Fostering Research Partnerships: Interview with Dr. Gina Browne

In conversation with Dorothy Pringle

Dr. Gina Browne, RN, PhD, is founder and director of the System-Linked Research Unit (SLRU) on Health and Social Service Utilization, established in 1991 and funded by the Ontario Ministry of Health. She is a professor of nursing; clinical epidemiology & biostatistics; and Ontario Training Centre in Health Services and Policy Research (OTC) at McMaster University, Faculty of Health Sciences.

The System-Linked Research Unit on Health and Social Service Utilization initiates, implements and coordinates studies of persons with co-existing problems simultaneously using health and social services. The studies test the effectiveness and efficiency of multi-sectoral and proactive service interventions provided through alliances between service agencies for vulnerable children, adults or seniors. Dr. Browne is responsible for the success of bringing partner health and social service agencies together as a group to discuss, review and implement current research priorities in Ontario.

DP: Let me start by asking you to give us some background on your unit: its name, how it got started and why you took the lead, because, I believe, you've been the director since its inception.

GB: Our unit is a System-Linked Research Unit on Health and Social Service Utilization, funded in competition by the Ontario Ministry of Health in 1991. My staff call me the founder, but I think everyone helps direct. It started when Ontario invested $25 million into these kinds of units. The Ministry of Health's criteria required applicants to be in partnership with a service agency so that our work was relevant and immediately useful. I think Dougal Campbell and Eugene Veda were part of the design of this ministry initiative. I learned about the power of funding criteria in determining investigator attitude, assumptions and function.

I wanted of course to take advantage of the opportunity. As a clinician, I really liked the idea that it needed to be in partnership with service agencies, because for 37 years I've been a family therapist and have seen how many agencies can be involved with one family. So we took a risk. Other units had one service partner, and I said, "Oh no, we'll need about 16." We had four planning and 12 delivery health and social service agencies in two counties that we joined together. I made the point that we couldn't help vulnerable people with so many complexities in their lives without a combined use of many services, because these vulnerable populations used fragmented mini-services and we needed to get a handle on this. One of our first studies was of shared clientele between public health and social assistance.

DP: To help us understand, what are the names of some of these agencies?

GB: Well we had the welfare department – it was called that at the time – social assistance; public health; a health service organization, which was a group of family physicians; and the VON. Some of the planning agencies were social and research councils and district health councils. A lot of this combination of agencies was guided by my earlier work with Fraser Mustard (the second dean of medicine at McMaster), and the social determinants of health. And in my practice I could really see how these determinants affected health and functioning. Each type of agency was recruited from two counties, Hamilton – the poor county; and Halton – a wealthier one.

DP: Tell me what the mandate ... what you saw the mandate of this unit being?

GB: We saw it as looking at more effective and less expensive service strategies for vulnerable populations. We created more proactive comprehensive services through strategic alliances among our service agency partners and other agencies when applicable.

DP: You have been funded for 17 years. Can you tell us about what that funding is and what difference it makes to the unit, having that funding?
GB: It's $450,000 annual infrastructure money, meaning it's to hire secretaries, unit managers and all kinds of staff. Currently I have 12 staff , including research assistants, data analysts and so on. We have a resource to put grant applications together and to get more grants. We have a reputation for delivering return on investment – the Ministry of Health reported a few years ago that for every dollar that its invested, we've brought in four more dollars.

DP: Could you run this without that infrastructure?
GB: No. Absolutely not.

DP: How often do you have to go back and renew it?
GB: Well, since 1999, we've been on one-year renewals, because the Ministry of Health were working on their 10-year strategic plan, which is yet to be launched. Every year at this time we hear it's going to be our final year. But people in the ministry like our program because we're the only ones who emphasize economic analysis of our strategies, and the ministry is interested in return on investment.

DP: Let's focus on your role now as the founder and director of this unit. What kinds of responsibilities do you take on, relative to the unit?
GB: Well, I take on a role of imagination – thinking of the clinical problem. I don't do administration because I have a unit manager. My role is to think, inspire, design the projects, reward the people, and create mixes and matches and to help the other investigators feel that they are – and they are! – directors of the unit. So I call them directors, in a sense. I don't see myself as the only director, but I do see myself as the standard of the principles by which we work.

DP: Who sets the research agenda for your unit?
GB: I set the broad agenda about the comparative costs and effects of service interventions for vulnerable populations. Research partners identify the specific vulnerable age group and problem. There are vulnerable seniors, children and adults. People are vulnerable not just because of their health circumstances, but also because of their social circumstance. Because of this breadth, what also helps influence what we apply for is our funding opportunities. We then bend our interests in vulnerable populations toward the funding opportunities – say it's social determinants in health.

