

# proceedings

Winter 2003

...of the Canadian Heart Health Network Workshop, October 2002

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## Moving from Heart Health to Chronic Disease Prevention

The ten provincial departments of health co-funded the Canadian Heart Health Initiative which linked national, provincial and local health departments. It combines research with the implementation of community-based heart health programs. The Initiative has created extensive inter-sectoral partnerships and networks as a means of developing and disseminating prevention knowledge. The ten provincial departments of health and Health Canada co-fund the Canadian Heart Health Initiative. The Heart and Stroke Foundation of Canada is also a major partner.

By acting both within and outside of the health system, the Initiative supports health promotion and disease prevention in several ways. In addition to the national "CHHI Health Promotion and Chronic Disease Prevention Database" of interventions from across Canada and the international "G8 Promoting Heart Health Database", the CHHI also operates a listserv and, approximately every 2-3 years, organizes a national networking event.

The 2002 networking event, held in Edmonton on October 28th, had as its focus "Moving from Heart Health to Chronic Disease Prevention". Some 80 delegates from across Canada gathered at the Delta Edmonton Centre Suite Hotel to hear a range of speakers share national, provincial, setting-based and epidemiological surveillance oriented perspectives on the topic. What follows are highlights from each of the presentations.

### ✓ ACTION IDEA

Find out more about the supports of the CHHI at: [www.med.mun.ca/chhdbc](http://www.med.mun.ca/chhdbc)



Presented by: Dr. Elinor Wilson, Co-Chair of COPI and Chief Science Officer, Heart and Stroke Foundation of Canada

## "Overview of the Workshop"

"Everything that happens in public health takes 20 years. "In this spirit, Elinor opened the workshop with a global perspective, based largely on the annual WHO World Health Report released in October, 2002, (<http://www.who.int/whr/en/>), which states, "The world has been living dangerously – either because it has little choice, which is often the case among the poor, or because it is making the wrong choices in terms of its consumption and its activities." Seven recommended actions were suggested to support the goal of helping governments of all countries raise the healthy life expectancy of populations by five years. Specifically, countries can:

- Strengthen scientific and empirical bases for their policies
- Improve public dialogue and communications
- Develop greater levels of trust for risk prevention
- Create sound strategies to manage risk uncertainties
- Consider ethical issues
- Give population-wide interventions priority
- Undertake targeted medical interventions.

This context led to the remainder of the workshop where many approaches currently underway in Canada were highlighted.

### ✓ ACTION IDEAS

"Who-Choice"-Choosing Interventions that are Cost Effective

<http://www3.who.int/whosis/menu/cfm?path=evidence,cea&language=english>



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## Presentation



Presented by: Dr. Sylvie Stachenko, Director General,  
Centre for Chronic Disease Prevention and Control, Health Canada

## "An integrated approach to chronic disease prevention at a Pan Canadian level"

### The Burden in Canada

#### Individuals and families

- 16,000,000 live with chronic illness
- Chronic disease accounts for 87% of disability

#### High risk groups

- Increased prevalence in vulnerable communities (e.g. Aboriginals) and in socio-economically disadvantaged groups.

#### Economy

- Direct health care costs: 67% of total direct costs are expended on chronic diseases
- Indirect costs: 60% of total indirect costs (\$52B), translating into loss of productivity and foregone income

#### All these numbers will increase

- Aging, increased prevalence of some risk factors, e.g. obesity

"We are at a cross roads in Canada to develop a truly comprehensive pan Canadian integrated approach to chronic disease prevention building on many achievements including the heart health initiative which has contributed to a solid foundation of knowledge and best practices." Dr. Stachenko shared current rates of chronic disease worldwide as compared to other causes of death and identified that, by the year 2020, it is estimated that 75% of all deaths will result from non-communicable diseases.

The encouraging news is that much of the burden of chronic disease is related to six distinct risk behaviours as identified in the schematic to the left and these can be linked to determinants and chronic diseases.

It is also known, through 30 years of practice, that risk reduction prevention strategies work. Knowing this, why then is the Canadian picture still so grim? Several "roadblocks" were identified:

- The prevention and public health capacity in the country has weakened and is variable across the country. Presently the public health infrastructure lacks tools, resources and critical mass for chronic disease prevention.
- There has been a failure in translating and disseminating the prevention knowledge base to policy makers and practitioners.
- The surveillance systems for chronic disease are inadequate and despite the fact that many of the provincial and federal health care reviews acknowledge the need to invest in "upstream approaches", the focus of current health care reform agendas continue to be on medical care, which is seen as the main contributor to health care expenditures.

Over the last two decades there has been an important investment in prevention and health promotion, but typically these initiatives have been single disease or single risk factor oriented. There have been some success stories, such as in the tobacco area. The health promotion strategies that have had the most success:

- used a multi-level intervention approach including education, environmental support, economic levers and legislation
- targeted a number of relevant settings such as school, workplace and community
- delivered a sufficient dose in terms of intensity and duration.

On the whole, most of the prevention initiatives have not exploited the possible synergies which can be accomplished by coordinating prevention efforts across diseases and risk factors. It is increasingly recognized that there are great opportunities to maximize prevention efforts and achieve the preventive dose through an integrated approach.

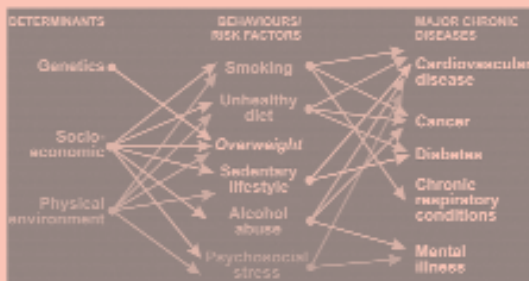
### What is an integrated approach?

- A **framework** for working with stakeholders aimed at interventions that bring about joint action on several risk factors common to major chronic diseases that reduces duplication, and improves resource utilization.
- **Links** preventive action of various components of the health system, including health promotion, primary health care, public health services, and curative care.
- Calls for a **comprehensive approach** combining different strategies for implementation including policy development, capacity building, partnerships, and information support at all levels.
- Calls for **inter-sectoral action** to implement health policies to address the major determinants of health that fall outside the health system.

### A little history on CDP:

This chronic disease prevention approach is not new – it was first introduced in the early '80s by the World Health Organization (WHO) and endorsed by the World Health Assembly in 1985 which led to the World Health Organization-Countrywide Integrated Noncommunicable Disease Intervention (WHO-CINDI) project to evaluate community based approaches to integrated chronic disease prevention. The Canadian Heart Health Initiative was inspired by the WHO-CINDI. CHHI has made important contributions to the global knowledge base in this area, including the process evaluation developed and the lessons learned in partnership and coalition building.

