Panel:
What Works? What Impact?

What works at MCHP?

Patricia Martens PhD
Director, MCHP;
Professor, Community Health Sciences, Faculty of Medicine, University of Manitoba;
CIHR/PHAC Applied Public Health Chair

CIHR IRSC

Edmonton, Alberta: May 2, 2011

Manitoba Centre for Health Policy

MCHP: Who we are

- The Manitoba Centre for Health Policy
  - Community Health Sciences, Faculty of Medicine
  - 5-year grant relationship with Manitoba Health since 1991 … but a long history pre-dates this
- A “magnet” centre
  - Attracts the attention of other national and international research centres
    - Constant visits from and consultations with other provinces and national/international groups
- Reports (deliverables) PLUS external funding
  - ½ of budget from peer-reviewed grants (varies)

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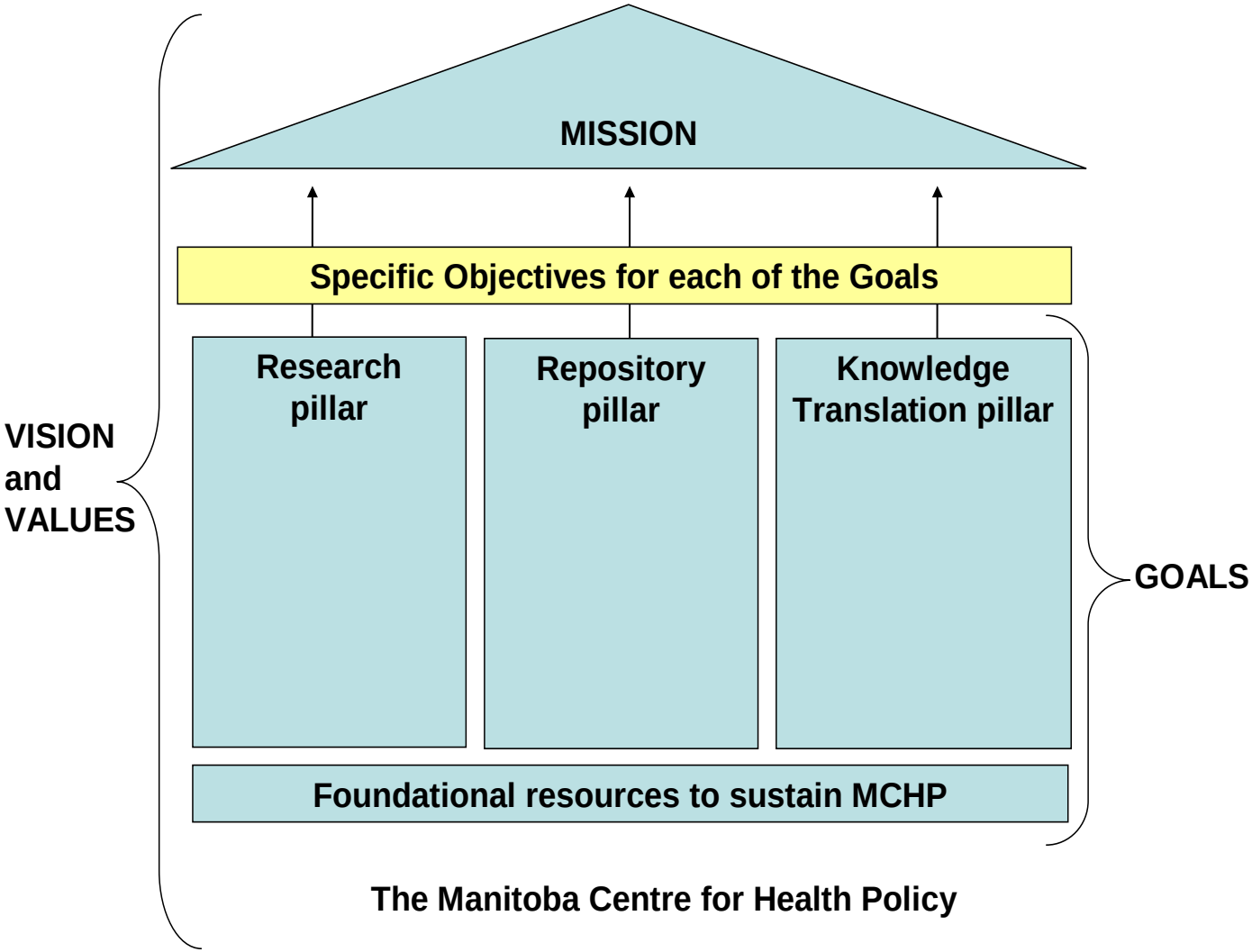
MCHP's Mission

The Manitoba Centre for Health Policy (MCHP) is a research centre of excellence that conducts world class population-based research on health services, population and public health, and the social determinants of health. MCHP develops and maintains the comprehensive population-based data repository on behalf of the Province of Manitoba for use by the local, national and international research community. MCHP promotes a collaborative environment to create, disseminate and apply its research. The work of MCHP supports the development of policy, programs and services that maintain and improve the health of Manitobans.

The three pillars



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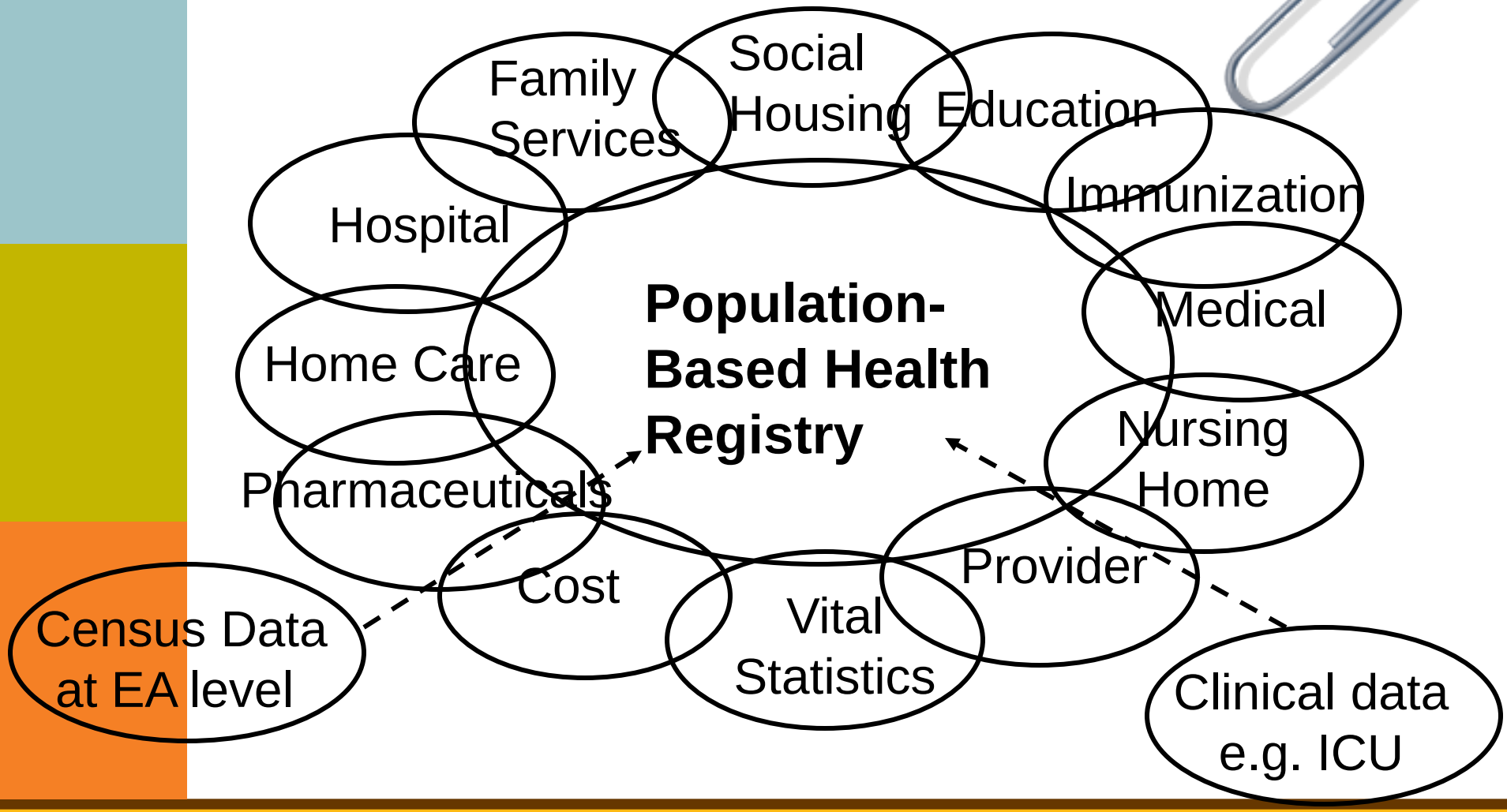
Repository … “paperclips”?

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"Going for the Gold":
Celebrating 20 Years of Experience in
Population-Based Research in Manitoba and Beyond
« À la recherche de l'or » :
célébrer 20 ans d'expérience en recherche fondée
sur la population au Manitoba et ailleurs
A LONGWOODS PUBLICATION
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MCHP: What we do with the information - KT

- At the government level
  - Deliverables (i.e., research reports); briefing of ADMs, DM, Minister of Health, other Ministers, workshops
- At the RHA level
  - Annual Workshop Days (WRHA, MH, non-Winnipeg RHAs), dissemination of reports, website data
  - *The Need To Know* Team
- At the researcher level
  - Research reports, publications, conferences etc.
  - Concept Dictionary and Glossary, website
- At the public/clinician level
  - Four-pagers; clinician one-pagers; media interviews, op eds,, responses to news, website

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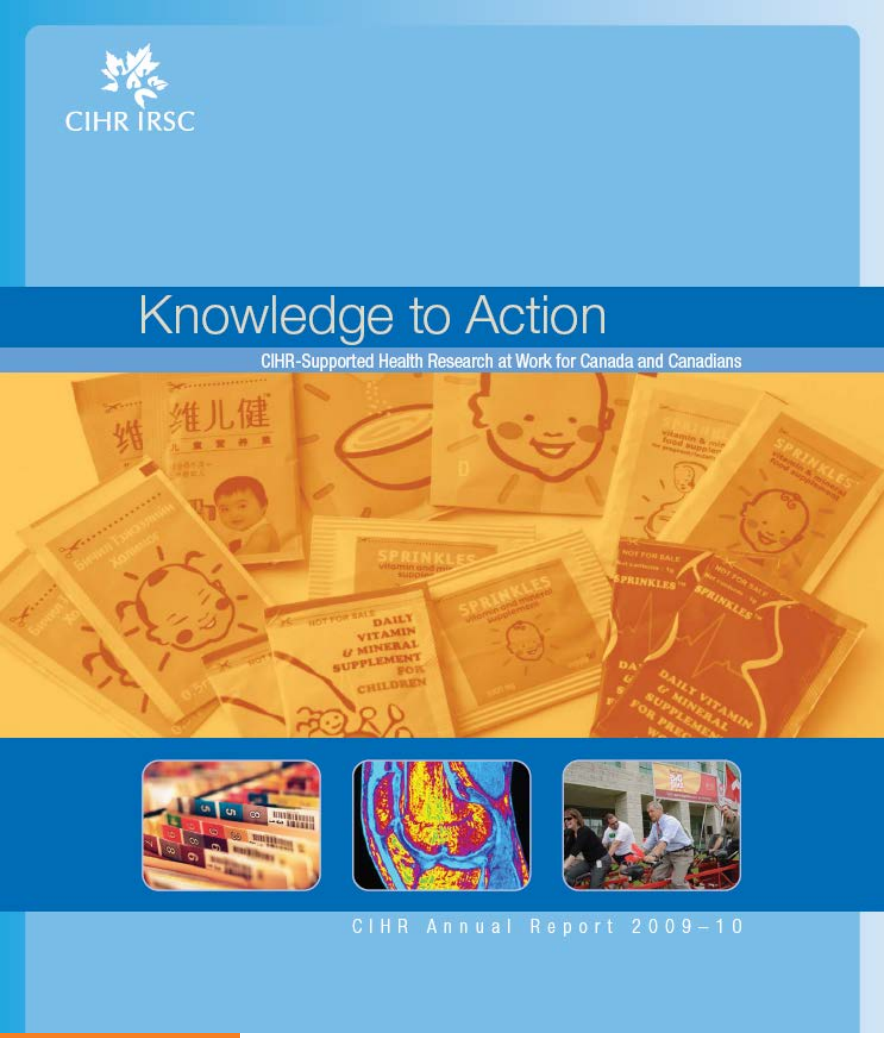
Involvement and influencing health policy

