HEALTH RESEARCH PRIORITIES SUMMIT:

Pier 21, Halifax. December 1, 2009

Executive Summary

The Nova Scotia Health Research Foundation (NSHRF) is updating its health research priorities. The objective of this initiative is to maximize the impact of the health research enterprise on informed decision-making through the focused and efficient use of NSHRF resources. As part of the Information Gathering phase, a number of background documents were prepared and an invitation only Health Research Priorities Summit was held. Participants at the December event included senior leaders in government, academia, District Health Authorities, and the health research community. The following questions were asked of participants in an effort to gather feedback to inform the priorities setting process.

What information is needed for decisions regarding the health of Nova Scotians? Summit participants talked about social demographics, chronic disease, invisible conditions like mental health and addictions, and workplace health. They felt that data must enable more precise analysis of issues by sub-population. They would also like to see information concerning best practices to address the province's priority health issues.

Where should we focus our energies for the greatest impact? Generally speaking, we should focus on building better knowledge transfer and exchange bridges amongst researchers, decision makers and communities … from science to policy to practice … to achieve research-based changes in public behaviour. Participants looked at this from 3 perspectives: the implications of how we (1) frame decisions; (2) support research; and (3) apply research findings (knowledge transfer and exchange, or KTE). To have impact, we must overcome tendencies to treat issues in isolation and to look for short-term results. Lack of alignment, lack of critical mass, and archaic IT systems must be addressed.

What did they advise about research priority development? First, participants talked about the roles that the Foundation might play: NSHRF as Architect of the Provincial Research Agenda? as KTE Catalyst or Enforcer? as Advisor/Coach to Decision-Makers? as Research Publicist? Then there was wide-ranging dialogue about priority setting that covered areas including: shifting the emphasis toward system-focused questions; looking at health program and system sustainability; greater emphasis on psycho-social questions; using KTE to foster inter-sectoral collaboration; finding links between research and community; and strategic use of teams in integrating dispersed intellectual capital or extending the reach of research to rural areas.

What is needed from NSHRF to ensure that the Province has been best served? Participants acknowledged the Foundation's transparency and track record in demonstrating accountability to date. Building on those strengths, they identified ways of monitoring progress with the strategies they had proposed for the earlier segments. They emphasized: using 'upstream' metrics drawn from the determinants of health as well as 'downstream' metrics targeting health status; tracking outcomes (and within that, socio-economic outcomes) not just outputs, and demonstrating KTE effectiveness.

Introduction

The NSHRF is updating its health research priorities. The objective of this initiative is to maximize the impact of the health research enterprise on informed decision-making through the focused and efficient use of NSHRF resources. The research priorities process has four phases: Process Identification and Information Gathering, Consultations, Priority Identification, Priority Implementation. This process is designed to be inclusive, respectful, fair, and transparent in order to respect the diversity of constituents that the NSHRF serves.

As part of the Information Gathering phase a number of background documents were prepared. These documents were considered "living documents" and were posted on the NSHRF website as they were completed for information, feedback, input and suggestions. If readers felt that information was missing, incorrect or misrepresented from any of the background documents, or the process, they had the opportunity to the NSHRF for consideration as priorities are established.

The Nova Scotia Health Research Foundation (NSHRF) was created by the Health Research Foundation Act and is required under this act to foster health research throughout the province by assisting, collaborating with and funding individuals and organizations conducting health research. According to its legislated mandate the NSHRF must support research that is consistent with the priorities identified by health boards, government, institutions and individuals. This report captures the findings from an invitation-only Health Research Priorities Summit held in December. Participants included senior leaders in government, academia, District Health Authorities, and the health research community.

The feedback in this document reflects the comments of Summit participants and may not be consistent with other documents that have been developed for the NSHRF's Priority Setting Process.

Summit Objectives

√ To gather input on the development of priorities that will directly impact the health of Nova Scotians;

… and in so doing,

√ To help inform the NSHRF Board's strategic decisions regarding organizational priorities.

Appendix A lists the attendees.

Nancy McCready Williams, CEO of the Workers' Compensation Board of Nova Scotia opened with perspectives on Informed Decision Making and Priority Setting. NSHRF CEO Krista Connell rounded out the context for the Summit with her remarks (see visuals, Appendix B).

Inside :

Advice Regarding Identifying & Addressing Diverse Needs

Facilitated small groups were asked:

a. *What are your most pressing short term, medium term, and longer term needs for information to make decisions (regarding the health of Nova Scotians)?*

b. *Where should we focus our energies to have the greatest impact? More specifically, what are the most important things that NSHRF could do to help improve the health of Nova Scotians through health research?*

Most Pressing Needs for Information to Make Decisions

Participants did not distinguish short term, medium term, and longer-term needs for information to make decisions regarding the health of Nova Scotians. They did, however speak to the types of information needed.