DP: Do you have representatives from all of these participating agencies?
GB: That's the Steering Committee. It has changed over time, but when we had solid funding for five years at a time, executive directors of agencies came and we would present our findings about their agencies, the mix of agencies and shared

clientele. We asked them to help us interpret the results, and they really like that. At the same time, we opened meetings with about 15 to 20 minutes of storytelling and sharing what else was going on, on the ground, and what was really happening – budget cuts and so forth. The meetings were well attended. It was, to me, amazing. CEOs came, and sometimes they brought senior staff. It was one of the only times counterparts from two different counties got together.

DP: How did you recruit the researchers in the unit?
GB: I selected the investigators, based on their being kindred spirits, meaning shared values, a shared kind of presence. I didn't want opportunists. The goal was to help service agencies answer their questions, so I needed investigators who would be of service, be respectful, and have a clinical interest. Also, they had the expertise that I needed: clinical, statistical and economic. I think the unit was successful because I got to pick the people who were the investigators – and younger trainees – and I continue to do that, including replacing retirees.

DP: Do you have any carrots to attract them? Like if you say, "I really would like this person in my unit; I like ..."
GB: Yes, it's the resources of the unit. We have secretaries; we say, "We'll type that for you." We have a travel budget; we say, "We can help you, we'd like to launch you."

DP: What about funding for students?
GB: I don't have funding for students in this particular grant, but we have resources to help them, for example, type transcripts or do the analysis. So the resource and the function are shared. Nobody gets money, but people get the resource.

DP: Is this an interdisciplinary group of researchers, and do you use any different approaches when you're going after nurses versus physicians versus epidemiologists, or do you use the same kind of approach?
GB: The style of approach is always different, because it starts off with questions: What's in it for them? Why would they want to collaborate? What are their problems, pressures, agendas? What could they get out of this? It always starts that way. In fact, I've even written this down in a publication on collaboration. It starts off with, what's their agenda, what are their personal issues – professional, parochial, what have you? You know, we have to talk honestly, and very much about whether they need to have the credit … give credit. Do they need to solve this problem or that one. Since our agenda is to be relevant, our projects always match the partner's problem. We don't need to do projects in one area. I help partners see that the investigators are the integrators. For example, the commissioner of social services said, "Gina, I don't have a research question; I just have a problem." So what's your problem? Well, it's the early '90s, and he said, "My case workers each have 200 clients and they should have 90 clients." I said, "That's it. What we'll do is a rand-

omized trial and allocate half of their clients to get the social assistance cheque and the case worker, and the other half just the cheque for social assistance." I bring the research mindedness to the question to translate the problem into a research project. Then I said, "You know, Public Health in our unit says that half of their visits are to social assistance clientele, so maybe they could help us, and your case workers wouldn't have to do so much." Then we'd bring in public health in both counties to the intervention.

Then I decided that parents receiving social assistance have all these children, and they're not getting what they need, and maybe we could help the parents most if we intervened and gave the children something, so that gave rise to the YMCA's involvement. I told the YMCA that they couldn't hog all the recreation dollars that came with the study grant. They needed to be the broker. We didn't want to get into the recreation business, but I expected them to coordinate a menu of recreation services provided by 29 other youth-serving agencies in the arts and recreation. That's how a project starts, and opens up, and evolves.

DP: How is it that you're able to build these relationships? I mean, you're pulling in some very disparate groups. Is there a secret or a skill set that you employ to get these people working together?

GB: I think the secret is to adopt their agenda. Start off with their issues and problems and how can you be of service. I'm very big on being "of service": my definition of being a director is to be of service – to investigators and their needs, the partner agencies and their needs.… I'm sure it comes from my origins in a large family! I know that "united we stand and divided we fall." Collaboration replaces competition – it's a win-win-win situation. How can we all get what we need out of the initiative And, of course, government funding enabled us to be a real resource for partner agencies. We said, "We'll do it for you. You'll be an investigator." Our commissioners of social services were some of the first real service providers to present one of our famous studies at the annual National Social Work Conference.

DP: Can we talk a little bit about graduate students, whether they have any role in this unit and, if they do, how you recruit them, and what role they play?

GB: Well, I am absolutely against exploiting research students, graduate students. I'm against having them ride on the coattails of faculty. I am for the same thing as their supervisor, as I am for partner agencies – for being of service to them. Many of my graduate students have their PhD thesis funded externally because their area of interest is a fundable priority. And this, of course, has rocked the graduate school. Because we're interested in vulnerable populations, the students take us into other territories that we might not have been in, like bereaved parents of young children. You see, their particular interest expands our agenda. You can see that no matter what the student's interest, it fits into our agenda about vulnerable populations.

