they did as the KT collaborative to support this work.

>> SHOMA WEBSTER: Thank you, Susan. In the knowledge synthesis case, the collaborative conducted a rapid review of literature to identify key challenges to participate in research for students with disabilities. What we found, that there were negative attitudes towards disabilities in higher education there was a lack of knowledge about disability and the potential accommodations that could be provided to the students. In addition, there was limited access to disability related supports and accommodations, and a lack of role models of disabilities in research and low expectations of students with disabilities and we found that those students are limited exposure to the core prerequisite classes. What's next? The collaborative then used this information to create knowledge product.

Here you see the infographic that was created. You see that there is information that 11 to 15% of students in higher education identify as having a disability. Sure, there are federal laws that support inclusion for People with Disabilities in education such as the Higher Education Opportunities Act, Americans with Disability Act and 504 of the Disability Act, however, we found that students with disabilities were still underrepresented in the science technology, engineering and mathematics or STEM fields, including cancer research. Pipeline programs are crucial to increase the diversity and reduce to the scarcity shown in higher education. They help to increase academic success and reduces barriers. These are just some of the reasons why the Fellowship was created and the Fellowship, it also became the first pipeline program for students with disabilities.

This is the second knowledge product that the collaborative created. We wanted to capture the raw emotions and challenges in the realities that some people with disabilities experience in higher education, and why we need pipeline programs like the Fellowship. Sit back, relax, enjoy the short film.

(VIDEO PLAYING)

>> Come in, please.

>> I just saw this flyer about cancer research Fellowship, and I was thinking of applying.

>> I know you're a good student, this is cancer research. Come to me next week and find something that fits better for you.

Don't listen to that advisor. We all know you have what it takes.

>> I know. Nobody ever gives me a chance to prove it.

>> You should still apply to the Fellowship.

>> There are candidates equally qualified for the Fellowship. I looked at their resumes. I like this one. We never had a student with disabilities in this lab before.

>> We do have a Disability Resource Center on campus.

>> That's a good point. I never had thought about that.

Okay. I think I made my decision.

>> Look at this. I think I'm on to something..

>> Oh, wow. That looks promising! We should write it up. I think we may even get published.

[Applause].

>> Can I talk to you for a second? I just wanted to be candid with you, I was a little skeptical at first bringing you into the lab. You have made some very solid contributions, very important contributions to the team. I would be more than happy to write you a letter of recommendation for grad school.

>> Thank you so much.

>> You're welcome. What are you working on over here?

>> Well, this is it a sample....

>> Good job! Congratulations, Alexa! Awesome job!

>> Congratulations, Alexa! What's next!

>> I'm going to grad school to continue my cancer research training!

>> I knew you could do it!

>> I knew I could do the work, somebody just needed to give me the opportunity.

>> Yes. Yes.

>> The University of Illinois at Chicago's Cancer Research Fellowship is the first pipeline program to support students with disabilities. By bringing together top cancer and disability researchers and educators the University of Illinois Cancer Center is uniquely positioned to make this program a reality. We need your support as mentors, partners, and future employers. Together, by focusing on abilities and not limitations, we can create a pathway to careers in cancer research and healthcare for students with disabilities.

>> SHOMA WEBSTER: We hope you enjoyed that short film. It was a blast to work on that project earlier this year.

After the film was completed, the CanResearch developers, they then used the videos to support the fundraising efforts and to get buy‑in from potential mentors and diverse stakeholders within the cancer center and the University.

Now Dr. Magasi will discuss about how we adapted the knowledge into the local context.

>> SUSAN MAGASI: Shoma, nice job. Yeah. As the KT collaborative was working to develop the video, we were working in parallel to further create and refine the Fellowship itself based on some of the work that the KT collaborative did.

What we did, we took that information that we learned about best practices in pipeline programs, mentoring programs, as well as the unique needs of the students of disabilities to create the core values and principles of the Fellowship. We organized it around the colors of immersive exposure to biomedical and social science cancer research, we recognized the importance of career development for undergraduate students so this included leadership training, further explanation and also tailored content about how to negotiate issues of access, accessibility, accommodations, within both a University context as a student, but then also thinking long‑term of what would that be to be a career scientist. Mentoring, role modeling from both high‑level cancer researchers, but also People with Disabilities who are doing this, if we're doing research, doing health, healthcare delivery.

We also were able to create field experiences that put the students and Fellows in the room with people like the leadership team at Walgreens. We had a group of medical directors from a pharma company that sat down with our Fellows for lunch. This is just opportunities that these undergrads with disabilities who had experienced a lot of barriers that Shoma talked about, but never felt like they would ever have a seat at that table.

Those were some ways that we were able to build a curriculum that acknowledged best practices.

We still had barriers to implementation and we worked on identifying those and tackling them. We identified these barriers both through the literature, but also as we were working to develop the Fellowship and to get buy in from stakeholders, different types of implementation barriers presented themselves. The next slide shows some of the strait gees that we used to identify some of the barriers.

