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COMMON MEASURES TO ADVANCE THE SCIENCE AND PRACTICE OF POPULATION INTERVENTION FOR CHRONIC DISEASE PREVENTION: THE PROMISE AND TWO EARLY EXPERIENCES IN TOBACCO CONTROL

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Abstract: Pertinent evidence to inform population interventions for chronic disease prevention is sparse. The use of common measures across multiple jurisdictions is a promising approach to study "natural experiments" that can dually advance research/knowledge development and evaluation/practice improvement for population intervention. Early experiences with provincial tobacco control strategies and North American quitlines reveal the importance of (a) sustained collaboration across research, evaluation, policy, and practice communities; (b) honouring different perspectives; and (c) stable institutional support for the creation and implementation of common measures. The promise of common measures will be better understood as mature examples of their use are explored.

Résumé : Les données pertinentes pour orienter les interventions auprès de la population en matière de prévention des maladies chroniques sont peu abondantes. L'utilisation de mesures communes dans diverses régions constitue une approche prometteuse à l'étude

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des « expériences naturelles » qui peut à la fois faire avancer la recherche et le développement du savoir et améliorer l'évaluation et sa pratique en ce qui concerne ces interventions. L'expérience acquise antérieurement grâce aux stratégies provinciales de lutte contre le tabagisme et aux lignes sans frais nord-américaines de renoncement au tabagisme révèle l'importance (a) d'une collaboration soutenue entre les communautés de la recherche, l'évaluation, la politique, et la pratique; (b) du respect des divers points de vue; et (c) d'un soutien institutionnel constant à la création et à l'application de mesures communes. La promesse de ces mesures communes se révélera à l'étude des exemples évolués de leur utilisation.

INTRODUCTION

Population intervention for chronic disease prevention involves implementation of policies and programs that can reduce the prevalence of risk behaviours, eradicate root causes of these behaviours, and ultimately reduce the incidence of disease. The effectiveness of such policies and programs will be maximized if relevant evidence is used to guide their development and implementation (Kiefer et al., 2005).

Yet pertinent evidence is sparse (Potvin, Hawe, & Di Ruggiero, 2009; Sweet & Moynihan, 2007). Descriptive studies of health *problems* abound (Di Ruggiero, Rose, & Gaudreau, 2009), but fewer studies examine interventions suited to "real world" conditions (cf. Anderson, Scrimshaw, Fullilove, Fielding, & the Task Force on Community Preventive Services, 2003; Sweet & Moynihan, 2007) or examine adaptation of interventions to diverse and dynamic contexts (see recent calls for enhancing the external validity of intervention studies in Glasgow, 2008; Green & Glasgow, 2006). There is a particular need to go beyond studying interventions under controlled or experimental conditions to focus more on studies of environmental and policy interventions that are not usually amenable to experimental manipulation (Sweet & Moynihan, 2007): it is these environmental and policy interventions that have greatest potential for population-wide impact.

Opportunities for such studies arise when innovative policies and major programs are implemented by prevention leaders who subscribe to the credo that there is urgency to act, and "you can't use the paucity of science as an excuse to do nothing" (Dileep Bal cited in Sweet & Moynihan, 2007, p. 23). These innovative interventions may be seen as "natural experiments," and provide unique opportunities to make

important contributions to science—by learning about what works, for whom, under what circumstances—and to service—by applying what is learned in a timely way given the urgency to act.

New approaches are needed to study these natural experiments and optimize their contribution to building the knowledge base (research/science goal) and improving practice (evaluation/service goal). A promising approach is to have common measures and data collection tools in place so that comparative data can be gathered quickly across multiple jurisdictions as natural variations occur in policies and programs. There is, however, little experience in developing and implementing common measures and tools.

In this article we provide lessons from two early experiences in tobacco control in which common measures were developed to study natural experiments across jurisdictions. Our aim is to stimulate dialogue and sharing of related experiences, so that the promise and practice of using common measures can be better understood. A secondary aim is to increase cross-talk between research and evaluation communities, building on the example set by a recent special issue on population health intervention research in the *Canadian Journal of Public Health* (Hawe & Potvin, 2009).

RESEARCH AND EVALUATION CONVERGE IN POPULATION INTERVENTION

The introduction above purposely refers to the interdependent goals of advancing science and improving service. The first goal—to build a knowledge base—is generally viewed as the primary purpose of research, whereas improving service is typically a major purpose of evaluation (Hawe & Potvin, 2009). Both research and evaluation use similar means, specifically the use of scientific methods, to achieve complementary ends of new knowledge and improved service.

