

Links

Volume 10, Number 2, Summer 2007
(ISSN 1496-5372)

The Newsletter of the Canadian Health Services Research Foundation

INSIDE THIS ISSUE

Of particular interest...

For Policy Makers and Managers

Helping decision makers improve
healthcare quality
Page 7

For Researchers

Teaching the next generation of
researchers to communicate with
decision makers
Page 8

For Both

Reflections on a decade and beyond
Page 1

PROMISING PRACTICES IN RESEARCH USE

How a B.C. health authority is boosting
its research capacity

EVIDENCE BOOST

Self-management education to optimize
health and reduce hospital admissions
for chronically ill patients

MYTHBUSTERS

Myth: Generic drugs are lower-quality
and less safe than brand-name drugs

Reflections on a decade and beyond

Changes are needed to ensure the work of current and future members of the emerging evidence-informed decision-making culture remains relevant, echoed panellists of a “fireside chat.” Six future leaders in health services research and policy-making reflected on what they hope to accomplish in the next 10 years of their careers as part of the Foundation’s 10th anniversary celebrations in March.

These change agents and recent graduates of Foundation programs (see page 3) revealed personal experiences with and thoughts on evidence-informed decision-making. They identified opportunities and common aspirations for the future, including:

- focusing on doing work that supports the making of timely evidence-informed decisions relevant to both those who work in the health system and those who use it;

“PEOPLE DON’T TAKE RISKS OR PLAY WITH NEW STRUCTURES UNLESS THEY ARE SUPPORTED TO DO SO. THAT’S WHAT I SEE THE FOUNDATION HAS DONE THROUGH ALL OF THESE DIFFERENT PROGRAMS AND GRANTS THEY’VE PROVIDED.”

- taking risks, especially in addressing relevant and timely healthcare priorities. As Catherine Scott, a Capacity for Applied and Developmental Research and Evaluation in Health Services and Nursing (CADRE) postdoctoral fellow, emphasized, “People don’t take risks or play with new structures unless they are supported to do so. That’s what I see the Foundation has done through all of these different programs and grants they’ve provided.”

Continues on page 3

Making
**Research
Work**

www.chsrf.ca



Canadian Health Services Research **Foundation**
Fondation canadienne de la recherche sur les services de santé

Publication Agreement #40025240

Return undeliverable Canadian addresses to:

1565 Carling Avenue, Suite 700, Ottawa, Ontario K1Z 8R1
Tel: 613-728-2238 * Fax: 613-728-3527

Adding value and voice

Jeanette Ward
Chief Executive Officer, Canadian Health Services Research Foundation

In these first months at the Canadian Health Services Research Foundation, I have been drawn daily to the perennial imperative of the Foundation's vision. It is one that inspires and energizes as it is so clearly central to the public's health. The Foundation has long envisaged a strong Canadian health system in which policy and management decisions are informed by evidence.

We are not alone in this aspiration and have garnered considerable support from our many partners, stakeholders, and the broader community as a result of this mutual goal. However, it is our focused mission that distinguishes the Foundation as a necessary and enabling organization in the 21st century. We are dedicated to the advancement of evidence-informed decision-making in the organization, management, and delivery of health services. Thus, we fund research, build capacity, and exchange knowledge. In this, the Foundation is a unique pan-Canadian resource that seeks to secure a position of privilege and utility for evidence in decision-making.

PATIENTS, CLIENTS, ADVOCATES, AND REPRESENTATIVES SEEK GREATER CONFIDENCE IN THEIR HEALTH SYSTEM AS IT IS THEY WHO BEAR THE BRUNT OF THOSE GAPS BETWEEN WHAT WE KNOW, WHAT WE DON'T KNOW, AND WHAT WE DO.

It has been my pleasure over recent weeks to meet many from across the country who not only feel the imperative of the Foundation's vision; they also

repeatedly reaffirm the importance of our mission. Something special is happening here in Canada. Researchers want to answer useful and contemporary questions about health services, structures, and unmet needs. They are eager to do more, to progress their fields, to mentor and train future researchers.