- MCHP's Annual Workshop Days
  - Rural & Northern RHAs, Winnipeg RHA, Manitoba Health Days
  - **Look for the STORIES!**
  - **Evidence-based stories lead to evidence-informed decision-making**

MCHP's involvement in influencing health policy

- *The Need To Know* Team
  - MCHP, RHAs, Manitoba Health
    - CIHR-funded, 2001-2006 through the Community Alliances for Health Research (CAHR) program, 2008-2013 CIHR/PHAC Applied Public Health Chair for Martens
    - CIHR 2005 KT Award for Regional Impact
    - Highlighted as 1 of 5 "knowledge to action" stories in the 2009/2010 annual report of CIHR

This was originally funded by the CIHR through the Community Alliances for Health Research Program (2001-2006) and a CIHR Knowledge Translation Award (2005). It is presently funded through Dr. Patricia Martens' CIHR/PHAC Applied Public Health Chair.



"Our whole philosophy is health planning based on evidence"

– Arlene Wilgosh, CEO of the WRHA, former DM of Health

INVITED PAPER

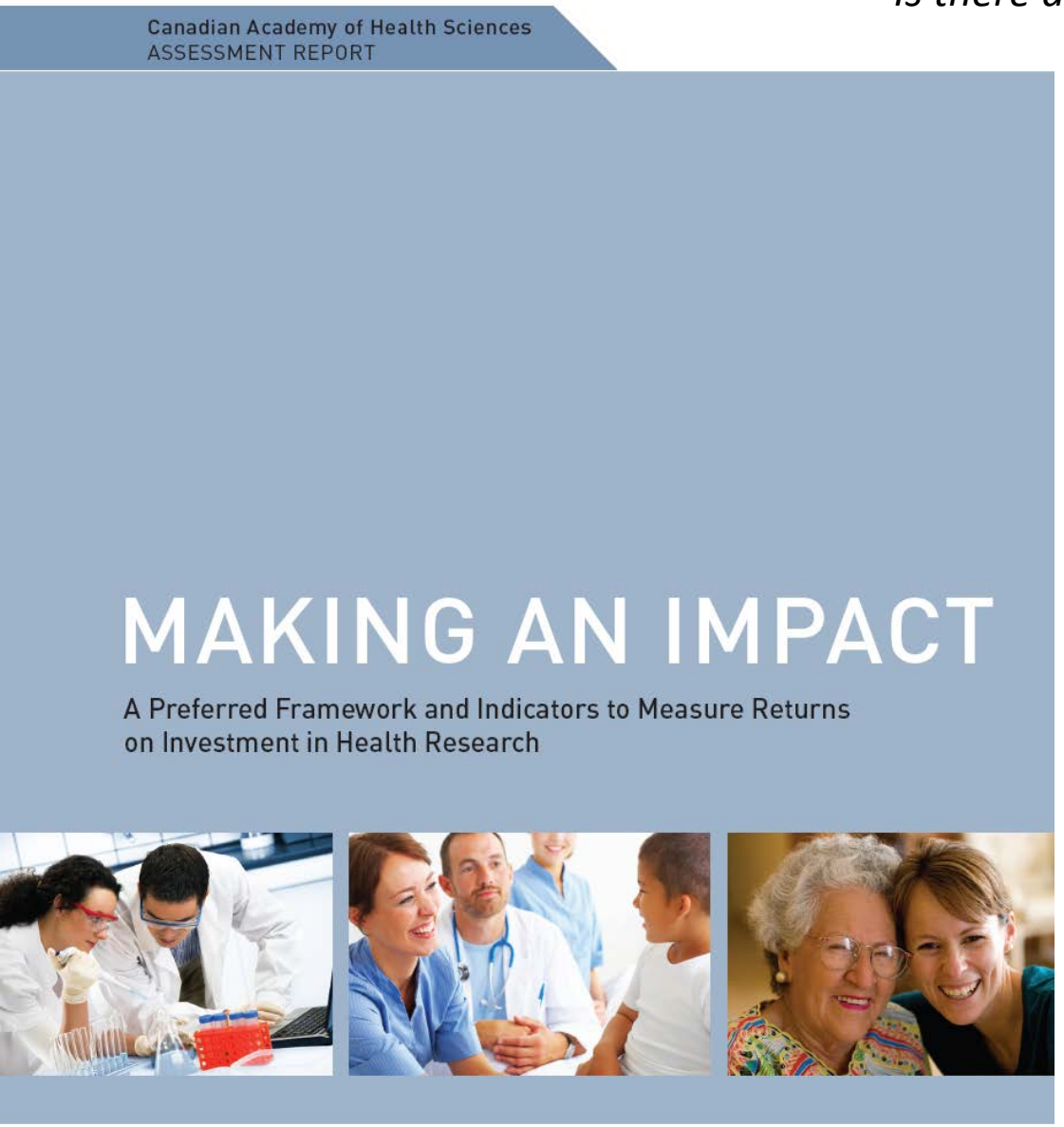
When Health Services Researchers and Policy Makers Interact: Tales from the Tectonic Plates

Healthcare Policy 2005;1(1):72-84

by PATRICIA J. MARTENS, PHD
New Investigator, Canadian Institutes of Health Research
Director, Manitoba Centre for Health Policy
Associate Professor, Department of Community Health Sciences
Faculty of Medicine, University of Manitoba
Winnipeg, MB

NORALOU P. ROOS, PHD
Canada Research Chair in Population Health
Founding Director, Manitoba Centre for Health Policy
Professor, Department of Community Health Sciences
Faculty of Medicine, University of Manitoba
Winnipeg, MB

Is there a GDP of Research Use, like GDPRU???



Lewis S, **Martens PJ**, Barre L. Estimating the Return on Investment for health services research: A theoretical and empirical analysis. *In* Canadian Academy of Health Sciences. Making an Impact: A preferred framework and indicators to measure returns in investment in health research. Ottawa, Canada: Canadian Academy of Health Sciences, January 2009. Appendix A (Commissioned Papers): A21-A42. Available at http://www.cahs-acss.ca/e/assessments/completedprojects.php

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So what works? … researchers, decision-makers

- **USER INVOLVEMENT FROM START TO FINISH**
  - **integrated KT**
- **INTERACTIVE FORUMS**
- **EVIDENCE-BASED STORY TELLING potentially leads to EVIDENCE-INFORMED DECISION MAKING**

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So what does it take?

To develop collaborative relationships around data stewardship and use, it takes:

- TIME and $ commitment
- SHARED LANGUAGE
- TRUST
- RELATIONSHIP BUILDING
- “LETTING GO” of traditional roles
- PATIENCE
- UNDERSTANDING

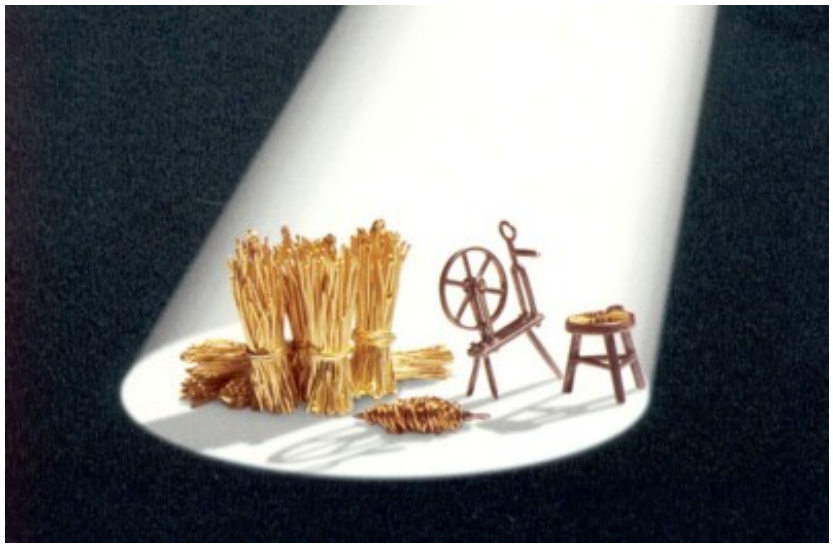
Bowen S, Erickson T, Martens P. More than “using research”: the real challenges in promoting evidence-informed decision-making. Healthcare Policy 2009;4(3):69-84.

Bowen S, Martens PJ. A model for collaborative evaluation of university-community partnerships. J. Epidemiol. Community Health 2006; 60: 902-907.

Bowen S, Martens PJ, *The Need To Know* Team. Demystifying “Knowledge Translation”: Learning from the community. Journal of Health Services Research & Policy 2005;10(4):203-211.

Martens PJ, Roos NP. When health services researchers and policy-makers interact: Tales from the tectonic plates. Healthcare Policy 2005;1(1):72-84.

And … the research! Straw into Gold?



Martens 2011

Straw into Gold: Lessons Learned (and Still Being Learned) at the Manitoba Centre for Health Policy

Changer la paille en or : leçons retenues (et qu'on continue d'apprendre) au Centre des politiques de santé du Manitoba

PATRICIA J. MARTENS, PHD
Director, Manitoba Centre for Health Policy
Professor, Department of Community Health Sciences, Faculty of Medicine
University of Manitoba
Winnipeg, MB

Abstract

What lessons have we learned at the Manitoba Centre for Health Policy (MCHP) about knowledge translation (KT) over the past 20 years, and what is our vision for the future? How does that KT interrelate with our other activities – research and the Population Health Data Repository? Who first noticed that "there's gold in them thar hills," and what did they do about it? How did we weave administrative database "straw" into gold, how have we panned for gold and how do we look for the pot of gold in the future? This paper describes how MCHP began with an integrated KT research relationship with government, and through *The Need to Know Team*, extended KT to regional health authority planners. It describes the various push–pull KT mechanisms that MCHP has used, including dissemination of research to planners through interactive workshops, and to other researchers through Web-based resources.