### Commonality of Risk and Determinants for Chronic Diseases



## Building blocks for CDP in Canada:

- 1 Australia (<http://www.dhs.vic.gov.au/nphp/ar2001/part2a.htm>) and New Zealand have developed CDP strategies
- 2 The Chronic Disease Prevention Alliance of Canada
- 3 The Canadian Coalition on Enhancing Preventative Practices
- 4 The Canadian Institutes for Health Research
- 5 Existing provincial strategies, such as Nova Scotia, Manitoba and Alberta
- 6 Federal-Provincial/Territorial "Healthy Living" strategy
- 7 Centre for Chronic Disease Prevention and Control at Health Canada

## What is needed to move CDP forward?

### a) An effective information base -

- 1 Ensure an effective information base to guide integrated preventive action by building on existing efforts and lessons learned in specific diseases and risk factor areas. Synthesize this knowledge into an analysis of best or most promising practices which would then help develop tools and models for integrated chronic disease prevention.
- 2 Develop a comprehensive surveillance and monitoring system for chronic diseases and expand current information systems to capture information on determinants, risk factors, and interventions.
- 3 Focus research efforts on translation and implementation research.

### b) Strengthen the capacity for a more integrated chronic disease prevention approach.

### c) Ensure a higher order of collaboration & strategic management for chronic disease prevention.

Presented by: Ms. Virginia Bales, Director for Division of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, USA

## "CDC's National Action Plan for Cardiovascular Health"

Ms. Bales is responsible for the cardiovascular initiative in the US that is designed "To chart a course for CDC, with the states and territories and our other partners, for achieving national goals for heart disease and stroke prevention over the next two decades, to 2010 and 2020". In her presentation, she reinforced the degree to which the Canadian Heart Health experience has driven the US strategy.

A comprehensive plan has been created based on an integrated the Organizational Structure to the right:

### Highlights of the US plan:

- 30 states have start-up funds that are provided in partnership with the American Heart Association, with 9 states more fully funded
- Based on the national Health People 2010 goals, which AHA has also adopted
- The 10 specific recommendations will be officially launched at the CDC Chronic Disease Conference in February, 2003 in Missouri
- The planning process was facilitated by the establishment of a small working group of influential and credible people, who were dedicated to the task and unencumbered by other responsibilities.

*Regarding CDC & the American Heart Association... "It is a cool partnership & it has only just begun. They have pushed us."*

### ✓ ACTION IDEA

Canadian provinces are encouraged to consider joining CINDI:

"Countrywide Integrated Non-Communicable Disease Intervention" Program  
<http://www.who.int>



### ✓ ACTION IDEA

Join the Chronic Disease Prevention Alliance of Canada

[www.cdpc.ca](http://www.cdpc.ca) (English)  
[www.apmcc.ca](http://www.apmcc.ca) (French)



## Presentation



### ✓ ACTION IDEA

CDC Planning Process  
<http://www.cdc.gov/cvh/nap-planningprocess.htm>

## Presentation



Presented by: Ms. Erica di Ruggiero, Assistant Director, Canadian Institute of Health Research – Institute for Population and Public Health

## “Facilitating Interdisciplinary Partnered Health Research and Knowledge Exchange”

### Where and how does Chronic Disease Prevention fit in the strategic research agenda of Institutes?

- CIHR cross-cutting initiatives to coordinate large programs of research that are integrative and help tackle important health problems for Canada (e.g. Tobacco, Canadian Lifelong Health Initiative, Reducing Health Disparities and Promoting the Health of Vulnerable Populations)
- Institute-led research and knowledge exchange initiatives (e.g. Institute of Population and Public Health priorities; Institute of Human Development, Child & Youth Health; Institute of Nutrition, Metabolism and Diabetes (INMD– Obesity and chronic disease prevention initiatives)

### 2001 New Emerging Teams with a Connection to Chronic Disease:

- In recognition of the potential benefit of research programs which focus on common aspects of chronic diseases
- Partnership of INMD, Institute of Circulatory & Respiratory Health (ICRH), Institute of Gender & Health (IGH) plus - the Kidney Foundation of Canada, the Heart and Stroke Foundation & the Canadian Diabetes Association.
- Funded six interdisciplinary research teams focusing on common and related aspects of kidney disease, cardiovascular disease and diabetes
- \$7.0 M over 5 years

The objective of CIHR is to “To excel, according to internationally accepted standards of scientific excellence, in the creation of new knowledge and its translation into improved health for Canadians, more effective health services and products, and a strengthened Canadian health care system” ...and there are four pillars of research:

- Biomedical
- Clinical
- Health services and health systems
- Health of populations, societal and cultural dimensions of health, and environmental influences on health

### The institutes have 3 primary roles

- Advancing the development of strategic research agendas with input from the broader research, policy and practice communities
- Increased emphasis on interdisciplinary partnered health research and knowledge exchange
- Funding criteria that now require meaningful engagement, and provide incentives for involving policy and program administrators, decision makers and public health practitioners in research

### Institute for Population & Public Health (IPPH) Strategic Priorities for 2002-07, are:

- Capacity building for cutting-edge and relevant PPH research
- Understanding and addressing the impacts of physical and social environments on health
- Analyzing and reducing health disparities
- Global health
- Environmental and genetic determinants of disease in human populations

### The Institute of Human Development, Child and Youth Health Strategic Research Priorities also has related themes:

- Healthy gametes and great embryos
- Reproductive aging
- Adverse fetal growth and pre-term birth
- Reducing the burden of congenital abnormalities
- Developmental trajectories of children and youth
- Causes, prevention and treatment of acute and chronic illness in children and youth.

Presented by: Dr. Catherine Donovan, Member of the CPHI Council, Canadian Institute for Health Information

## “Canadian Population Health Initiative”



## Presentation



CIHI is an independent, pan-Canadian not-for-profit organization working to improve the health of Canadians and the health care system by providing quality, reliable and timely health information. The Institute’s core functions are to:

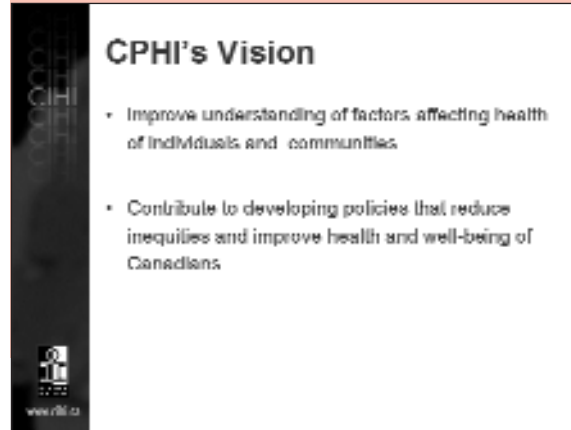
- identify and promote national health indicators
- coordinate and promote the development and maintenance of national health information standards
- develop and manage health databases and registries
- conduct analysis and special studies and participate in research
- publish reports and disseminate health information
- coordinate and conduct education sessions and conferences.