The Types of Information Needed (in no particular order)

- **Social Demographics.** Information is needed regarding: the health status of an aging population and workforce, the effects of immigration, the out-migration of our youth, and the return of retirees. Better, more comprehensive information could facilitate collaboration across institutions and allow us to "get ahead of the game".

  Poverty is already an issue amongst seniors, some not having contributed to pension plans until their 40s and 50s.

  There could be many more casual employees in light of the aging workforce.

- **Chronic Disease.** There are concerns about the looming burden of chronic disease as the boomer generation expands the segment of the population that is more susceptible.

- **Impacts of 'Invisible' Conditions.** Information is needed concerning the socio-economic impacts of 'invisible' conditions such as mental health and addictions. People feel well served relative to acute care. But given that we're spending only 3% of our budget on mental health and addictions, strides could be made through research in avoiding many downstream costs.

- **Sub-Populations.** Research for marginalized groups is different than for the mainstream. Health data must enable more precise analysis of issues by sub-population … e.g. by race, for marginalized groups and for communities within counties. Further, research for rural issues is different from urban. Community issues are different from counties.

- **Our Health Priorities (and related best practices)**
  - *An MLA's* pressing need is to know constituents' priorities: What are their major concerns, what do we already know about those concerns, and what are the major resources to address them?
  - *Academics* need information about priority research questions and strategy agendas at the DHA, provincial, and national levels.
  - *Policy and decision-makers* need information from other jurisdictions about best practices to address Nova Scotia's priority health issues. We know we have poor health

Most Pressing Needs for Information/Types of Information Needed (cont'd)

outcomes but we're data rich and knowledge poor. Best practice information would enable policy and strategy decisions about which areas could be addressed effectively at an affordable cost (or the benefits that could be achieved cost-effectively). For example, what are the best ways to emphasize local food supplies and farming to drive uptake of a healthier food supply and drive down unhealthy food consumption?

- *The Public* could use best practice information to help them achieve healthy lifestyles.

- **Workplace Health.** We lack a central resource with information about workplace health in Nova Scotia. The ability of methods like the Civility, Respect, and Engagement at Work (CREW) model[1] to produce measurable results should be explored.

Where should we focus our energies to have the greatest impact?

Nova Scotia is falling behind in: research dollars per capita[2]; in the proportion of research grants awarded in Canada; and in the role of education funding and support for research infrastructure. It was also noted that we miss opportunities to make our grant applications as competitive as possible (through pre-submission peer review, for example).

Participants addressed the question of focus from 3 perspectives: the implications of the way that we (1) frame decisions, (2) support research, and (3) apply research findings (knowledge transfer and exchange)

1. Implications of the Way We Frame Problems, Solutions & Decisions

We tend to treat issues in isolation due to competing interests. We also focus on near term investments and results. Both of these tendencies splinter our focus and compromise impact.

a. **Short vs. Long Term View.** Political will drives the system in a 4-year cycle. Although research can have longer-term time lines than elections, rewards for pursuing longer-term results are few. We need to shift to a long-term mindset relative to the issues, solutions, resource allocation, and evaluation.

   We talk about the expense of healthy living but do we know the real, long-term costs of not making these investments? What are the long-term costs of inequalities in social and economic status or illiteracy for example?

   We seem to consider short-term program expenses as barriers without factoring in longer-term costs to be avoided through prevention. Sustainable financial strategies won't emerge without effective social strategies. For example what savings could be achieved for the health system through the elimination of homelessness?

b. **Disease-Based Diagnosis & Treatment vs. Prevention & Health Promotion.** Groups perceive that NSHRF's historic priorities have been more aligned with acute care and academic centres, relatively speaking. We need a broader focus on health than just health care. The balance should shift further 'upstream' toward population health

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1 http://www.workengagement.com/

2 In Ontario, the government and various groups (including academia) invest more than 2.5 times what Nova Scotia does on research per capita.

investigating best practices for proactively addressing basic causes of poor health. Related observations:

- One group suggested for example that although harder to track, investments in the social determinants would help get at root causes of mental health and addictions.
- A disease-based approach doesn't flag mental health as an underlying cause of primary health care issues nor give the family doctor a central role in accessing appropriate resources.
- It would be interesting to look at the Teen Health initiative in the Annapolis Valley. Are those strategies … which are not disease-based … achieving different health outcomes?
- We shouldn't be considering healthy beginnings and early childhood development as distinct from family and child wellness from primary through to grade 12. They are not competing issues.

c. **Rural vs. Urban.** To achieve sustainable rural communities, we can't treat rural health delivery, education & environmental sustainability in isolation. They are not competing issues. Further, decision makers' 'bigger is better" thinking relative to health and education has to shift.