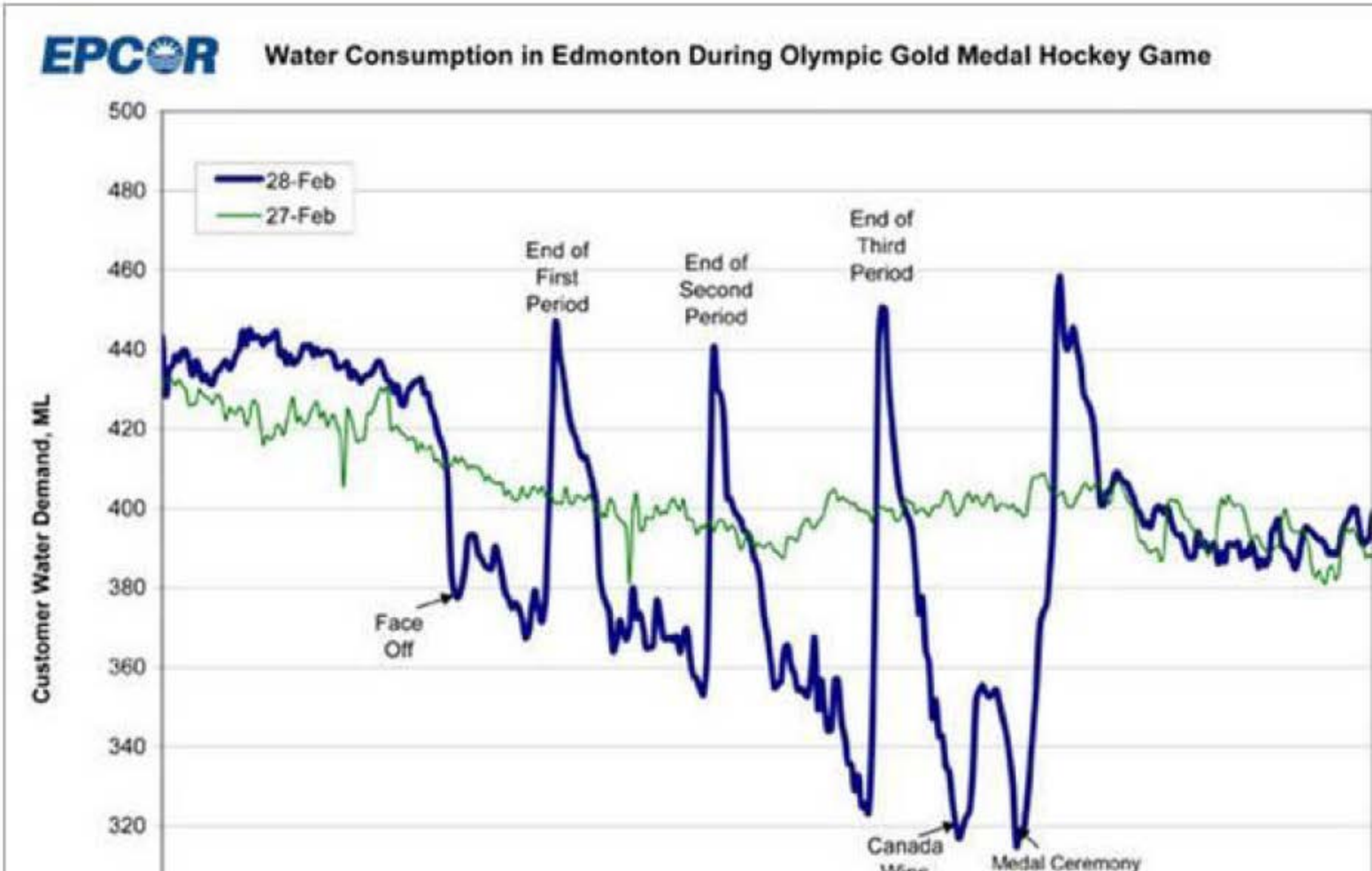
Observational data are powerful!! (you don't always need an RCT)

- Time series are powerful for population health interventions
  - Time trends with comparison groups
  - Interrupted time series
  - Toilet flushing and the Olympic hockey game – water consumption graph

- Sometimes, RCTs don't capture the effect of social network causal factors

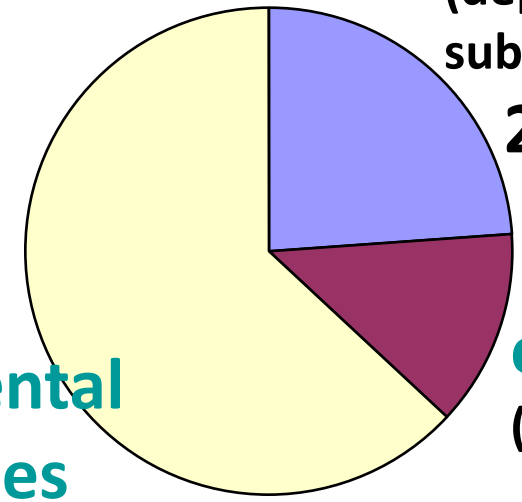
What If Everybody in Canada Flushed At Once?

Written by Pats Papers | Monday, 8 March 2010 12:42 PM



The Mental Health Report:

Five-year prevalence of mental illness in Manitoba, age 10+



cumulative mental illnesses
(depression, anxiety, personality disorders, substance abuse, schizophrenia)
24%

other mental illnesses
(e.g. dementia)
13%

no mental illnesses
63%

Martens et al. 2004

Who sees psychiatrists?

For 100 people with cumulative mental illness disorders

- Urban richest: 100 visits
- Urban poorest: 70 visits

- Rural richest: 30 visits
- Rural poorest: 10 visits

- Middle aged: 80 visits
- Older (70+): 15 visits

Who accesses psychiatrists?

Urban people in the **wealthier** neighbourhoods

… and **middle-agers**

Martens et al. 2004

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KT in action: Mental Illness Report

"Our Branch has specifically used it to work in four key areas: (a) It is informing the **Provincial Suicide Prevention Strategy**; (b) we are using it as further evidence for the need for a new **mental health (and addictions) data system** - and this is moving along; (c) we have used it to pull together a planning group to look at current and future needs in the area of **access to psychiatrists**; (d) we are using it as further evidence for the need for collaboration between **mental health and primary health care initiatives**. . .

Personally the piece that stood out for me is the whole thing about how **all health concerns are increased when there is a mental illness** diagnosis. This is a piece that I pull out frequently in briefings, meetings etc."

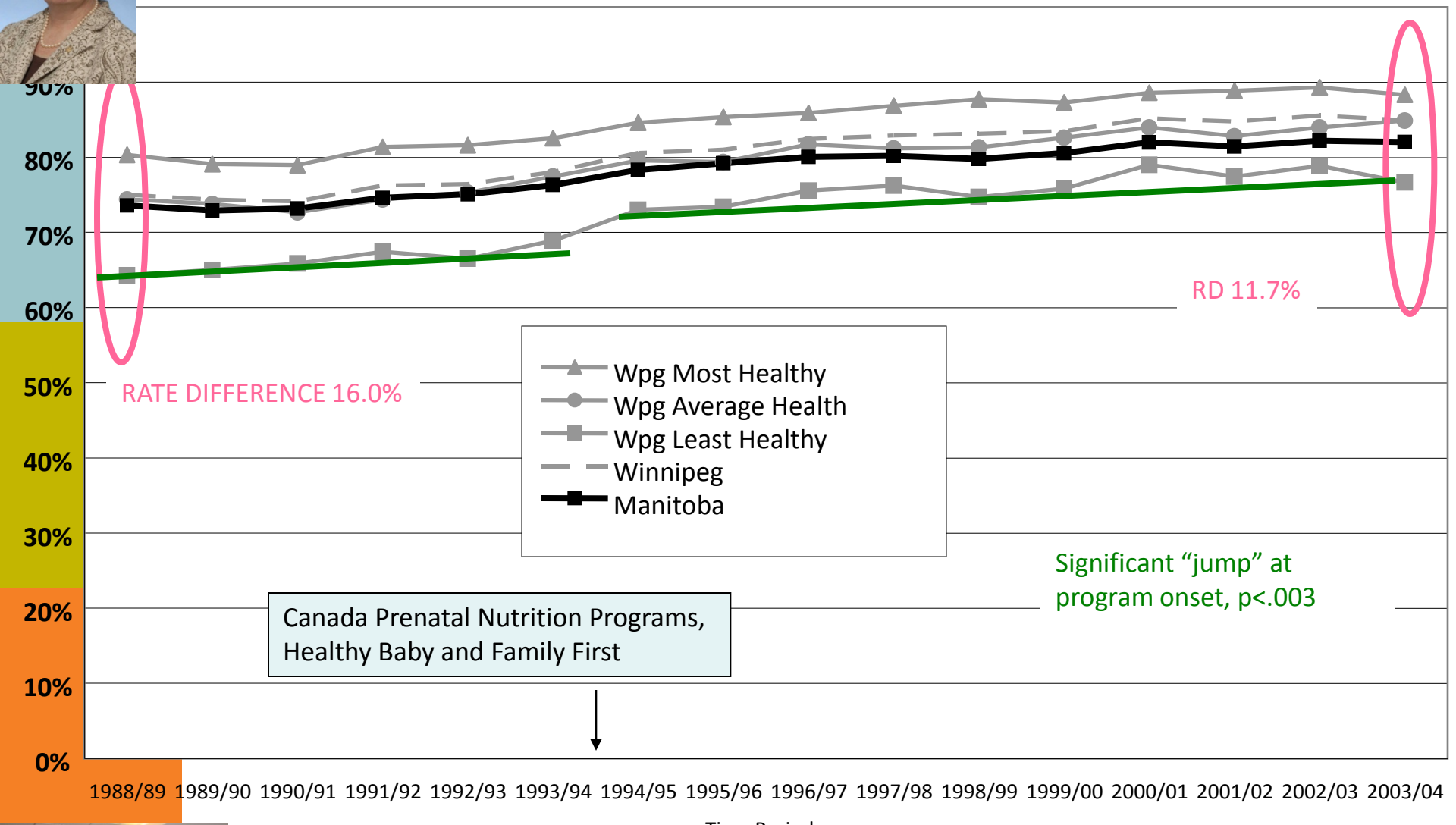
CIHR IRSC

Yvonne Block, Director of Mental Health, Addictions and Agency Relations, Manitoba Health. January 2005

Faculty of Medicine
Sciences

Figure 7.6: Trends in Winnipeg Breastfeeding Initiation Rates

Maternal age-adjusted percent of newborns breastfeeding at hospital discharge



source: Manitoba Centre for Health Policy, 2007

What Works Report

Martens et al. 2008

University of Manitoba | Faculty of Medicine
Community Health Sciences

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Initial analysis of Emergency Departments (EDs)

- Frequent users of ED (9+ visits per year):
  - 54% have a history of 2+ mental illness diagnoses
  - But they also have high use of other health care providers (2,400 people; 80,000 health care contacts)
- Very frequent users (18+/yr): 85% have 2+ mental illness diagnoses
- A different way to approach EDs for those living with mental illness – WRHA vision

Doupe et al. 2008

Population Aging and the Continuum of Care

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Figure 3.8: Projected Number of PCH Beds Required for Older Adults in Manitoba, 2008/09 - 2030/31

2021
Baby Boomers reach 75

- 7.0 % projected increase in # of PCH beds

2031
Baby Boomers reach 85

- 25.8 % projected increase in # of PCH beds

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February 18, 2011 release

PROVINCE RENEWS LONG-TERM CARE PLAN TO MEET GROWING DEMAND FOR SERVICES

$216-million Investment Provides More Choice, More Independence, Better Quality of Life for Growing Number of Seniors: Selinger

Manitoba families will benefit from enhanced access to home-care services, more affordable supportive-housing options and an expansion of personal-care home (PCH) beds under a renewed long-term care plan announced today by Premier Greg Selinger.

"Seniors and their families now have access to a wide range of care options as a result of our investments over the past 10 years," said Selinger. "Many people aren't aware the first universal home-care program in North America started right here in Manitoba. Today we are building on this legacy by announcing new supports and innovations to enable older Manitobans to live at home longer."

