

# Translating Health Research (& Evaluation) into Policy & Practice

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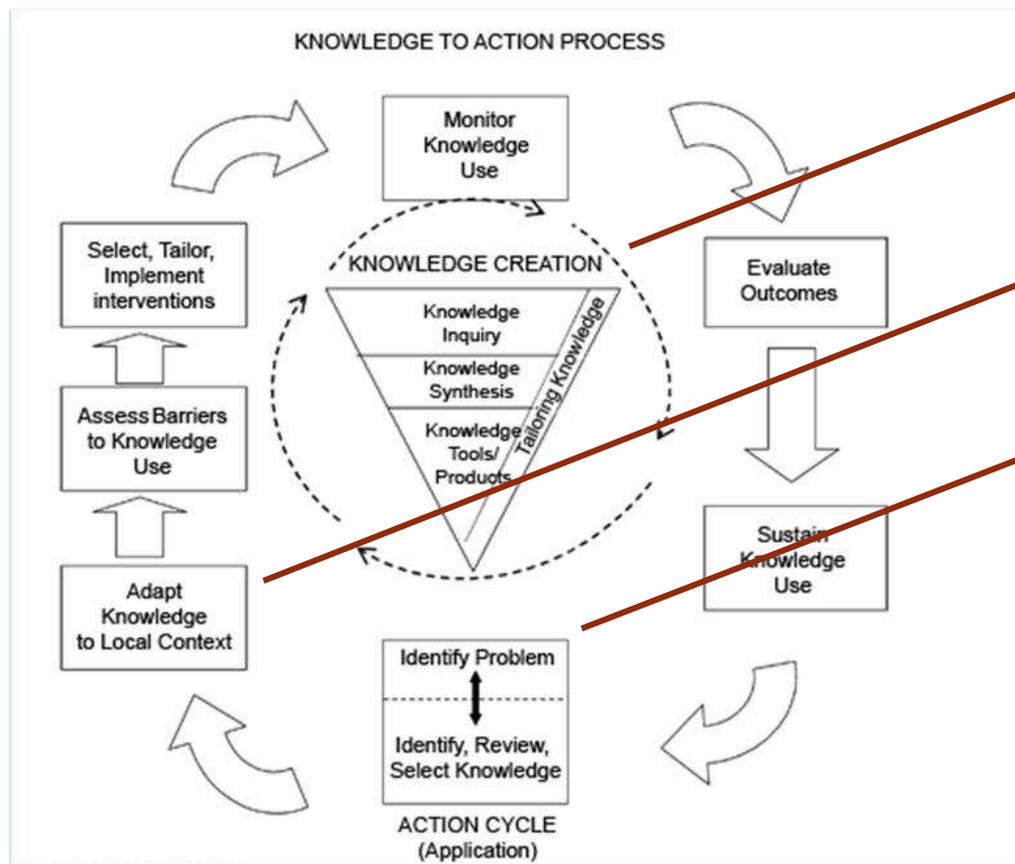
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# By way of introduction: An early application of K-to-A cycle



...**KC**: From 12 years with the profession

...**Adapt knowledge to local context**: Short explanation of possible interventions + cost impacts for MD Medicaid

...**Problem ID**: From sitting on a joint medicine/pharmacy advisory body with Maryland state advisors

*Document written into legislative budget language without further consultation*



# Contributions of Research & Evaluation to Health Policy & Practice

The **challenge** for knowledge producers is to package one's findings for easy policy consumption & manage the (sometimes) frequent turnover of people within policy positions\*

Two things ***increase the influence of research*** or evaluation on policy:

1. Ensure your subject matter is compelling
2. Build productive relationships

\*Dwan KM et al. Austr Hlth Rev 2013 v37 p194-98



## Dancing with strangers: understanding the parallel universes of researchers & public sector policy makers\*

<b>Key drivers, assumptions &amp; expectations</b>	<b>Policy makers</b>	<b>Researchers</b>
<i>Core aim &amp; motivation</i>	Solving policy problems	Building knowledge
<i>Primary responsibility</i>	Ministers/Snr Mgt	Funding agencies
<i>Time frame for results</i>	Short-medium term	Medium-long term
<i>Assumptions about impact</i>	Pragmatism is more NB than rigour	Rigour is more NB than pragmatism
<i>Most valued communications approach</i>	1-2 pg policy briefs	Peer-reviewed articles