Research and evaluation tend to operate as separate fields, with separate functions, supported by separate institutions. Perpetuating this separation will impede progress in the field of population intervention. This silo approach has "retarded the development of knowledge and led to patchy evidence about policies and programs" (Hawe & Potvin, 2009, p. I8).

Bringing the fields together offers potential benefits. There is potential to enhance the relevance of population intervention research, to create

a community of people and organizations working with shared purpose to advance both knowledge and the betterment of society. Common effort across research and evaluation communities has potential to enrich the methods brought to bear on questions of mutual interest. It also has potential to create a shared pool of resources, invested by institutions in both science and practice realms, and the related promotion of both rigour and relevance within one enterprise. Such joint effort could enable coherent studies across settings and jurisdictions, as opposed to more piecemeal, fragmented studies of individual policies and programs: a coherent approach would undoubtedly be much more informative (e.g., by making it possible to systematically study not only individual interventions, but interactions between interventions and contexts). Common measures and data collection tools could be part of a shared investment, and a means to bridge the worlds of research and evaluation.

THE NEED FOR KNOWLEDGE DEVELOPMENT IN POPULATION INTERVENTION

As noted previously, most population-oriented research in prevention is descriptive (Millward, Kelly, & Nutbeam, 2003; Sanson-Fisher, Bonevski, Green, & D'Este, 2007), and more intervention, or solution-oriented research is needed (Robinson & Sirard, 2005). In particular, research is needed that emphasizes (a) external validity—the extent to which findings apply to diverse settings and conditions (Glasgow, 2008; Green & Glasgow, 2006); (b) questions relevant to program or policy design and strategies for implementation—for example, a literature review commissioned by the Canadian Cancer Society (Manske, Miller, Moyer, Phaneuf, & Cameron, 2004) on group smoking cessation programs did not yield a single study in 20 years of research that systematically studied issues related to design and delivery; and (c) natural experiments, as innovative policies and programs are implemented (Charlton, 2004; Petticrew et al., 2005).

With respect to natural experiments, experience from tobacco control has shown that the major innovations at a population level were not done by researchers, but by social actors: people with large program budgets (e.g., to mount comprehensive social marketing campaigns), policy levers, or capacity to advocate effectively for social change.

The limited relevance of existing research to these social actors is illustrated by the following comments made by Dileep Bal, who led the groundbreaking anti-tobacco program in California for 15 years:

> There was no science on how to do a community intervention on something of this global dimension ... We created the science, we did the interventions, and then all the scientists came in behind us and analyzed what we did. (Dileep Bal cited in Sweet & Moynihan, 2007, p. 23)

Based on the tobacco experience and in other areas of population health (Di Ruggiero et al., 2009), the need to support evaluation studies to examine interventions under real world conditions is now widely recognized. Evaluation methods enable the study of natural experiments that emerge as innovative policies and programs are implemented (Charlton, 2004; Petticrew et al., 2005). Understanding how interventions work in the real world increases the relevance of the results for policymakers and practitioners who work in complex settings. Further value is added when we go beyond studying individual natural experiments, and enable comparative studies of policy and program alternatives across settings or jurisdictions. Common measures and data collection tools would facilitate such comparative studies.

THE IMPERATIVE OF KNOWLEDGE UTILIZATION FOR IMPROVING PRACTICE

Knowledge development alone seldom contributes to improved practice. Findings must be understood, valued, and used by those responsible for program and policy decisions (cf. Kirkhart, 2000; Patton, 2008; Weiss, 1972). The literature on evaluation utilization and influence illustrates the importance of a wide range of factors, including the relevance of findings to potential users of evidence (Kirkhart, 2000; Owen, 2007; Patton, 2008). Developing a shared and valued set of common measures across jurisdictions is a plausible way to maximize the relevance of information for those making policy and program decisions.

RECONCILING SCIENCE AND PRACTICE PERSPECTIVES

The interests of researchers may not align with the needs and realities of service providers. How can these different perspectives be reconciled, without compromising on knowledge development and practice improvement goals?