A section of CIHI deals with the **Canadian Population Health Initiative (CPHI)** which was established to generate new knowledge on the determinants of health, contribute to the development of population health information infrastructure, support policy analysis and synthesis of evidence, and transfer new knowledge to decision-makers and the public. As a key actor in population health, CPHI will undertake the following core functions:

- Generate new knowledge on the determinants of health
- Contribute to the development of a national population health information system and infrastructure
- Support synthesis of research evidence and analysis of policy options.
- Contribute to regular reporting to Canadians on their health and well-being.

### ✓ ACTION IDEA

Watch for the CIHI flagship report “Improving the Health of Canadians” in late 2003.  
<http://secure.cihi.ca>



Presented by: Dr. Yang Mao, Director of the Surveillance and Risk Assessment Division, Centre for Chronic Disease Prevention and Control, Health Canada

## “Chronic Disease Surveillance within Health Canada”



## Presentation

In Yang Mao’s words, “Surveillance is my life” and his philosophy is that surveillance should exist only to support action, such as setting government priorities. This relationship is depicted in Figure 1.

Within each of the “Data” categories in the diagram, the following information can be found:

Registry Based	Administration Based	Census & Surveys	Action Driven
<ul style="list-style-type: none"> <li>• Cancer</li> <li>• End stage renal disease</li> <li>• Trauma</li> <li>• Stroke</li> </ul>	<ul style="list-style-type: none"> <li>• Mortality</li> <li>• Hospital admissions</li> <li>• Traffic injury database</li> <li>• Mental health institute</li> <li>• Linked to NDSS</li> </ul>	<ul style="list-style-type: none"> <li>• Canada Census</li> <li>• Canada Population Health Survey</li> <li>• Canada Community Health Survey</li> <li>• Heart Health Survey</li> <li>• Provincial Health Surveys</li> </ul>	<ul style="list-style-type: none"> <li>• NECSS<sup>1</sup></li> <li>• EQDB<sup>2</sup></li> <li>• Senior Cohort Follow-up</li> <li>• Immigrant Database</li> </ul>

Fig 1: Chronic Disease Surveillance System Flow Diagram - Ongoing and Iterative -



<sup>1</sup> National Enhanced Cancer Surveillance System  
<sup>2</sup> Environmental Quality DataBase

...Proceedings of the October, 2002 Session

## ✓ ACTION IDEA

## Access for CVD

(http://cythera.ic.gc.ca/dsol/cvd/index\_e.html):

- Cardiovascular Disease Mortality Maps
- Cardiovascular Disease Hospital Separations Charts
- Economic Burden of Illness
- Glossary

## Access for Cancer

(http://cythera.ic.gc.ca/dsol/cancer/index\_e.html):

- Cancer Incidence Maps & Charts
- Cancer Mortality Maps & Charts
- Glossary

## Dr. Yang Mao's Presentation Cont'd:

"This is another example of provincial and federal collaboration that is needed. We always have troubles sharing in this country, promoting an integrated approach."

Within the "Information" category, the National Chronic Disease Surveillance Statistics track CCS, arthritis, heart and stroke, diabetes and mental health in order to identify the current and future burdens of CD.

In the future, the direction of the Surveillance Department will include:

- Enhancing the patient data collection for the registration database
- Promoting the application of National Diabetes Surveillance System model for other chronic diseases
- Establishing a sentinel center NCD surveillance network
- Advancing the community health surveillance paradigm.

## Presentation



Presented by: Ms. Anne Lessio, Manager, Ontario Heart Health Resource Centre (HHRC)

## "Best Practices in Heart Health and Stroke Prevention"

### "A Brief History of Best Practice documents..."

- 1997 "What Worked for Us" – 41 interventions from Ontario's five HH Demonstration sites
- 1998 "International Scan for Best Practices in Heart Health: Part 1" – done in conjunction with the Health Behaviour Research Group at the University of Waterloo
- 1999 "International Scan for Best Practices in Heart Health: Part 2"
- 2001
  - Partnership with BC Ministry of Health Planning to repeat International Scan of Best Practices for Heart Health. Dalhousie University, Community Health & Epidemiology & University of Alberta, Heart Health Project partnered later on.
  - Collaborative workshop with G8 Heart Health Telematics Project
  - Best Practices for Stroke Prevention through Ontario's Ministry of Health & Long-term Care
- 2002/03
  - International Scan of Best Practices in Prevention of Diabetes Type II through Canadian Diabetes Strategy

## ✓ ACTION IDEA

Visit [www.hhrc.net/resources.htm](http://www.hhrc.net/resources.htm) for details on the Best Practices documents



In support of the 37 community heart health coalitions in Ontario, the HHRC provides a range of supports for health promoters. This is done in conjunction with 20 other provincial partners.

One of the supports provided by the HHRC is the collection of "best practices" related to heart health programs. This has evolved over time, as outlined in the Brief History to the side.

For the international scans, a fairly consistent methodology has been used over the years, involving the nomination of potential practices by key informants around the world in addition to a literature review. Details are gathered on the programs and assessment criteria applied. "Effectiveness" criteria include Selection Bias, Study Design, Cofounders, Blinding, Data Collection Methods, Withdrawals and Drop-outs and the "Plausibility" criteria address Program Development Attributes, Established Principles of Behaviour Change in the Intervention, and Process Attributes.

In monitoring the local uptake of these "best practices", a few barriers have been identified which include the volume of material provided to local program planners, the timeliness of the information as compared to the stage where communities are "at" in the intervention process, the difficulty in accessing program support materials (e.g. kits, tools, materials) so communities can experience it first hand, and, the "fit" of particular programs in each local community.

In conclusion, Ms. Lessio recommended three areas for further work:

- 1 Discussion, & perhaps agreement, on the terminology of "best practice" be collaboratively defined & consistently used
- 2 Consensus about assessment criteria across jurisdictions of risk factor, organization or disease
- 3 The need for supportive dissemination practices for best practices.

