
*Antoine Hakim delivered a webinar in AllerGen's* Planning for Research Success *series on April 19, 2016, offering lessons learned about bringing evidence to bear on policy and practice from his experience with the Canadian Stroke Network (CSN). His key messages and a hyperlinked index to his presentation follow.*

## CHANGING HEALTH POLICY AND PRACTICE

**Compile evidence.** Data is the ultimate weapon for bringing change to the health sector. In the Canadian Stroke Network (CSN), one of the more expensive but most effective things that we did was to create our stroke registry. The information in this registry allowed us to pressure political leaders by showing them that there was a problem with Canada's approach to stroke care.

*To develop the registry*, we hired nurse specialists to go to Emergency Rooms (ERs) in over 20 sites across Canada, to investigate: the numbers of stroke patients received; how long it took patients to arrive to an ER after their symptoms started; how long it took for the medical system to respond after they arrived; and whether or not they were given a CT scan or a treatment. We then linked this data to administrative databases so that we knew each patient's history and vascular risk factors. We did this for over 10,000 patients.

*With the help of health economists*, who have very effective ways of measuring these things, we then calculated what the gains would be—economically (by reducing healthcare costs and impacts on workplace productivity), and in terms of patient outcomes—if available knowledge were applied to improve practices in stroke care. These calculations made it clear that an investment of millions into making change would radically improve health outcomes for stroke patients, and would return billions to the treasury.

These data represented the ultimate "weapon" by which the CSN changed the response systems involved in the treatment of stroke patients.

**Analyze your data by province.** Advocating for change can only be successful if you have data, and when trying to change health policy in Canada the data must be broken down by province. Although NCEs like AllerGen and many health advocacy groups have national programs, these changes occur provincially. You also need to look at data province-by-province to see where you might push harder: if you know that in a particular province a given health issue is more urgent, that may be important for your strategy.

**Use provincial differences to apply political pressure.** A recent study looked at in-hospital deaths of stroke patients across provinces, and found that those provinces that had implemented a stroke strategy had much lower death rates from stroke within hospital than those that had not. We took this evidence to the deputy ministers of health in the laggard provinces, for whom it became a matter of protecting their political turf. Just saying: "Your province is not looking as good as others, and the report that shows this is going to come out in six months," made some ministers rush to address the situation so that when the report came out they'd be able to say: "Oh, that's old information—we've already fixed this problem."

**Take the needs of policymakers into account.** Politicians mean well; that's why they enter the difficult life of politics. But very quickly, they become focused on the fact that they are in office for only four years, and they need to show progress within their four-year mandate.

I was once talking to a provincial minister of health about the full spectrum of changes needed in stroke care—from prevention to treatment, paramedics and ER practices, public education, *etc*.—when the minister said: "Stop, stop, stop—Can I close beds if I do what you are asking me to do?" That was his focus. So I learned, before telling the entire story, to find out where the deputy minister or minister was coming from: What pressures did he or she face? If you can connect your program for change with the needs of political leaders, you will be heard.

**Start with a simple program.** With policymakers, simple, focused proposals fare better than complex and expansive ones. Presenting a massive program causes their eyes to glaze over. But simple proposals— "We want paramedics in your jurisdiction to turn on the lights and sirens and to give stroke patients precedence" —they can more readily understand and implement. Simple things have traction; if you go in with complicated charts, they will tune out.

**Choose the right partner and build trust.** The Canadian Stroke Strategy emerged from combining what the CSN was doing with the work of the Heart & Stroke Foundation (HSF). Our partnership was one of mutual benefit, as is true of all successful partnerships. The HSF benefited from our scientific discoveries and the influence we had on ER physicians, paramedics, neurologists, *etc*., while we benefited from their political connections and their "deep pockets," which funded public awareness television campaigns for which the CSN hadn't the money. But the first years of our partnership involved watching what the other was doing, clarifying our roles, and building trust.

**Don't overlook the social dimension of knowledge translation.** To improve stroke care in Canada, most of the scientific knowledge was already there, in the literature, before the CSN came into existence. The CSN did not conduct the clinical trials that proved the efficacy of tPA in treating strokes, for example. We already had the knowledge on day one. However, no one had brought all this knowledge together, or calculated the economic impact of even going halfway toward applying it to the improvement of policy and practice.

It is not enough to know that something can be done for a specific patient group; you also need to take into account the social dimension involved in translating that knowledge. People may mistrust your motives—some accused me, for example, of being "on the take" of the pharmaceutical companies when advocating for the use of tPA—and it can be difficult to educate those resistant to change. The CSN had knowledge that was solid; the struggle was in how to transfer it to those who would implement change.

**Never underestimate the conservatism of people toward change.** In general, people don't like change and will resist it. They like to think they already know it all. This is true of most, including clinicians and politicians. To effect change, you need to keep going back and back again until the job is done. And you have to accept that you won't succeed everywhere. The biggest hurdle to changing policy and practice is people's conservative attitude to change, be it systemic or individual.

But you can be persistent, and you can apply pressure. Sometimes the resulting efforts at change are not very deep, just enough to say "we did something about it," but other times people can be messianic about it and really take it on. With the CSN, for example, when we educated clinicians about the reversibility of stroke and the positive impact of swift treatment, some of my neurologist colleagues actually sold their houses to move closer to the hospitals in which they worked, to reduce the time it would take them to attend to stroke patients in the ER.

# INDEX OF WEBINAR CONTENT



***Available for this webinar: slideshow (in PDF) | video recording***


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