PHAC Casebook on the Use of Intervention Evidence in Health Promotion and Chronic Disease Prevention
Case Description Form

Thank you for taking the time to complete this case description form. The form is comprised of six sections. Please complete all components.

1. Background:

1.1 Organization

Name: Partners In Planning for Healthy Living
Address: C/O CancerCare Manitoba
Room OG008
409 Tache Ave
Winnipeg, MB
R2H 2A6

Case Title/Name: Youth Risk Factor Surveillance

1.2 Please list the name, title, and institution of all case author(s) as you wish them to appear in the casebook:

- Addictions Foundation of Manitoba
- Alliance for the Prevention of Chronic Disease
- Assiniboine Regional Health Authority
- Brandon Regional Health Authority
- Burntwood Regional Health Authority
- Canadian Cancer Society, Manitoba Division
- CancerCare Manitoba
- Churchill Regional Health Authority
- Health in Common
- Healthy Child Manitoba
- Heart and Stroke Foundation of Manitoba
- Interlake Regional Health Authority
- Manitoba Education
- Manitoba Health
- Manitoba Healthy Living, Youth and Seniors
- Manitoba Physical Education Supervisors' Association
- NOR-MAN Regional Health Authority
- North Eastman Regional Health Authority
- Parkland Regional Health Authority
- Public Health Agency of Canada, Manitoba and Saskatchewan Division
- Regional Health Authority -Central Manitoba Inc.
- South Eastman Regional Health Authority
- Winnipeg Regional Health Authority

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2. Case Description:

2.1 Issue:

Please briefly describe (approximately 500 words each):

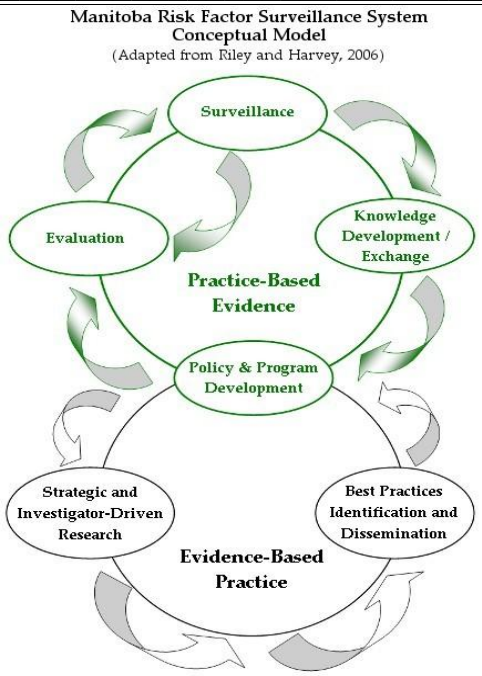
(a) the policy, program, or practice issue that needed to be addressed

Manitoba regional health authorities (RHAs) identified the need for local data for the planning and delivery of health services and programming. It was felt that large national surveys, and provincial surveys where they exist, did not collect enough representative responses to make precise estimates at the community level. This need for local-level data by the regional health authorities also coincided with Manitoba Education's need for baseline data on youth health to evaluate their new Active Healthy Lifestyles: Physical/Health Education curriculum.

To address this lack of local level data a group of partners with the common mandate for the prevention of chronic disease came together to pool resources and build a Manitoba Risk Factor Surveillance System. In 2006, Partners in Planning for Healthy Living (PPHL) was formed with members working together in a collegial manner to better support the use of evidence in planning interventions that will promote healthy living in communities across Manitoba.

Our integrated planning model – our knowledge system – involves interaction between several key activities:

- local-level risk factor surveillance (gathering data about community members' health status and risk factor prevalence),
- identification and dissemination of effective (best) practices (knowledge exchange),
- strategic and investigator-driven research,
- policy and program implementation, and
- policy and program evaluation.



PPHL is a Community of Practice – working and learning together to build our own capacity and to use evidence to build an integrated knowledge system that spans Manitoba and reflects the unique context in Manitoba. PPHL also connects and interfaces with national and international resources, expertise and direction.

PPHL is not incorporated; our host and partner organizations work together in a collegial manner to use evidence in planning programs for healthy living. PPHL is guided by three values and three principles.

Our values:

- We are inclusive and flexible.
- We are non-judgmental.
- We are community friendly.