\*John Wiseman, University of Melbourne, 2010

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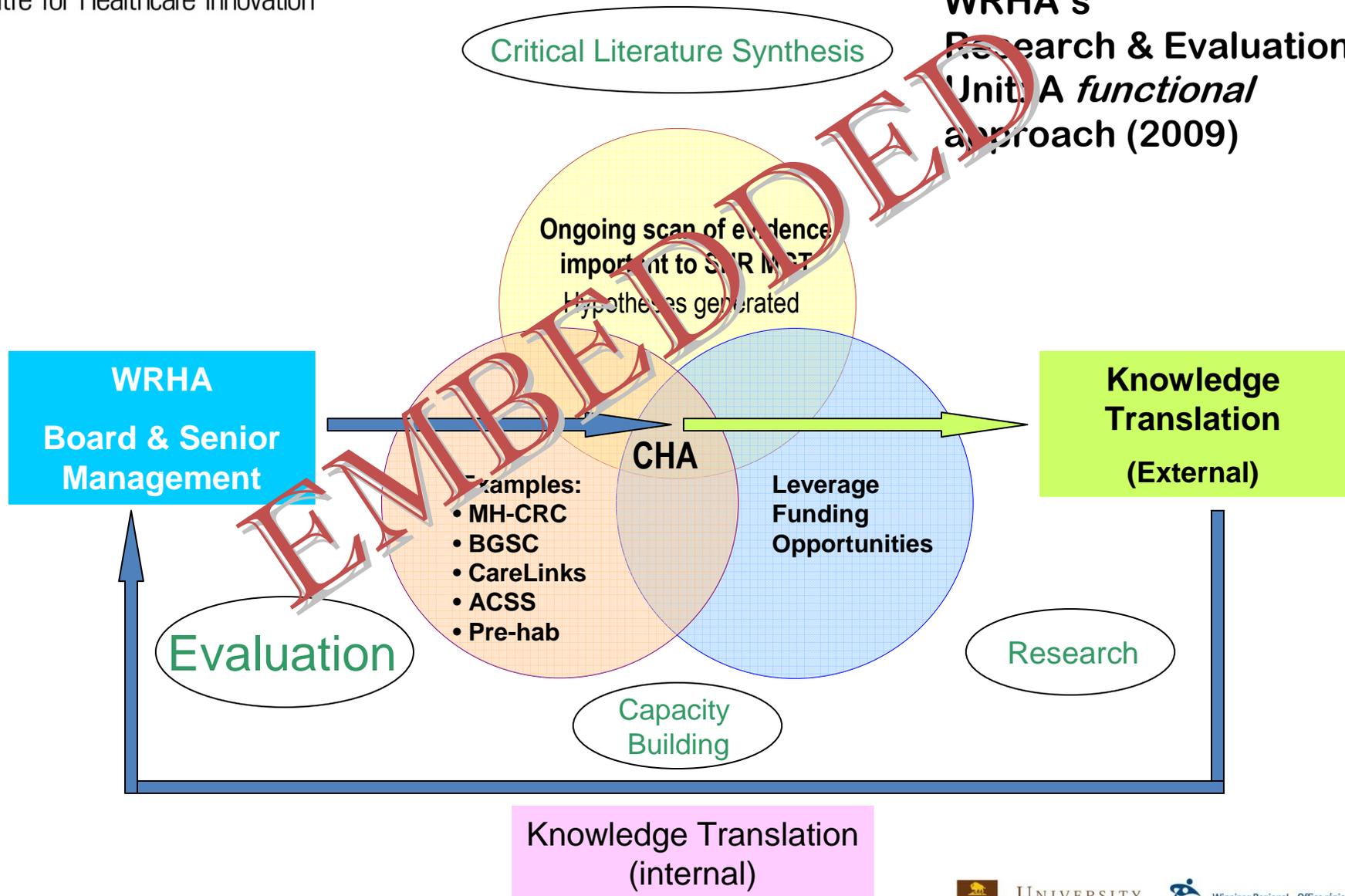
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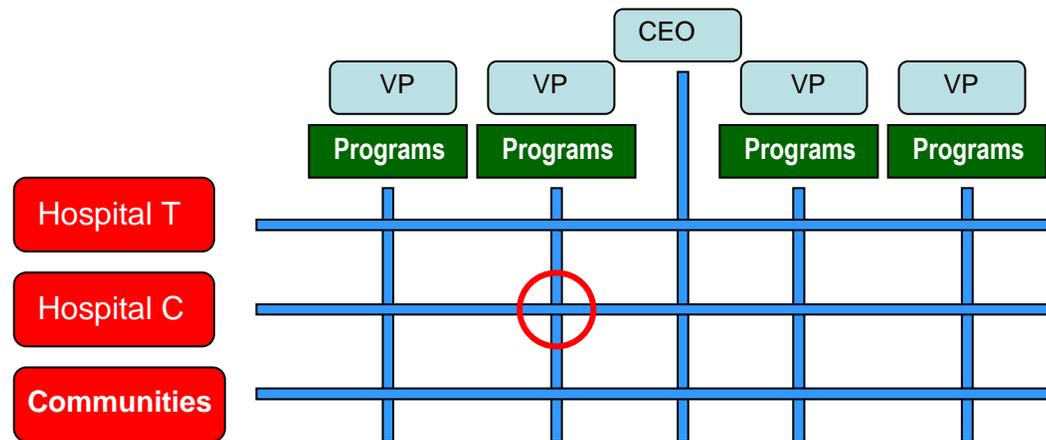
WRHA's  
Research & Evaluation  
Unit: A functional  
approach (2009)



