
Family Health Teams

Advancing Primary Health Care

Guide to Health Promotion and Disease Prevention

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Introduction

Health promotion, disease prevention and chronic disease management are proactive approaches to health care that stress prevention at different points along the health care continuum. Health promotion and disease prevention strategies focus on keeping people well and preventing diseases from occurring. These strategies are referred to as primary prevention activities. Secondary and tertiary prevention activities focus on maintaining the health of individuals with chronic conditions, delaying progression of their conditions, and preventing complications.

Health promotion is the process of empowering people to make healthy lifestyle choices and motivating them to become better self-managers. To achieve this, health promotion strategies focus on patient education, counselling and support tools. Examples of health promotion strategies in primary practice include education and counselling programs that promote physical activity, improve nutrition or reduce the use of tobacco, alcohol or drugs.

Disease prevention focuses on prevention strategies that reduce the risk of disease, identify risk factors, or detect disease in its early, most treatable stages. Examples of disease prevention activities include well-baby visits, immunizations, calcium and Vitamin D supplements to reduce the risk of osteoporosis, blood pressure and cholesterol assessments during annual health exams, and screening for illnesses such as breast, cervical, colorectal and prostate cancer.

Purpose

This guide has been developed to assist groups that are forming Family Health Teams to plan health promotion and primary prevention strategies that can assist in maintaining and improving the health of their patients. It is intended as a companion to the Family Health Team Guide to Chronic Disease Management and Prevention that focuses on secondary and tertiary prevention activities.

Each team will develop health promotion and disease prevention strategies at its own pace, based on their patients' needs and the skills and expertise of their interdisciplinary providers.

Background

Health promotion and disease prevention are being addressed both nationally and internationally. Five key action areas were identified in the Ottawa Charter of 1986 and reaffirmed by the Bangkok Charter for Health Promotion adopted on August 11, 2005. These five key action areas include:

- Building Healthy Public Policy
- Create Supportive Environments
- Strengthen Community Action
- Develop Personal Skills
- Reorient Health Services

To recognize the importance that health promotion and disease prevention play in Ontario's health care system, the Ministry of Health and Long-Term Care (the ministry) has supported the development of community-based programs together with Public Health Units and local partners to reduce the risk of developing specific conditions and improve overall health and well-being. These initiatives include alcohol and substance abuse prevention programs, heart health, tobacco use reduction, promotion of physical activity and good nutrition, and programs such as "Best Start" and "Healthy Babies, Healthy Children," to protect and promote children's health and well-being. More recently, Ontario has committed to promoting healthy eating and regular physical activity through the "Healthy Weights, Health Lives" strategy (<http://www.health.gov.on.ca/english/public/pub/hpromo/hpromo.html>).

These initiatives support Ontario's larger Chronic Disease Prevention and Management (CDPM) Framework. The goal of this framework is to recognize and promote collaboration between providers, health care organizations, patients and communities to keep people healthy and ensure quality, evidence-based care.

Beginning April 1, 2006, physicians will be eligible to receive a number of new preventive care incentives for services such as colorectal screening, counselling for smoking cessation, and diabetes management based on recommended guidelines.

Developing health promotion and disease prevention programs

Successful health promotion and disease prevention programs share the following characteristics. They:

- Address defined, measurable and modifiable risk factors
- Involve proactive care, targeting programs and services to "well" individuals and communities
- Use multiple strategies based on best evidence and accepted clinical practice guidelines
- Encourage integrated and collaborative service delivery
- Empower patients and communities to take greater responsibility for their health
- Include an evaluation component to ensure that programs are effective

Strategies should be clinically appropriate and adapted to local needs, taking into account the social, cultural and economic needs of patients.

The following steps will help Family Health Teams plan successful health promotion and disease prevention programs for their patients.

Step 1: Identifying patient needs and community resources

An understanding of patient needs and community resources will assist Family Health Teams to identify risk factors, community resources and potential gaps in community services. To accomplish this, Family Health Teams should:

- Gather information regarding their patient population. Screening tools, such as health history questionnaires, health risk appraisals, and cardiac risk profiles can assist in identifying risk factors.
- Identify risk factors for chronic diseases that are prevalent within their community. A number of chronic diseases may share similar risk factors.
- Determine priority health promotion and disease prevention activities based on their patient needs (e.g., nutritional counselling, smoking cessation counselling, etc).
- Develop an inventory of health care resources offered within their community. Research programs and services offered by local Public Health Units, hospitals, Community Care Access Centres, social service agencies, or non-profit groups in the community.
- Identify gaps in available community services and focus on developing promotion and prevention programs that address these gaps.

Step 2: Program planning – addressing patient needs

Information about the Team's patient population (e.g., the proportion of smokers, obese, elderly, etc.) and the health resources in their community can help Family Health Teams to plan programs that address identified needs and potential gaps in services as well as strategies for linking patients to community resources (see the Guide to Strategic and Program Planning and the Guide to Community Funding Partnerships and Program/Service Integration).