The Propel Centre for Population Health Impact is exploring ways to achieve such reconciliation of research and evaluation perspectives

to stimulate relevant studies, and enhance the use of the resulting evidence. Informed by a growing literature on knowledge translation and exchange as it pertains to population intervention (National Cancer Institute, 2007; Riley, Cameron, & Reid, 2009), the Centre's approach has involved bringing together leaders in research, evaluation, policy, and practice, to build capacity to study natural experiments and especially comparative studies across settings and jurisdictions. The development of common measures is a core part of this approach. We describe two early experiences of the Propel Centre and colleagues in developing and implementing common measures: the first for comprehensive tobacco control strategies, and the second for North American quitlines. For each experience, we describe how the idea for common measures originated, the development and implementation process, lessons about what worked well, and challenges. The lessons are the product of reflections from key players involved in each experience.

ILLUSTRATION #1: COMMON MEASURES FOR COMPREHENSIVE PROVINCIAL TOBACCO CONTROL STRATEGIES

In the late 1990s and early 2000s, colleagues in several provinces approached Propel for assistance in developing an evaluation framework for their provincial tobacco control strategies. The aim in each case was primarily to use evaluation results to meet accountability requirements and to inform ongoing decisions about the tobacco control policy and program agenda (in the spirit of the Bal quote, above). The requests provided an opportunity to create new knowledge: the use of a common evaluation framework in several or all provinces would create a platform for studying natural experiments unfolding across the country as each province mounted its own mix of policy and program interventions. There was an opportunity to learn what works, for whom, under what circumstances. A multi-province effort would also facilitate peer learning across provinces, further enhancing contributions to service.

Three organizations joined forces to respond to expressed needs from several provinces: Health Canada's Tobacco Control Programme, the Canadian Tobacco Control Research Initiative for Canada (CTCRI), and the Centre for Behavioural Research and Program Evaluation (now the Propel Centre for Population Health Impact). CTCRI and Propel were both established by the Canadian Cancer Society and (historically) the National Cancer Institute of Canada with complementary mandates to build capacity for solution-oriented science in

tobacco control. These mandates were complementary to the federal and provincial government roles in implementing comprehensive tobacco control strategies.

As a first step, Health Canada, CTCRI, and the Propel Centre convened a workshop that brought together researchers and those responsible for tobacco control policies and programs (referred to as decision makers). The workshop was attended by 43 decision makers and researchers from 12 Canadian jurisdictions (at the provincial, territorial, and federal levels). Workshop participants were enthusiastic about developing a shared agenda. At the same time, the prospect was somewhat daunting. Although more common today, working at the interface of science and practice was new for most participants, and considerable effort was needed to reconcile science and practice language and goals.

The major outcome of the workshop was a recommendation that common indicators be developed for monitoring comprehensive tobacco control strategies (Manske, Maule, O'Connor, Lovato, & Harvey, 2003). The broader aspiration was to develop a useful evaluation framework that would serve both scientific and decision-making purposes.

To implement the call for developing common indicators, CTCRI formed the National Advisory Group on Monitoring and Evaluation (NAGME). Scientists and decision makers were invited to participate on the Advisory Group; however, scientists were most actively involved. The Advisory Group (a) commissioned a review of national surveys, (b) developed a logic model for tobacco control programs, (c) reviewed the literature to identify common indicators and measures that could be linked to outcomes, and (d) examined national surveys as potential data sources for indicators. The end product was a scientifically strong corporate publication from CTCRI that recommended an "ideal" set of indicators and measures, and guidelines for using existing national surveys to gather information on these indicators (Copley, Lovato, & O'Connor, 2006).

Throughout the process, it was difficult for the Advisory Group to sustain its efforts. Members believed in the importance of the initiative, but they volunteered their time and had neither the authority nor responsibility to ensure the indicators were used by provinces. Reward systems of science versus practice environments also created challenges. Technical documents with corporate authorship are not as highly valued by universities as peer-reviewed publications.

There was also a downside for participants from the practice community. The interval between the workshop and the final report was three years. By the time the product was available, the window of opportunity for significantly influencing provincial decisions had passed: no specific efforts had been made to keep provincial tobacco control leaders actively engaged, and, with the exception of distribution of the report, there was no dissemination strategy.

The use of the document and implementation of the indicators is largely unknown. To our knowledge, use of the indicators (or a modified version of them) has been greatest in the province that contributed significantly to indicator development, and has the largest budget for monitoring and evaluation. Efforts to sustain or renew the initial work completed by NAGME were not undertaken, mostly due to significant changes in the organizational landscape for tobacco control, including the dissolution of CTCRI, a change in Health Canada's Tobacco Control Programme mandate (or change in federal government mandates/priorities), and less time availability of Propel and other scientists to sustain or re-engage.