- Schools are costly to build, but consolidating them as we do renders school-based programs inaccessible to most communities. In rural areas, walking is often the only transportation option. What are the implications for rural health of reduced physical activity through bussing?
- Large, 24-hour emergency rooms centralized in regional centres are not necessarily better than local drop-in clinics.

d. **Professional Silos.** Professional competition (e.g. nurse practitioners vs. physicians) further illustrates the lack of an integrative approach. Many people are happy visiting nurse practitioners and are well served.

e. **Departmental Silos.** Finally, it's difficult to drill down for information across government departments on a topic of broad, system interest. Health, Justice and Community Services all play roles in addressing poverty for example. But it seems that each is unaware of information the others hold or of what they are doing.

Obviously our research must be attractive to government. However decisions are needed that don't win elections and research results may not be politically sexy. We must land on themes (including those around determinants of health) that do not change with the government of the day. And we need to shift to a more integrative, long-term mindset relative to the issues, solutions resource allocation, and evaluation. This will require educating decision-makers and working collaboratively to solve complex problems.

Where should we focus our energies (cont'd)

2. Implications of the Way We Support Research

Why are we falling behind?

a. **Lack of Alignment.** Nova Scotia has the most university seats per capita in Canada, but we have not aligned ourselves very well. Competition among researchers and institutions is a problem fueled by how grants are awarded. However to bring research to bear in ways that facilitate decisions, we must overcome this. We need to learn how to create optimum networks:

- *At the DHA level.* Given our province's size and number of organizational stakeholders, we should be able to identify collective priorities and impact outcomes fairly easily. Just because smaller health and academic institutions can't compete (alone) on the national stage doesn't mean that they couldn't contribute to the multi-disciplinary critical mass of a well-run network.
- *Across the Atlantic region* (the way that the Atlantic Computational Excellence Network (ACEnet[3]) created a network for high performance computing across the region).

b. **Lack of Critical Mass.** Focusing only on Nova Scotia when many of the issues are international, pan-Canadian or regional risks missing opportunities. Nova Scotia alone is too small to try and compete in every arena. Any time a province is getting more than what's expected (as BC is), they have focused on creating critical mass through clusters of excellence.

Even greater leverage could be achieved if the Maritime or Atlantic provinces were to collaborate strategically.

- National funding protocols benefit larger areas/research units. It's tough for Nova Scotia to leverage grant opportunities with matching funds, etc.
- There has been more collaboration around research training, but duplication still exists. We could have better core facilities by supporting clusters of individuals with common interests.

  For instance, Dalhousie's Faculty of Medicine is investigating the possibility of creating a research chair in occupational medicine to be situated in the new medical school wing opening in Saint John next year. This could help fund and train a variety of inter-institutional, collaborative teams throughout the region.
- We perform poorly in CIHR Pillars 3 (Health systems services) and 4 (Social, cultural, environmental and population health). We should use team grants here as well, to draw on the best people in different universities, leveraging diverse institutional strengths.

[3] ACEnet is a pan-Atlantic network of world-class, high performance computing clusters. ACEnet's resources allow researchers in the Atlantic Provinces to be at the forefront of innovation, and to push their work to new heights through collaboration opportunities, instant access to data and ultra high speed computing.

Where should we focus our energies / How We Support Research (cont'd)

c. **Archaic IT systems.** While fundamental to the research enterprise, our lack of information on even a basic level is a drawback that seems to be part of the culture. A centralized health and social services data platform would help inform policy and more effectively integrate research findings with the evolution of health services. Electronic charting capability would enable us to monitor the effects of our interventions on the determinants of health and on ultimate health status. Our acceptance of this capacity deficit seems almost cultural.

d. **Investigator-driven research ideas need more support to be successful.**

- There would be more successful grant applications if they were peer-reviewed before submission.
- CIHR grants are for 2, 3 or 5 years and are question-specific. Investigators would benefit from funding to sustain longitudinal research by bridging developmental steps as they form a team or perhaps take the research to the next level / in a new direction.
- There should be ways to encourage people who are close to the cut-off in grant award rankings.