Our principles:

- We focus on evidence.
- We support the development of knowledge and capacity within communities.
- We support integrated, community planning for healthy living.

The main activity to date for PPHL has been the implementation and knowledge exchange/translation of the Youth Health Survey.

(b) the context in which this issue arose including why this issue presented a problem and what your objectives were in addressing it

Three groups identified the need for local level data.

Regional Health Authorities
Manitoba's RHAs initially recognized a need for local level data. Every five years the RHAs have to complete a Community Health Assessment Report to support their health services planning. Given the large geographical size of the province and diversity of the communities within it, national and provincial data was not resonating with or meeting the needs of communities, schools and regions. In addition, many regions have communities involved in the Healthy Together Now program, and as a result, need data for planning and evaluation purposes and for setting priority areas.

Schools
Many schools reported being open to local level surveys because they were interested in obtaining their school-specific report. Schools seek their own data to evaluate the effectiveness of their new mandatory written nutrition policies. In addition, there is an existing culture of student health within the schools leading to a genuine concern for their students' well-being. School health has been a government priority for over a decade as is evident by the Healthy Schools Initiative which was implemented in 2002. The Manitoba Healthy Schools Initiative provides funding to school divisions and schools to implement healthy lifestyle programs and activities. Given the schools' readiness many were supportive of completing a school level survey because it could help schools evaluate existing programs and Healthy School grant applications.

Province
At the same time as the RHAs were seeking local level evidence a new demonstration project Healthy Together Now (formerly the Chronic Disease Prevention Initiative) was being implemented. Healthy Together Now started as a five year project that was community-led, regionally coordinated, and government supported (both provincially and federally). Today there are 83 Healthy Together Now communities across the province. Intersectoral committees and communities were also seeking evidence to plan and lead chronic disease prevention programs. The Healthy Together Now infrastructure and funding (provincial and community committees) has been important in building capacity at the community level for the use of local level evidence to identify, plan, implement and evaluate the chronic disease prevention initiatives.

Manitoba Education was also in need of local level data to act as the baseline from which to evaluate the new Grades 11 and 12 Active Healthy Lifestyles: Physical/Health Education curriculum which was to be implemented province-wide in the fall of 2008.

The readiness to make changes in youth health was emerging across the province at all levels. It was the vision of one champion to bring together these different stakeholders to create one chronic disease prevention system. This was achieved through the creation of a formal network of partners which today we call PPHL. Partners work together to support and build capacity for the collection and use of local level evidence to inform healthy living programs and policies and evaluation of such activities. The first activity completed was administration of the Youth Health Survey (YHS) and the generation of feedback reports on youth health behaviours (grades 6-12). Work is underway to complete an Adult Health Survey as well.

(c) why evidence was needed to help with resolution of the issue

Manitoba spans a large diverse geographical area and barriers to healthy living vary across communities. Current national and existing provincial surveys do not provide local level data for communities and schools to use when planning or evaluating school, community, or regional healthy living activities. Without local level data, schools, communities and RHAs had no way to measure youth health behaviours, or to monitor/evaluate any changes.

2.2 Case Features:

Case Features	☑	**Please specify/briefly explain:**
HEALTH TOPIC		
Integrated health promotion/chronic disease focus (common risk factors/diseases addressed)	x	The Youth Health Survey collects data on modifiable chronic disease risk factors; physical activity, healthy eating, tobacco and drug use, and well-being.
Specific chronic disease or health promotion topic focus		
GEOGRAPHIC SETTING		
Rural/Remote		
Urban		
Mixed urban/rural	x	The YHS was a census style survey. All 11 MB RHAs approached all school divisions within their region including First Nation, independent and Francophone schools. Feed back reports were generated at the school, school division, regional and provincial level
POPULATION FOCUS		
Immigrant populations/Cultural focus		