New seniors homes, more home care

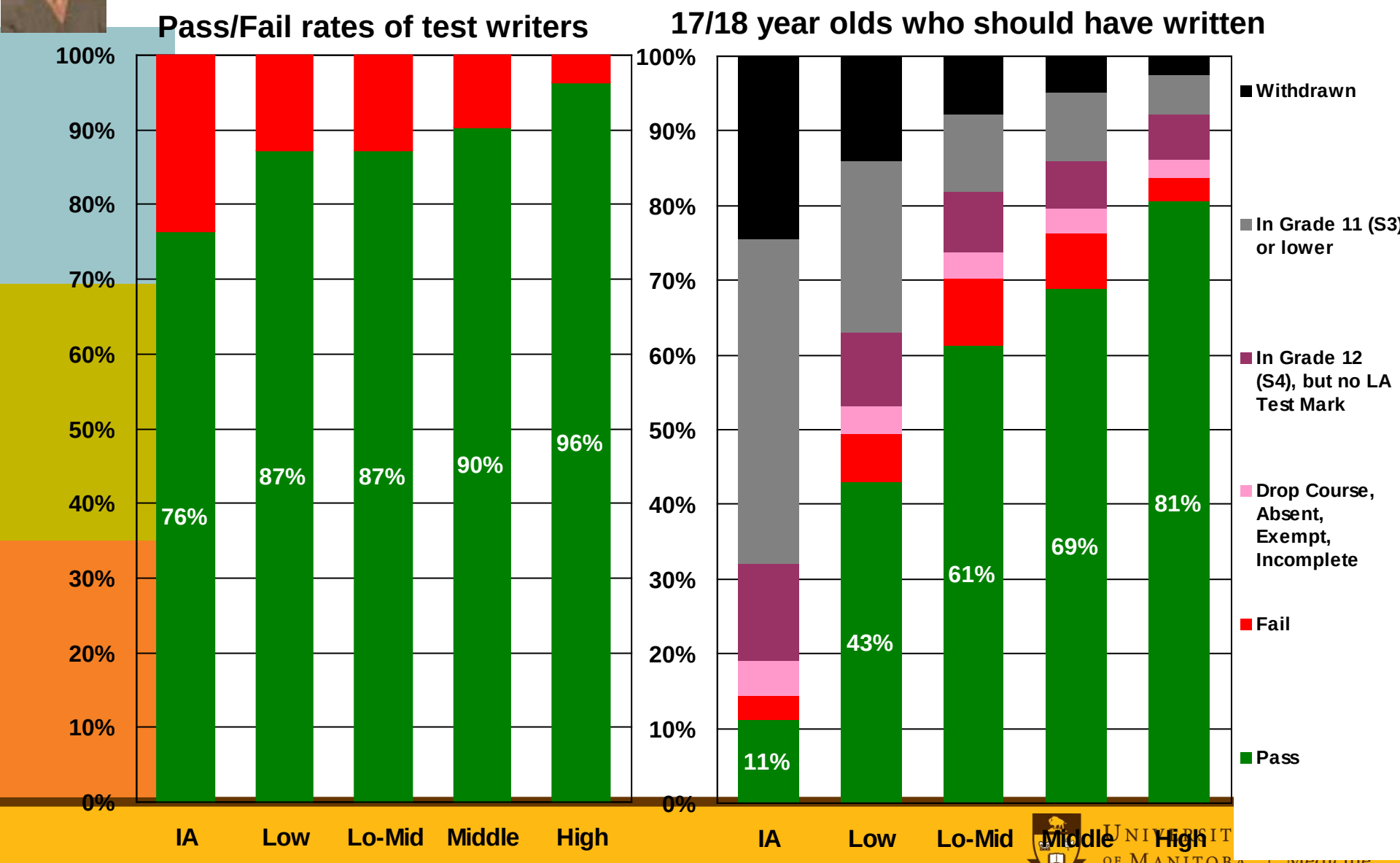
Province readying for boom of aging Manitobans

Aging facts

What was announced Friday

'This is a long-term plan. It's a long-term vision. It recognizes the demographic reality in Manitoba'

Grade 12 (S4) Performance by SES Group
Language Arts Standards Test 2001/02



Brownell et al. 2004

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Evaluation of Healthy Baby Program (Brownell et al. 2010)

- Prenatal Benefit (PB) reaches the majority of low income women as an income supplement in their 2nd and 3rd trimesters, and is associated with positive maternal/child outcomes
  - Decrease in preterm birth and low birth weight; increase in breastfeeding rates

Table 2: Summary of outcomes associated with Healthy Baby program components

What outcomes were associated with receiving the Prenatal Benefit?
1.4%-9.0% Reduction in low birth weight births
0.4%-6.0% Reduction in preterm births
10.0%-21.0% Increase in breastfeeding initiation

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Metis Health At

Martens, Bartlett et a

MMF is doing community dialogues through Knowledge Networks, to give context to the data

Burden of disease:

- Poorer health status for Metis compared to all other Manitobans; mostly higher (13%-49%) rates of illness
  - Particularly high diabetes-related illnesses
  - Health care use is higher for Metis, associated with greater need

Child health:

- Very high risk in indicators of education & social services
- Higher behavioural risks for youth, high teen pregnancy

Prevention and screening:

- Metis rates mostly similar or better than all others;
- Continuity of care consistently associated with ***higher uptake of prevention and screening***

Geography:

- Geographical variation provides context of “promising practices”

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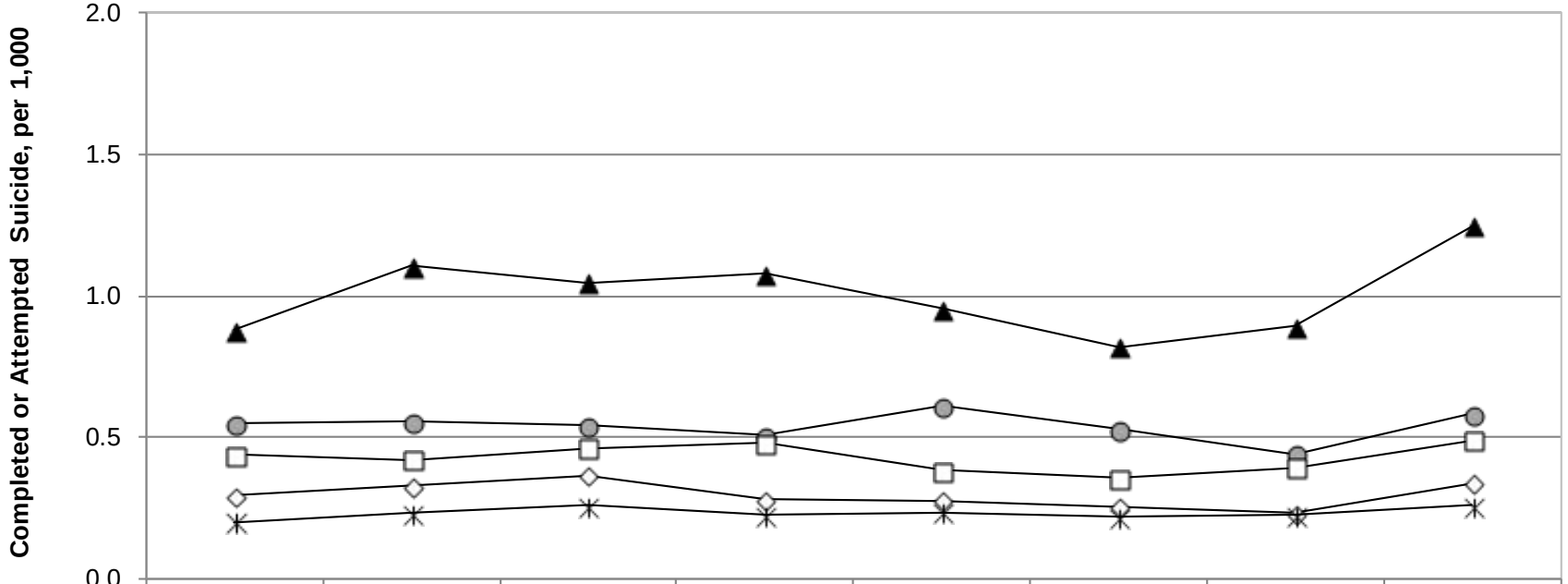
Health Inequities: Is the socioeconomic gap in health widening or narrowing?

- Time trend graphs, Lorenz curves
- Of the 18 indicators for both rural and urban:
  - ½ showed increase in gap
  - ½ showed no change
  - only 1 indicator (breastfeeding in urban areas) showed decreased gap.

Figure 7.17: Prevalence of Completed or Attempted Suicide Over Time by Urban Income Quintile

Adjusted by (2005-2007) age, per 1,000 residents aged 10 years and older



	T1:1984-1986	T2:1987-1989	T2:1987-1989	T4:1993-1995	T5:1996-1998	T6:1999-2001	T7:2002-2004	T8:2005-2007
NF (Not displayed)	1.92	1.37	2.14	0.94	1.29	1.72	1.17	2.20
U1 (lowest income)	0.88	1.11	1.05	1.08	0.96	0.82	0.89	1.25
U2	0.55	0.56	0.54	0.51	0.61	0.53	0.44	0.58
U3	0.44	0.42	0.46	0.48	0.38	0.36	0.39	0.49
U4	0.29	0.33	0.37	0.28	0.28	0.25	0.23	0.34
U5 (highest income)	0.20	0.23	0.26	0.22	0.23	0.22	0.23	0.26
Disparity Rate Ratios (U1/U5)	4.40	4.78	4.04	4.83	4.09	3.79	3.96	4.85
Disparity Rate Differences (U1-U5)	0.68	0.87	0.79	0.85	0.72	0.60	0.67	0.99

Time Period (years)

Comparison of Disparity Rate Ratios T8 to T1: 1.10 (95% CI 0.70, 1.73) NS

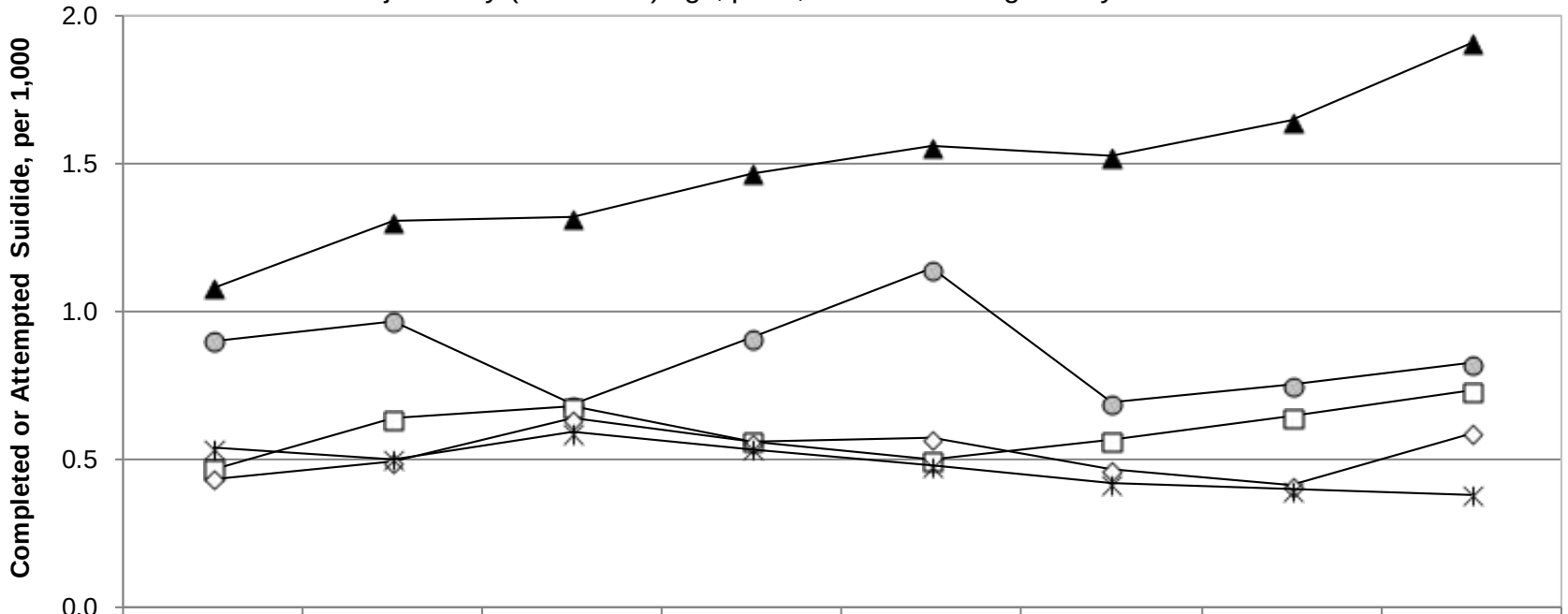
Comparison of Disparity Rate Differences T8 to T1: 1.46, p<.01

