Using evidence to bring “balance” along the continuum of care

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The issue – an important problem for Public Health

- Special challenges in promoting evidence to action for ‘upstream’ use of evidence
  - Issues related to “soft” science
  - Data driven or evidence informed?
  - Issues of low health system awareness
  - Particular challenges for evidence related to ‘underserved’ populations
    - ‘marginalization of evidence’

- Common result: even when compelling evidence, important issues often fail to ‘make it on to the agenda’ of health planners
Collaborative WRHA initiative – 2 phase CIHR Knowledge to Action grant (2005-09)

• Focus – *What strategies are effective in moving evidence related to culturally diverse populations into action?*

• Phase 1: *Interpreting* knowledge into action
  – Language access/trained health interpreters

• Phase 2: *From interpreting to integrating marginalized evidence*
  – Ethnicity indicators in health data collection
  – I/R health service planning
  – Regional concept paper (diversity/cultural proficiency)
  – Focused Community Health Assessment report
The example of language access

- KT strategies focused on 4 clear stages
  - Getting issue on the agenda
  - Informing the response
  - Informing implementation
  - Changing practice

- Organizational/community/research collaboration

- Continual focus on evidence
  - Synthesis of research, demographic data & projections, local & national consultations
  - Summarized in 2 reports
    - *Language barriers in the WRHA: Evidence and Implications*
    - *Development of a coordinated response to addressing language barriers within the WRHA.*
  - Ongoing role in informing decisions on priority areas, communities, and services
What “evidence”? 

- Critical review of international research literature
  - Phase 1: impacts of language barriers, untrained interpreters
  - Phase 2: issues related to model development
- Demographic data and predictions
- Experience of trained health interpreter services in other jurisdictions
- Organizational experiences, priorities & challenges
- Experience and preferences of communities
How was “evidence” used?

1. Illustrate the importance of the problem, health and organizational impacts (Phase 1)
   - Getting it on the agenda (“we have a problem”)
   - Identifying strength of evidence of risks in key areas
     • Evidence related to Primary care, prevention, promotion
     • Linked to organizational integrated risk management framework

2. Design an ‘evidence-informed’ model (Phase 2)
   - Approval to support/fund a model that addresses issues identified in Phase 1.

3. Inform implementation (including training, standards) and provider/manager educational interventions (ongoing)
Phase 1: Determining the impacts

- Literature review highlighted risks in key areas
  - Health promotion
  - Prevention/screening
  - Primary care – receipt of recommended care
  - Reproductive and mental health

- Lack of fit with acute care based interpretation services

- Mapping evidence on impact of language barriers on utilization and costs
  - Including barriers to early, initial access, health promotion, ambient information
  - Visible vs. invisible costs
Phase 1: Determining the impacts

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- Looking at organizational risk
<table>
<thead>
<tr>
<th>CORPORATE RISK FRAMEWORK</th>
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<tr>
<td><strong>BUSINESS RISK</strong></td>
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<td>Risks that may relate to the delivery of health care that include internal and external factors impacting on the operations of the department.</td>
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<td>Quality Care &amp; Patient Safety</td>
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<td>- Admission, Transfer and Discharge</td>
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<td>- Patient Assessment</td>
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<td>- Care and Service Accessibility</td>
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<td>- Care Team Service Plan</td>
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<td>- Informed Consent</td>
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<td>- Treatment, Procedures and Surgery Consults/Referrals</td>
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<td>Corporate Governance</td>
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<td>- Strategic Goals &amp; Objectives</td>
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<td>- Performance Reporting and Measurement</td>
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<td>- Culture and Ethics</td>
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<td>- Research</td>
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<td>- Community Partnerships and Alliances</td>
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<td>- Organizational Structure</td>
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<td>Operations &amp; Business Support</td>
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### WINNIPEG REGIONAL HEALTH AUTHORITY

**RISK ASSESSMENT AND CONTROL EVALUATION MATRIX**

**PROGRAM/SERVICE**  
**OBJECTIVE(S)**

**INHERENT RISK FACTORS** have a direct impact on the level of risk associated with achieving the aforementioned objective (please list).

<table>
<thead>
<tr>
<th>Potential Risk</th>
<th>Impact</th>
<th>Expected Control</th>
<th>Actual Control</th>
<th>Control Gap</th>
<th>Residual Risk Analysis</th>
<th>Recommendation</th>
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<tr>
<td>13. The organization does not protect community against health hazards</td>
<td>- Increased likelihood of health hazard incidents - Poor response to &amp; management of incidents - Potential non-compliance with legal responsibilities</td>
<td>- Partnerships engage in activities to prevent health hazards, prepare for and respond to health hazards and prevent/manage outbreaks - Processes are in place for managing and sharing information about the health hazards that exist in the community</td>
<td>Public Health processes are in place and linked provincially</td>
<td>Language barriers prevent access to ambient information &amp; campaigns to prevent &amp; manage disease outbreaks – Lack of strategies to communicate with those not fluent in English</td>
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<td>- Adopt model for trained health interpreters - Develop strategic plan for communicating and integrating recommended model into organizational planning and processes – including communication regarding health hazards and disease outbreaks - Partner with community based groups to develop strategies for orientation and communication in first language</td>
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Phase 2: Designing a model

• Identifying the dimensions
  – Accountability
  – Role of interpreter
  – Interpreter employment
  – Location of interpreter services
  – Area of coverage of interpreter services
  – Scope of interpreter services

• Reviewing evidence for each dimension separately (e.g. strengths and weaknesses of each alternative)

• Decision-making based on this evidence

• Assembling the model from agreements made on each of the dimensions
E.g. Area coverage of service provision

