Report of the International Scientific Advisory Group of the Institute for Public Health September 30th and October 1st 2013

A site visit by the International Scientific Advisory Group (ISAG) of the Institute was organized to seek expert advice to inform future directions. This report provides a summary of observations and input. A description of the process of the visit is included in the Addenda. Members of the ISAG participating in the visit included John Ayanian, Fred Paccaud and Ilse Treurnicht. Tom Feasby, former Dean of Medicine at University of Calgary, chaired the review.

1. Overview of most notable overall impressions

The Institute for Public Health has demonstrated commendable accomplishments in the academic realm since its creation, has attracted a cadre of talented and enthusiastic researchers and has clearly benefited from exceptional scientific leadership from Bill Ghali and more recently Lynn McIntyre. The Institute has earned considerable respect from both researchers and knowledge users in the health system in Alberta. It is clearly a major asset to the University of Calgary and to the Province and is poised to make much greater contributions.

Institute leaders have done an outstanding job of developing junior investigators and are building a great foundation for future accomplishments. An important contribution of this foundation is the conceptualization of public health as inclusive of health services research as well as population health.

The Institute has demonstrated impressive return on the modest investment that the Faculty of Medicine has made. There are several opportunities that could position IPH to play a key role in the province with respect to making significant contributions to 'better health and health care'. While impact in the province is an essential focus, this Institute has considerable potential to do work that impacts other places in Canada and other countries.

2. Optimizing Scientific Output

a. Strategies for linkages, partnerships, KT

The internal peer review process and responsive mentoring program supported by the Institute are highly valued by research members from various departments and Faculties. The provision of space and a 'meeting space' (real and virtual) has been an important asset for investigators who felt somewhat 'orphaned' or had limited opportunities to connect with researchers with complementary interests. This is particularly important for those from other Faculties or other departments in the Faculty of Medicine than Community Health Sciences.

While we only received indirect evidence of the number and nature of partnerships, we believe there could/should be more industry partnerships reflected.

b. Themes/Priorities

While the three priority themes (health system performance; population health; tools and methods for public health) seem reasonable, it would have been helpful to have a more substantive description of activities under each of those themes. The themes as described do not 'speak to' the public and other

key partners as effectively as they could. There may be benefit in reframing priorities using targets that reflect community needs (e.g., low income children; frail seniors) and under which many of the research activities could be grouped.

W21C has been a high-profile and successful venture in many respects and is nearing its 10th anniversary. However, as presented to the Advisory Group it seems to have a rather limited horizon with respect to system performance. It is surprising that there was no intellectual property accruing to the University from work based at W21C. There could be fuller integration of the work in W21C with the rest of IPH work. The identification of community-based care in the home is a timely topic. In addition to the current focus on simulation training of students and health care professionals, a greater focus should be placed on assessing whether these training programs and innovative care processes fostered by W21C are linked to improved outcomes. Further, an alignment with massive developments in health care is needed, e.g., the development of care provided by non-professionals or the delegation of competencies between professionals.

W21C could generate its own opportunities rather than responding primarily to others' priorities. It may be timely to refresh the vision for the Ward (including perhaps renaming it?), given its profile within the IPH enterprise. Research presentations we saw from other IPH groups referred to crucial areas where system performance could be a focus as well (e.g. kidney disease; inflammatory bowel disease). This represents an important opportunity for linking W21C within IPH.

The contribution of tools and methods to international projects is notable; given reportedly strong data sets available for Alberta, could this expertise be put to demonstrable use to affect health information management in this province?

The WHO work seems to 'stand alone'. Is there opportunity for application in the local context? There also may well be opportunity for collaboration and application beyond Alberta's borders. For example, accountable care organizations that are developing at the state and local level in the USA may benefit from this expertise.

The population health focus on inequities, although an emerging centre at present, has considerable potential, especially if it continues to incorporate interventions into its work rather than focusing primarily on descriptive social analyses. It would be beneficial to highlight and focus on a small number of specific targeted priorities and coalesce efforts to make a difference in a few areas (e.g., improve prospects for low income children or frail elders). This will be helpful in fundraising efforts and will help to engage new strategic partners. This would improve the likelihood of impact.

Social inequities is an overarching concern in many areas, and could/should be considered across all research groups and not limited to those projects within that centre. It is desirable to infuse other groups with this important concept and this could lead to impact measures for linkages within IPH.

