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Reflection Article

Publishing Is Not Implementing: Reflections on Internal Scientific Communication and a Culture of Learning in Health Organizations

Publicar Não é Implementar: Reflexões sobre Comunicação Científica Interna e Cultura de Aprendizagem em Organizações de Saúde

Publicar No Es Implementar: Reflexiones sobre la Comunicación Científica Interna y la Cultura de Aprendizaje en Organizaciones de Salud

Abstract

Objective: Reflect on the reasons why technical and scientific output in healthcare organizations does not always translate into consistent learning and use, and propose guidelines for structuring an internal scientific communication ecosystem geared toward institutional culture. **Method:** A theoretical-conceptual reflective paper grounded in the literature on knowledge translation, diffusion of innovations, learning health systems, and plain-language scientific communication. **Results:** It is argued that "publishing" is not equivalent to "disseminating" or "implementing" and that, without curation, translation, and governance, evidence tends to become fragmented or reduced to a "showcase." A pragmatic four-pillar model is proposed: (1) integrity and evidence; (2) applicability; (3) language and format; (4) governance and metrics, along with operational strategies (micro-content, an integrated channel journey, spaces for exchange and feedback) and indicators that prioritize understanding and use rather than reach alone. **Conclusion:** Treating internal scientific communication as a learning infrastructure can reduce the gap between knowledge and practice, strengthen trust, and accelerate continuous improvement cycles in clinical and administrative routines.

Descriptors: Implementation Science; Information Dissemination; Health Communication; Plain Language Summaries; Organizational Culture.

Resumo

Objetivo: Refletir sobre as razões pelas quais a produção técnico-científica em organizações de saúde nem sempre se transforma em aprendizagem e uso consistentes, e propor diretrizes para estruturar um ecossistema de comunicação científica interna orientado à cultura institucional. **Método:** Artigo de reflexão teórico-conceitual, fundamentado em literatura sobre *knowledge translation* (Tradução do Conhecimento), difusão de inovações, sistemas de saúde de aprendizagem e comunicação científica em linguagem simples. **Resultados:** Argumenta-se que "publicar" não equivale a "difundir" nem a "implementar" e que, sem curadoria, tradução e governança, a evidência tende a fragmentar-se ou tornar-se "vitrine". Propõe-se um modelo pragmático em quatro pilares: (1) integridade e evidência; (2) aplicabilidade; (3) linguagem e formato; (4) governança e métricas, além de estratégias operacionais (microconteúdos, jornada integrada de canais, espaços de troca e feedback) e indicadores que privilegiem compreensão e uso, e não apenas alcance. **Conclusão:** Tratar a comunicação científica interna como infraestrutura de aprendizagem pode reduzir o hiato entre conhecimento e prática, fortalecer confiança e acelerar ciclos de melhoria contínua nas rotinas assistenciais e administrativas.

Descritores: Ciência da Implementação; Disseminação de Informação; Comunicação em Saúde; Resumos em Linguagem Simples; Cultura Organizacional.

Resumen

Objetivos: Reflexionar sobre las razones por las que la producción técnico-científica en las organizaciones sanitarias no siempre se traduce en un aprendizaje y un uso consistentes, y proponer directrices para estructurar un ecosistema de comunicación científica interna orientado a la cultura institucional. **Método:** Artículo de reflexión teórico-conceptual, fundamentado en la literatura sobre traducción del conocimiento, difusión de innovaciones, sistemas de salud de aprendizaje y comunicación científica en lenguaje claro. **Resultados:** Se argumenta que "publicar" no equivale a "difundir" ni a "implementar" y que, sin curaduría, traducción y gobernanza, la evidencia tiende a fragmentarse o a convertirse en una "vitrina". Se propone un modelo pragmático de cuatro pilares: (1) integridad y evidencia; (2) aplicabilidad; (3) lenguaje y formato; (4) gobernanza y métricas, además de estrategias operativas (microcontenidos, recorrido integrado de canales, espacios de intercambio y retroalimentación) e indicadores que prioricen la comprensión y el uso, y no solo el alcance. **Conclusión:** Tratar la comunicación científica interna como una infraestructura de aprendizaje puede reducir la brecha entre conocimiento y práctica, fortalecer la confianza y acelerar ciclos de mejora continua en las rutinas asistenciales y administrativas.

Descriptoros: Ciencia de la Implementación; Difusión de la Información; Comunicación en Salud; Resúmenes en Lenguaje Claro; Cultura Organizacional.