## ✓ ACTION IDEA



The Heart Health Resource Centre is part of the Ontario Health Promotion Resource System which is comprised of 14 resource centres. All can be accessed via [www.ohprs.ca](http://www.ohprs.ca)

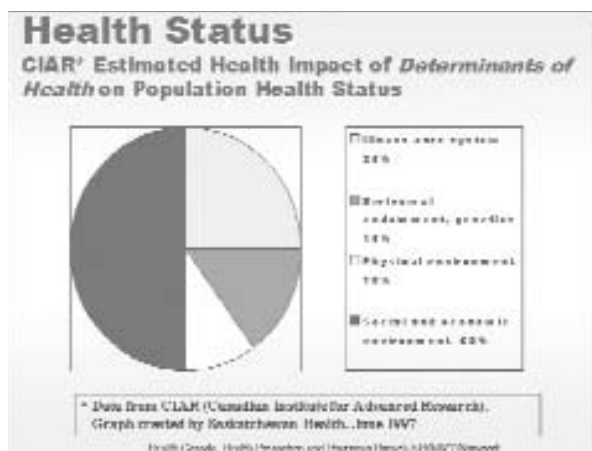
Presented by: Dr. Kim Raine, Director and Associate Professor of the Centre for Health Promotion Studies, University of Alberta

## “Health Promotion / Primary Prevention”



## Presentation

Dr. Raine began her presentation by identifying the burden of chronic disease, therefore the need for **prevention**; because of common risk factors, there is a need for **integration**; and because the social determinants of health are common across chronic diseases, there is a need for **health promotion**. The latter aspect, the “determinants of health”, contribute significantly to the health status of the population, as the figure below illustrates.



These determinants include:

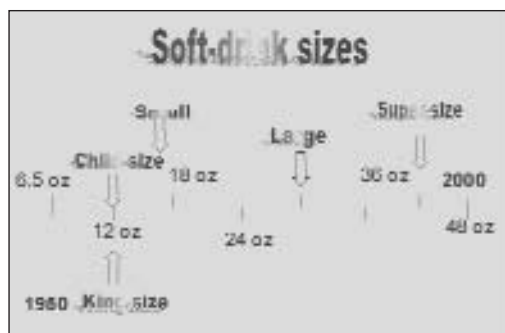
- Income & social status
- Social support networks
- Education
- Employment / working conditions
- Social environments
- Gender
- Culture

The definition of health promotion and the elements of the Ottawa Charter for Health Promotion were shared as an introduction to the Social Ecology Framework (below).

### Social Ecology Framework

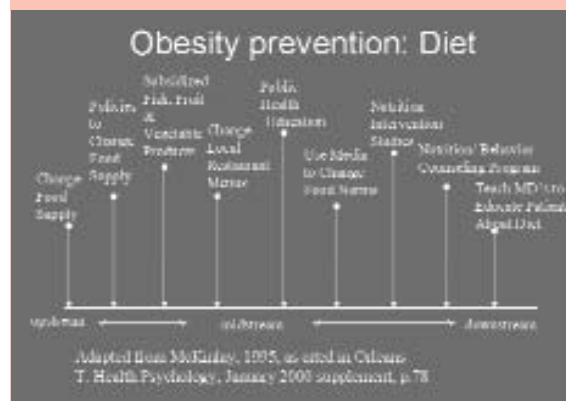
Level	Change Process	Change Targets	Strategies
Intra-personal	Psycho-logical	Knowledge, Beliefs	Info, media, Soc Mkt
Inter-personal	Psycho-social	Social Support	Soc Support Groups
Organizational	Organizational	Org. Culture & Structure	Org. Devel, Coalitions
Community	Cultural & Social	City Competenc	City Engage
Public Policy	Political	Legislation & Policy	Policy analysis & change

Examples of strategies were then shared regarding the need for Personal Change interactions:



Caution was recommended when taking solely a lifestyle approach. An individual focus can only limit the impact on population health. Focusing on the individual's choice could help justify cutbacks to health and social services and lead to “victim blaming”. The distinction was made between personal responsibility and “response-ability”.

The following nutritional example was then used to depict a broader approach:

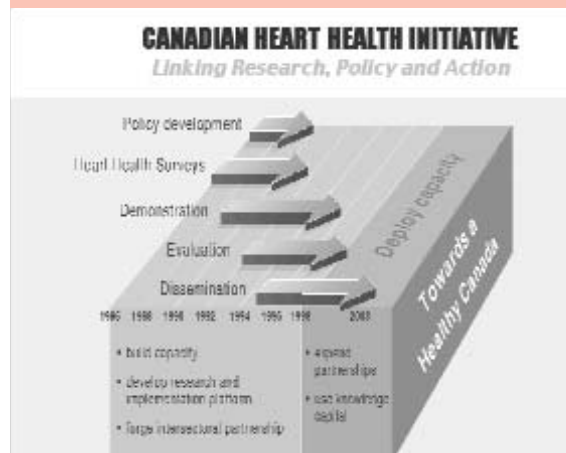


Is this your family's idea of a fitness centre?

We all know physical activity plays a major role in preventing heart disease. So how come 63% of Canadian women - and their families - don't get enough exercise?

The good news is you don't have to join a club or buy a lot of expensive gear. The Toronto Heart Health Partnership has put together a Get Going information pack to help you. It has physical activity guides for the whole family, tips on relieving stress, neat maps of paths in Toronto, and a whole lot more.

A focus on organizations and communities is a strong entry point to address social determinants of health. Strengthening community action uses a process of capacity-building, empowerment and participation. The Canadian Heart Health Initiative, as depicted in the model below and to the right, addresses the spectrum of individual to community.



(Cont'd on next page)

## The Importance of Policy

Policies shape how money, power and material resources flow through society and therefore affect the determinants of health. Advocating for healthy public policies is the most important strategy we can use to act on the determinants of health. Current policies that emphasize deficit reduction and private sector economic growth can be unhealthy for people. These policies may increase economic inequalities, environmental degradation, social intolerance and violence.

CPHA Action Statement on Health Promotion, 1996

### ✓ ACTION IDEA

Check out:  
 "Inequality is Bad for our Hearts" @ <http://depts.washington.edu/eqlth/paperA15.html>  
 or  
 Social Justice is Good for our Hearts @ [www.socialjustice.org/pubs/index.html](http://www.socialjustice.org/pubs/index.html)  
 by Dennis Raphael

Dr. Kim Raine's Presentation Cont'd:

Two examples of successful interventions were shared.

- The Kahnawake Schools Diabetes Prevention Project (1994-1998) is focused on Mokawk elders who want to spare their children the burden of diabetes. They created a supportive school environment, generated 85% community participation and saw an increase in physical activity as well as fruits and vegetable consumption, and a reduction in TV viewing and soda intake.
- The North Karelia Heart Health Project began in 1972. Political will existed to change the situation of having the highest CVD mortality in the world. A community-based intervention was launched that included education (in partnership with industry and the media), environmental change to make the healthy choice the easy choice, and policy changes regarding tobacco legislation, food content and advertising. Between 1969 and 1995 the age-adjusted mortality rates of coronary heart disease in males aged 35-64 dropped 73%. Interestingly, lung cancer rates in the same population over the same period dropped 71%.

Dr. Raine concluded with a caution on an over-emphasis on a social determinants approach because of the potential to ignore the role of people in health promoting social change. A balanced approach rather than an "either/or" orientation was recommended so as to encourage collaboration not competition. It is worthwhile to invest in health promotion when:

- A variety of action strategies are used
- A range of health determinants are addressed
- Capacity-building is involved
- Inter-sectoral coalitions and partnerships are developed
- Cultural values are considered
- Accessibility is considered
- The target group participates
- A "preventative dose" is provided.