Patients, clients, advocates, and representatives seek greater confidence in their health system as it is they who bear the brunt of those gaps between what we know, what we don't know, and what we do. They are asking how to be informed participants in health. Decision makers also see a new era for evidence-informed decisions. I have heard a great deal about the need for better tools to support their efforts in public policy. Decision makers would welcome a more extensive range of policy and management solutions tested for impact, acceptability, and sustainability.

For each of these constituencies, evidence is the "stuff of life" (to borrow loosely from Benjamin Franklin). Those who seek it, seize it, and use it would agree. Those who supply it have known all along.

As the Foundation pursues its mandate by adding value and voice to the scientific basis of healthcare, it is clear the environment in which we work is now quite different from the one in which the Foundation was first created. As readers will know, the Foundation's flagship initiatives in research, knowledge transfer and exchange, capacity development, and partnerships reflect a decade of innovation and collaboration made possible by your contributions and creativity.

In this, my first editorial for *Links*, let me conclude by requesting your suggestions as to how we can better work together to realize a shared vision for



Jeanette Ward

Canada. To achieve the greatest impact, we at the Foundation must hear from you.

ABOUT US

Report of the international review panel now available

In an effort to ensure it is both evidence-informed and accountable to stakeholders, the Foundation undergoes a review by an external panel every five years. The board of trustees received the panel's final report in late March and thanks the eminent panel for its time and hard work.

The report will form an important part of the board of trustees' deliberations when it meets in June of this year to evaluate the Foundation's strategic direction for the next phase of its life. In addition to the report, the board will consider other reports such as the results from the *Listening for Direction III* priority-setting workshops conducted during the first part of 2007.

The report, along with a commentary from the board of trustees, is available at www.chsrf.ca/about/ga_accountability_impact_ol_e.php.



Reflections on a decade and beyond (continued from page 1)

People throughout the health delivery system are ready for a change, and organizations, the panel contended, must be able to support risk-taking behaviour to promote cultural change;

- ensuring that knowledge transfer and exchange activities – essential to having research noticed in practice – is recognized in academia throughout the tenure and promotion process. By recognizing and supporting a

cultural shift, universities and health systems can change the reward and incentives systems; and

- recognizing that evidence can and will inform decisions. In a perfect world, there would be an abundance of irrefutable evidence to support decisions in the health system. As Brock Wright, 2004-06 Executive Training for Research Application (EXTRA) program fellow, said, sometimes “the lack of evidence is almost as important as the evidence.”

Panel members stressed the importance of further cultivating mutually-beneficial relationships. And any real change, panel members believe, can only be accomplished by investing in public engagement, fostering closer ties between the agendas for research and evidence-informed decision-making, and developing capacity-building initiatives such as the Foundation’s EXTRA program.

The last word

Leaving the last word to this panel, the moderator, Dr. Jeanette Ward, asked each member to provide one word to describe their aspirations for the future of evidence-informed decision-making:

Proximity

Mylaine Breton (CADRE PhD candidate), public health PhD student, University of Montreal

Team

Mélanie Lavoie-Tremblay (former CADRE postdoctoral fellow), Assistant Professor, School of Nursing, McGill University

Balance

Steve Morgan (2001 Harkness associate), Assistant Professor, Department of Health Care and Epidemiology; Faculty, Centre for Health Services and Policy Research

Connection

Catherine Scott (CADRE postdoctoral fellow), Director, Knowledge into Action (K2A) Department, Calgary Health Region

Synergy

Susan Richardson (EXTRA fellow, 2005-07), Vice-President, Patient Services and Allied Health, Children’s Hospital of Eastern Ontario

Hope

Brock Wright (EXTRA fellow, 2004-06), Vice-President and Chief Medical Officer, Winnipeg Regional Health Authority; Chief Operating Officer, Winnipeg Health Sciences Centre

Executive Leadership Profile

In 2004, the Foundation launched the Executive Training for Research Application (EXTRA) program to develop capacity and leadership skills to optimize the use of research evidence in managing Canadian healthcare organizations. Senior nurse, physician, and health service executives spend two years learning how research evidence can improve their decision-making and working on an intervention project to apply their new skills to their organizations. The EXTRA program was set up with a grant from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

Noella Leydon
Director, Department of Food & Nutrition Service, Saskatoon Health Region – Saskatchewan

“Malnutrition in Continuity of Care: No One’s Problem and Everyone’s Problem – An Integrated Systematic Approach to Improving Nutritional Outcomes, and Therefore the Quality of Life for Residents of Special Care Homes in the Saskatoon Health Region”

Though research into appropriate menus and textures for long-term care food services has been ongoing in the Saskatoon Health Region and the University of Saskatchewan since the late 1990s, for Noella Leydon, a student of the Foundation’s Executive Training for Research Application (EXTRA) program, the opportunity to change dining room services for long-term care patients was too tempting to resist.