# Facilitators/Hindrances of Knowledge-to-Action

- Hindrances:

- **Fragmentation** of levels of government (in the WRHA we have a **matrix structure**)...this limits research reception and dissemination



- **Competing forms of information: power of the anecdote**, rights talk, interest groups, political values, **attacks on an evidence-based approach**

# Facilitators/Hindrances\* of Knowledge-to-Action

- Hindrances:
  - ***Institutional features*** (administrative & legislative contexts) are usually not amenable to change
  - ***Evidence supply features***
    1. Research quantity: few relevant studies for many health issues (including systematic reviews) **Rapid Reviews**
    2. Research quality: poor quality and/or limited applicability **Knowledge Syntheses** (e.g., e-Mental Health in children, youth & adolescents)
    3. Accessibility: how to obtain research when needed **Not asked**
    4. Usability: Research is not driven by policymakers' needs **Patient flow**

Draws on: \*Jewell CJ & Bero LA. Milbank Q 2008 v86 n2 p177-208



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# Facilitators/Hindrances of Knowledge-to-Action

- Facilitators:

- ***In-house research units*** CHI Evaluation Platform (WRHA)
- ***Concretizing impact*** ...research-based evidence is neither a necessary nor sufficient part of the policy-making process
  - Package it to incite and persuade “to translate the evidence into something that is understandable by the average legislator, policy maker, average citizen” **Patient flow & Implementation**

## “Getting to the source of the patient flow problem”

INTRO: Action without strategy and strategy without action

Patient flow or patient first (or both)?

Capacity or efficiency (or both)?