Martens et al. 2010

Source: Manitoba Centre for Health Policy, 2010

Figure 7.18: Prevalence of Completed or Attempted Suicide Over Time by Rural Income Quintile

Adjusted by (2005-2007) age, per 1,000 residents aged 10 years and older



	T1:1984-1986	T2:1987-1989	T2:1987-1989	T4:1993-1995	T5:1996-1998	T6:1999-2001	T7:2002-2004	T8:2005-2007
NF (Not displayed)	1.92	1.37	2.14	0.94	1.29	1.72	1.17	2.20
R1 (lowest income)	1.08	1.30	1.32	1.47	1.56	1.52	1.64	1.91
R2	0.90	0.97	0.68	0.91	1.15	0.69	0.75	0.83
R3	0.47	0.64	0.68	0.56	0.50	0.57	0.65	0.73
R4	0.44	0.49	0.64	0.56	0.57	0.47	0.41	0.59
R5 (highest income)	0.54	0.50	0.59	0.53	0.48	0.42	0.40	0.38
Disparity Rate Ratios (R1/R5)	2.01	2.61	2.23	2.75	3.25	3.65	4.11	5.01
Disparity Rate Differences (R1-R5)	0.55	0.80	0.73	0.94	1.08	1.11	1.24	1.53

Time Period (years)

Comparison of Disparity Rate Ratios T8 to T1: 2.49 (95% CI 1.61, 3.85) p< .001

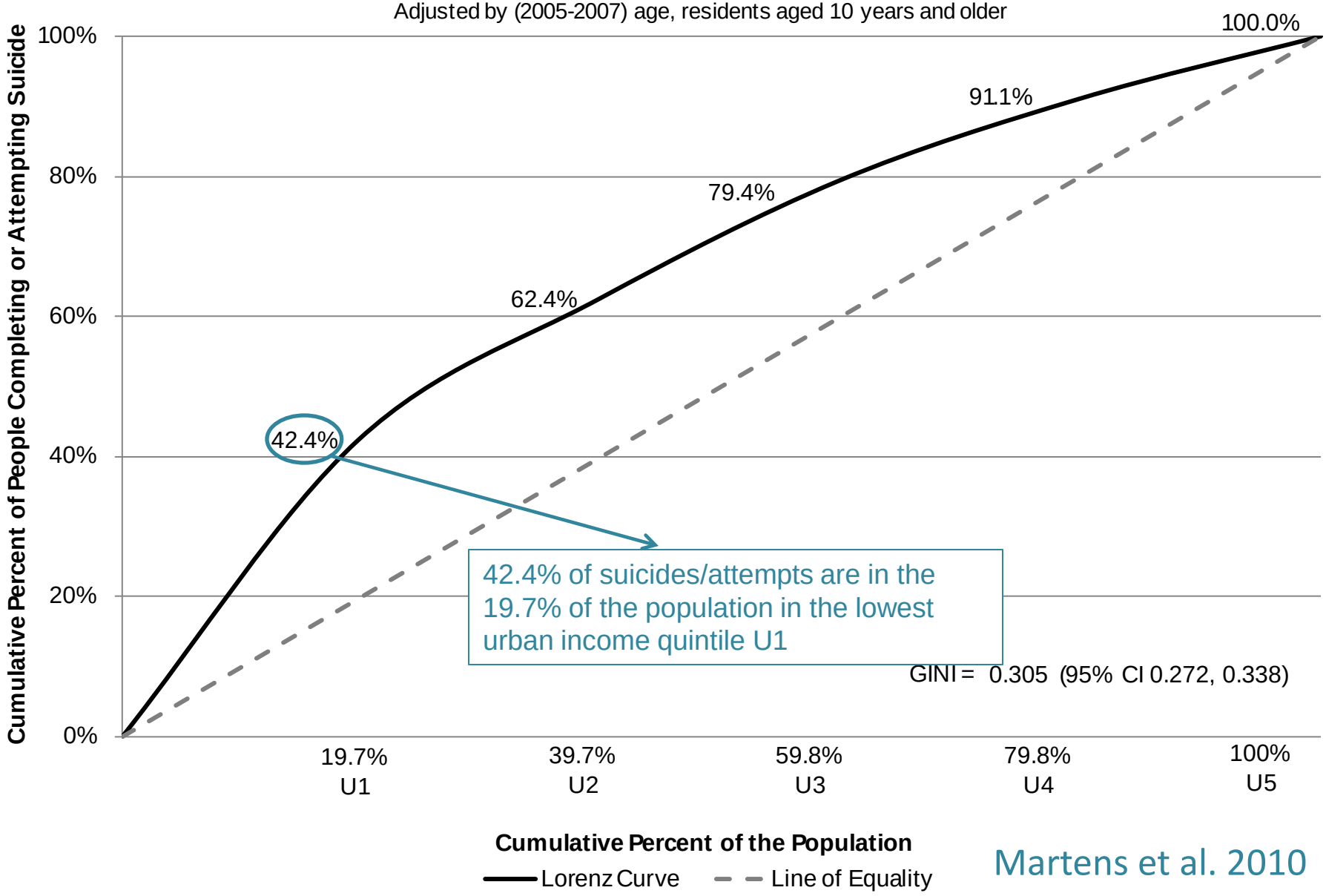
Comparison of Disparity Rate Differences T8 to T1: 2.81, p<.001

Martens et al. 2010

Source: Manitoba Centre for Health Policy, 2010

Figure 7.22: Adjusted Lorenz Curve for Completed or Attempted Suicide in Urban Areas, 2005-2007

Adjusted by (2005-2007) age, residents aged 10 years and older

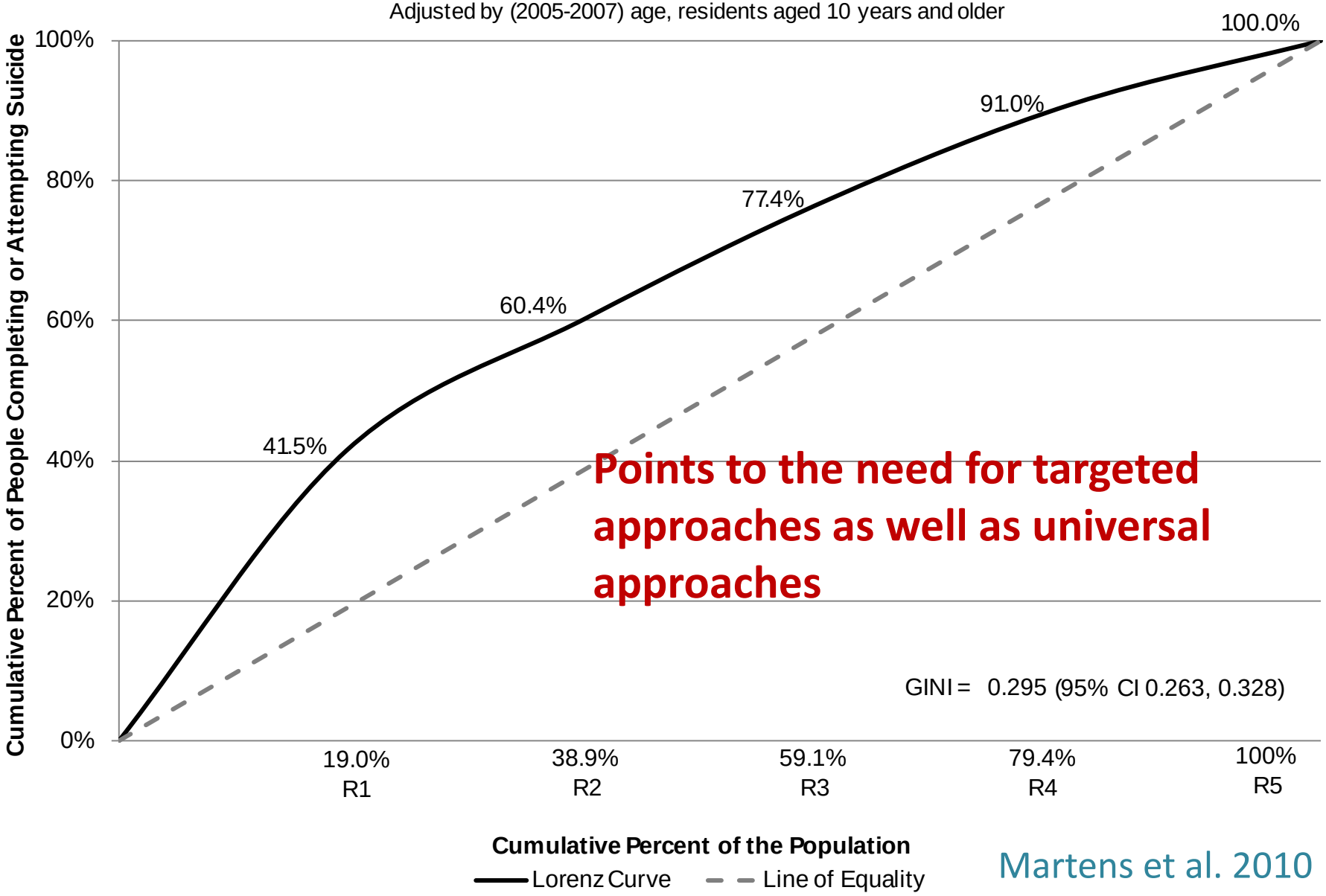


Martens et al. 2010

Source: Manitoba Centre for Health Policy, 2010

Figure 7.20: Adjusted Lorenz Curve for Completed or Attempted Suicide in Rural Areas, 2005-2007