Participants suggested finding out what successful provinces are doing to support research. Then, armed with the demonstrated economic benefit of funded research (i.e. the 7.5 economic multiplier), we should ask government to consider:

- a funding benchmark that is a certain % of the health budget; and
- a capital budget for universities and colleges.

3. Implications of the Way We Leverage Research Findings for Improved Health

Participants felt that ensuring translation of the evidence for application is "huge". How has knowledge translation and exchange (KTE) created value for our society, for communities, for families and individuals? Do we know why people behave the way they do despite the evidence/ research?

How could we build better KTE bridges amongst researchers, decision makers and communities … from science to policy to practice … to achieve research-based changes in public behavior? Should we use applied psychology to get people to change behaviors?

Does it make sense to do more of same research until we know how to ensure societal change? Some felt that we should de-emphasize research generating new information in favour of research that shows us how to apply knowledge that's already available. They were frustrated in their belief that, "We know these things". They advocated just getting on with demonstrating outcomes/impacts focused on the greatest needs of the population.

a. **Emphasize Planning for Action on the part of Researchers**

It was suggested that the KTE part of each grantee's application is not optimally leveraged. There needs to be validity to achieve KTE and provide for application issues. Has the researcher thought about who the target audiences will eventually be

for KTE? Have they looked into best KTE practice in the area under study?

Some wondered whether it really is the role of research to determine 'the how' strategies. Challenges arise in figuring out 'the how' of affecting the determinants; different conditions affect and shape someone's health … we know this. For example, there is strong evidence on the value of early learning in childcare, but there is resistance around exactly "how to" do this. We are failing to intervene and resolve the conundrum. Is finding ways to overcome this resistance a research function?

b. **Emphasize Action on the part of Decision Makers to Leverage What's Known**

But how do we take *existing* research and actually apply it? What does it mean to make recommendations real? For one thing, we need information about how to do high-impact knowledge transfer on healthy lifestyle to the population. Do we know what it takes to make healthy living programs work well?

Do we need inter-disciplinary and inter-sectoral pilot projects (perhaps at the primary health care level) that emphasize action? To make the point, perhaps we could assemble evidence for a particular community[4]. Start by demonstrating what we've done well. Then target areas where we could create different economic, social and health impacts and show how things can be turned around.

c. **Facilitate Evidence-Informed Action as a Matter of Practice**

Day-to-day issues swamp practitioners who are unable to take time from direct service to compare research studies or weigh the evidence for best practice. We need ways to make research relevant and easily accessible for them.

Participants pointed out that coming up with the evidence-based protocol or guideline is the easy part. The difficult part is reorienting the system pieces and building a system around best practice. How do we engage the system to think in an evidence-based way and to try different service delivery approaches?

d. **Emphasize Action on the part of the Public / Communities**

As a society, how do we become users of research findings? Many people perceive that *nothing* is delivered at end of a 2 to 3 year grant.

People felt that we must bring the results closer to the community. Beyond publications and academic presentations, we need to unleash the "power of storytelling" … take the mystery out of research by talking about it. Tell stories about the benefits from where research monies have gone. As people become more aware, they are likely to be more open to research.

It is important to understand a community's readiness to change in the face of major issues and trends. What's in it for them to make the right health decision? Can we

[4] In a related thought, it was noted that research subjects/ informants are often ignored after the reports are written. We should do a better job of working with people that the research actually involves.

make a convincing case for how people would be better off if they adopted healthier lifestyles?

Outside of academic centres it seems that we don't have resources to make information readily accessible. It seems that fringe groups are not utilizing resources that are already available. Representatives from rural settings spoke of challenges with trying to access information. In a simple picture, we need to show how people can access information.

Can we take utilization of research findings to another level by popularizing changes we know would be both helpful and feasible? This will not only require conversations but also people working together differently. We must:

- ✓ Avoid duplication (of not only information itself but also of effort around gathering, analysis, storage, and distribution/reporting);
- ✓ Do a better job of profiling research successes in language that people can understand;
- ✓ Facilitate access and sharing (addressing privacy or protectionism was a sub-topic here); and
- ✓ Adopt different media to make it a public relations event: i.e. Twitter, Facebook, and blogs. Create a '*Participaction*' approach for the modern age[5]. Get a high-profile person like Sidney Crosby to speak out on obesity.

NSHRF could become a leader in packaging discoveries … a conduit for high quality information.