Presented by: Dr. Doug Wilson, Professor Emeritus in the Departments of Public Health Sciences and Medicine at the University of Alberta.

## "Chronic Disease Prevention Strategy for Health Services & Primary Care"

Health care settings are **about** health where improved health is a primary objective, unlike the educational or workplace setting where health is only a part, and often a small part. Health care is high on the public agenda so Dr. Wilson recommended using this position to its fullest. This is demonstrated by such things as the Health Transition Fund, Primary Health Care Transition Fund, and the provincial health system renewal reports in Saskatchewan, Quebec and Alberta. Health care settings can be a conducive environment for health promotion as health care providers are considered a credible source of information from the public's perspective and in this setting, patients are usually motivated to address health issues.

There are 3 elements to consider in this setting:

- 1 the **patient** (with both personal and social determinants)
- 2 the **health care provider** (with both personal and professional factors)
- 3 the **practice environment** (with local, organizational and health system policy factors).

Each of these elements brings challenges: the size, bureaucracy and paternalism within the institution; the typical short-term illness focus and narrow professional roles of the health care provider and the "sick" nature of the patient that often creates a loss of control. Each also brings opportunities and strengths, as outlined in the following table.

Presentation



## HEALTH CARE SETTINGS: Opportunities &amp; Strengths

Institution	Health Care Provider	Patient
<ul style="list-style-type: none"> <li>• Health Canada's "Guide for Health Promotion in Health Care Facilities"</li> <li>• WHO Network for Health Promoting Hospitals (<a href="http://es.euro.who.int/areas_of_work/mgt/hph/frameset_hph.htm">http://es.euro.who.int/areas_of_work/mgt/hph/frameset_hph.htm</a>)</li> <li>• Community support for hospitals</li> <li>• Institutions are seen as credible sources for health information</li> <li>• Increasing links with home care</li> </ul>	<ul style="list-style-type: none"> <li>• There is evidence of benefits of self-managed care and disease prevention</li> <li>• Re-orientation of education is in progress</li> <li>• Professional standards and practice guidelines regarding prevention becoming more evident</li> </ul>	<ul style="list-style-type: none"> <li>• Have a need and the ability to access health information to prevent illness</li> <li>• Possible to influence policy-makers</li> </ul>

Dr. Wilson recommended that health care institutions be linked with other community partners both in traditional health organizations (e.g. home care, long-term care, mental health, rehabilitation) and in other settings such as schools and workplaces. Secondly, he suggested addressing the health care institution as a workplace because they are usually a large employer in a community. Working to change the organizational culture to "walk the talk" might mean influencing accreditation standards, unions and/or professional associations.

Another reason why primary care settings provide a key opportunity for intervention is contact:

- 90% of health services provided are in this "first contact" environment.
- 80-90% of Canadians see a family physician at least once a year.

There is also strong evidence of effectiveness in selected preventative measures. Canada has shown leadership in this area with "The Canadian Guide to Clinical Preventive Health Care" ([http://www.hcsc.gc.ca/hppb/healthcare/pubs/clinical\\_preventive/index.html](http://www.hcsc.gc.ca/hppb/healthcare/pubs/clinical_preventive/index.html)). There is a history of professional associations collaborating to address prevention in the 11 members of the "Canadian Coalition on Enhancing Preventive Practices of Health Professionals".

In conclusion, Dr. Wilson identified that:

- 1 Health care institutions are an important setting and potential partners for CDP strategies
- 2 Primary care settings (offices and community health centres) are a major site for CDP strategies
- 3 Primary care is currently the focus of national and provincial strategies for health system renewal
- 4 Considerable work on the integration of prevention in primary care has been done in U.K., USA, Australia and Canada.
  - An up-to-date synthesis of this work is important to assess current best practices
- 5 Gaps/opportunities for CDP in primary care include:
  - Diffusion/uptake of effective programs
  - Use of new technologies
  - Influence of policy
  - Relations between settings for prevention
  - Approaches to special groups
- 6 Primary health care should be linked with public health services, and also home care and pharmacy services for prevention
- 7 CDP strategies in primary care/health service settings can enhance strategies in community, workplace, and school settings

## So what works in the health care setting?

- 1 HEART – Health Education and Research Trial, USA, uses 45 practices & 4 interventions in a multicentre trial for heart disease prevention.
- 2 An observational study in the US in 84 practices regarding primary care practice organization and prevention service delivery.
- 3 Oxford Prevention Trial for Heart Attack and Stroke – in place for more than 10 years in the UK.
- 4 Trial of 3 approaches to marketing smoking cessation programs to Australian GPs
- 5 Provision of preventative care to unannounced standardized patients (McMaster University)
- 6 Trial of tailored multifaceted approach to improving preventive care using nurse facilitators (Ottawa)

## Primary care reform emphasizes the importance of the following ingredients:

- Chronic disease/injury prevention and health promotion
- Multidisciplinary teams
- Enhanced information systems
- Changing incentives
- Investing in primary care infrastructure (in the health care office)
- Public or community involvement.

Primary care reform also presents challenges in the form of patients who, when healthy, are not interested; physicians who are busy and have already complex guidelines to follow; patients and physicians who have other priorities; a perceived lack of effectiveness and high cost for the prevention interventions; and no reminders or incentives within the system for this type of work.

## ✓ ACTION IDEA

Recommended Text:

"Settings for Health Promotion"  
B. Poland, L. Green, I. Rootman.  
Sage Publications, 2000. 0803974183

See chapters on Health Care Institutions & Clinical Practice.



## Presentation



Presented by: Ms. Mary-Elizabeth Harriman, Director, Policy Coordination and External Relations, Heart and Stroke Foundation of Canada

## “Chronic Disease Prevention Alliance of Canada (CDPAC)”

### Mission

CDPAC will work to develop and help sustain a coordinated, countrywide movement for an integrated, population health approach to chronic disease prevention through collaborative leadership, advocacy and capacity building.

### CDPAC Steering Committee:

- Canadian Cancer Society (Cheryl Moyer)
- Canadian Council for Tobacco Control (John Garcia)
- Coalition for Active Living (Nancy Dubois)
- Canadian Diabetes Association (Donna Little)
- Dietitians of Canada (Marsha Sharp)
- Health Canada, (Greg Taylor, Nancy Porteous) and
- Heart and Stroke Foundation of Canada (Elinor Wilson)

### ✓ ACTION IDEA

#### “The Kirby Report”

The Health of Canadians - The Federal Role. Final Report. Vol.6 - Recommendations for Reform  
Part VI: Health Promotion & Disease Prevention  
<http://www.parl.gc.ca/37/2/parlbus/commbus/senate/com-e/soci-e/rep-e/repoct02vol6part5-e.htm>



The presentation opened with a quote from Senator Kirby's “Final Report on the Health of Canadians.” The Committee recommends that:

- The federal government, in collaboration with the provinces and territories and in consultation with major stakeholders (including the Chronic Disease Prevention Alliance of Canada), implement a National Chronic Disease Prevention Strategy.
- The National Chronic Disease Prevention Strategy build on current initiatives through better integration and coordination.
- The federal government contribute \$125 million annually to the National Chronic Disease Prevention Strategy.
- Specific goals and objectives should be set under the National Chronic Disease Prevention Strategy. The outcomes of the strategy should be evaluated against these goals and objectives on a regular basis.