The priority areas above quite naturally reflect areas where there is particular strength in Calgary. Questions to consider in future strategic conversations include:

- Is there a need to include genomics, metabolomics and gene/environment interactions as a core component of some selected streams of research?
- Can health economics play a greater role in the activities of the Institute?

c. Focus on CIHR

Focussing on the CIHR is natural as it represents the gold standard for competitive funding. However, it is essential to assess important achievements in fund procurement from multiple sources (e.g., Social Sciences and Humanities Research Council; National Science and Engineering Research Council, Heart and Stroke Foundation) that are appropriate and support a public health agenda. This is essential to reflect the diversity of the group and its aspirations.

3. Optimizing Societal Impact

a. Strategies for linkages, partnerships, KT

Strengths include strong working relationships with many groups (e.g., Alberta Health Services, City of Calgary, and perhaps aboriginal groups.) It is notable that there is no formal relationship (with attendant financial contribution) with Alberta Health Services given the history of co-sponsoring other institutes and obvious complementarity of interests. Cementing this partnership formally with AHS and selecting a small number of projects to demonstrate value are key next steps, although the partnership is more important than the funding.

We heard about the improved access to health data through AHS, with AH data added. This is critical to the success of IPH. We encourage IPH to work with AHS closely to ensure access to the data for all researchers and to expand the data sources to include provincial data on justice, education, socioeconomics, etc.. This would provide a very powerful tool for studies on both 'health and health care'.

IPH has developed effective processes for internal peer review and mentoring regarding research outputs. Similar processes should be introduced to focus on outcomes that impact society through improved health policies, population health, and health care delivery. The IPH could demonstrate unique value to its research and community members by building specific capacity for KT and impact delivery that is helpful to all research teams in the Institute.

b. Themes/Priorities

The priority themes have naturally been built on the strength of the members, leading to demonstrated academic accomplishments. When the focus is on informing and supporting positive changes in society from a population based perspective, closer alignment/engagement with knowledge users and health system leaders to set priorities and conduct research is desirable.

Priorities should be revisited while thinking through a strategy that includes impact at the population level as a critical outcome. In collaboration with a key partner (e.g., AHS) one or two areas should be chosen for 'deep engagement' through which to demonstrate and learn how to work together effectively for impact. This is a natural next phase for the Institute. Relationships with key decision-makers and influencers should be developed and could be enhanced by, for example, shared fellowships where the candidate spends time in both settings. Another way to go could be to develop joint-appointments between the IPH and the agencies addressing public health themes.

It is not clear what role the Institute is taking with respect to advocacy for public policy. There were several areas mentioned (HPV vaccinations, fluoridation, salt content of foods) where members clearly have played a role, but this is not identified as a strategic priority. There were other areas where it seemed clear advocacy and/or education was warranted (e.g., marketing of food to children), but a clear strategy was not identified. There are no doubt opportunities with community partners who must be involved in implementation of any desired changes (e.g., City of Calgary, school system).

Knowledge use or change implementation needs to be identified as a priority. The Institute should strive to create a knowledge culture around impact strategies. For example, it may be helpful to step back and revisit the whole process around the fluoridation issue and identify lessons for future work. How does the team learn to advocate? How is the team socialized to accept advocacy and policy influence as a legitimate stream of work? (After academic integrity of the position has been determined).

Taking a public role on health issues is a legitimate and key strategy for IPH. Doing so will help to advance the visibility and credibility of public health as a system of knowledge. Building more effective relationships with the School of Public Policy at the University, or other relevant partners, should be considered.

4. Aligning IPH's Organization for Success

a. Governance structure

The structure that has evolved (Scientific Director, Associate Scientific Director, and Administrative Director) and Executive Committee and Strategic Advisory Board seems to be working well. The Executive Committee and Strategic Advisory Board are advisory to the Institute leadership. Members of the Executive Committee take active roles in specific operational areas (mentorship, seminars). Its role in governance is less clear. There is meaningful involvement of key agencies in structures (e.g., AHS, multiple Faculties). With the creation of the Strategic Advisory Board and implementation of a fund raising plan, it can be expected that the governance will become more formal. Very strong dependence on the current Director and Associate Director creates a potential risk for the Institute. Efforts should be made to develop leadership talent and create shared leadership opportunities for emerging leaders within IPH. This will lead to more time available for the senior leaders to focus on external relationships to foster greater policy impact, leadership development and strategy.