How Family Health Teams integrate health promotion and disease prevention strategies into everyday practice will depend on the range and skills of providers in each Family Health Team. Depending on the needs of each practice population, Teams may include different interdisciplinary providers with expertise in health education, behaviour change management and counselling to provide support to patients requiring preventive clinical interventions (see the Guide to Collaborative Team Practice and the Guide to Interdisciplinary Team Roles and Responsibilities).

As Teams develop health promotion/disease prevention programs, they will need to define a set of objectives for each program describing what the program plans to achieve. Objectives should be measurable, meaningful and centred on outcomes such as program impact, quality, patient or client satisfaction, timeliness, and efficiency. These objectives will set the stage for program evaluation (see Step 4).

a) Integrating Health Promotion and Disease Prevention into everyday practice

- Access information on how to incorporate health promotion theory into clinical practice. An on-line health promotion course, offered at no cost by the Ontario Health Promotion Resource System, covers essential health promotion concepts (www.ohprs.ca/hp101/main.htm – see Resources, page 8).
- Adopt evidence-based health promotion and disease prevention strategies. These are available from a number of reliable sources including the Canadian Guide to Clinical Preventive Health Care, the Guidelines Advisory Committee, the Canadian Task Force on Preventive Health Care and the Cochrane Library among others (see Resources, page 10).
- The Clinical Tobacco Intervention (CTI) program offers training and support to practitioners interested in providing evidence based smoking cessation and prevention interventions within their clinical practice. In addition, the Registered Nurses Association of Ontario (RNAO) offers an on-line mini-course covering the basics of conducting minimal or brief intervention on smoking cessation based on nursing best practice guidelines (see Resources, page 9).
- Smoking cessation guidelines and flow sheets based on the recommendations of the Clinical Tobacco Intervention Task Force will be developed by the Primary and Community Care Committee (PCCC), a joint committee of the OMA and the ministry for distribution by April 1, 2006. Incentives for colorectal cancer screening by Fecal Occult Blood Testing based on recommended criteria will also be implemented on April 1, 2006.

b) Developing your Team

- Identify Team roles, responsibilities, and tasks. Team members should have clear roles and responsibilities so that each provider knows his or her role in providing preventive care to patients.
- Consider using patient flow sheets to facilitate communication among all members of the Family Health Team.

c) Care coordination and system navigation

- Develop strategies to link patients with specific risk factors to the appropriate interdisciplinary provider in your Family Health Team or within your community.

Step 3: Delivering Health Promotion and Disease Prevention Programs

Family Health Teams should consider how they can make the most of opportunities that present themselves in the practice setting to deliver health promotion and disease prevention activities. A number of formal and informal strategies are available to support patient participation in health promotion and disease prevention activities. Strategies range from posters and brochures in the waiting room, to counselling during routine office visits or specific programs or events designed to prevent illness and promote well-being offered by your Team or another community resource.

All patients can benefit from health promotion and disease prevention initiatives. Certain cultural groups or other populations within your community who may be at higher risk of developing chronic conditions could benefit from health promotion and disease prevention programs targeted to their specific needs. Information may be available through Public Health Units to assist in identifying those population groups at higher risk of developing certain chronic diseases and developing programs to address these needs.

In the absence of illness, some patients may be less likely to visit their provider regularly and benefit from preventive care services. To reach as many patients as possible, Teams may wish to consider potential outreach initiatives.

Activities can be used alone, but are more likely to be effective when used in combination.

a) Patient education and self-care

- Use educational materials to help patients make a positive change and take responsibility for their health. Patient education is an important aspect of patient-centred care and helps to foster a partnership between the patient and provider. Educational materials are available from stakeholder groups (e.g., Canadian Diabetes Association), government-funded agencies (e.g., Cancer Care Ontario) and patient/caregiver support groups (e.g., Canadian Cancer Society).
- Assist patients to set goals for themselves and improve their health maintenance strategies. Collaborative goal-setting has the best chance of positive behavioural change.

b) Outreach activities

- Consider developing outreach initiatives such as a Family Health Team newsletter to reach all patients in your practice population, or those at risk of developing certain conditions. Local service delivery organizations may be interested in collaborating in the development or dissemination of information about healthy choices and health promotion and disease prevention resources in the community.
- Consider developing a patient registry to follow up with patients with certain risk factors or those who are due or overdue for routine preventive care. For example, Family Health Teams may consider creating a registry of patients who are at risk of developing colorectal cancer and use this list to invite patients to the practice for screening. Other reminders such as health summary sheets or case note stickers can be used to initiate preventive activities during patient visits.
- Administrative staff can play an important role in health promotion/disease prevention by calling patients to schedule routine preventive care and distributing health questionnaires and educational materials in the waiting room.
- Offer appropriate follow-up to screening by giving patients the results of their tests with healthy behaviour tips, arranging an appointment to share the results of the test, providing counselling or group education opportunities, or linking patients with appropriate community resources.