Adjusted by (2005-2007) age, residents aged 10 years and older



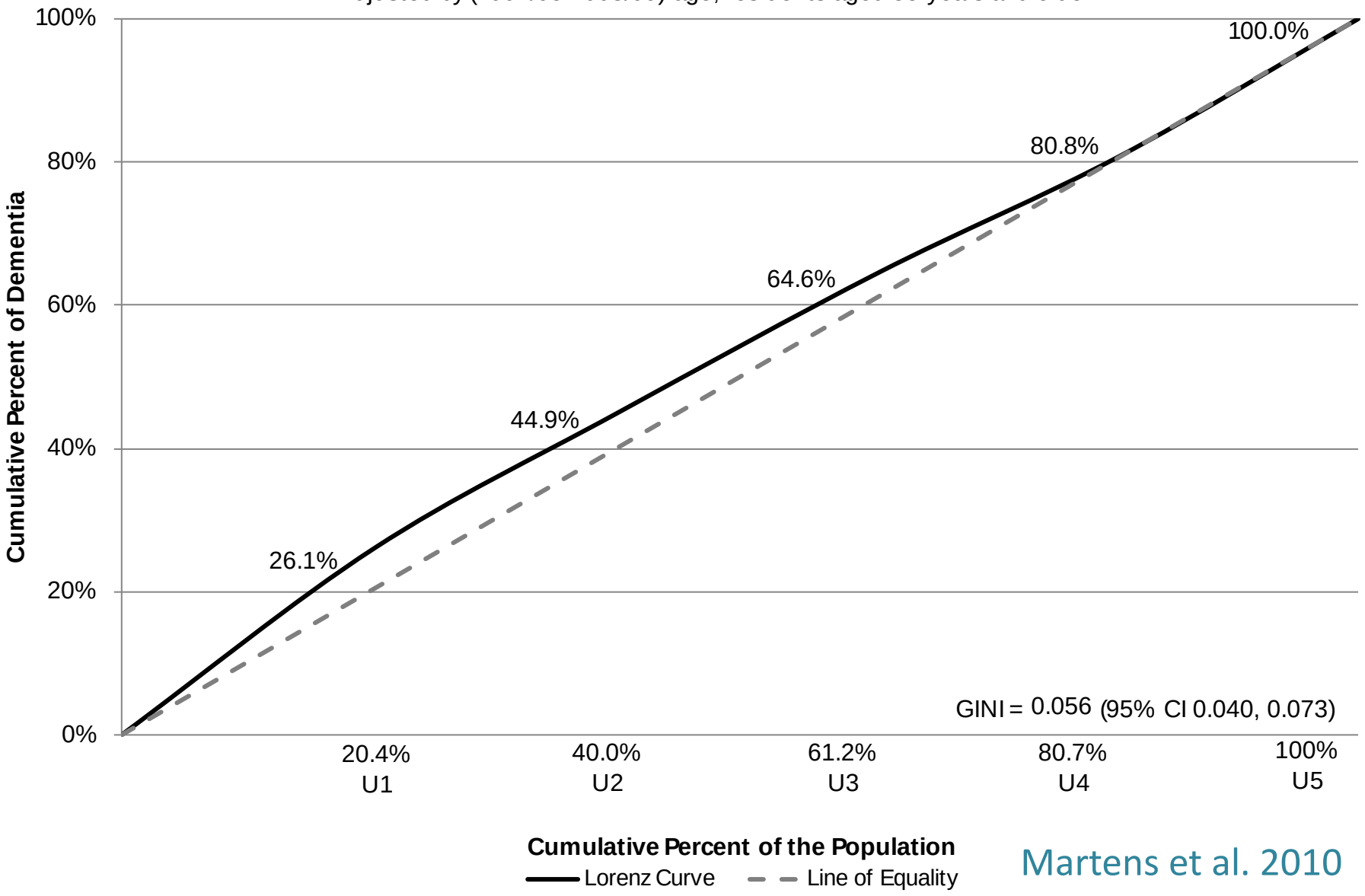
Points to the need for targeted approaches as well as universal approaches

Martens et al. 2010

Source: Manitoba Centre for Health Policy, 2010

Figure 7.14: Adjusted Lorenz Curve for Dementia in Urban Areas 2004/ 05-2008/ 09

Adjusted by (2004/05-2008/09) age, residents aged 55 years and older

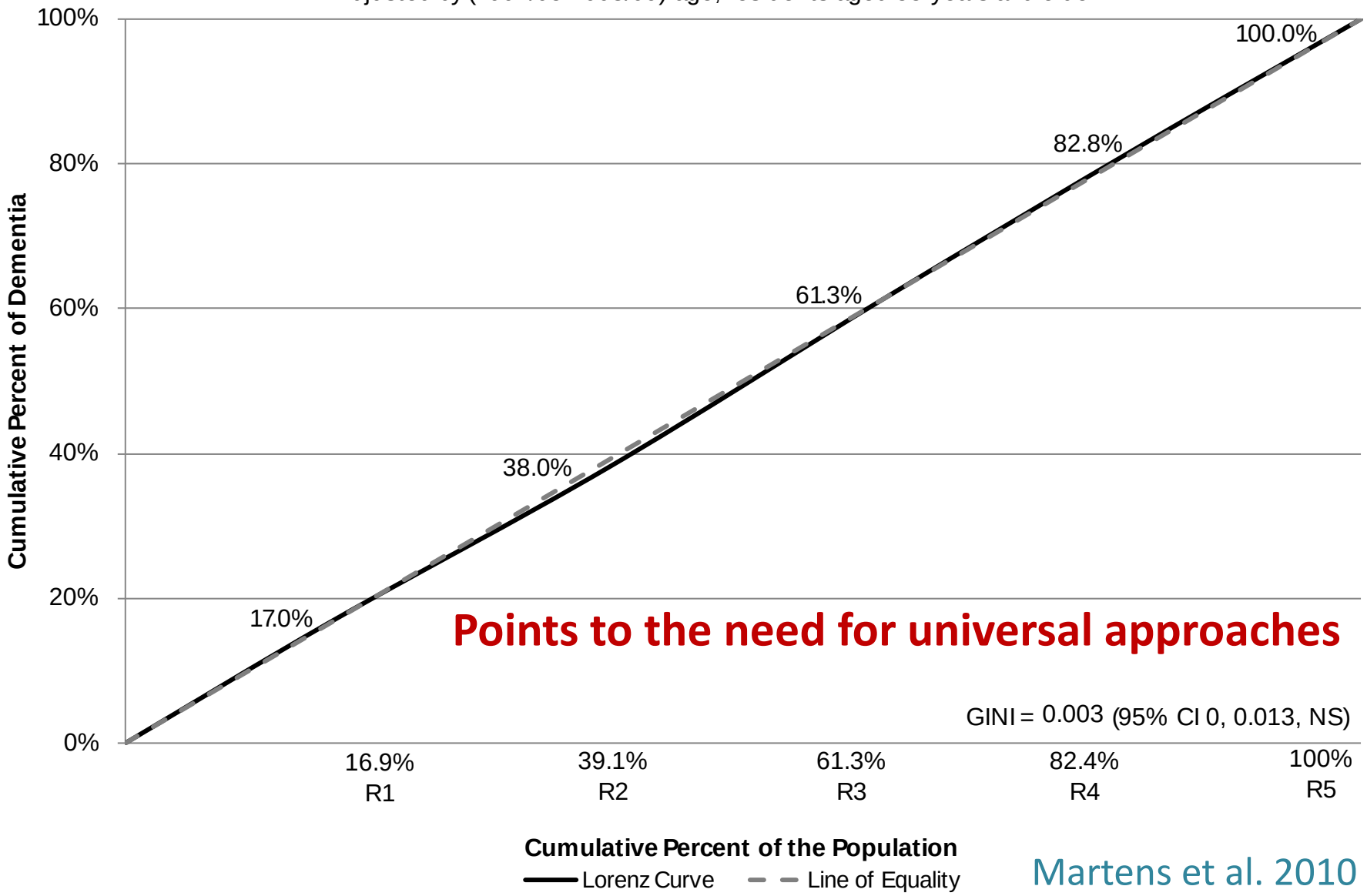


Martens et al. 2010

Source: Manitoba Centre for Health Policy, 2010

Figure 7.12: Adjusted Lorenz Curve for Dementia in Rural Areas 2004/05-2008/09

Adjusted by (2004/05-2008/09) age, residents aged 55 years and older



Martens et al. 2010

Source: Manitoba Centre for Health Policy, 2010

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Table E.5: Percentage of health events occurring in the lowest income quintile group, for most recent time period

Indicator	Percentage of the health event which occurs in the lowest income quintile group (bracketed number shows the exact percentage of the population in the lowest income quintile group for that indicator)*	
	Rural percentage	Urban percentage
Premature death before age 75	**29.1%** (20.0%)	**33.4%** (19.5%)
Potential years of life lost	**33.0%** (20.0%)	**38.5%** (19.5%)
Death before age five	**31.2%** (26.2%)	**37.7%** (24.0%)
Teen pregnancy	**44.7%** (22.5%)	**44.6%** (17.4%)
High school completion	**13.9%** (19.9%)	**11.0**% (16.5%)
Dental extractions ages 0-5	**53.6%** (26.0%)	**55.9%** (23.7%)
Breastfed newborns	**22.3%** (27.7%)	**23.2%** (26.2%)
Diabetes age 19 and older	**28.8%** (18.2%)	**27.4%** (20.2%)
Amputation due to diabetes	**45.9%** (26.2%)	**44.9%** (26.0%)
Ischemic heart disease	**24.4%** (18.2%)	**23.9%** (20.2%)
Multiple sclerosis	**13.5%** (18.4%)	**19.0%** (19.8%)
Continuity of care	**16.3%** (18.3%)	**19.5%** (20.8%)
Hospitalization for TB	**57.8%** (19.9%)	**52.3%** (20.0%)
Pap tests	**14.6%** (18.3%)	**16.7%** (19.1%)
Mental illness age 10 and older	**20.1%** (18.9%)	**25.0%** (19.8%)
Dementia age 55 and older	**17.0%** (16.9%)	**26.1%** (20.4%)
Suicide/suicide attempts age 10+	**41.5%** (19.0%)	**42.4%** (19.7%)
Beta-blocker prescriptions post-heart attack	**22.5%** (23.6%)	**24.3%** (25.0%)

*note: if the health events are distributed equally amongst the five income groupings in rural and urban Manitoba, then the percentage of health events should equal the percentage of the population in the income group, i.e., around 20% of health events in 20% of the population

Martens et al. 2010

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A little diversion into epidemiology

TWO IMPORTANT IDEAS

- How to design the world for change
- The importance of lots of people doing a bit (rather than focusing on a few people doing a lot)
  - Elements of the Rose Theorem

Paradigmatic obstacles to improving the health of populations -Implications for health policy*

John B. McKinlay, Ph.D.[1]

**McKinlay JB.
Paradigmatic obstacles to improving the health of populations -Implications for health policy.
Salud Publica Mex 1998;40:369-379.**

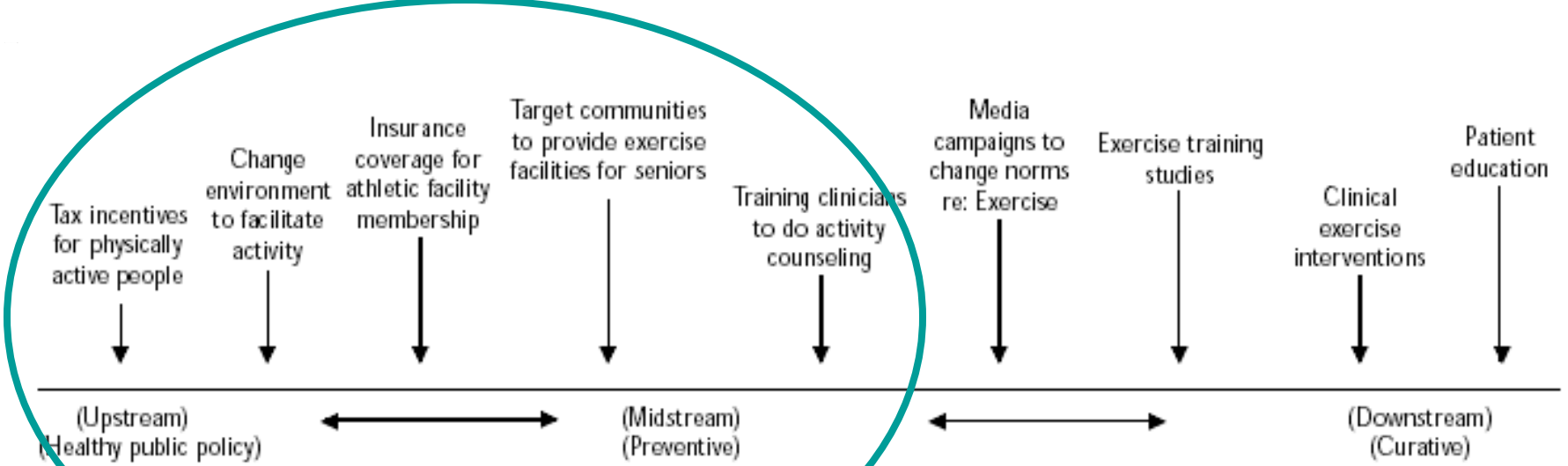
Abstract

While there are promising developments in public health, most interventions (both at the individual and community levels) remain focused on "downstream" tertiary treatments or one-on-one interventions. These efforts have their origins in the biomedical paradigm and risk factor epidemiology and the behavioral science research methods that serve as their handmaidens. This paper argues for a more appropriate balance of "downstream" efforts with a more appropriate whole population public health approach to health policy –what may be termed a social policy approach to