Summary

Despite initial enthusiasm from both researchers and decision makers about the promise of common measures and evaluation frameworks, and the development of a recommended set of relevant and credible common measures, implementation by provinces was limited. Some of the main challenges were the inability to keep tobacco control leaders engaged throughout the process; the length of time it took to produce the recommendations; no dissemination plan for the written product; and organizational changes that compromised ongoing leadership, at least temporarily.

ILLUSTRATION #2: COMMON MEASURES FOR SMOKING CESSATION QUITLINES

Smoking cessation quitlines (telephone-based tobacco cessation services that help tobacco users quit) are a best practice in tobacco control as a low-cost, high-reach population-based approach (Centers for Disease Control and Prevention, 2007; Fiore et al., 2008). Widespread implementation of quitlines created both an opportunity for comparative studies and a demand from quitline providers, researchers, and evaluators to learn from each other in order to improve services, promotion, and impact. To advance science and service goals, the quitline

community developed a common set of measures (Minimal Data Set, or MDS). We describe the development of the MDS and some lessons from its implementation in Canadian quitlines.

Minimal data set

The MDS vision was to develop measures that would provide valid, standardized data on a few indicators that quitline operators, quitline funders (generally state or provincial governments), evaluators, and the research community deemed important and informative. The intent was for these data to inform quitline operations, identify successful practices to improve services, support resource allocation, and facilitate comparative studies across quitlines.

The North American Quitline Consortium (NAQC), an international, nonprofit membership organization to promote evidence-based quitline services, established a 14-member MDS Working Group that included researchers, service providers, evaluators, and funders. Members of the Working Group represented key, influential organizational affiliations, and had linkages to leading-edge quitlines. The Working Group was pivotal in developing the MDS, bringing science, service, and political perspectives to the task. Importantly, the collaboration also extended beyond the Working Group members. Extensive consultation was used to select relevant intake and follow-up questions, and to address feasibility, cost, and other concerns.

An iterative, collaborative process was used to identify, assess, and select key indicators for inclusion in the MDS. The first step was to develop a set of principles to guide the process and decisions about specific indicators (Table 1). Honouring these principles facilitated collaboration between quitline providers and scientists. For example, quitline providers had historical data they wanted to include for comparisons over time, so the MDS was designed to accommodate some, but not all, pre-existing questions and/or response categories. Scientists, on the other hand, wanted many more questions than were reasonable to ask someone seeking a service, as opposed to participating in a study. The guiding principles and collegial process enabled satisfactory resolution between researchers' desire for comprehensive baseline data and service providers' concerns about the effect of lengthy data collection on client service.

> The collaborative approach was unique and progressive. By bringing together such a range of stakeholders, all perspectives were represented from the very beginning,

> which allowed informed and rapid input, critiquing, and feedback to produce a MDS that will be relevant and manageable to implement. (Campbell, Ossip-Klein, Bailey, & Saul, 2007)

Table 1
MDS Guiding Principles

1.	Indicators must inform decisions important to the improvement of quitlines.
2.	Whenever possible, questions and wording already in use will be preserved to allow quitlines to continue historical comparisons.
3.	Preference will be given to measures with acceptable reliability and validity, endorsed by scientific bodies (e.g., SRNT), or used in national surveys (e.g., census demographic questions).
4.	Size (total number of items) of the MDS must not create barriers to meeting the needs of smokers calling for help with quitting.
5.	Keep the MDS small and operationally feasible.
6.	The MDS must be easy to implement and be respectful of quitlines' service mandate.
7.	The MDS must accommodate differences across quitlines.

With respect to evaluation methodology, the Working Group developed recommendations for selecting evaluation participants, length of follow-up and protocols for repeat callers. Despite some efforts to standardize, the Working Group concluded:

> Each quitline will need to determine how follow-up will be conducted and on which population.… [Quitlines] should strive to survey enough people to draw valid conclusions about their outcomes, but it will be up to the individual quitline to determine whether census surveying, random sampling, cohort sampling, or some other sampling method will be most appropriate. (Campbell et al., 2007)

While not ideal from a research perspective, this approach made implementation of the MDS possible with the expectation that common evaluation methodologies could evolve over time.

Since the ability of the MDS to facilitate decision making hinges on its use, substantial effort was put into disseminating the MDS and facilitating its implementation. Throughout its development and particularly at the time of its launch, NAQC shared the MDS with all NAQC members and interested parties by e-mail, on the NAQC website, at tobacco control conferences, and during the first NAQC annual meeting in May 2005. NAQC also hired a technical expert and offered assistance via conference calls, online resources, and individual consultation for a six-month period.