b. Membership

The Institute has done a good job of attracting a broad base of members from both the academy and from the community. There was little descriptive information about the members of the Institute, with the exception of data showing that approximately 50 (of 330) members produced most of the research publications. An asset map of members' attributes would provide a more robust understanding of the characteristics and interests of all members and would inform many aspects of the Institute's activities, especially in regard to establishing a firm foundation for knowledge translation and uptake. It will also allow for targeted service offerings and engagement strategies for the different groups.

There is a natural tension surrounding the membership process – the desire to be inclusive versus a need to be performance driven. Viewing the two processes as related but distinct (engaging members and focusing on results) could be helpful in promoting engagement and driving the best performance.

c. Operations/ core budget

The operating budget (about $250,000 per year) is very modest relative to the mandate for IPH and opportunities to have greater impact. The Institute has been remarkably productive. Given the strategic importance of the Institute to the Faculty of Medicine and the University, a greater contribution to core operating funds is essential and would be a highly worthwhile investment likely to yield a highly valuable return. This Institute is ideally positioned to align with the national/ international movement toward pillars 3 and 4 (CIHR terminology) of translational research.

The Institute is the natural home for highly engaged relationships with Alberta Health Services. As noted above, a more formal partnership with AHS would be an important step to institutionalize a working relationship that has benefit for both partners. It is anticipated that this would include a specific financial commitment as well, but the importance goes well beyond funding.

The currently available funds are used appropriately and to good advantage. There are some compelling places where additional funds would be beneficial (e.g., faculty recruitment, support of trainees; cross sectoral international fellowships; knowledge translation and impact). The proposed budget if fund raising is successful is focused primarily on building research capacity. This direction is important but should be revisited after strategic discussions surrounding societal impact are held and should reflect specific plans to enhance the desired impact of IPH on health and health care.

Fund raising is critical to future strategy and success. We recommend the University and Faculty engage with and support the Strategic Advisory Board to ensure fund raising targets are met. Other revenue generation streams (e.g., contract research; service contracts) should also be explored.

5. Benchmarking

a. Current performance and Metrics

The current academic achievements are commendable. Identification and monitoring of academic metrics and benchmarking should go beyond CIHR indicators. The academic metrics identified are appropriate. However, more effort is required to identify metrics that reflect societal impact. One example is to track how many knowledge users are involved in each project and in what ways. There were several examples given where IPH research had or will influence policy (e.g., banning of body checking in peewee hockey; changes to ICD11). Methods need to be developed to systematically track influence on policy and practice.

b. Appropriate comparator organizations

Organizations that may be worthy of comparison include: Manitoba Centre for Health Policy, centres that serve as a resource for public health practice by housing data and information systems (such as those based at Berkley and Denver), University of Michigan Institute for Healthcare Policy and Innovation, Dartmouth Institute and University of Toronto School of Public Health. As well, all of these could potentially be attractive partners.

6. SWOT analysis

a. Strengths

- Senior research leadership with national and international profiles.
- Growing cadre of successful researchers within IPH
- Effective and respectful working relationship with Alberta Health Services
- Commitment to standardized way of measuring to enable comparisons
- Ability of IPH to contribute to achieving goals of University of Calgary 'Eyes High' campaign
- IPH brings diverse researchers together to create synergy. Aligns with 'Human dynamics in a changing world' (University of Calgary priority)
- Ethics approval process is being harmonized in province (launch end of 2013).

b. Weaknesses

- Inadequate funding
- Inadequate resources and expertise related to knowledge translation and societal impact in the Institute.

c. Opportunities

- One single health service provider in province. (Unique globally) There is huge upside potential in this Alberta context.
- Access to health data repositories for analysis purposes, especially in AHS and AH has been enhanced recently, but is not yet fully operational.
- Strategic engagement of foundations that target areas being studied by IPH.
- Refresh vision/mission of W21C to reflect future priorities and to realize potential synergy by aligning work more closely with selected research programs of IPH researchers.
- The Health Information Act is being revised currently. There is opportunity to influence so that research that will benefit society is not rendered impossible.

d. Threats

- The ability of the team to achieve meaningful societal level change is directly linked to resources available. They have demonstrated their ability to achieve results with limited funding.
- Future plans rely heavily on private fundraising efforts.
- Departure of Scientific Director would create a risk to the sustainability of the Institute.
- Cuts to academic budgets and reductions in number of funded spaces in medical school.