**McKinlay JB.
Obstáculos paradigmáticos para mejorar la salud de las poblaciones: implicaciones para las políticas de salud.
Salud Publica Mex 1998;40:369-379.**

Resumen

Aunque existen desarrollos prometedores en el área de la salud pública, la mayoría de las intervenciones (en los ámbitos individual y comunitario) se enfocan al tratamiento terciario de tipo curativo o se trata de intervenciones individuales. Estos esfuerzos tienen sus orígenes, tanto en el paradigma biomédico y la epidemiología de factores de riesgo, como en los métodos de investigación de las ciencias de la conducta, que actúan como sus herramientas. Este documento plantea un balance entre los esfuerzos de atención curativa y los esfuerzos más apropiados de una política

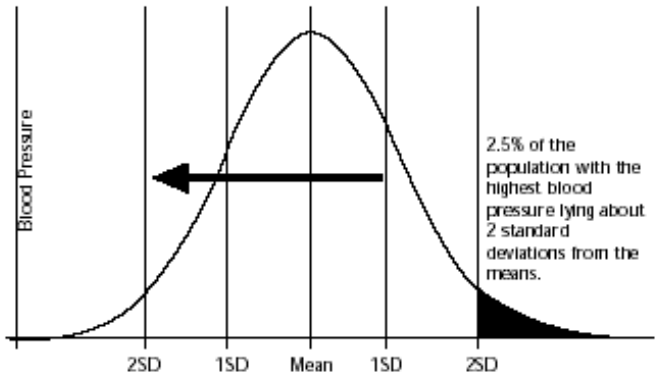


From: Jette, 1994

FIGURE 3. POINTS OF INTERVENTION FOR PHYSICAL INACTIVITY

Paradigmatic obstacles to improvin the health of populations -Implicatio for health policy*

John B. McKinlay, Ph.D.[1]



The public health approach involves a shift in the entire distribution to the left.

From: reference 64

FIGURE 2. THE NORMAL DISTRIBUTION OF BLOOD PRESSURE IN A HUMAN POPULATION

McKinlay JB.
Paradigmatic obstacles to improving the health of populations -Implications for health policy.
Salud Publica Mex 1998;40:369-379.

McKinlay JB.
Obstáculos paradigmáticos para mejorar la salud de las poblaciones: implicaciones para las políticas de salud.
Salud Publica Mex 1998;40:369-379.

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The importance of a population perspective on public health

- **Rose's Theorem:** "a large number of people at small risk may give rise to more cases of disease than a small number who are at high risk."

  – Rose, G. The Strategy of Preventive Medicine. Oxford, England: Oxford University Press; 1992.

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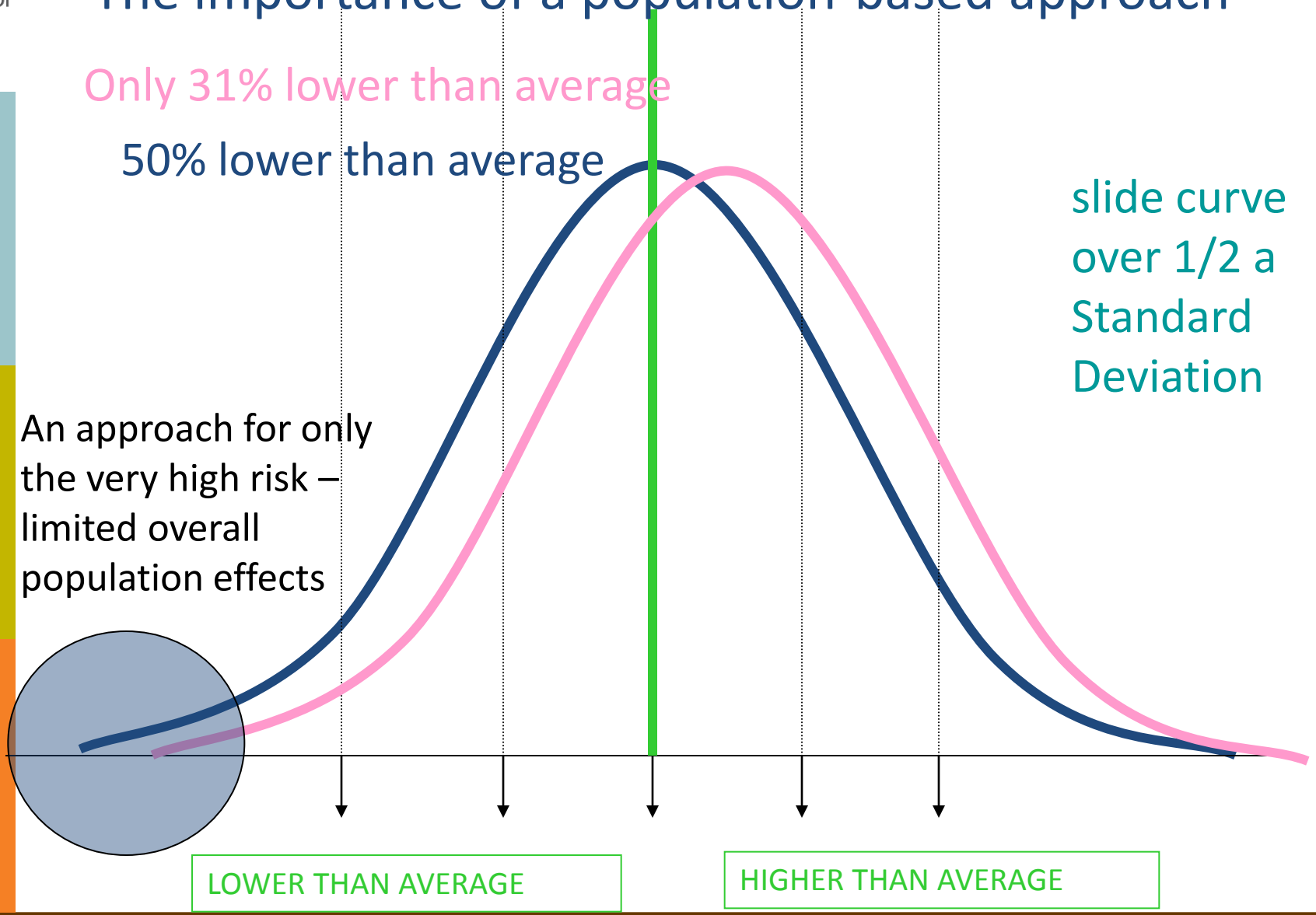
The importance of a population-based approach



ORIGINAL ARTICLE

Breastfeeding and Child Cognitive Development

New Evidence From a Large Randomized Trial

Michael S. Kramer, MD; Frances Aboud, PhD; Elena Mironova, MSc; Irina Vanilovich, MD, MSc; Robert W. Platt, PhD; Lidia Matush, MD, MSc; Sergei Igumnov, MD, PhD; Eric Fombonne, MD; Natalia Bogdanovich, MD, MSc; Thierry Ducruet, MSc; Jean-Paul Collet, MD, PhD; Beverley Chalmers, DSc, PhD; Ellen Hodnett, PhD; Sergei Davidovsky, MD, MSc; Oleg Skugarevsky, MD, PhD; Oleg Trofimovich, BSc; Ludmila Kozlova, BSc; Stanley Shapiro, PhD; for the Promotion of Breastfeeding Intervention Trial (PROBIT) Study Group

Context: The evidence that breastfeeding improves cognitive development is based almost entirely on observa- subtle er's be- clusive at age t from p from als and ing in- re fol- ention modeled on the Baby-Friendly Hospital Initiative by the World Health Organization and UNICEF.

Main Outcome Measures: Subtest and IQ scores on the Wechsler Abbreviated Scales of Intelligence, and teacher evaluations of academic performance in reading, writing, mathematics, and other subjects.

Results: The experimental intervention led to a large increase in exclusive breastfeeding at age 3 months (43.3% for the experimental group vs 6.4% for the control group; $P<.001$) and a significantly higher prevalence of any breastfeeding at all ages up to and including 12 months. The experimental group had higher means on all of the Wechsler Abbreviated Scales of Intelligence measures, with cluster-adjusted mean differences (95% confidence intervals) of +7.5 (+0.8 to +14.3) for verbal IQ, +2.9 (−3.3 to +9.1) for performance IQ, and +5.9 (−1.0 to +12.8) for full-scale IQ. Teachers' academic ratings were significantly higher in the experimental group for both reading and writing.

Conclusion: These results, based on the largest randomized trial ever conducted in the area of human lactation, provide strong evidence that prolonged and exclusive breastfeeding improves children's cognitive development.

Trial Registration: isrctn.org Identifier: ISRCTN37687716

Arch Gen Psychiatry. 2008;65(5):578-584

IQ: mean is 100, SD is 15.

Breastfeeding research often finds a 4 to 7.5 point difference (even in the RCT of Kramer et al. 2008)

i.e. ¼ to ½ a SD!!

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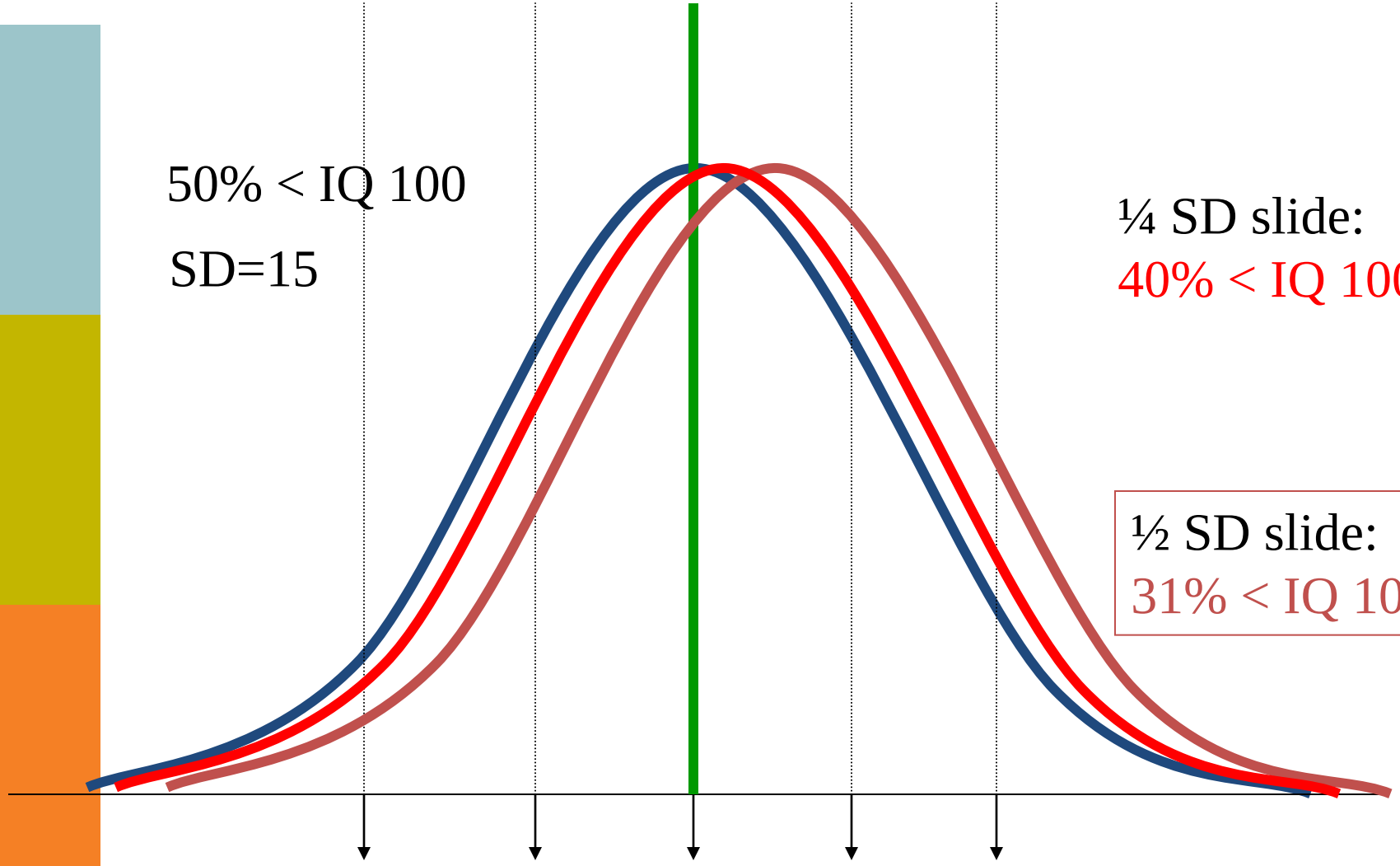
50% < IQ 100