Halfway through Ms. Leydon’s EXTRA program, her mother went from living independently to long-term care within seven months, sustaining very rapid physical and cognitive decline. One day, a staff member mentioned her mother’s teeth were bothering her and she seemed to be choking on a piece of fruit. Ms. Leydon then noticed a set of teeth on a chair.

Picking them up, she saw her mother’s name on them. Her mother had somehow ended up with another resident’s teeth.

The proverbial light bulb went on for Ms. Leydon.

“Front-line staff need to be trained to pay close attention to any issue affecting a resident’s ability to nourish themselves,” says Ms. Leydon. “Besides paying attention to the teeth or the texture of the food, there are also the questions of mobility and ability to eat in the dining room.”

Ms. Leydon joined the EXTRA program in 2005 and is now working to create a systematic integrated approach to ensure proper nutrition of residents of long-term care homes in the Saskatoon Health Region. Ms. Leydon certainly had her work cut out for her. The challenge, she says, was getting the health system to acknowledge food service as an integral part of healthcare.

Using research evidence to leverage her work, Ms. Leydon put a spotlight on the importance of proper nutrition for those in long-term care. “Some patients arrive from acute care and home care already malnourished, and do not improve during their stay in long-term care,” she says. “Whatever their initial status, many become increasingly malnourished. The evidence I reviewed determined which specific interventions could make a change in the nutritional status of these residents.”

The EXTRA intervention project also includes working with Saskatchewan Health to develop long-term care food services policies, which have not been updated in Saskatchewan since 1982. As part of a pilot, she will measure nutritional status and patient satisfaction before and after instituting three types of interventions: developing staff competence in 12 areas; ensuring the menu in the home is complete (for example,



Noella Leydon

providing adequate nutrient density); and providing nutrition assessment and intervention as required.

The EXTRA program gave Ms. Leydon the opportunity to develop her project in a creative way. “That is what the EXTRA program itself does,” she says. “It gives participants a chance to think, plan, create, and innovate. One receives valuable feedback during the EXTRA sessions when testing implementation models.”

As her intervention project continues, Ms. Leydon now understands the importance of telling her story to others. Though the technical evidence supporting change is compelling, she realizes the driving force will be more cultural and political.

“Storytelling is a big way to stimulate change; it is the emotional lever that moves things. Many of my colleagues are now living the experience of having a parent in long-term care. We have found telling our stories is what has made the big difference, increasing receptivity to making the changes that our evidence supports.”

For more information about the EXTRA program, please go to www.chsrf.ca/extra.

Putting research into practice

Researchers want their work to be used in the “real world” of healthcare decision-making. But most of them have not received formal training on how to get their messages out to non-academic audiences. Now, they have some guidance in the form of “From Research to Practice: A Knowledge Transfer Planning Guide” published by the Institute for Work and Health.

“IDEALLY KNOWLEDGE TRANSFER HAPPENS WHERE YOU HAVE RELATIONSHIPS THAT ARE ESTABLISHED OVER TIME, IT’S NOT A ONE-OFF DEAL,” SAYS MS. REARDON.

Rhoda Reardon, one of the authors of the guide and now the education co-ordinator for the College of Physicians and Surgeons of Ontario, says it is based largely on the conceptual work of John Lavis, a Canada Research Chair in knowledge transfer and exchange at McMaster University. In the early 2000s, Ms. Reardon, Dr. Lavis, and the other co-author of the guide, Jane Gibson, worked together at the institute developing “operational” principles of knowledge transfer based on the evidence and ideas of how the institute would approach it.