INTRODUCTION

In health organizations, the production of technical and scientific knowledge tends to grow as applied research programs, events, internal repositories, and institutional journals become more established. However, the existence of products (articles, reports, posters, abstracts) does not in itself guarantee that this knowledge will be understood, circulated, and used consistently in everyday work. This mismatch between producing evidence and transforming it into practice and learning is widely recognized in the *knowledge translation* (KT) literature, which describes the implementation of knowledge as an active process with specific stages, barriers, and strategies, rather than as an automatic consequence of publication⁽¹⁾.

In health services, the complexity of the system, multiple teams, competing priorities, care pressure, and standardized routines amplify this challenge. Classic reviews on the diffusion and sustainability of innovations in health organizations show that the adoption of changes depends on factors such as organizational context, leadership, characteristics of innovation, social networks, communication channels, and absorption capacity, and not only on the quality of available knowledge⁽²⁾.

From this perspective, internal communication is a structural variable: when there is no curation and translation of knowledge, evidence becomes fragmented, remains restricted to specific groups, and loses its power to guide decisions and improve processes

The gap between evidence and use is also addressed by intermediation and *sensemaking* initiatives (the human process of creating meaning), which seek to connect knowledge producers and users. Studies on *knowledge brokering* describe this role as facilitating translation, contextualization, and rapprochement between research and decision-making, especially in environments where time, language, and priorities hinder the direct use of scientific literature⁽³⁾.

Complementarily, communities of practice (CoPs) have been proposed as spaces for social learning and continuous exchange, capable of supporting mentoring, dissemination, and incorporation of good practices in the health sector; systematic reviews indicate that CoPs are used as a strategy to improve knowledge absorption and professional learning, although their effectiveness depends on design, objectives, and organizational support⁽⁴⁾.

This discussion converges with the concept of *the learning health system*, which emphasizes the institutional capacity to learn continuously from data, evidence, and improvement cycles. In this logic, producing knowledge is necessary but insufficient; mechanisms must be structured to make evidence accessible and actionable, reducing the time between discovery, communication, and application. A scientific agenda for learning health systems highlights the importance of socio-technical and organizational infrastructure to sustain learning cycles⁽⁵⁾.

Similarly, reference documents from National Academies highlight continuous improvement as an essential component of a learning health system, reinforcing the need for institutional routines and capabilities to transform information into action⁽⁶⁾.

Despite this, many organizations treat internal scientific communication as a byproduct (or as mere dissemination), rather than as an important part of transforming intellectual production into culture. In practical terms, this confusion creates two risks: research becomes a collection with low internal social use, and communication becomes marketing of results, without methodological integrity and without utility for routine practice.

This reflective article starts from the premise that publishing is not synonymous with disseminating, and disseminating is not equivalent to effectively transferring knowledge. It argues that building institutional scientific culture requires an internal communication ecosystem that combines epistemological responsibility (clarity about what is known and its limits) with organizational pragmatism (formats and channels that reach different audiences and result in learning).

Based on the literature on KT and organizational learning in health, it is argued that sustainable internal scientific communication can be organized into four pillars: Integrity and evidence (what was done, how it was done, and what limitations there were), aligned with the understanding of KT as a structured process⁽¹⁾; Applicability; Language and format (translation into micro-content and clear narratives, supported by networks such as CoPs⁽⁴⁾); and Governance and metrics (roles, routines, and indicators of learning, not just reach), compatible with organizational determinants of innovation adoption and sustainability⁽²⁾.

Therefore, the objective of this communication is to reflect on the reasons why technical and scientific production in healthcare organizations does not always translate into consistent learning and use and, ultimately, to propose a set of practical guidelines for structuring this ecosystem, aiming to transform scientific production into institutional learning, engagement, and continuous improvement.

METHOD

Design and Procedures

This is a theoretical-conceptual reflection article, developed from a critical reading and integrative synthesis of key literature on KT, diffusion of innovations, *learning health systems*, implementation science, and scientific communication in plain language.

The selection of sources was guided by their relevance to the problem discussed -the gap between technical-scientific production, dissemination, and consistent use of evidence-prioritizing models, *frameworks*, and studies applied to the organizational context. The analysis consisted of identifying convergent concepts, tensions, and practical implications, culminating in the proposal of a pragmatic four-pillar model and operational strategies to structure an internal scientific communication ecosystem aligned with institutional culture.