First Nations/Aboriginal population focus		
Other special population focus	x	Youth
INITIATIVE LEAD		
Government led	x	All PPHL partners contributed (in-kind human resources and/or financially) to the Youth Risk Factor Surveillance activities. The ministers of Education and Health and Healthy Living/Chair of the Healthy Child Manitoba Committee of Cabinet wrote a letter in support of the Youth Health Survey (YHS) to all superintendents in the province.
NGO led	x	CancerCare Manitoba completed data analysis and report generation. Heart and Stroke Foundation of Manitoba contributed small grants to regions to help offset survey printing costs. Canadian Cancer Society – Manitoba Division provided expertise in knowledge exchange through their Knowledge Exchange Network.
Health Authority led	x	The regional health authorities provided in kind staff time and resources to collect and disseminate YHS findings.
Led by other (e.g. public health unit, dep't)		
ORGANIZATION SIZE		
Large organization (> 500 staff) led		
Medium organization (< 500 staff) led		
Small organization (<100 staff) led	x	PPHL has one staff member-0.2FTE and funding for the position is provided in kind.
INITIATIVE SCALE		
Local level initiative	x	Over 400 schools agreed to participate in the YHS.
Regional level initiative	x	RHAs championed the YHS within their regions. Regional data is owned by each RHA respectively. Reports were generated able at the school, school division, and regional level for use in program planning.
Provincial level initiative	x	Provincial level report and data are available for program and policy planning.

Pan-Canadian/National level initiative		
Other form of initiative		

3. Role of Evidence:

3.1 Type of Evidence:

Please describe (max 500 words each):

(a) what type of evidence was sought

The purpose of the YHS was and is to provide schools, school divisions and RHAs with current school- and community- specific information on youth health with a particular focus on risk factors for chronic disease. To do so we implemented a YHS province-wide using a survey tool developed in one Manitoba RHA. The YHS consists of 51 multiple choice questions focused on physical activity, smoking, alcohol and drug use, and well-being. The YHS framework is based on tools, indicators, questionnaires and methodologies that have been used extensively in other risk factor surveillance systems including the American Behavioural Risk Factor Surveillance System (BRFSS), the Canadian Community Health Survey (CCHS), the Canadian Tobacco Use Monitoring Survey (CTUMS), the World Health Organization STEPwise Approach (STEPS) and the Ontario Rapid Risk Factor Surveillance System (RRFSS).

(b) how evidence was sought and acquired and analyzed/examined to address the problem.

We pooled resources and expertise to implement the YHS. We started with youth because they are easy to access in the school setting.

Our YHS was implemented census-style to avoid study design and weighting issues. It was completed by grade 6-12 students in more than 400 schools across Manitoba. PPHL provided provincial coordination and members contributed expertise and funding with all RHAs donating in kind staff time and resources to collect and then disseminate the YHS results.

By the end of the 2007-2008, schools in all RHAs were contacted to implement the YHS. Many regions surveyed students in grades 6-12, while all regions surveyed students in grades 9-12. In total over 46,000 students completed the survey. RHAs approached all school divisions in the province as well as independent, colony, First Nations and francophone schools (survey was translated) .

It is our intention to repeat the YHS every 4 years. The second cycle of the YHS will take place in the fall of 2012. We are also in the midst of preparation for gathering local adult health behaviour data.

The following is breakdown of what each member has contributed to the YHS implementation:

Manitoba Government- The ministers of Education and Health and Healthy Living/Chair of the Healthy Child Manitoba Committee of Cabinet wrote a letter in support of the YHS to all superintendents in the province. This letter encouraged school participation in the YHS.

Heart and Stroke Foundation of Manitoba- HSFM contributed $50,000 over two years to establish $5,000 grants that each RHA could access to offset survey costs.

CancerCare Manitoba/CancerCare Manitoba Foundation- The former CancerCare Manitoba Provincial Director of Cancer Control saw the need for work in prevention (and in particular risk factor surveillance) and created a risk factor epidemiology position and two programmer/analyst positions with support from the CancerCare Manitoba Foundation. With the department's increase in capacity they were able to provide analytical support to all RHAs. In addition, they populated the feedback reports at the school, school division, and regional level.

The Public Health Agency of Canada – PHAC provided PPHL with in-kind staff time and KE expertise to support and facilitate knowledge exchange.

Canadian Cancer Society- Knowledge Exchange Network- The Knowledge Exchange Network provided training on gathering, interpreting and using data to build capacity within the regions to make evidence-informed decisions.