“Ideally knowledge transfer happens where you have relationships that are established over time, it’s not a one-off

deal,” says Ms. Reardon. This exchange model of knowledge transfer (which she refers to as the “Lavis model” and which Dr. Lavis refers to as the “Lomas model,” after the Foundation’s inaugural CEO, Jonathan Lomas) involves researchers and decision makers working together – researchers help decision makers build the capacity to use research, and decision makers help researchers understand what research questions are most relevant to the clinical, policy, and management worlds.

Ms. Reardon says the genesis of the guide was several years ago when she led a session at a conference where researchers could develop knowledge transfer plans for their studies. “It was so successfully received we thought we should formalize it and make it widely available.”

The guide is intended to be used in a facilitated workshop and helps researchers think through five key questions:

1. What is the message?
2. Who is the audience?
3. Who is the messenger?
4. How will the message be transferred?
5. What is the expected impact?

Ms. Reardon notes the guide implicitly assumes the researchers who use it are able to tap into a knowledge transfer “infrastructure” – processes and structures that foster knowledge transfer, such as

knowledge transfer professionals who are able to bring researchers together with decision makers.

A detailed summary of “From Research to Practice: A Knowledge Transfer Planning Guide” by Rhoda Reardon, John Lavis, and Jane Gibson is available in the first issue of *Insight and Action: A digest linking those who practice knowledge transfer and exchange with relevant evidence-informed resources*, available at www.chsrf.ca/other_documents/insight_action/index_e.php.

The workbook is available online at www.iwh.on.ca/kte/images/IWH_kte_workbook.pdf.

ABOUT US

New digest series launched

The Foundation is pleased to announce the launch of a new weekly digest — *Insight and Action: A digest linking those who practice knowledge transfer and exchange with relevant evidence-informed resources*.

This new digest provides insights into important concepts of knowledge transfer and exchange, including networks, brokering, dissemination, and research use.

To view *Insight and Action* please visit www.chsrf.ca/other_documents/insight_action/index_e.php.

ABOUT US

Latest report released by foundation

The following final research report was recently released and can be found on our web site at www.chsrf.ca/final_research/index_e.php.

Nursing leadership, organization, and policy

Determinants of the Sustained Use of Research Evidence in Nursing

Barbara Davies et al.

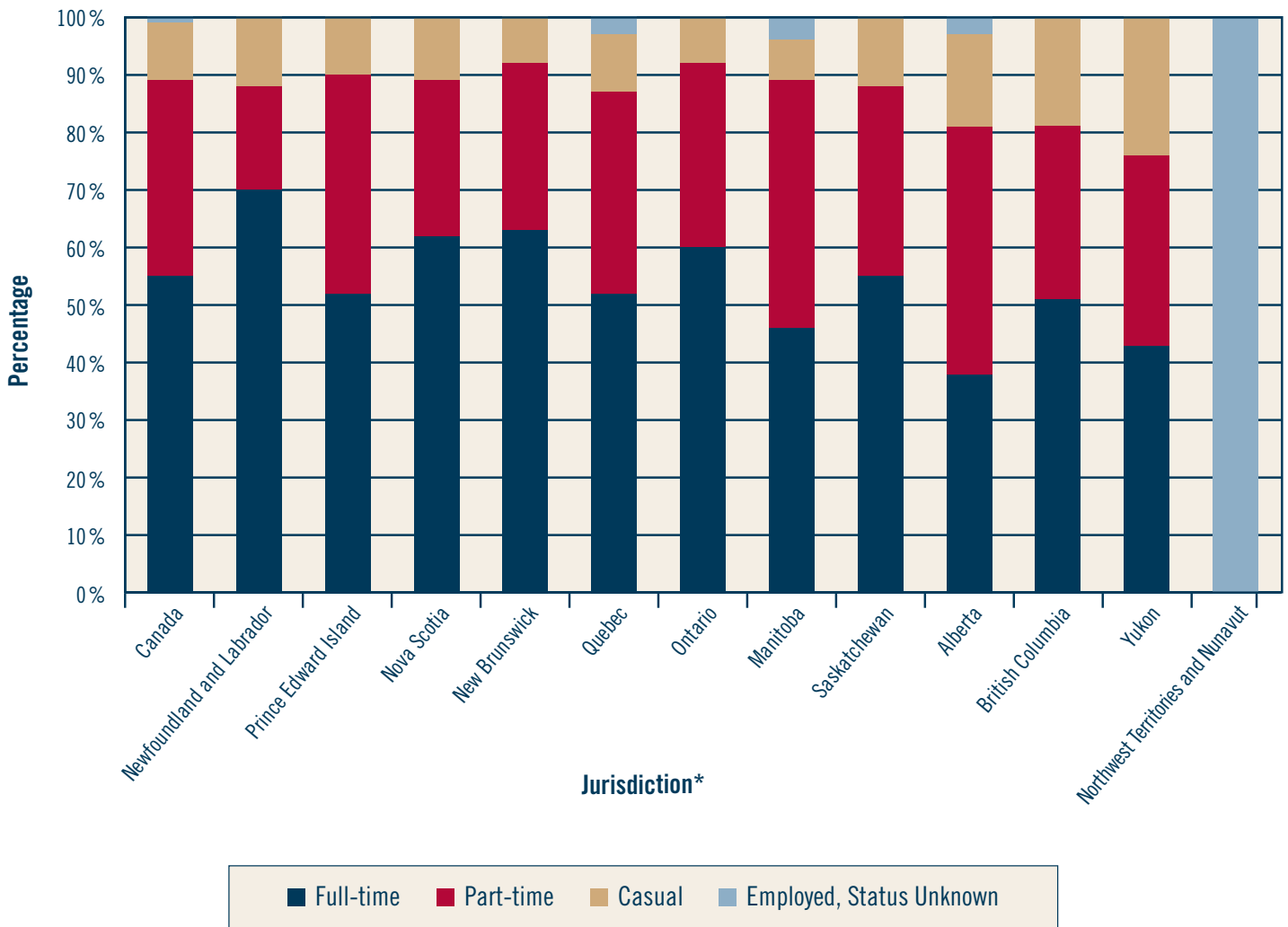
The numbers behind one of healthcare's current debates