One year after the MDS implementation date of October 2005, NAQC reconvened a new MDS Working Group to assess how consistently the MDS had been implemented by North American quitlines. Almost 90% of quitlines participated in the evaluation, and results showed approximately 60% of quitlines implemented the intake and follow-up questions as intended with minimal disruption to existing services (North American Quitline Consortium, 2008). Challenges with some of the questions were identified and revisions made, using the same consensual process as before. NAQC has continued to provide resources, tools, and support to quitlines as well as determine, and act on, needed changes to the MDS itself. NAQC identified in its Report on MDS Implementation Assessment that the "MDS is a work in progress ... [and] quitlines may have implemented specific questions differently than NAQC had intended—but for very good reasons" (North American Quitline Consortium, 2008, p. 2). The revised MDS 2009, based on this evaluation, has recently been released.

Canadian experience in use of the MDS

As noted earlier, common measures cannot advance knowledge or assist with decision making unless they are used. By 2006 all Canadian quitlines had implemented the MDS although, as noted by NAQC's assessment, not all measures were implemented as intended. Propel evaluates seven of the Canadian quitlines and is thus able to compare quitline performance across different jurisdictions. The ability to make comparisons depends on data collected by each quitline. For example, because quitlines collect MDS measures about smokers' reasons for calling, it was possible to examine the effect of promotional strategies, funding, level of integration within the health system, and baseline smoking rates within the province on quitline reach (the proportion of provincial smokers receiving evidence-based intervention) (Centre for Behavioural Research and Program Evaluation, 2009). On the other hand, education, as a proxy measure for socio-economic status, is an MDS measure that has not been implemented by all quitlines because of discomfort with asking this level of personal information. Thus the impact of quitlines in disadvantaged groups cannot be determined, and interventions to reach those with low education are more difficult to plan and assess.

In order to conduct these and other comparative studies, differences in how the intervention is implemented and differences in the context must be taken into account. To illustrate, within Canada there are 5 different counselling protocols, 4 different call centre technologies, and 11 different social and political environments. It is these dif-

ferences that create the natural experiments, and that can help us understand the conditions under which quitlines are effective. As a result, the performance of two or more quitlines, even with the same MDS indicators, cannot be compared without taking into account the quitline service model and context. Work is currently underway to build on the MDS and capture pertinent information on quitline service models and context, which will facilitate a wider range of informative comparative studies.

Summary

The MDS experience has engaged researchers, evaluators, service providers, and funders over a long period of time. This sustained engagement is made possible by the stable and substantial leadership from the NAQC, and a way of working that is collaborative and honours both scientific and practical perspectives. Some examples of comparative studies using MDS begin to show the promise of common measures. Some challenges include variable implementation of some MDS measures, and limited information on quitline service models and context.

DISCUSSION: AN EMERGING AGENDA FOR COMMON MEASURES ACROSS JURISDICTIONS

The two examples provide some initial guidance on developing and implementing common measures and data collection tools for population interventions. We discuss three lessons and suggest how to build on these early experiences.

Lesson #1: Sustain a Collaborative Approach

A common feature of both examples was an approach that enabled those involved in research, evaluation, policy, and practice to align their efforts. It is beyond the scope of this article to perform an in-depth analysis of how and why various players worked together. Nevertheless, a clear lesson was the importance of ongoing consultation and engagement. This was identified as a key lesson by the MDS Working Group (Campbell et al., 2007). And it was a limitation with NAGME: engagement of a broad set of end users was not sustained and was likely a major factor limiting uptake and implementation of the common measures. End users also may have shaped the NAGME product differently, perhaps addressing issues of implementation and cost that would influence adoption and use of the measures. Why

certain players chose (or not) to engage and collaborate is not fully understood. Given the critical role of engagement, there is a need to understand more fully the perceived benefits and costs for different players related to developing and implementing common measures, and using them in research and evaluation studies. This lesson reinforces the collaboration imperative that is part of best practices in evaluation (Patton, 2008) and the need to explore more deeply perceived benefits and drawbacks of those involved in various partnership arrangements (Friedman et al., 2007; Luke & Harris, 2007).

Lesson #2: Honour Differences in Perspectives

Both cases demonstrated the need to adopt and cultivate a new way of working that honours the norms, values, and working requirements of different stakeholder groups. There are specific skills (e.g., facilitative leadership, negotiation) and values (e.g., synergy, impact-orientation) that are required to achieve the dual goals of contributions to science and service. While these attributes and skills are relatively new within the research community, they are more characteristic of evaluation practice (Hawe & Potvin, 2009), especially with newer methods, such as appreciative inquiry, developmental evaluation, participatory research, and internal evaluation (Owen, 2007; Torres, Preskill, & Piontek, 2005). This is an example where greater cross-talk between research and evaluation communities might cultivate new perspectives and skills for jointly advancing science and service goals.