Limitations and Scope of Reflection

This manuscript is a theoretical-conceptual reflection article, oriented toward problematization and the proposal of practical recommendations for internal scientific communication and organizational learning in health institutions. Thus, it does not intend to estimate effects, test causality hypotheses, compare interventions, or produce empirical inferences typical of experimental, quasi-experimental, or observational designs.

The argumentative construction is based on key literature and an interpretive synthesis of the concepts and *frameworks* mobilized throughout the text. For this reason, the work is subject to reference selection bias and interpretative emphases resulting from the adopted approach; consequently, it is not a systematic review, does not follow a formal search and eligibility protocol, and does not perform a standardized critical methodological evaluation of the included studies.

The proposed guidelines should be understood as a pragmatic model to support institutional decisions, with the potential to guide routines, governance, and the design of communication channels. However, their applicability may require adaptation to the context, considering differences in organizational size, maturity of scientific culture, availability of digital and informational infrastructure, editorial curation capacity, as well as local governance and decision-making arrangements.

Recommendations on channels and formats (e.g., institutional TV, intranet, and email) depend on operational capacity and can be implemented incrementally, with successive adjustments based on indicators of understanding, use, and incorporation into care and administrative processes.

RESULTS AND DISCUSSION

Why Doesn't "Publishing" Become Culture?

The literature on KT describes that moving evidence into use involves stages and mechanisms (such as synthesis, adaptation to context, implementation, evaluation, and sustainability) and also points to frequent conceptual confusion when organizations treat publication, dissemination, and implementation as if they were the same thing^(1,7).

When the institution sees publication as the end of the cycle, it tends to underinvest in what comes next -translation to diverse audiences, incorporation into routines, and continuous learning- which are central components for knowledge to become shared practice and, therefore, institutional culture⁽¹⁾.

Even when the organization has knowledge management policies, flows, committees, and documents, this does not ensure that such devices are appropriate in the daily lives of teams. In healthcare contexts, there is a recurring risk of formalization without use: structures exist, but they do not translate into decision-making, standardization, learning, and sustained change, especially when they compete with healthcare pressures, competing priorities, and limited time availability. In this scenario, the gap is not only in evidence production, but also in operational translation: making explicit how knowledge enters into actual work, who carries the content into routines, and what conditions allow for adoption and continuity^(2,5,9).

This disconnect between the formal and the everyday is consistent with the literature on the diffusion of innovations in healthcare organizations, which points to the influence of factors such as values, climate of innovation, leadership, system readiness, communication flows, presence of local researchers, and compatibility with care routines⁽²⁾. Thus, even robust evidence may not be perceived as relevant if it seems distant from the reality of work, competes with care priorities, or if there are no internal channels that support understanding, alignment, and continuity⁽²⁾.

Even when there is an effort to disseminate information, the process can fail due to lack of time, poor alignment among actors, absence of defined responsibility, and fragility of the channels that deliver information in a useful way⁽⁸⁾.

A recent study on health networks suggests that the dissemination of decisions and lessons learned does not occur in a linear fashion: it is a cyclical process, with back-and-forth movements and feedback, and it is multilevel, as it depends on coordination between the network, its representatives, and the teams within each organization. Therefore, it is susceptible to failures at different stages and requires active coordination so that information reaches operational units consistently⁽⁸⁾.

Two strategies frequently appear in the literature to reduce the gap between knowledge production and use. The first is *knowledge brokering*, in which individuals or functions connect producers and users, translate and contextualize evidence, and support exchange and local capacity building, with support described in a systematic review⁽³⁾. The second is communities of practice (CoPs), understood as spaces for social learning that favor continuous exchange, mentoring, and incorporation of practices. A systematic review describes their use in the health sector and highlights that their effects depend on design and organizational support⁽⁴⁾.

Without these bridges (roles) and arenas (rituals), production tends to be restricted to specialized groups, reducing collective appropriation and weakening the construction of an internal scientific culture⁽³⁻⁴⁾.

Publishing is necessary, but not sufficient. Institutional scientific culture is strengthened when the organization creates routines and infrastructure for continuous learning, connected to evidence, responsible internal communication, and improvement cycles -a logic aligned with the concept of a *learning health system*^(5,9). In addition, dissemination must be handled with integrity (avoiding showcase communication), with clear boundaries and responsibility in the way results are communicated to different audiences⁽¹⁰⁾.

Table 1 - Problems and solutions in the translation of knowledge into institutional practice, São Paulo, Brazil, 2025.