SD=15

¼ SD slide:
40% < IQ 100

½ SD slide:
31% < IQ 100



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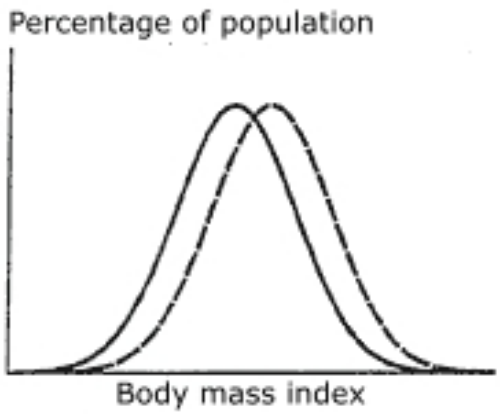
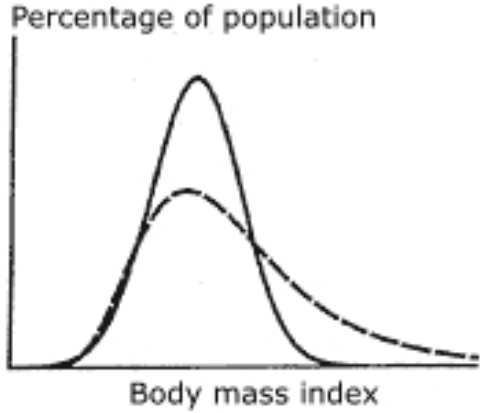
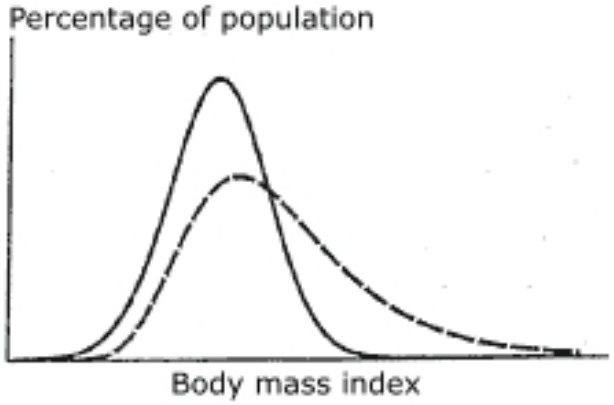


(A)



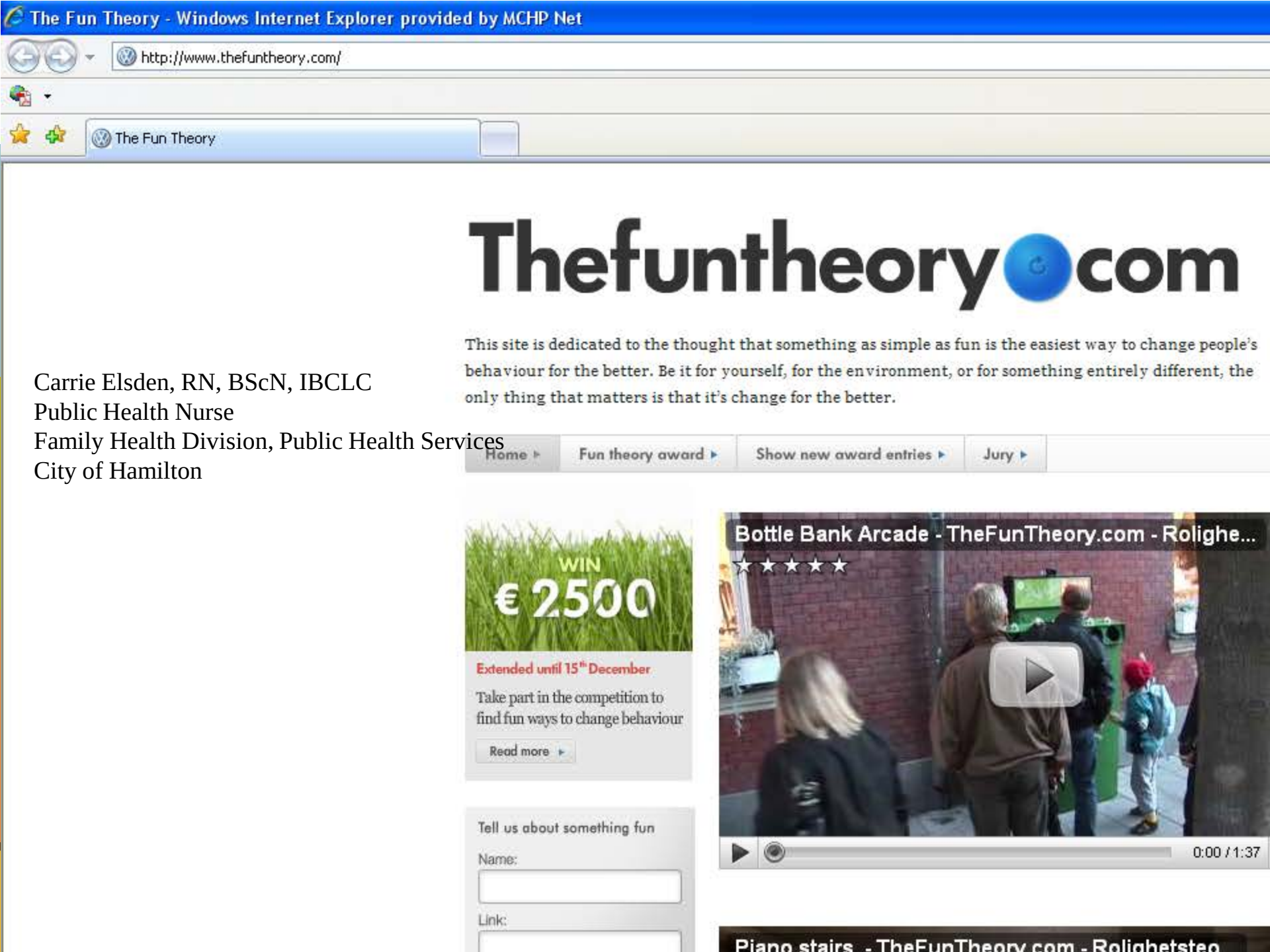
(B)

So how do you not "leave people behind" in a shift?? Shift and squish? Use upstream, midstream and downstream simultaneously!



(C)

- Making the “right” choice the easy choice
  - Upstream measures are essential (in combination with mid- and downstream)



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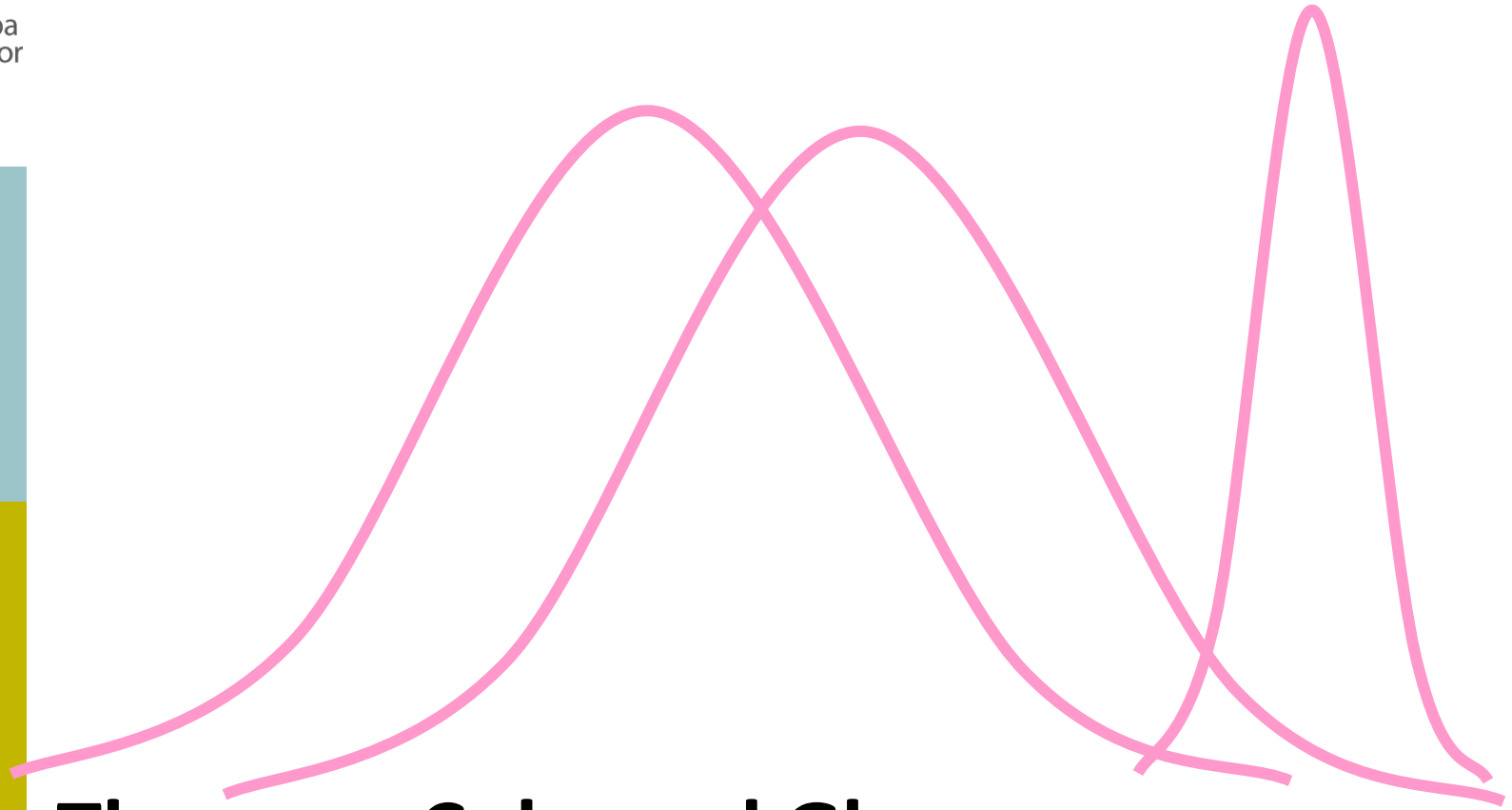

Rose-Theorem Coloured Glasses:
Population-based Effects of SHIFT and SQUISH!
UNIVERSAL AND TARGETED programs
Marmot Review's proportionate universalism
Shape our future to reduce inequity!

University of Manitoba | Faculty of Medicine
Community Health Sciences

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What does it take to shape our future together?

- Rose Theorem perspectives – put on those Rose-Theorem glasses
- Reduction of inequity
- Research on what works to shift and squish
- Research and health messages turned into stories (melt the ice)
- Relationships across all sectors

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www.umanitoba.ca/faculties/medicine/units/mchp/

Youtube video about our workplace …
http://www.youtube.com/watch?v=r--a96JEuXo&feature=youtube_gdata