Ms. Harriman went on to describe the Alliance. The CDPAC is a coalition of organizations who share a common vision for an integrated system of chronic disease prevention in Canada.

The CDPAC intends to build on the successes of the Canadian Heart Health Initiative, the Canadian Strategy for Cancer Control, the Canadian Diabetes Strategy, the Canadian Cardiovascular Disease Action Plan and the existing risk factor plans for physical activity, nutrition and tobacco control.

The current context for this work includes:

- Focus on health reform - Kirby, Romanow and provincial reports – and primary care
- Government interest and/or investment in tobacco, obesity, physical activity, nutrition
- Little/no government interest in stand-alone strategies or approaches – integrate!
- Chronic disease a priority in several provinces, many innovative approaches
- Chronic Disease Surveillance System in development
- CIHR – changing world of research - includes population health and health service research, promotes partnership and integration; project on The Future of Public Health in Canada
- Advisory Committee on Population Health – “Advancing Integrated Prevention Strategies”
- Ministers of Health announce Health Living agenda.

### CDPAC Priorities

#### 1 Building the Alliance

- Early success: secured funding through the Voluntary Sector Initiative - Sectoral Involvement in Department Policy Development (SIDPD) and Population Health
- Stakeholder engagement
- Capacity building
- Communications
- Established secretariat
- Created Steering Committee structure



## 2 Defining Priority Public Health Changes

- Defining the elements needed in a public health system
- Conceptual framework and discussion paper
- Input and consultation "think tank"
- Advocacy platform
- "Making the case" supports
- Brief and presentation to Romanow Commission

## 3 Provincial, territorial and national stakeholders will meet in November 2002 to

- Develop a shared understanding of an integrated approach
- Increase awareness of current status of CDP in Canada
- Seek advice on options for stimulating and supporting work in the provinces and territories

Based on the outcomes of the above, a fourth objective is...

- 4 To explore the development of a network of individuals and organizations who share the CDPAC vision and who are committed to action Development of a Web based communications system to support the work of CDPAC, to be launched in early 2003.

For more info:

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### ✓ ACTION IDEA

Sign up to receive CDPAC updates - as an individual, active participant or organizational member at:

English: [www.cdpac.ca](http://www.cdpac.ca)  
French: [www.apmcc.ca](http://www.apmcc.ca)



Presented by: Dr. Gregory Taylor, Director, Chronic Disease Prevention Division at the Centre for Chronic Disease Prevention and Control, Health Canada

## "Advisory Committee on Population Health / Healthy Living"

The Federal-Provincial-Territorial Deputy Ministers' Advisory Committee on Population Health exists:

- To be a best practices initiative to support the design & implementation of integrated approaches
- To develop a research agenda in conjunction with CIHR & other research funding agencies
- To hold a national consultative conference on integrated approaches to chronic disease in Canada. In September, 2002, the provincial health ministers met and set an agenda to work together on short, medium and long-term, pan-Canadian "healthy living" strategies that emphasize nutrition, physical activity, and healthy weights. This was reinforced in the September, 2002 Speech from the Throne:

*"We will work with its partners to develop a national strategy for healthy living, physical activity and sport, and will convene the first ever national summit on these issues in 2003."*



## Presentation

*"It used to be - location, location, location & now it's integrate, integrate, integrate."*

*"The Healthy Living agenda could be the best thing for CDP... to seize the window of opportunity... or the worst thing... a big summit is held and nothing happens. Heart health folks are uniquely positioned to take advantage of this."*

## Presentation



Presented by: Jodi Abbott, PhD, Co-Chair, Alberta Healthy Living Network and Executive Director, Prairies Area Canadian Diabetes Association

## "Alberta Healthy Living Network"

### Current AHLN Members

- Federal and Provincial Governments
- Voluntary sector organizations
- Professional Organizations
- Educational Institutions
- Community Groups
- Southern Alberta Chronic Disease Network
- Public Health Works
- Research Organizations
- COMOSH, representing RHA's
- Occupational Health Practitioners
- Corporations
- Other Networks



Organizations across Alberta are directing their efforts towards increasing awareness about the major risk factors for diabetes, cancer and cardiovascular disease. The steps taken to develop the AHLN included a Professional Forum, "Preventing Chronic Disease: Working Together in an Integrated Approach", March 20 - 21, 2002. The purpose was to create opportunities for developing and implementing an integrated chronic disease prevention and health promotion strategy for Alberta. Disease related organizations, educational institutions, Regional Health Authorities' board and staff, federal and provincial governments, politicians and professionals from the areas of health, health promotion, social marketing, physical activity, tobacco and nutrition attended.

Seven components and challenges of an integrated CD strategy have been identified:

- Partnership Development
- Consensus Building
- Communications / Constituency Building
- Working Differently / Sharing Power
- Vision and Creativity
- Taking Action
- Relationships and Perseverance

An Environmental Scan was conducted to learn more about integrated CDP strategies and health promotion initiatives internationally, nationally and provincially.

A planning session was held during which Terms of Reference, a Mission Statement & other strategic decisions were made.

The AHLN is open to all organizations who subscribe to the mission, vision, and guiding principles of the Alberta Healthy Living Network. They are supported through the leadership of the AHLN Coordinating Committee.

Functions of the AHLN include the:

- development, implementation and monitoring of a framework;
- collecting, reviewing and disseminating relevant information;
- communicate and share progress of activities;
- foster coordination;
- participate in working groups; and,
- advocate.

Recently, the network has submitted funding proposals to the provincial & federal governments, created a Communications Plan, submitted an abstract to the CPHA conference, participated in the CDPAC consultation process, developed a list serv, begun development of a Web site, selected a vendor to work on a framework, identified a short & long-term secretariat, and are in the beginning stages of consistent "healthy living" messages among members.

### Mission Statement

Providing leadership for integrated collaborative action to promote health and prevent chronic disease in Alberta.



Presented by: Ms. Ethel Hook, University of Manitoba

## "Alliance for the Prevention of Chronic Disease"



## Presentation

The Manitoba Alliance for the Prevention of Chronic Disease was born out of the Manitoba Heart Health Project.