- Institution, region or province

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<tr>
<th>Area of coverage</th>
<th>Advantages</th>
<th>Disadvantages</th>
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| Facility         | • Interpreters better known to staff  
|                  | • Can focus on populations served where high density  
|                  | • May be need for full time staff in some facilities  | • Interpreter cannot follow patient  
|                  |           | • Gaps in service  
|                  |           | • Inconsistent standards  
|                  |           | • Less cost efficient  
|                  |           | • Few language communities served  
|                  |           | • Often limited to acute care – evidence this is not where need greatest  |
E.g. Area coverage of service provision

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<thead>
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<th>Area of coverage</th>
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</table>
| Regional         | • Economies of scale  
• Consistency of personnel, service, standards  
• Greater # languages  
• More flexibility | • More difficult for staff to know individual interpreters  
• Travel time |
| Province         | • Larger service area efficiencies  
• Remote interpretation  
• MB context – WRHA provision of services | • Not yet models in other provinces  
• Negotiation with regions and province |
Developing recommendations

• Based on synthesis & analysis of information from:
  – Experience of established Canadian health interpretation programs
  – Results from Winnipeg-based consultations within all language constituencies
  – Data on currently available services in the Winnipeg region
  – Research literature: impact of language barriers & identified best practice in providing language access services
  – Organizational diversification research and theory
  – Demographic data and trends for Manitoba
  – Analysis of the strengths and limitations of the various model dimensions, and the potential of various responses to support identified best practice.
Key recommendations

- All four language constituencies
  - Aboriginal, immigrant, Deaf, official language minorities
  - Shared challenges, efficiencies of scale, commitment to consistent standards

- Single point of access
  - Input from communities, staff

- Acute care & community services
  - “Broad definition of health”
  - Evidence related to impact on health promotion, prevention, primary care services
  - System “costs” of barriers to primary care

- 24/7 coverage
  - Potential of current technology
Phase 3: Informing implementation

• Initial focus on reproductive, child health
  – Tertiary centre (outpatients)

• Resulted in increased demand for hospital based services (e.g. paediatric clinics)
  – Implications of costs to system
  – Reflection on principles of model

• Decision to confirm recommendation to “follow the patient”
  – FFS, community based
  – Availability to Cancer Care
    • screening clinics (e.g. Pap)
Evaluation strategies

- Collaborative (organizational, community, research) steering committees to develop and guide multi-faceted knowledge to action strategy

- Strategies tracked for each project
  - Language access
  - Language and ethnicity indicators
  - Immigrant Refugee working group
  - Concept paper, organizational diversity framework
  - Focused Community Health Assessment report

- Consultation with steering committees re: their experience of strategies

- Survey re: revised list of strategies
Results of evaluation of strategies

• Key Messages:
  – NOT techniques, but an approach
  – Integrated with operational planning
  – Partnership essential
  – Research “running alongside”
  – Overlapping and diversely interpreted activities

• Role of evidence use in:
  – Building consensus
  – Increasing capacity
  – Promoting change
  – Supporting quality services
Strategies

- Creating structures to engage planners, managers & staff with direct practice experience (LA Cttee)
- Recognizing importance of, time needed for, development of strategies for promoting EI action (regular reporting of research/evaluation activities)
- Starting with, & remaining focused on, evidence related to the issue (Reports, committee discussions)
- Ongoing researcher participation to inform activities/strategies (WRHA & CIHR funding)
- Positioning issue around emerging incidents and organizational pressures (e.g. PHIA)
- Building on success of related projects/initiatives
Strategies (2)

• Identifying key areas for decision-making around issue & addressing each separately (LA Services model)

• Combining local community and/or client experience with research evidence (use of local case examples)

• Aligning with provincial or federal policy direction or trends (e.g. immigration policy, trends)

• Working with strategically placed champions (VP role)

• Using evidence to address concerns of decision makers & staff (Cost model)

• Aligning with organizational strategic priorities or ongoing activities (e.g. risk management)
Strategies (3)

- Presentation of proposed response as a solution to an existing problem (e.g. organizational risks)
- Phased and sequential presentation of evidence over time (multiple and staged presentations to senior management)
- Mechanism (e.g. formal reporting, policy) for accountability within organizational structure (VP role)
- Providing forums that provide reflective space to consider evidence (role of LA committee)
- Developing & disseminating evidence-informed reports, backgrounders, concept papers (2 reports)
Result

- Recognition of issue – request for development of model for context
- Adoption of model – initial funding
- Unique characteristics of evidence informed model
  - Full spectrum of health services, including primary care, prevention, promotion
Ongoing challenges

• Keeping the issue on the agenda
  – Holding ground
  – Rational vs. naturalistic decision-making?
  – Competing priorities for $$
  – Visible vs. invisible costs

• Need for policy

• Educational challenges in large organization
Conclusion

- Evidence can be used to build consensus on issues across the continuum of care, and among diverse stakeholders
- Appropriate KT strategies can facilitate the needed shift to upstream interventions
- These strategies appear to be effective across a number of related activities to promote action on diverse populations
- Not a one-time activity
Acknowledgements

CIHR Knowledge to Action Grant (Phase 1 and 2)
- Co-investigators Dr. Brock Wright, Dr. Michael Moffatt, Jeannette Edwards, Anna Ling, Dr. Ingrid Botting, Dr. Catherine Cook, Dr. Sharon Macdonald
- Research Coordinator Michelle Gibbens

WRHA
- Language Access Committee
- Language and Ethnicity Indicators Steering Committee
- Immigrant/Refugee Working Group
References


- **Bowen S.** *Development of a coordinated response to addressing language barriers within the WRHA.* Winnipeg Regional Health Authority, 2005.

- **Bowen S.** *Language barriers within the Winnipeg Regional Health Authority: Evidence and implications.* Winnipeg Regional Health Authority, September, 2004.


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