Advice on Priority-Setting & Accountability

Small Group Dialogue

a. *What advice or considerations do you have for the development of priorities?*

b. *What do you need from NSHRF to ensure that the province has been best served through its public investment in health research?*

Advice or Considerations for the Development of Priorities

Reflecting on the earlier questions surfaced an array of unmet needs relative to helping improve the health of Nova Scotians through health research. There were a number of questions and suggestions regarding the role that NSHRF might play relative to those gaps. And assuming that we can't do it all, participants wondered at what level NSHRF should be targeting its efforts … at the policy level? at provider teams?

[5] The Saskatchewan in motion initiative was cited as an example. http://www.saskatchewaninmotion.ca/

Advice on Priority-Setting & Accountability / The Development of Priorities

First, the Matter of NSHRF's Role

a. *Architect of the Provincial Research Agenda.* It's perceived that the province does not have an overall health strategy and that having clear priorities for the system is important. Some felt that NSHRF must be found "pushing the right agenda" … i.e. advancing topics that are both relevant and that have a good chance of application through KTE.

> NSHRF's mandate is critical … essentially helping inform decision making throughout the health system and facilitating negotiations between researchers and system.
>
> —— *Participant*

Might NSHRF play the role of facilitator in focusing priority development areas? Could NSHRF help plan beyond the politics? Perhaps NSHRF could be a facilitator among likeminded institutions to develop a provincial research agenda … a provincially-guided direction to organize under and leverage shared opportunities that achieve results, the sum of which is greater than the parts.

b. *KTE: Catalyst or Enforcer?* We have to be better off after the research. But is ensuring the use of research findings an NSHRF function? Or are we asking the Foundation to take on an impossible task?

There seemed to be consensus that the system must be the focus of our longer-term efforts … addressing problems for which we already have evidence. Some felt that the Foundation can be a catalyst for KTE but cannot ensure it. Others felt that to ensure support from government, the Foundation should figure out how to have research positively impact government itself.

Perhaps given that this is public money going into public research, there should be an audit function that assesses what change/impact is this having. Is there significant benefit? Are those all the benefits we want?

c. *Advisor/Coach to Decision-Makers.* If we're talking about applied health research, it requires fostering productive relationships amongst researchers and decision makers. NSHRF was advised to use its credibility and unique position to advise decision makers and reduce the effects of competitive, interdepartmental cultures.

While there are efforts to be evidence based, government officials really don't have the background to assess the information. How can we help them find evidence that may be relevant and then conduct the critical appraisal needed to integrate it appropriately into the policy-making context?

- This knowledge broker role might involve developing programs to enhance end users' capacity to find, analyze and incorporate knowledge in their decision-making processes.[6]
  - Sponsor seminars for further exchange and dissemination of stories;
  - Organize collaborative projects to spur on knowledge transfer and exchange.

[6] The Australian approach to research partnerships for better health was mentioned; http://www.saxinstitute.org.au/publicdocs/SAX_AR_091020.pdf

The Matter of NSHRF's Role

Advisor/Coach to Decision-Makers. (cont'd)

- It might also require conducting a synthesis of best practice pertinent to the issues of the day, and providing the provincial government, municipalities and employers with accurate, timely information.

  Adopting a systematic review of inter-sectoral evidence would strengthen the approach by helping free up people's thinking around more collaborative ventures.
  So rather than duplicating federal research grant investment, NSHRF could add value by finding and making existing, theme-specific knowledge available and more accessible to communities and fund more action-oriented research.

> It doesn't make sense to save an hour in the library by spending another year in the laboratory. We need to learn how to set people in motion.

- Manitoba and Saskatchewan are models for how a research community can inform and work with government. Perhaps there could be a system of Provincial Health Councils that share knowledge around health priorities in common.

NSHRF would need to find ways to get the right researchers and decision makers together and this all takes time.

d. *Research Publicist.* The public gets conflicting and fragmented information. A broader public understanding is needed, propelling people to urge government to focus on strategic target areas where research could make a difference. Can this problem be addressed by creating a single source of information at the provincial/national levels? We should be looking at individual and community psychology.

Might NSHRF play a role in using evidence to shape and evolve public attitudes? The Foundation could help balance stories … the good news messages where we're getting it right vs. those where we aren't. Use evidence to celebrate what we've done well (e.g. like school board nutritional policies, day support programs, the number of Nova Scotians who are centenarians, couples celebrating 70th anniversaries, etc.).