Recurring challenge	Typical consequence	Pragmatic internal communication strategy
Scientific content is already in article format	Low readership and low uptake	Create microformats : "1 minute," "1 slide," "FAQ (Frequently Asked Questions)," and "what changes in practice"
Technical language without translation into everyday language	Resistance / "this is not useful to me"	Required field: Applicability (decision, process, target audience, and when to use)
Communication becomes a showcase (results only)	Loss of trust	Template with integrity : 3-line method + limitations + next steps
Disconnected channels (TV, email, intranet without integration)	Repetition or gaps	Single journey: teaser (TV) → detail (intranet) → discussion (meeting/CoP)
Lack of spaces for exchange or low participation from departments	Knowledge does not become shared practice	Monthly rapid rounds/community of practice by theme/line
Evidence is not connected to institutional priorities	Perception of "extra" work	Explicit link to safety, quality, indicators, flow (why it matters now) [2]
Lack of return for those who produce	Disengagement and drop in submissions	Structured feedback: "what was used," "where it had an impact," "what is the next question" [5]

Source: Prepared by the author

Four Pillars of Internal Scientific Communication

The KT literature describes that bringing evidence into use is an active process, with distinct stages, actors, and mechanisms, and warns of the recurring confusion when publishing, disseminating, and implementing are treated as synonyms^(1,7).

In healthcare organizations, this distinction is even more relevant because knowledge adoption is sensitive to context, culture, networks, and leadership; therefore, even good results may have little practical effect when they are not translated, prioritized, and incorporated into routines.

In addition, recent studies in healthcare networks reinforce that dissemination is often cyclical and multilevel, subject to breakdowns at different stages, requiring coordination so that decisions and learning circulate consistently to the operational level⁽⁸⁾.

Given this scenario, we propose a pragmatic model of internal scientific communication based on four pillars (integrity and evidence, applicability, language and format, and governance and metrics) guided by principles of KT, implementation science, and continuous learning. The central idea is simple: institutional scientific culture is not sustained solely by production, but by a communication ecosystem that makes evidence understandable, actionable, and traceable over time, in cycles of improvement. This logic is compatible with the vision of a *learning health system*, which emphasizes infrastructure and routines for continuous learning and putting knowledge back into practice^(5,9).

Pillar 1 (integrity and evidence) is based on the principle that internal scientific communication cannot be reduced to the dissemination of results: it must preserve context and fidelity to the method. In diverse audiences, credibility is sustained when what has been done, what has been found, and what the limits are explained objectively, avoiding simplifications that transform nuances into certainties and conclusions into slogans. The literature on communication materials (such as lay summaries and infographics) indicates that dissemination tends to be more effective when there is planning, clarity, and adaptation to the audience, and when the production of the material is conceived as part of the project itself, rather than as an appendix at the end of the process⁽¹¹⁾.

At the same time, there are relevant warnings about the risk of *spin* (distortion or embellishment in the interpretation and presentation of results) in research infographics, which reinforces the need for internal validation and editorial responsibility to prevent content from taking on a tone of institutional persuasion rather than evidence-based communication⁽¹²⁾.

Furthermore, without minimum criteria for curation and transparency, internal communication can introduce biases that affect trust and the use of knowledge, such as selection bias (prioritizing only positive results or successful cases), confirmation bias (writing messages to reinforce decisions already made, reducing room for uncertainty), undue generalization (extrapolating local findings to the entire institution without delimiting contextual conditions), authority bias (taking "it was published/presented" as sufficient justification without discussing applicability), and channel/metric bias (confusing reach, views, or clicks with understanding and incorporation). These biases amplify the risk of distortion and can generate noise, overconfidence, or skepticism, reducing the likelihood of consistent use of knowledge in everyday life⁽²⁰⁻²³⁾.

To mitigate these risks, a lean set of editorial and technical practices is recommended, such as adopting a mandatory checklist for each piece, instituting rapid technical validation by internal peers before publishing on broad channels, making explicit to whom it applies and when it does not apply, and defining editorial responsibility with minimum traceability of the decision. With these mechanisms, the pillar ceases to be just a principle and begins to operate as institutional protection against distortions, preserving the integrity and practical usefulness of internal scientific communication.