4. Summary of Strategic Recommendations

- Faculty of Medicine and the University of Calgary commit more funds to core operating budget.

- A formal partnership agreement be negotiated with AHS with funding contribution, perhaps focused initially on one or two concrete demonstration projects that set out to specifically influence relevant health system performance.
- Develop an explicit strategy to enhance societal impact. Consider such things as formal relationship with AHS, targeted areas for improvement and position on advocacy activities.
- Enhance resources and expertise in knowledge translation.
- Examine closely the potential for moving into amalgamation of various sources of community data in additional to health and health system data – e.g., justice, education, socioeconomic. IPH should take a leadership role in public policy influence to achieve dual goals of having research informed policy and to enhance the profile of public health as a robust societal influence.
- Work with leaders of key programs within IPH (W21C, WHO collaborative, PHIRC) to align their program activities and plans with ISAG strategic recommendations related to societal impact, knowledge translation, partnership with AHS, and more explicitly defined outcomes related to the IPH mission to improve health and health care
- Consider partnerships with similar and complementary organizations beyond Alberta

Addendum 1. Agenda for the Site Visit

AGENDA

Institute for Public Health International Scientific Advisory Group (ISAG)
Monday, September 30 – Tuesday, October 1, 2013

Monday, September 30, 2013			
Time	**Location**	**Agenda Item**	**Participants**
8:00 – 9:00 (breakfast provided)	Rose Room, TRW 3rd Floor	Introduction • Meeting goals and deliverables • Agenda overview • IPH overview	Ichiro Kawachi (by phone) William Ghali Lynn McIntyre Jamie Day
9:15 – 10:15	W21C, TRW Ground Floor	Showcase of 3 IPH priority themes	W21 C - J DeGrood/J Conly WHO Collaborating Ctr - H Quan PHIRC - M Rock/L McLaren
10:15 – 10:45	W21C and TRW 3rd floor	Facilities tour	Jill DeGrood Jamie Day
11:00 – 11:45	Faculty of Medicine TRW 7th floor boardroom	IPH institutional environment	U of C Assoc VP Research - John Reynolds AHS VP Research – Kathryn Todd (by phone) Fac Med Dean - Jon Meddings Fac Med Assoc Dean (Clinical Research) - Sam Wiebe
11:45 – 12:15	TRW 3rd floor lunch room	Informal lunch	IPH Executive Committee, Ghali, McIntyre, Day
12:15 – 12:30		BREAK	
12:30 – 1:15	Rose Room	IPH organizational structure	IPH Executive Committee
1:15 – 2:45	Rose Room	Showcase of IPH researchers	Fiona Clement Charlene Elliott Brenda Hemmelgarn Gil Kaplan Tom Stelfox
2:45 – 3:00		BREAK	
3:00 – 5:00	Rose Room	Group work session	
5:00		Travel to offsite meeting	
5:30 – 6:30	Muse Restaurant, Kensington	Meeting with IPH Strategic Advisory Board	Strategic Advisory Board members
6:30 – 8:00	Muse Restaurant	Dinner	Strategic Advisory Board, Ghali, McIntyre, Day

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Tuesday, October 1, 2013			
Time	**Location**	**Agenda Item**	**Participants**
8:00 – 9:30 (breakfast provided)	W21C	Group work session	
9:30 – 11:00	W21C	Group feedback to IPH	William Ghali Lynn McIntyre Jamie Day
11:00		Departure of guests	

All meetings attended by:
John Ayanian
Ilse Treurnicht
Fred Paccaud
Tom Feasby (Chair)
Judy Birdsell (Recorder)

Addendum 2. List of Background Materials Pre-circulated

1. Terms of Reference. International Scientific Advisory Group
2. Terms of Reference. Strategic Advisory Board
3. Brief Biographies of Personnel involved in Site Visit
4. Institute for Public Health – Overview
5. Institute for Public Health – Metrics Report
6. Institute for Public Health – Communications Report
7. Institute for Public Health – Business Plan