We recognized all of the barriers that students with disabilities faced, but we also experienced some roadblocks from administration, particularly on the skepticism of the value of such a program and had whether there was actually kind of a target audience of quality qualified students. We implemented a few strategies, including building this interdisciplinary team of collaborators on campus who would participate in creating and supporting the program. Not just the education and the research team, but also experts in the disability resource center who could inform on providing accommodation. We created a training for mentors to address fears and concerns that they may have about working with students with disabilities and their labs. Were you we handpicked the mentors that served as champions for the program within the cancer center but also within their own labs.

We tried to do our own funding, which neutralized some of the concerns addressed by administration that we were placing the financial burden on the cancer center, and then we also just engaged in continual feedback with mentors, with students to foster this sense of community and buying and make them feel like they were part of something interesting and important.

So, this is a picture at the bottom of some of our Fellows meeting with cancer survivors and researchers.

Once we were able to raise the money and recruit the mentors for the program, it took a long time in delayed advertising and recruitment, despite only having a two‑week recruitment period that overlapped with finals here at the University, we were able to receive competitive applications from 13 qualified students who we screened for eligibility and appropriateness, we interviewed nine of them, and ultimately welcomed four into the program, all of whom completed the 6‑week Fellowship.

Throughout the Fellowship itself, we made sure accessibility and accommodation needs were met, we received and used qualitative feedback from both the Fellows and the mentors to strengthen, to program and to make sure it was well tailored to the needs and expectations of the Fellows and the mentors and made those real time adjustments. We continued the disability training throughout to ensure access.

We evaluated both the process of implementing the Fellowship in the doing of the Fellowship, and also are in the process of documenting both short and long‑term outcomes for this cohort of students.

This is the phase we're in now. After Dr. Moore's wonderful presentation, we can be even more strategic in the sustainability plan. The goals now are how to figure out how to sustain and scale up the intervention.

Last slide, just in conclusion, what we hope you walk away from this presentation with is a recognition of the value of a KT collaborative approach to teaching and learning about Knowledge Translation, the way that KT collaborative model can be implemented in synergy with both terminal KT and ongoing integrated initiatives, both students and consumers bring valuable energy and creativity in the process and planning and implementing this kind of thing, it has to be done with intentionality and a strong attention to group dynamics.

That's part all of our slides. We'll put it on mute and turn it over to Donna to facilitate the discussion.

>> DONNA MITRANI: Thank you so much. That was fantastic. It was great.

At this time I would like to invite all of you to turn on your webcams and the reactors, Rosmin, Mary Goldberg and Meg Ann Traci.

I will remind folks we're taking questions in the chat box. You still have time to ask questions, please put them there, we'll make sure we're able to answer them during this time.

Our first question actually comes from Mary Goldberg, this is for either Susan or Shoma.

Mary Goldberg raised the issue of how best to recruit consumer participants. I was wondering if either of you could talk a bit more about that.

>> SUSAN MAGASI: I'm having trouble turning on the camera. My microphone is working. This is Susan. The way we have recruited the consumer participants is through our fairly extensive network of community collaborators here in the disability community in Chicago. All of my research, as Donna mentioned at the very beginning is done using communitybased participatory approaches. Members of the disability community are partners throughout the process, so that gives us a fairly large network to recruit from. We do word of mouth and other approaches to find the right people to bring into the class. It is a big commitment.

One of the things we have noticed over the years, this is a little different from your question, but a lot of our strong advocates in the disability community are used to coming in and doing the one dips ability lecture where they participate as sort of the expert on disability experience and what this process, it challenges the consumers to also engage a little bit differently as collaborators and engage in some of the give and take and negotiating out some of those tensions that come from bringing together people who are honestly in the course with a shared commitment to justice often, but maybe some are coming because they're passionate about advocacy, some students are coming at it because they want a good grade, they want to get certain learning, so that's also some of the challenges of figuring out the right people who can participate and commit at that level.

>> DONNA MITRANI: The next question, I'll turn it over to Meg Traci. In what way have you integrated consumers in the KT process.

>> MEG ANN TRACI: Thank you for the opportunity. A lot of this presentation resonated with work that we were charged with years ago with the Right To Know Campaign that was developed using participatory approach with partners and Dr. Thury from the Center of Disease Control and Prevention. We were funded to implement this campaign to increase awareness among women with physical disabilities of the importance of early detection screening for breast cancer. We were positioned through previous activities that we conduct with our centers for independent living and with People First, an advocacy group of chapters across Montana and other communities across the country, other disability providers to start with this is the intervention and really see what adaptations would need to be made locally before we implemented it.

Really looking at the context in which we would be delivering it. We were able to do some pretty multilevel things with direction from our consumer base, along with disability centers in the state so that we could clearly message that every one of them had ‑‑ we had to make sure that consumers knew to ask and we had to increase awareness of the centers that it was an asset they had to promote when scheduling screening appointments and diagnostic follow-ups and we were also able to collect some of the initial data like we heard about, what are the major barriers that are real and being experienced so that ‑‑ I think from our position, that tension, being able to acknowledge it was very important. I think people involved in cancer did not want to believe they were overlooking this population. Initially some of the feedback we got was that these screenings are not for everybody, people who are very old, for example, would not necessarily want to participate in mammography screening anymore, women over 90, we had very real data and stories from local consumers at our centers for independent living and in our People First chapters to say, well, that's not who we're talking about. So, we had a variety of focused groups or listening sessions across the state where we collected those stories.