A SYSTEM LEVEL ANALYSIS: the three paradoxes of patient flow

Many small successes or one big failure? The matrix, overloaded

Your order is my chaos

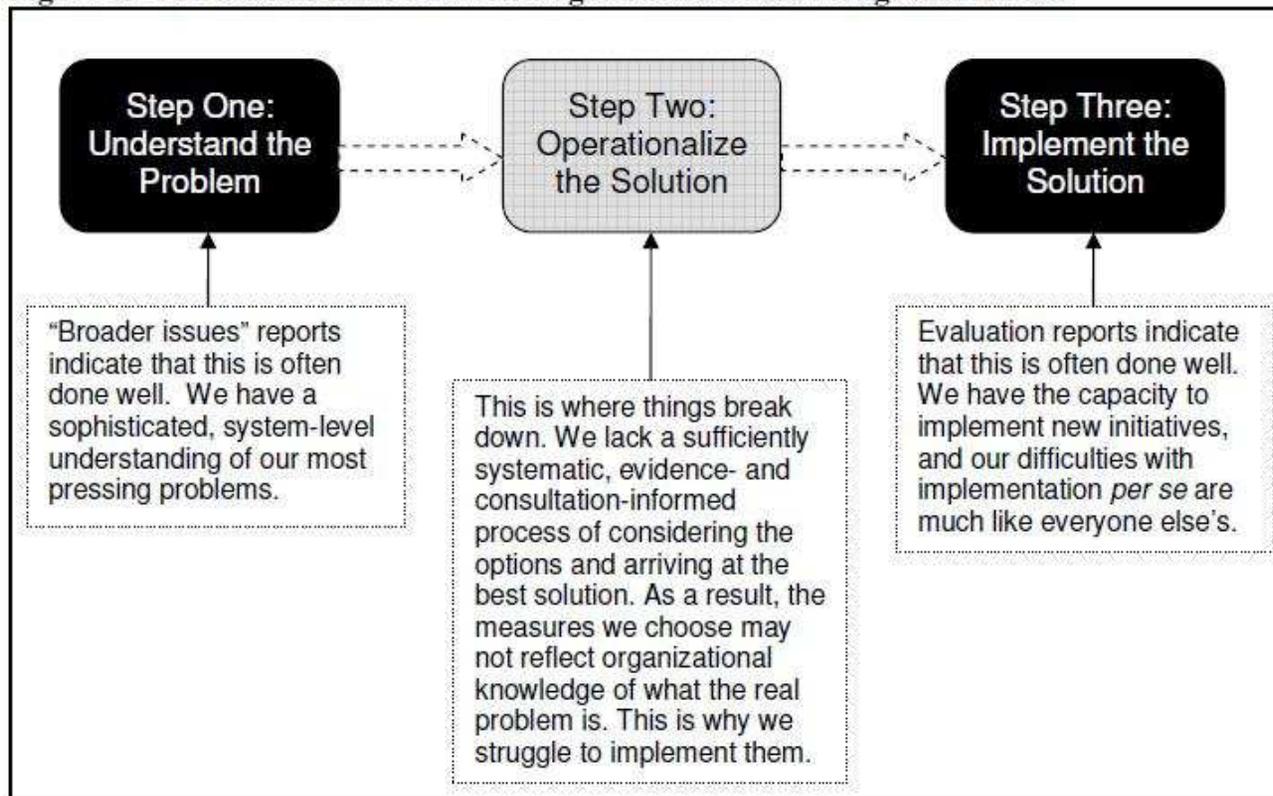
Your innovation is my aggravation

S.Kreindler, WRHA 2013

**Q: Why does the WRHA still have an implementation problem?**

**A: Because it's not an implementation problem.**

Figure 1. The Broken Link Between Organizational Knowledge and Action



**“Concretizing Impact”**

The importance of developing a good research question/ query with the decision maker

S Kreindler. WRHA Report 2012



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# Facilitators/Hindrances of Knowledge-to-Action

- Facilitators:
  - **Linking research on health effects to costs & benefits**  
defining costs associated with policy inactions helps; from a regional perspective developing the means to describe **value = outcomes / money spent** (better allocation of \$s)
  - **Evidence-based skills training** We build up in-region capacity by helping with a necessary skill set for interpreting evaluations. Use of Glasgow's **RE-AIM framework** to ask about impact: reach, effectiveness, adoption, implementation and maintenance (or sustainability)
  - **Generating & Sharing Information through Collaboration:**  
presence of collaborative efforts for ready access (e.g., Community Mental Health **Crisis Response Centre** & the **Birth Centre**)



# The Structure of a Briefing Note

- **Header:** For whom is the note intended? Most officials expect their name and title at the top.
- **Regarding (Title):** One line. What is the issue being advanced for decision making?
- **Background:** What led up to the need to discuss this issue?
- **Issue:** What is the real problem? What is the objective?
- **Analysis:** What do we know about the problem?
- **Recommendation:** What would constitute a solution?
- **These are the parts that make up the body of the Note.**



# Advisory Note for the MB Minister of Health

- **Division/Branch:** ...that prepared the note
- **Subject:** One line. What is the issue being advanced for decision making?
- **Issue Summary:** What led up to the need to discuss this issue? (one paragraph)
- **Background:** Historical. What we know about the issue or problem
- **Current Status:** What do we know about the issue/problem now?
- **Cautionary Notes:**
- **Prepared by & Contact information**