DP: So you follow the student, as opposed to the student following you?
GB: Absolutely. And we believe in McGregor's definition of "leadership," that it is "follower-ship."

DP: Have you been affected or influenced by a shifting funding environment?
GB: Oh yes. I think CIHR (Canadian Institutes of Health Research) says only 16% of their submissions are ever funded. Most of the time I'm funded on the fourth resubmission, so it's always good to have a number of grant applications submitted, because you couldn't possibly handle them all at the same time. The other thing is, all of us are usually on each other's investigations. One of us is the lead, but every one of us needs the statistician, the economists, and so forth. So if anybody is funded, everybody is funded. That's one of our principles too – you can only win, you can't lose. If you have five projects in, you're either on, or leading. One of them will get funded.

DP: I want to go back to this interdisciplinarity. Does it matter that your background is nursing and that this unit is associated with the School of Nursing? Or could it be located anywhere? Does the nursing background influence you and the unit?
GB: It does, because I think nurses are one of the few professions that cares about everything. I always think of nurses in a clinical role as the coordinator of care. As the coordinator of comprehensive care, they have to look at all the needs – be it housing, child care, finances, health, whatever. I don't know of many other professions that think that way, except that social work is close to us. Accordingly, we have social workers in our units.

But yes, it can be located anywhere. It can be anybody, I think. That has been my philosophy, but I'm not sure it can be anybody with alternative philosophies. You see, we really are of service, and I think that is why we are so popular, because nobody has to lose anything and everybody gets something.

DP: How many researchers do you have associated with the unit now?
GB: Five of us are funded. Some are retiring right now, so I can describe the transition plan. New, young investigators have been selected, and I expect them to develop other people, to share their opportunity, to pay it forward, and to demonstrate that kind of leadership in the faculty. They'll add somebody to their project who's not necessarily in the unit. So it pays forward and it snowballs.

The point is, there's a changing mix of investigators but the same broad agenda and expanding service agency partners. We had faculty release money in our grant, so that faculty were relieved of teaching, and they could concentrate more on this. I still taught but didn't have to. I always think that clinical education and research

just have to go together – always, if we are to investigate relative approaches to the provision of human services.

DP: Are there other returns on investment for the government?
GB: The government is very interested in our unit because our unit shows that unless you change the practice pattern, you're costing them more this year. It's not just in the future; we have 18 randomized trials that show the same thing. It's blowing them away. I always say that if you're in Kentucky and you just let people die, it's cheaper that year. But in Canada, in a national health system, if you don't give people what they need, they will use, however inappropriately, some other service that's insured. It's going to cost you more. And they'll often use crisis services if you don't get into prevention, health promotion and more comprehensive care.

In study after study after study, we're able to show that a more comprehensive intervention achieved by strategic alliances through different yet complementary agencies – public health, social assistance, whatever – is both more effective and less expensive in the same year. Then, people will usually say, but how did you pay for the intervention? The intervention is also priced in our studies. The price of the intervention can be seen in the utilization data that we gather. For example, the use of public health was higher in the experimental group, just as we had planned, and we priced the intervention. But what's reduced is always crisis services and dependency on social assistance and unemployment [insurance] and so forth … more expensive crisis services.

DP: Is there anything else on that return on investment, because I'm hearing you say it's the knowledge that you generate that is the greatest return on investment?
GB: There's the knowledge, but, in fact, if you just start implementing this practice, it will give you an immediate return on investment. For example, out of that social service study of ours, the only thing that really helps children is the direct service to them, not money. Interventions aimed at the mother didn't immediately help the child. So it's not just the knowledge, it's the change toward more effective, less expensive practice as we study it.

DP: I think that's all the questions I have, but I'm wondering if there's something you would like to tell us that I haven't asked?
GB: I really do think that my philosophy could be boiled down to "Just do unto others," and be the example. Don't tell people; do it! And I guess it's not unlike what we think about raising children. The constant message of: "I believe in you; I trust you; I expect of you, I know you won't disappoint me." That kind of constant message, which is what I mean by being inspiring. And the messages should be rewarding, because the more you reward people, the more you get of that behav-

iour. To reward a faculty, one could acknowledge their often brilliant ideas. That's the way you can reward imagination.

I don't think we've talked much about imagination, but I'm very big on imagination, meaning thinking oppositely. And don't work on patients' deficits, work on their strengths. I know that's an old adage, but the point of it is, we create what we see.