Regional Health Authorities- RHAs contributed hours of in-kind time to PPHL and the YHS data collection. RHAs donated staff time and resources to the YHS coordination and to the PPHL working groups. The Interlake RHA shared their YHS tool and materials and each RHA contacted their respective school divisions, and independent, First Nation, Francophone and colony schools within their region. RHAs also prepared survey materials, delivered and collected surveys and in some cases even went to the schools to administer surveys in their regions. RHA leadership in survey administration has been important in building and strengthening existing relationships with schools in their communities.

Health in Common- HIC works to strengthen connections for healthy sustainable communities by facilitating communication and collaboration within and across sectors providing planning and evaluation support to organizations and communities. Their staff have contributed evaluation expertise and have facilitated knowledge exchange through their existing network of partners and by hosting and managing the PPHL website.

3.2 Use of Evidence:

Please describe (max 500 words each):

(a) the target audiences for the evidence

Any stakeholders interested in improving youth health, and interested in using evidence to tailor

health programs and policies to local needs.

(b) how the evidence was communicated or presented

We generated feedback reports at the school, school division, regional and provincial level. Given that the survey was a census and was conducted to be used for local planning, the data was not age- or sex- standardized. This allowed us to present the results as averages with no statistical explanation required. Therefore the reports are written in simple clear language and the graphs are easy to interpret. As one PPHL member stated *"It was very easy to understand, comprehensive and straight-forward."*

Regional health authorities own the data they have collected. This has created a sense of ownership and has increased the dissemination of local YHS results/reports. The YHS reports were an important tool for RHAs in reaching out to schools and community partners and beginning the conversations around youth health. As Knowledge Exchange (KE) brokers, RHAs have also helped to strengthen the relationship between the health and education sectors. However, the one drawback we found was that knowledge exchange/translation capacity varied amongst regions.

In addition to the reports RHAs have implemented all kinds of KE activities including health expos, health symposiums, and teacher professional development days at which YHS results were shared and action plans created.
In addition presentations on school- and community- specific YHS results have been made to:

- Students
- Teachers
- Parent councils
- School division boards
- Community partners
- Recreation directors and
- Local policy makers.

RHAs have also championed the use of the YHS within their regions by giving presentations to Health Promoters, Senior Management and Executives.

We as a group of partners have acted as KE brokers at the provincial level. Presentations have been made to:

- Manitoba School Boards Association
- Manitoba Association of Parent Councils
- Chronic Disease Prevention Initiative Provincial Share and Learn (2009, 2010) currently known as Healthy Together Now
- Healthy Together Now Training Committee
- Inter-Organizational Curriculum Advisory Committee
- Healthy Child Committee of Cabinet (ministerial representation from nine departments) and
- 2011 Healthy Schools Conference.

We have also produced a video "Moving Towards Healthier Lifestyles: Stories from the Manitoba Youth Health Survey" that highlights success stories of schools/communities using the data to address opportunities for change in the health of their youth. It is hoped that the video will not only celebrate successes but also motivate others to address opportunities for change as identified in their YHS reports.

(c) how the evidence was used/applied

As part of our case study of the Manitoba Risk Factor Surveillance System and the YHS that took place last year we had the opportunity to speak with end-users at the school, school division, and regional and provincial level to find out how they have utilized the YHS data. Below is a list of some examples.

Provincial Level

- The YHS data was utilized in the Chief Provincial Health Officer's Report on the Health Status of Manitobans 2010, Priorities for Prevention: Everyone, Every Place, Every Day.

- At the YHS press release the Minister of Family Services and Consumer Affairs, which is also charged with the administration of the Liquor Control Act announced the hosting of a 2010 Youth Alcohol Summit which was sparked by high level of alcohol use identified by the YHS results.

Regional Health Authority/Community

- RHAs used the YHS data in their Community Health Assessment reports which inform health service delivery planning.

- A partnership with recreation directors in one community led to re-vamping the community center kitchens so that they could prepare healthy foods.

- A recreation director used the data to re-institute a floor hockey league as well as swimming lessons at the local pool.

- Two RHAs indicated that they used the data in a business case to hire new staff in the region to conduct community health promotion and education.

- One community used the data to help make the case to keep the school gym open in the evenings and weekends to increase physical activity.

School Division/School

- One school division used the data to help make a business case to keep their Addictions Foundation of Manitoba counsellor.

- One high school found from the report that their students have a high sense of hopelessness. They are now focusing on creating a sense of school connectedness,

particularly during the transition into high school by making incoming grade 9s feel welcome and connected to their new school.