Employment status of registered nurses

When registered nurses work full-time there is a whole host of benefits to the healthcare system, including improved patient outcomes, better teamwork, and more successful recruitment and retention. Since 2000, the Registered Nurses' Association of Ontario has pushed for 70 percent of the

province's RNs to have full-time jobs. However, as the latest data from the Canadian Institute for Health Information show, only 60 percent of Ontario's RNs were working full-time in 2005 – and only one province hit the 70-percent target.

Employment status of registered nurses in Canada, 2005



* For the 2005 data year, it was not possible to accurately identify the full-time, part-time, or casual status for registered nurses employed in registered nursing in the Northwest Territories and Nunavut. Therefore, registered nurses in the Northwest Territories and Nunavut employed in registered nursing were coded as “Employed in Nursing, Status Unknown.”

For more information:
Canadian Institute for Health Information. 2006. *Workforce Trends of Registered Nurses in Canada, 2005*. www.cihi.ca

Registered Nurses' Association of Ontario. 2005. *Seventy per cent (70%) full-time RN employment*. www.rnao.org/Page.asp?PageID=122&ContentID=1430&SiteNodeID=331&BL_ExpandID=

Helping decision makers improve healthcare quality

Decision makers faced with tough choices about how to improve healthcare quality will welcome a new guide from the World Health Organization that gives them a template to follow when contemplating quality improvement initiatives.

Primarily a self-assessment and discussion guide, *Quality of Care: A Process for Making Strategic Choices in Health Systems*, offers a seven-step process to help decision makers move from analysis to developing a strategy to implementation.

Analysis

Step 1: Ensure stakeholder involvement

Key stakeholders in any quality improvement process will normally include political and community leaders, service users, healthcare delivery organizations, regulatory bodies, organizations representing providers, and senior policy makers responsible for quality at ministries of health.

Step 2: Conduct a situational analysis

Decision makers need to decide on quality improvement interventions, taking into consideration existing policies, priorities, and current health system performance. This step allows them to establish a clear baseline understanding before implementing new interventions or adapting existing ones.

Step 3: Confirm health goals

Health goals are the aims of the wider health system. They are usually broad and may include such things as reducing mortality, improving outcomes for specific diseases, or making healthcare safer. This step is important for aligning new quality improvement interventions with broader health goals.

Strategy

Step 4: Develop quality goals

The quality goals are driven by the broader health goals and related to different quality dimensions. They will eventually lead to the selection of quality interventions. These goals must be explicit, measurable, and have a specific timeframe to be met within.