Through the MHHP, essential components for a primary prevention system in Manitoba were identified to be:

- Address all the common modifiable risks and conditions
- Comprehensive: all ages, community-wide, multi-risk, multi-sector/levels
- Evidence-based
  - Accountable
- Well-resourced
  - Integrated

Six non-profit organizations with an interest in CDP came together to explore the idea of a coalition as none had the resources to address the issue on their own. Together they approached the provincial government and were encouraged to proceed. The government agreed to sit on the committee.

The Alliance started out, after 18 months of initial meetings, as a registered charity with a three-year self-funded business plan. Their activities and achievements are highlighted in the chart below:

Leadership	Support	Partnership	Advocacy
<ul style="list-style-type: none"> <li>• Promote primary prevention to health regions.</li> <li>• Build health region capacity in primary prevention.</li> </ul>	<ul style="list-style-type: none"> <li>• Resource inventory</li> <li>• Workshops &amp; Institutes</li> <li>• Convening &amp; consulting</li> </ul>	<ul style="list-style-type: none"> <li>• Tobacco Reduction Strategy</li> <li>• Physical Activity Action Plan</li> </ul>	<ul style="list-style-type: none"> <li>• Promote a primary prevention focus to government sectors</li> </ul>

Based on their experience, the challenges and solutions to building a healthy coalition include:

- Have **decision-makers** at the table so no time is wasted gaining permissions.
- Keep the **membership small** with only members who can put their reputations and dollars on the table, and be publicly committed.
- Keep **common issues** front and center – don't stray from primary prevention.
- **Credibility** should be treasured initially and **trust** nurtured, particularly as timelines and projects are delivered as promised.
- Foster **Cohesion and collaboration** between CEO's, ED's and senior program staff.
- **Commit** to Alliance goals – no "idle observer" status.
- **Member visibility** is important as they work directly with the public, not the Alliance; Alliance has no logo and does not fundraise or develop programs.
- **Dynamic, renewable and sustainable group.**
- **Forward moving.**
- **Means to an end** and not an end in itself as the Alliance doesn't "own" projects.
- **Move quickly and achieve success early** by recognizing the value in getting partners to know how to partner.
- **Ramp up** activities together so everyone's strength is built.
- **Keep costs realistic** as the benefits are obvious with good value for members' financial commitment; a huge volunteer component is evident.

Begin with the end in mind - "Everything starts with a dream... with some luck and appreciation and a bit of application it may evolve into an idea. But to develop the idea into a plan and to bring that plan to reality requires an enormous amount of skills, dedication and hard work." **Richard Pound**

### Alliance Members

- Canadian Cancer Society (Manitoba Division)
- CancerCare Manitoba
- Canadian Diabetes Association (Manitoba/Nunavut Region)
- Heart & Stroke Foundation of Manitoba
- Manitoba Lung Association
- The Kidney Foundation of Canada (Manitoba Branch)

### Manitoba Alliance for the Prevention of Chronic Disease

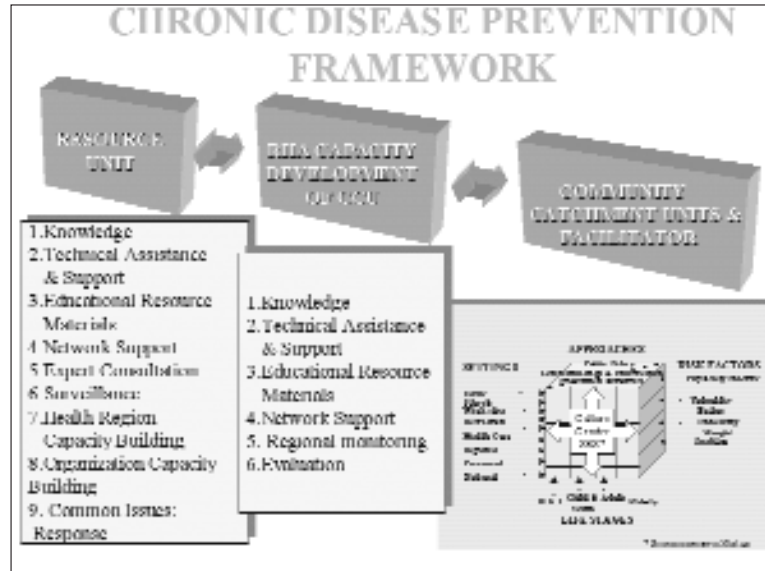
#### Mission:

To strengthen health care capacity for the primary prevention of chronic disease and the enhancement of the quality of life of Manitobans

### Alliance Goals

- 1 Build partnerships and linkages for information, resources, advocacy and action.
- 2 Contribute to better policy and decision-making on preventing chronic disease with evidence-based health related information.
- 3 Reduce the incidence and prevalence of chronic diseases through education, advocacy and action on the determinants of health.

Currently, the Alliance is working as a catalyst to build a CDP initiative with Manitoba Health (Diabetes and Chronic Disease Unit, Primary Health Care Accountability, Expectations and Evaluation); Manitoba Culture, Heritage and Tourism; seven Regional Health Authorities; and Health Canada. A CDP Framework has been developed, as depicted here.



## Presentation



Presented by: Kari Barkhouse, Planning & Development Manager, Community Health and Epidemiology, Dalhousie University

## “Developing a Chronic Disease Prevention Strategy in Nova Scotia: Process & Implications”

In Nova Scotia, the chronic disease prevention approach was also born from the Heart Health Project. The logos here illustrate one dimension of the similarity.

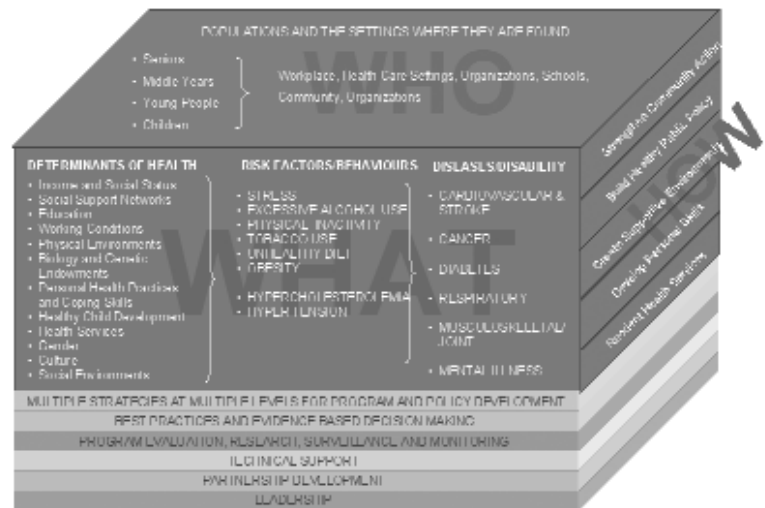


A year ago, the **mandate** was developed: **In collaboration with other partners**, develop a comprehensive, provincial chronic disease prevention strategy with an implementation and evaluation plan.