We did an electronic survey for those that couldn't participate on site and those opportunities. We organized those into a report and shared that with our partners. Then we looked, we organized planned pink student communities statewide and got input from consumers on what they thought about the campaign materials from Atlanta and even though they saw some of our national leaders reflected in the campaign materials, including Judy Rogers, June Cales they still wanted to see themselves. We created a multimedia exhibit with 12 women with visible disabilities across the state that had all had breast health concerns and we created a very similar materials, where they were telling their stories locally and we rolled those out with our materials from CDC and so we had a lot of buy in from our consumers throughout the adoption of that campaign locally and I think that that led to the partnerships that have been sustained within our cancer coalition in the healthcare providers that actively participate in that coalition.

I should add that having a disability advisor in the Steering Committee for the coalition, it is a major policy change that happened as a part of this process and is important to the sustainability. That's one example that comes to mind and resonates here.

I would say within the disability section which I Chair, a student just let me know she was interested in leadership opportunities and I began conversations with her about what that would look like, and she said she would like them entering a program within the section, so we had the opportunity to recruit Dr. McKie, Michael McKie, to be our mentoring Chair to the Executive Committee and to work with this student Meredith Williams to develop a mentoring program which we're really lucky to be working with the National Disability Mentoring Coalition to shape and we're launching it this year, on Sunday.

I think that creating intentionally student co-Chair positions in that Committee allows us to be innovative and making sure that we're talking with students about ‑‑ and students with disabilities, about what's needed in the section and within the public health workforce, it is really important in responding and helping to build the collaborations of cross‑sectors who are working on the disability challenges, barriers, creating opportunities.

>> DONNA MITRANI: Thank you. That's exciting that you'll launch this weekend. I hope it goes well. Congratulations. This next question actually comes from Rosmin, a reactor, the question is for any of the presenters, and so the question is this: Great application to the KT model, I may have missed this, did you incorporate the consolidated framework for implementation research or theoretical domain framework to identify and assess barriers and facilitators?

>> SUSAN MAGASI: Not specifically. No.

>> DONNA MITRANI: This question is from Mary Goldberg, could your researcher partners pay the insurance stay pends as a way to sustain the program?

>> SUSAN MAGASI: That's our goal. Financially, that's the NCI model for the pipeline programs, so that it is not just a six‑weeklong immersion, but there are actually wraparound mentoring services. We know it is often not enough to get excited and immersed in research for six weeks, but true career development and the true fostering of that, that pipeline, it requires a greater sustained investment in these Fellows our cap stone event for the Fellows was dolphin tank, it is a kinder, Ghent letter version of the shark tank where the students kind of pitched to themselves as the product. Here are the knowledge, skills and strengths that I gained through this Fellowship, here are my long‑term career goals, and then how could they use the opportunity to have this sort of cohort of mentors and leaders be a sounding board and network for them to sort of make the quote, unquote big ask and help them to move on to whatever the next step was. Whether it is being a research assistant, paid position with one of the actual mentors, in some cases the mentors fostered introduction to other people within their extended networks who better aligned with the Fellows' interests.

>> DONNA MITRANI: This next question, Mary Goldberg, the question is this: The equity‑focused KT includes recognizing ones exclusionary practices. How have you engaged in critical self‑inquiry in the context of your work, and what are some challenges and benefits of this reflect reflective practice?

>> MARY GOLDBERG: Boy. This is a heavy question. I'm a faculty member from the University of Pittsburgh. Our performance review process encourages this type of reflective practice. Certainly in my teaching, but also our programming, and I think it comes back to the connections that we make with our students on the teaching side and our advisees to guide us on how we can be better leaders, and on the research side, if you're not in touch with your stakeholders, from the beginning, even at the concept stage, there's real danger to barriers to ultimate adoption or implementation of your work. The nature of our positions requires us to do this relatively frequently. Can you rephrase or remind me the second part of the question?

>> DONNA MITRANI: Of course. The second part, it was about what are challenges and benefits of this process? Like you said, it is pretty heavy.

>> MARY GOLDBERG: The challenges is that we all have unconscious biases, perhaps towards working with a particular group, and so understanding what we might be reworking by asking ourselves the tough questions, it is a process that I should engage in a lot more than just annually. Benefits to that, I think, certainly, expanding the reach for whom your work can benefit and also I think the likelihood of obtaining additional grants and additional funding to yourself and to make sure that your work is not biased in that way and can help in that process. It is a hard question. Thank you for asking.

>> DONNA MITRANI: No problem. With that, I want to thank, again, all of our presenters ands and everyone for participating in the discussion. Thank you so much.