- New and/or existing school health committees are utilizing the data in their planning.
- One division responded to their feedback report by providing training during in-services to increase teachers' comfort on a particular health topic.
- One school was concerned about the students' alcohol use. The guidance counsellors partnered with the RHA addiction worker to give presentations to students once a month.
- The data was used by several schools to determine which presentations/guest speakers to bring into the entire school.
- Schools have also used the data to implement or seek out resources/programs to address the identified areas of concern. Some schools have implemented SWAT (Students Working Against Tobacco) and others are using the Back Off Tobacco resources to reduce tobacco use.
- One school division used the data to reinforce their division's policy on daily physical activity which was not being adhered to or supported by school principals.

The YHS provincial database is also available upon request for use by community, government and university researchers seeking to carry out activities that will further enhance and advance our understanding of youth health and well-being in Manitoba. One example is the recent publication: Leggett C, Irwin M, Griffith J, Xue L, Fradette K (2011). Factors associated with physical activity among Canadian high school students. International Journal of Public Health.

3.3 Impact of Evidence:

Please describe (max 500 words each):

(a) what kinds of changes in practice, program or policy resulted from the application of evidence

It is still very early days in regards to the YHS. However, the fact that the surveillance system is cyclical means that YHS data will be available every four years to evaluate programs and policies. From our case study on the Manitoba Risk Factor Surveillance System we know that schools are interested and are looking forward to the next YHS to be able to evaluate their progress. There is an increase in the use of data in making informed decisions at the school level. The Healthy Schools Grants request that they use the YHS data if available in grant applications. This has motivated schools to review reports and take action on areas of opportunity for change.

We also see organizations seeking out their YHS reports and asking when we are going to collect

data again. The end-users are keen to use the data to monitor trends and changes and are anxiously awaiting the next YHS.

We are also seeing a shift in how to motivate people to utilize data. We have learnt from the case study that health must communicate with education in way that is supportive and understanding that schools are very busy places. We should remain clear that the YHS is not intended to create more work but assist and support the work that is on-going. This is best captured by the following statement from a case study participant:

"I'm not coming to ask you to do something unrelated to what you are already doing, but can we identify things that are important or significant in the school report and connect it with something that is already being done in the school? And how can I help you do that?"

We have also seen an increase in collaboration across partners. Our network of partners has grown to over 23 partners. We have openly shared resources, tools, lessons learned and success stories in how our communities and schools are utilizing the data. We have also engaged with other networks and existing infrastructure such as Health Together Now. RHAs and schools have used the opportunity to partner to support healthy living programming within schools and communities.

(b) what the impacts of these changes were and how these changes were measured/observable (e.g. programs were better targeted or contextualized; programs increased their reach; what health/development, organizational or environmental outcomes were observed)

PPHL is working to embed the practice of sharing and using data with all stakeholders who work in youth health. Last year we participated in a case study on the Manitoba Risk Factor Surveillance System which focused on the YHS and PPHL. From that case study we have learnt that the data has been used to develop and better target programming and to support existing programs. Below are a just a few examples on the impact/outcomes of having access to local data.

<u>Schools</u>
Girl's Club- This club was developed through a partnership with an RHAs and 2 schools to target the low physical activity of girls as identified by the school's YHS results. The girl's within the club do a variety of games and activities to build confidence, self-esteem and improve physical fitness.

Welcome Initiative- One high school learnt from their YHS data that students did not feel connected with the school. They are now focusing on the transition from middle school to high school. New grade 9 students participate in an orientation which includes activities designed to make the students feel welcome in their new school.

Retaining staff- The YHS data was used to justify retaining an existing addictions counsellor

even when a school division budget was being cut. Administrative staff presented the YHS data to the school board which showed high alcohol and drug use amongst students. The board realized that it was not in the best interest of the students to remove the counsellor and therefore the position was up held.

Several more examples of how YHS data have been used in schools were captured and filmed as part of the video "Moving Towards Healthier Lifestyles: Stories from the Manitoba Youth Health Survey".

Regional Level

Community Health Assessment Reports- All regions have used the data in their community health assessment reports which inform regional health service delivery planning.