Lesson #3: Build Institutional Support for the Development and Implementation of Common Measures

These examples suggest that institutions (including funders, universities, governments, and non-government organizations) need to support collaborative efforts beyond just the development of common measures. Organizations with non-traditional mandates catalyzed both examples. NAGME was initiated by CTCRI and Propel, whose mandates were to help bridge science and practice. At the time of initiating NAGME, the primary focus of CTCRI was to create funding mechanisms suitable to support population intervention studies in tobacco. Propel was to build capacity for population intervention studies, including and beyond tobacco. Despite serving an important catalytic role, these organizations were not able to secure adoption and implementation of the common measures in provinces. In contrast, the MDS was initiated by NAQC with strong support from a Propel scientist who was integrated in the quitline community through

evaluation. MDS was a priority for NAQC and resources were made available for wide consultation, technical help with implementation, one year evaluation, and revision of the MDS based on feedback. NAQC's stable and strong institutional support was a critical success factor for the MDS.

BUILDING ON THESE EARLY EXPERIENCES

The NAGME and MDS experiences described in this article are a modest start to learning about the promise and practice of developing and implementing common measures to achieve science and service goals. Additional examples will build a richer understanding. Cases that are particularly rich will involve data collection on common measures over a long period of time, and include examples of using common measures to answer relevant research questions and to inform decision making about practice. Learning will also be enhanced if studies are theoretically informed (for example, including principles and approaches of internal, interaction and multisite evaluations) and include multiple perspectives (e.g., scientists, service providers, funders).

Some recent institutional changes may also help to build on early experiences with common measures. For example, although CTCRI has been dissolved, partner organizations are exploring ways to sustain the solution-oriented mandate of CTCRI. Also, Propel was recently repositioned. Propel's five-year plans (2011–16) include strengthening efforts to integrate science and service. This direction emerged from a major strategic planning process in 2008–09 under the auspices of Propel's founders, CCS and the University of Waterloo. Extensive environmental scanning and consultations with leaders in research, evaluation, surveillance, policy, and practice resulted in a new charge to accelerate the generation and use of evidence that enables leaders in policy, program, and advocacy to develop and implement effective population health interventions. The essence of this new mandate is to integrate research and evaluation as a way to achieve goals in prevention and improved health through population-level solutions.

Another promising institutional change is the Population Health Intervention Research Initiative for Canada (PHIRIC), which was initiated to create an environment to accelerate the generation and use of evidence to guide population intervention (Potvin et al., 2009). Founding organizations included Canadian Institutes of Health Research, the Public Health Agency of Canada, the Chronic Disease

Prevention Alliance of Canada, the Canadian Population Health Initiative of Canadian Institutes for Health Information, and the Propel Centre. Note the representation from organizations that fund research, do research, and use research: a growing number of organizations representing all three constituencies are becoming involved. This is an encouraging development for creating an environment that values and integrates knowledge creation (to advance science) and knowledge use (to improve practice).

A final institutional development is a major investment in primary prevention by the Canadian Partnership Against Cancer (CPAC). On behalf of cancer and chronic disease prevention communities, CPAC is supporting a Canadian Platform to Increase Usage of Real-World Evidence (CAPTURE). This represents a timely opportunity to develop a vision and accelerate action toward developing and using meaningful data platforms that are common across programs, settings, and/or jurisdictions to jointly advance scientific and practical goals.

CONCLUSION

The use of common measures to serve both research/knowledge development and evaluation/practice improvement purposes is promising. The experiences shared in this article—provincial tobacco control strategies and smoking cessation quitlines—provide some preliminary insights related to the development and implementation of common measures. A collaborative approach is needed that is sensitive to the mandates and incentives of diverse stakeholders (funders, scientists, service organizations). Institutional change is needed to support the development and use of common measures and involvement of key players from relevant sectors. These changes can build on promising developments, including the repositioning of Propel and the Population Health Intervention Research Initiative for Canada. The agenda could be usefully informed by comparative case studies, including cases with sufficient development to yield meaningful lessons related to design, implementation, and use of common measures. These directions could help to accelerate efforts to advance knowledge generation and practice improvement, both of which contribute to better health for Canadians.

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