Step 5: Choose interventions for quality

The guide lists six domains where quality intervention initiatives could be located: leadership; information; patient and population engagement; regulation and standards; organizational capacity; and models of care. An appendix offers a detailed list of questions decision makers can consider for each domain, to help them determine where to focus their efforts.

Implementation

Step 6: Implement the quality improvement initiative

The third part of the cycle puts quality improvement into action and moves the focus to managing an implementation process. The guide emphasizes the need for those involved to maintain a clear focus and sustain interest in and commitment to the intervention.

Step 7: Monitor the quality improvement initiative

The final step is to determine what effects the initiative had in terms of improved outcomes. Monitoring progress can be done by using quality measures agreed upon early in the process as well as existing information sources.

To read the report, please visit www.who.int/management/quality/assurance/QualityCare_B.Def.pdf.

Some good examples of doing, communicating, or using research to inform decision makers

Teaching the next generation of researchers to communicate with decision makers

Writing plain-language documents for decision makers isn't a routine part of the training most applied health services researchers undertake. But that is changing at a few universities, inspired in part by the Foundation.

“THE MYTHBUSTER HAS ALL THE COMPONENTS I WANTED TO TEACH — STUDENTS HAVE TO LEARN HOW TO IDENTIFY A MYTH AND WHEN THEY CAN SAY EVIDENCE EXISTS, SEARCH THE LITERATURE, EVALUATE THE EVIDENCE, AND WRITE SOMETHING CONCISE AND FUN TO READ.”

Yukiko Asada teaches a master's course on health services systems at the department of community health and epidemiology at Dalhousie University. Trying to come up with a way to teach her students about research, writing, and having fun, she developed an assignment based on the Foundation's popular *Mythbusters* series.

“The *Mythbuster* has all the components I wanted to teach — students have to learn how to identify a myth and when they can say evidence exists, search the literature, evaluate the

evidence, and write something concise and fun to read,” says Dr. Asada. “This combination was quite attractive.”

Dr. Asada has used the assignment twice so far and says many of her students are surprised by how difficult it can be to write a two-page research summary.

“On the first day of class I explain the assignment, and their first impression is this assignment is going to be easy,” she says. “When they start to write they wonder what they've gotten into. They find it's actually more difficult to write shorter than longer.

“It's also the first time they've had to write for an educated lay audience,” she adds. “In their previous training they never had to write for that kind of audience.”

Another aspect that surprises many students is how difficult it is to concretely say “evidence exists.” Dr. Asada says once students start reading through the literature on their topic and trying to compare and summarize different research questions and designs, they start to wonder how people can ever make a definitive statement about what works and what doesn't.

So far, her students have tackled myths ranging from how to fix the nursing shortage to the effectiveness of community treatment orders in reducing admissions to psychiatric facilities.

“WHEN THEY START TO WRITE THEY WONDER WHAT THEY'VE GOTTEN INTO. THEY FIND IT'S ACTUALLY MORE DIFFICULT TO WRITE SHORTER THAN LONGER.”

Dr. Asada is also helping the Foundation develop a curriculum module on how to write plain-language research summaries, like *Mythbusters*, that will be freely available to professors across the country. The module will be launched this summer and will cover all steps of the process, from identifying the myth to evaluating the research to writing the summary.

For more information on the Foundation's upcoming curriculum module, please contact Jennifer Thornhill at jennifer.thornhill@chrsf.ca.

For more information on Yukiko Asada's use of the *Mythbuster* as a teaching tool, please contact her at Yukiko.Asada@Dal.Ca.

Our mission is to support evidence-informed decision-making in the organization, management, and delivery of health services through funding research, building capacity, and transferring knowledge.

Questions? Comments? Please see our web site at www.chrsf.ca, or e-mail the newsletter editor, Kindha Gorman, at kindha.gorman@chrsf.ca.

Address Change? Please send your new address to publications@chrsf.ca.



Canadian Health Services Research **Foundation**
Fondation canadienne de la recherche sur les services de santé

1565 Carling Avenue, Suite 700, Ottawa, Ontario K1Z 8R1
Tel: 613-728-2238 * Fax: 613-728-3527