Now, Advice Concerning the Development of Priorities (in no particular order)

a. Keep in mind that research activities have many purposes:
   - ✓ To establish and sustain a vibrant post secondary atmosphere;
   - ✓ To encourage intrinsic curiosity and foster focused innovation that informs decision-making; and
   - ✓ To address societal determinants of health and help improve health outcomes.

b. Some perceive that 'research for the sake of research' (investigator-driven research ideas) should be deemphasized. We shouldn't be too directive, but with only $5 million to work with, it is important for NSHRF to focus on meaningful results. The legislation would seem to provide limited latitude.

Advice Concerning Priority Development (cont'd)

So think about investments and manage a portfolio that balances curiosity-based research with health system priorities … fundamental, think-outside-the-box projects versus KTE projects driving off of applied research. In identifying the right thing to do at government level, balance short-term versus long-term payoffs.

c. Look at models for sustainability. Analyze our health programs to see if they are sustainable.

d. Stay the course in funding research excellence. Maintain a strong science base but don't restrict it to a bio-medical/diseased base. Move away from 'sickness' research to research that explores what could be done on psycho-social fronts and with known risk factors to prevent problems or to mitigate symptoms. For example, what are the best policy options for reducing Nova Scotians' overall intake of low cost, high-salt foods for example? How do we build bridges out of the health silo to get community gardens and common kitchens? What is the best approach to public education relative to an issue like this?

e. Health is bigger than the Health Authorities and system-wide culture of research is important. Look at how to foster collaboration that improves the whole system. Develop a research culture such that everybody can be involved. NSHRF can grow these basic ideas, ensuring that all of the key players are involved in the dialogue (some were missing today). Involve charities and community-based members.

f. When appropriate, expect intersectional collaboration amongst health researchers, policy makers and communities (not forced artificially). For example, we need a better sense of alignment amongst government, major employers and schools regarding healthy lifestyles. Use KTE strategically to foster information exchange and lower barriers between departments around priority topics like this.

g. Look for a link between the research and community. Research activity must be responsive to needs and sensitive to variation in new knowledge requirements of different areas. Perhaps there are ways to bring community more in on the research design process so that findings will be more ready for use and application.

h. Capacity building is critical. But before capacity can be established, any roadblocks need to be identified. Understand what the issues are and build in that capacity. Changing the culture of an organization relative to the utilization of research is key to enabling the capacity to do something new.

i. We have dispersed intellectual capital. Teams allow you to leverage funds and strike balances between evidence-based and idea-based research. Relative to rural areas, where foundations raise few funds (and even less for research), bringing teams together across the province would help overcome the limitations of tackling system issues one project at a time, in isolation. The research would also have a better chance of connecting with community.

j. Governments are looking for value-added research; not so much interested in having more of the same. NSHRF has to focus on what they can do to fulfill that mandate; look at

Advice Concerning Priority Development (cont'd)

government platform and see how potential initiatives fit with the priorities. Research must be relevant and promoted where it fulfills the mandate's needs.

k. Giving clusters of excellence renewable grants tied to strategic system priorities would help address swings in interest as short-term academic and political agendas change.

What's Needed from NSHRF to Ensure that the Province has been Best Served

Some felt that the Foundation is already a leader in demonstrating accountability to stakeholders. Having said that, the room offered these opportunities for improvement.

1. **The Foundation was advised to monitor:**
   a. Generally, priorities/goals achieved;
   b. Economic value added and in particular, contributions to growing a knowledge–based economy;
   c. The production of future health researchers;
   d. Recruitment, support and retention of health researchers so they remain in the province,
   e. Research capacity built and maintained;
   f. Commercialization of research results;
   g. Growth of the research budget base, and of budgets for targeted teams in particular;
   h. Enhanced community use of research;
   i. Relative to applications for national grants, the % of team members that are from rural Nova Scotia;
   j. Use both 'upstream' metrics drawn from the determinants of health and 'downstream' metrics targeting health status. We need a comprehensive database, but stay away from commercial data warehouses.

2. **Other advice around accountability:**
   a. It was acknowledged that enhancements to the culture of research would be hard to measure.
   b. Maintain open dialogue at all levels to foster understanding and trust and communicate successes: between NSHRF and the province; front line, person-to-person;
   c. Dissemination is an important part of accountability and transparency. Demonstrate relevance by explaining what was funded and tracking *outcomes/impacts/effects* (Did the research make a difference?) vs. *outputs* (publications and presentations).
   d. Go beyond historic tracking and try to track and communicate socio-economic impacts of any new policy. Monitor KTE effectiveness and get those findings back to the

Advice on Priority-Setting & Accountability / The Development of Priorities

Advice Concerning Priority Development (cont'd)

stakeholders (difficult to do, but would pay dividends regarding true accountability questions).