The Nova Scotia process:

- A Partnership Forum was held in October, 2001 which 21 organizations attended. The idea of a provincial CDP strategy was put forth and a conceptual framework developed.
- The conceptual framework consists of 5 elements:
  - Leadership
  - Partnership Development
  - Technical Support
  - Program & Policy Development
  - Program Evaluation, Research, Surveillance & Monitoring
- Four key functions were determined to be: Coordination, Partnership Development, Consultation, Technical Support
- Organizational Consultations were done with the 21 from the Forum plus 31 more organizations including all the Regional Health Authorities to gain their input to Involvement, Commitment, Process and Outcome

## CONCEPTUAL FRAMEWORK FOR A CHRONIC DISEASE PREVENTION STRATEGY



- A series of presentations and discussions were held and after 3 briefings with the Deputy Minister, he started to strongly support the concept
- The cost of chronic disease in Nova Scotia was summarized in a report and shared via a press conference
- Several recommendations were made through the consultations regarding the process and content
- A second Partnership Forum will be held in early November, 2002 with 45 organizations to establish a Vision, Scope, Definitions and Priority Areas
- Work groups will be established between November, 2002 and May, 2003 to work on a scan, best practices, implementation details, roles and evaluation aspects
- A review and validation process will be conducted in June, 2003
- A strategy will be submitted to the government in September, 2003.
- There are now 50 organizations involved (24 of which were from the Heart Health Project)

## Challenges to date:

- 1 There is a risk of losing momentum after a full year of consultation.
- 2 Integration of the tobacco and physical activity strategies funded in the last year.
- 3 Ensuring appropriate linkages between parallel groups (e.g. Pan Atlantic Wellness Initiative)
- 4 Should mental health be included as part of the scope?

## ✓ ACTION IDEA

Stay tuned to the Health Promotion Clearinghouse for more details:

[www.heart-health.ns.ca/hpc](http://www.heart-health.ns.ca/hpc)



Presented by: Dr. Catherine Donovan, Principal Investigator, Newfoundland and Labrador Heart Health Program

## "From Heart Health to Wellness in Newfoundland and Labrador"



## Presentation

This provincial initiative also had its roots in the provincial Heart Health program. Following the Demonstration phase, six regional Heart Health coalitions were established to continue with the diffusion of heart health activities. Activities continued to diffuse throughout the province. The regional coalitions are comprised of:

- Health & Community Services Staff
- Existing Projects
- Volunteers
- Health and community organizations
- Recreation
- Local governments

Between 1998 and 2001, more than 400 activities with 22,000 participants and 600 volunteers have been held. Other achievements include skills development, sustained health promotion activity, sustained community action and inter-sectoral and community action.

Several assets of the Heart Health program were built upon. It brought experience with intersectoral collaboration, a focus on health promotion not primarily disease prevention, a wealth of experience and training resources with broad applications, recognition within government and community health structures, and a strong communication infrastructure (teleconferences, newsletter, Web site). In building the new Strategic Health Plan for the province, the NLHHP acted as a key informant and the local coalitions are specifically identified in the plan as a foundation of the community-based strategy. The Wellness Strategy Advisory Council includes several members of the HH Advisory Committee and the NLHHP Manager is a key member of the Department Wellness Team.



In September, 2002 "Healthier Together: A Strategic Health Plan for Newfoundland and Labrador" was released. The following GOALS & OBJECTIVES were established:

### Goal #1 Improve the Health Status of the Population of Newfoundland & Labrador

- Objective 1 - Increase health behaviours & support
- Objective 2 - Improve health outcomes and reduce negative impacts of selected diseases
- Objective 3 - Improve health growth and development of children and youth

### Goal #2 Improve the Capacity of Communities to Support Health & Well Being

- Objective 1 - Develop and enhance community partnerships and resources that focus on health & well being
- Objective 2 - Enhance individual and family participation in community groups and organizations which enable them to make healthy decisions

### Goal #3 Improve the Quality, Accessibility, & Sustainability of Health and Community Services

- Objective 1 - Ensure Communities have reasonable access to primary health care services
- Objective 2 - Improve the quality and accessibility of secondary and tertiary care in the province
- Objective 3 - Improve the efficiency and the effectiveness of the health and community system
- Objective 4 - Develop and strengthen services in the areas of long term care and supportive services and mental health

## Key Attributes of the Initiative

- Success
- Momentum
- Skills (in health promotion, volunteer development, community mobilization)
- Credibility
- Lack of a "disease allegiance"
- Commitment
- Demonstrated willingness & capacity (e.g. diabetes)

## Guiding Principles of the Strategic Health Plan

- People centred
- Accessibility
- Accountability
- Affordability
- Equity
- Evidence-based
- Quality
- Sustainability

## ✓ ACTION IDEA

For more details, check out: <http://www.infonet.st-johns.nf.ca/providers/nhnp/home.html>

The full Plan is on the following website: <http://www.gov.nf.ca/health/strategichealthplan>

...Proceedings of the October, 2002 Session

## Summary



Presented by: Dr. Elinor Wilson, Co-Chair of COPI and Chief Science Officer,  
Heart and Stroke Foundation of Canada

## "Summary of the Workshop"

Watch for the Andres Petrasovits  
Research Award: "Make it Sing"

There is a need for four key components  
to be strengthened:

Research

Surveillance

Health Promotion  
Disease Prevention

Health  
Services

*"Work expands  
to fill the time  
available"*

Elinor Wilson summarized the day's sessions and made the following observations:

In the transition from Heart Health to Chronic Disease Prevention, we will require increased capacity in public health and the expansion of partnerships into non-traditional arenas. More of this is encouraged. There are also some key lessons to be applied based on the significant experiences gained through the Canadian Heart Health Initiative experience.

- A "preventative dose" of population-health intervention is necessary if changes are to be seen.
- We must be active advocates to lobby for policy changes - this will start to move our efforts "upstream"; at this point we are seeing "a ripple in the pond"
- Attention must be paid to health disparities
- Learn from other areas e.g. tobacco control.

In order to do this work, dedicated resources at the federal and provincial levels are necessary. The distribution of resources in the short and long-term will need to be examined and a solid health promotion and disease prevention agenda is a strong basis for this work.

We need to build bridges especially between the researchers, practitioners and policy practitioners

In summary, what is needed in order to make a difference in preventing chronic disease, as outlined by many of the speakers in the workshop:

- ① An effective information base to guide action and build on lessons learned ("best" or "most promising" practices)
- ② On-going surveillance
- ③ Inter-disciplinary research that can be translated into implementation of policy, programs and clinical interventions.
- ④ The capacity for an integrated approach with government, NGO's, academics, health professionals
- ⑤ Strategic alliances

special edition

# proceedings

Winter 2003

...of the Canadian Heart Health Network Workshop, October 2002

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