Recreational programming- Using the YHS data recreational directors have instituted recreational activities better suited to what youth want. This has included for example re-institution of floor hockey leagues, and swimming lessons at local pools.

Provincial Level

Commitment to Reduce Youth Alcohol Consumption- High alcohol consumption, which was identified in the YHS results prompted the minister charged with the administration of the Liquor Control Act to make a commitment to reduce alcohol consumption amongst youth. To date they have hosted a youth alcohol summit with stakeholder and youth to discuss the issue and possible solutions.

Healthy School Grants- The province encourages schools to use their YHS data to identify and justify their particular proposed program/activity when applying for provincial funded Healthy School Grants. Linking the grants to the YHS reports has helped to encourage staff and students to spend time reviewing the reports and determining next steps.

In addition, because the data is local, end-users understand the context in which they are immersed and are using the data as a guide to develop appropriate context-specific interventions and promising practices. As we enter into the second cycle of the YHS end-users will be able to evaluate whether current programs and policies have made a difference in the health of Manitoba students.

(c) how the initiative was (or will be) evaluated

Last year a case study was undertaken to examine the Manitoba Risk Factor Surveillance System, in particular, the YHS and PPHL. A case study methodology allowed us to explore diverse perspectives and relationships situated within specific but complex contexts. The focus on the case study was to also document the processes, and identify critical success factors and

lessons learned.

In addition, the next cycle of the YHS in the fall of 2012 will provide data to schools, school divisions, regions and Manitoba Education to evaluate their programs, policies and the overall health and well-being of their youth. Plans are being developed to support and increase local evaluation capacity.

4. Lessons Learned:

Please describe (approximately 500 words):

(a) 3-5 major lessons you have learned through this effort – both good and bad

Data collection: Timing of the data collection should take into consideration end-users' needs to ensure greater uptake of evidence because data is then current and readily available for partner use. In future, the cycle timing should be considered so that it meets the needs of the education school level stakeholders. In addition a conceptual model is important because it can act as road map. It communicates to stakeholders that the YHS is not just a "one-off" survey but rather one activity of the surveillance system. It can help to clarify for stakeholders their roles and potential linkages to the system.

Communicating Evidence:
We learnt that you need to employ a wide variety of different **knowledge products and process** that are tailored to meet end-users' needs. The language used should be familiar to stakeholders when communicating evidence. Reports need to be easy to read, understand and therefore use.

One well-received knowledge product was quick fact sheets as it gave the reader information they needed quickly in a condensed format. It can also act as a method to get end-users to want to read the full report. Having knowledge products was important because they gave us an entry point to dialogue on the YHS results, youth health and next steps (i.e. action plans, program development).

Successful **knowledge exchange/translation** is also critical to the uptake and use of evidence in program planning and evaluation. We learnt that personal follow-up(s), sharing success stories, support from partners, resources (eg. money, time and people) and engaging youth are critical for successful knowledge translation. Personal follow-up is important to create opportunities to review, dialogue with us to further understand the YHS data and opportunities to improve youth health. Sharing our successes can encourage others to be creative in applying their knowledge in planning. Resources (e.g. money, time, and people) are also critical for us to be able to widely engage in communication activities and encourage use of data. Grants are one resource that encourage schools and other end-users to review and reflect upon their YHS information and implement an action plan. School, community and RHA partnerships are also important to building the capacity of schools to implement initiatives aimed to improve youth health. Lastly engaging youth is also extremely important in positively influencing student health and wellness.

Partnerships are critical to increasing the local and provincial capacity to collect and use local level evidence. Within PPHL we saw leaders/champions emerge at all levels – schools, school divisions, regions and within government. The PPHL partnership model has supported these leaders through the sharing of decision making and power which in turn has increased the sense of ownership and evidence use. In addition, our network of partners increases the reach of knowledge exchange through the use of personal and professional networks**.** **Funding** to date has been patchwork, and sustainable funding will be critical to the ongoing success of the YHS. However, we have not allowed the lack of sustainable funding to be a barrier in moving forward.

5. Additional Advice and Resources You Would Share in a Casebook

Please provide your advice on:

(a) how casebook information – including your case example - should be presented to be of most value to others

(b) additional resources that could accompany the casebook that would enhance its usefulness.

Website address: www.healthincommon.ca/pphl A took kit is available on line.