The Canada Foundation for Innovation (CFI) application is a good example. It asks for outcomes (influences on health policy, health outcomes, etc.) to be identified and requires them to be defended at the end.

e. Five years from now look at research priorities again. Report on: what has been accomplished; how priorities have evolved; and stops us from using research.

Closing Remarks

Dr. Alexa MacDonough, Interim President and Vice-Chancellor for Mount Saint Vincent University, provided closing remarks to both encourage and challenge the Foundation as it draws on the Summit findings to help set priorities.

Dr. Jean Gray, the Foundation's Board Chair, thanked the participants for their contributions.

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Appendix A

Summit Attendees

Delegates

First Name	Last Name	Position	Organization
Steve	Armstrong	President & CEO	Genome Atlantic
Bill	Bean	President & CEO	QEII Foundation
Bob	Bortolussi	Professor of Pediatrics and Microbiology and Immunology	IWK Health Centre
Lloyd	Brown	Executive Director	Alzheimer Society of Nova Scotia
Keith	De'Bell	Associate Vice President Research	St. Francis Xavier University
Richard	Donald	Vice President, Research, Extension & Outreach Services	Nova Scotia Agricultural College
Judith	Ferguson	Deputy Minister, Community Services	Government of Nova Scotia
Ian	Graham	Vice President, Knowledge Translation	Canadian Institutes of Health Research
Fred	Harrington	Associate Vice President, Research	Mount Saint Vincent University
Tom	Herman	Vice President, Academic	Acadia University
Joan	Jessome	President	Nova Scotia Government & General Employees Union
Paul	Kent	President & CEO	Greater Halifax Partnership
Janet	Knox	President & CEO	Annapolis Valley Health
Ray	LeBlanc	Vice President, Research and Academic Affairs	Capital Health
Pat	Lee	Chief Executive Officer	Pictou County Health Authority
Mary	Lee	President & CEO	Nova Scotia Association of Health Organizations
Nancy	MacCready - Williams	Chief Executive Officer	Workers Compensation Board of Nova Scotia
Menna	MacIsaac	Executive Director	Heart and Stroke Foundation of Nova Scotia

Tom	Marrie	Dean, Faculty of Medicine	Dalhousie University
Alexa	McDonough	Interim President & Vice-Chancellor	Mount Saint Vincent University

Delegates (cont'd)

First Name	Last Name	Position	Organization
Marilyn	More	Minister of Education/Labour & Workforce Development	Government of Nova Scotia
Leonard	Preyra	MLA - New Democratic Party	Government of Nova Scotia
Gary	Ramey	MLA - New Democratic Party	Government of Nova Scotia
John	Ruedy	Professor Emeritus, Pharmacology	Dalhousie University
Wanda	Thomas Bernard	Director, School of Social Work	Dalhousie University
George	Turnbull	Associate Dean, Academic and Research	Dalhousie University
Debbie	Trask	Executive Office Manager	Nova Scotia Department of Health
Lisa	Underwood	Director of Research Services	Capital Health
William	Webster	Dean, Faculty of Health Professions	Dalhousie University
Diana	Whalen	MLA - Liberal Party	Government of Nova Scotia
Agnes	Young	Administrative Assistant	Nova Scotia Department of Health

Facilitators

Nathalie	Blanchet	Research Advisory Committee	Government of Nova Scotia
Patricia	Conrad	Research Advisory Committee	Government of Nova Scotia
Gerry	Johnston	Research Advisory Committee	Dalhousie University
Janice	Kaffer	Research Advisory Committee	Pictou County Health Authority
William	Marshall	Research Advisory Committee	St. Francis Xavier University
Charmaine	McPherson	Research Advisory Committee	Guysborough Antigonish Strait Health Authority
Ben	Rusak	Research Advisory Committee	Dalhousie University
Wanda	Thomas Bernard	Research Advisory Committee	Dalhousie University
George	Turnbull	Research Advisory Committee	Dalhousie University
Peter	Vaughan	Research Advisory Committee	South Shore Health

NSHRF Staff

First Name	Last Name	Position	Organization
Meredith	Campbell	Manager, Capacity Program	Nova Scotia Health Research Foundation

Krista	Connell	Chief Executive Officer	Nova Scotia Health Research Foundation
Jeremy	Godfrey	Communications Assistant	Nova Scotia Health Research Foundation
Deborah	Langille	Director, Performance Accountability	Nova Scotia Health Research Foundation
Ryan	McCarthy	Manager, Knowledge Transfer/Exchange Program	Nova Scotia Health Research Foundation
Jennifer	McNutt	Manager, Health Research and Matching Grants Programs	Nova Scotia Health Research Foundation