Pillar 2 (applicability) addresses the main point of rupture between research and culture: the lack of a clear "so what?" for the actual work. Even when teams recognize the value of evidence, its use is weakened if there is no explicit connection to

decisions, processes, priorities, and routines. In practical terms, each piece of internal communication needs to be made explicit: who is the target audience, which decision/process can be improved, and what is the expected gain (quality, safety, efficiency, standardization, learning).

Van der Ven's study (2025)⁽⁸⁾, by mapping dissemination in networks, exemplifies this point by showing that the circulation of content depends on the actions of representatives and internal transfer until adoption; without this bridge to the operational level, knowledge tends to remain at the level of governance or specialized groups.

Pillar 3 (language and format) is based on an operational observation: if the message is not consumable in everyday language and time, it does not become collective learning. Practical guidelines on communicating research in plain language reinforce that readability, text organization, and visual adequacy are crucial for comprehension and use^(11,13).

And there is empirical evidence that plain language summaries can still be difficult when they retain jargon and low readability, suggesting that simplicity must be verified (e.g., through readability tools and reader tests) and not assumed⁽¹⁴⁻¹⁵⁾.

Thus, the pillar recommends a strategy of multimodal micro-content (1 slide, FAQ, short text for TV/intranet, simple infographic), with consistent key messages and links to full materials when necessary. The function is to reduce cognitive cost and increase comprehension rates without losing integrity.

Pillar 4 (governance and metrics) recognizes that internal scientific communication cannot be sustained by individual effort; it needs roles, routines, and indicators to avoid becoming intermittent. The science of implementation treats strategies as methods for increasing adoption and sustainability, and the ERIC (*Expert Recommendations for Implementing Change*) project has organized a vocabulary of terms and definitions for implementation strategies, offering a standardized repertoire that makes it easier to specify actions, assign responsibilities, and select combinations appropriate to the context⁽¹⁶⁾.

A typical risk is fragmentation into functional silos: research produces, communication disseminates, education trains, management priorities, and assistance executes, but without an arrangement that coordinates the complete cycle of knowledge, from production to incorporation into decisions and routines. When this cross-cutting coordination does not exist (or is diffuse), content circulates intermittently, loses context as it crosses areas, and tends to stop at governance or specialized groups, rather than reaching the operational level with clarity of applicability and follow-up.

In this vein, minimum governance includes: editorial curation (agenda, calendar, standardization), technical validation (content and limits), channel operation (TV/intranet/newsletter), and *feedback* mechanisms to fuel improvement cycles. Instead of vanity metrics (views only), it is suggested to combine reach indicators with comprehension indicators (most accessed FAQ; short quiz) and usage indicators (requests for material; incorporation into meetings/routines), which is consistent with the continuous learning logic described for *learning health systems*^(5,9).

In summary, the model proposes that publishing should become part of the culture when the organization invests in a communication ecosystem that communicates with integrity, connects evidence to decisions, translates into accessible formats, and supports the practice with governance and metrics focused on learning and use.

CONCLUSION

This reflection article argued that publishing is not synonymous with disseminating, and that disseminating, in itself, does not guarantee use. The literature on KT already points out that the shift from knowledge to action is a process with its own stages and mechanisms, often confused with the simple production or dissemination of content.

In healthcare organizations, this gap is intensified because adoption and sustainability depend on context, leadership, networks, and compatibility with routines; thus, even relevant evidence may not translate into shared practice without the organizational conditions to support it.

In this sense, the central argument was that internal scientific communication should be treated as a learning infrastructure, aligned with the logic of *learning health systems*, in which knowledge, practice, and *feedback* are connected in continuous cycles of improvement.

The proposed model, integrity and evidence; applicability; language and format; governance and metrics, is not intended to be a universal prescription, but rather a pragmatic framework for reducing two common deviations: research as a collection (it exists, but circulates little) and communication as a showcase (it circulates, but loses rigor and trust). The contribution of this reflection is to shift the institutional question from "how to disseminate more?" to "how to ensure understanding, use, and sustainability of what is produced?"

As a practical implication, it is suggested that the success of this ecosystem be evaluated with metrics consistent with organizational change, distinguishing implementation results (acceptability, adoption, adequacy, fidelity, sustainability) from simple reach indicators.

The adoption of recognized structures can help balance reach and maintenance, preventing "visibility" from being confused with effect.

As a reflective article, this text does not claim empirical generalization. Its value lies in proposing an interpretive framework and a set of operational guidelines for institutions that wish to transform scientific production into institutional culture.

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Transparency in authors' contributions according to the [CRediT Taxonomy](#).

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