Translating Health Research (& Evaluation) into Policy & Practice

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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

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*Dwan KM et al. Austr Hlth Rev 2013 v37 p194-98*
Dancing with strangers: understanding the parallel universes of researchers & public sector policy makers*

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

*John Wiseman, University of Melbourne, 2010
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.

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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*
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**

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“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.

“Concretizing Impact”

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

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S Kreindler. WRHA Report 2012
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**