NSHRF Staff (cont'd)

First Name	Last Name	Position	Organization
Eric	Rushton	Chief Financial Officer	Nova Scotia Health Research Foundation
Linda	Waterhouse	Program Assistant	Nova Scotia Health Research Foundation

Observers

First Name	Last Name	Position	Organization
Roger	Cole	Director of Finance and Operations	New Brunswick Health Research Foundation
Jim	Davie	Executive Director	Manitoba Health Research Council
Lori	Francis	Board Member	Nova Scotia Health Research Foundation
Joanne	Gallivan	Board Member	Nova Scotia Health Research Foundation
Jean	Gray	Board Chair	Nova Scotia Health Research Foundation
Peter	McLeod	Board Members	Nova Scotia Health Research Foundation
Richard	Singer	Board Member	Nova Scotia Health Research Foundation
Maureen	Summers	Board Member	Nova Scotia Health Research Foundation

Appendix B

Visual Materials: Opening Remarks

Krista Connell, CEO NSHRF

Context and History

Krista Connell
Chief Executive Officer

History

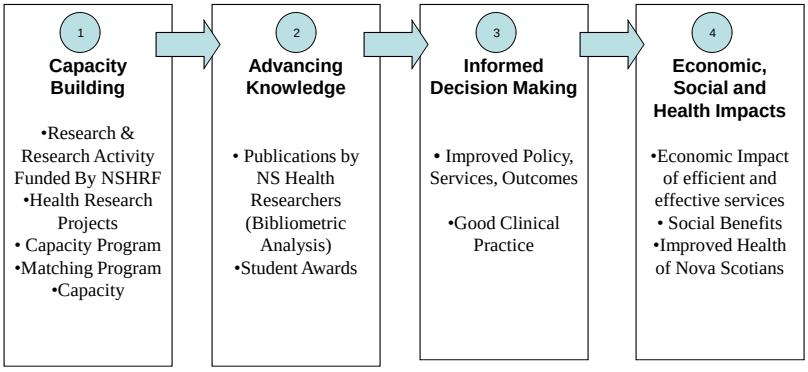
- Established in 2000
  - Entering 10th year
  - Ultimate Goal - Informed Decision Making
- Programs:
  - Levels of Inquiry - direct support
  - Capacity
  - Knowledge Transfer & Exchange (KTE)
  - Health Researchers, Students
- Funding
  - Annual grant from Provincial Government through the DOH - approx $ 5 million
- *An Updated Strategy*: NSHRF Strategic Plan (2009 - 12)

Health Research Priorities
Summit

Inclusive View of Health

- "Health" is a complete state of physical, mental, social and emotional well-being. Health is a resource for living that enables peoples of all ages to realize their hopes and needs and to change or cope with the environments around them (Ottawa Charter, 1986).

NSHRF Supports Inquiry



Health Research Priorities
Summit

Health Research Foundation Act

- Establish priorities through consultation
- Support the Province's health research priorities
- Support health research capacity development including retention of skilled personnel
- Communicate research findings
- Facilitate interaction between health researchers and those who use health research

Regulations

- Establishes further criteria under which we work
- Four areas of research;
  - health policy (10%),
  - health services (10%),
  - health outcomes (10%), and
  - medical (including basic science, clinical and epidemiological) (30%)
- Other stipulations:
  - programming (>=20%), and
  - administration (<=20%)

Consultation Process

- 5 Background documents
  - 4 Environmental scans:
    - Major Health Issues Facing Nova Scotians
    - Health Research Priorities in the Province
    - Current Research Priorities in Nova Scotia
    - Analysis of Strategic Research Plans
  - The Economics of Health Research in Nova Scotia

Consultation Process

- Performance Metrics
  - Bibliometric Results
  - NSHRF Funding and program support trends
  - NSHRF Accountability metrics
  - Funding performance trends at National Agencies
    - CIHR, SSHRC, NSERC
    - Health Charities
    - CFI

Consultation Process

- 2 Surveys and a Poll
  - 2 web based surveys
    - Public
    - Research Community (government, scientists, health system)
  - Omnibus Poll

Consultation Process

- 28 Consultation meetings
  - Summit is 29th
  - Government departments, health charities, business community, DHA's, academic and scientific community, community and health system program representatives

Results Thus Far

- Data and infrastructure a challenge for decision making and research activities
- Challenges in accessing, using and the existence of relevant research evidence for decision making at all levels
- Serious health issues facing Nova Scotians