Step 4: Measuring success – program evaluation

Evaluation is an ongoing process that can help Family Health Teams to determine if a health promotion and disease prevention program is meeting its stated goals and objectives. Following up with patients to determine if health promotion goals are being achieved is part of the evaluation process. Feedback provides an opportunity to adjust programs and strategies if the program is not meeting its objectives.

- Develop a process to collect and review information that will determine if a program is meeting the objectives set out in the program planning stage. For example, to determine the effectiveness of a smoking cessation program developed to reduce the number of smokers by 50 per cent, a Family Health Team may choose to collect information about the number of smokers who participated and successfully stopped smoking after the program's conclusion.

Funding Assistance

A developmental assistance grant is available to assist eligible groups, where appropriate, with program planning for health promotion and disease prevention (see the Guide to Development Grant Application and Family Health Team Development Grant Agreement).

Where to get more information

For more information on health promotion and disease prevention please refer to the list of resources on page 10 or contact your professional college or association.

All potential Family Health Teams will be assigned a ministry FHT coordinator. This ministry contact person will be your guide to assist you to work through the details and options of establishing a FHT.

If you have not yet been assigned a coordinator, please contact the ministry at:

E-mail: FHTinquiry@moh.gov.on.ca
Address: Primary Health Care Team
Ministry of Health and Long-Term Care
1075 Bay Street, 9th Floor
Toronto, ON M5S 2B1
Telephone: 416-212-6155
Toll-Free Phone: 1-866-766-0266

For more information on Family Health Teams in general, please refer to the Family Health Team Fact Sheets or the Ministry of Health and Long-Term Care website at: <http://www.health.gov.on.ca/familyhealthteams>.

Resources

Health Promotion and Disease Promotion

Ontario Ministry of Health and Long-Term Care

Healthy Ontario.com: A web destination for health information, services and advice for healthy living.

<http://www.healthyontario.com>

Public Information: Links to health promotion programs offered by the Ontario.

<http://www.health.gov.on.ca/english/public/pub/hpromo/hpromo.html>

Public Health Units in Ontario

Links to health promotion and disease prevention programs in local communities.

http://www.health.gov.on.ca/english/public/contact/phu/phuloc_mn.html

Public Health Agency of Canada

Links to Health Promotion Programs offered by Public Health Agency of Canada.

<http://www.phac-aspc.gc.ca/hp-ps/index.html>

Canadian Health Network

Offers information from theory to disease prevention education.

<http://www.canadian-health-network.ca>

Ontario Health Promotion Resource System

Resource system supporting health promotion in Ontario funded by the Ministry of Health and Long-Term Care, with 23 member organizations.

www.ohprs.ca

The Health Communication Unit (THCU)

Offers an on-line course covering essential health promotion concepts.

<http://www.thcu.ca/workshops/2005hp101.htm>

Ontario Prevention Clearinghouse

Assists individuals, groups and communities to use health promotion strategies to achieve health and well-being.

<http://www.opc.on.ca/english/index.htm>

Nutrition Resource Centre

Assists community nutrition practitioners across Ontario to deliver quality nutrition programming in a health promotion context.

www.nutritionrc.ca

Physical Activity Resource Centre

Provides support to Physical Activity Promoters across Ontario through consultation, training, networking, referrals and information-sharing.

www.ophea.net/parc

Best Start Resource Centre

Supports service providers in Ontario working on health promotion initiatives to enhance the health of expectant and new parents, newborns and young children.

www.beststart.org

Ontario Self-Help Network

Provides information on self-help in the community and among professionals.
www.selfhelp.on.ca

Canadian Cancer Society

Provides information on risk reduction activities to reduce the risk of developing cancer, including smokers helpline and other health promotion strategies.
http://www.cancer.ca/ccs/internet/standard/0,3182,3543_10139__langId-en,00.html

Cancer Care Ontario

Provides information on primary prevention activities to assist in reducing the risk of many preventable cancers.
http://www.cancercare.on.ca/index_prevention.htm

Clinical Tobacco Intervention (CTI)

Offers 5A Model Training and ongoing support for practitioners.
<http://ctica.org>

Nursing Best Practice Guideline 2003

Comprehensive document advocating for the 4A Model Training and offers an on-line mini course for minimal or brief interventions.
<http://www.rnao.org/smokingcessation>

ACT Health Promotion

Offers information, resources and practical tips.
<http://www.healthpromotion.act.gov.au/howto/default.htm>

Evidence-Based Guidelines

Canadian Medical Association (CMA) Infobase

Provides guidelines produced or endorsed in Canada by national, provincial/territorial or regional medical or health organizations, professional societies, government agencies or expert panels.

<http://mdm.ca/cpgsnew/cpgs/index.asp>

Cochrane Library

Consists of regularly updated collection of evidence-based medicine databases, including The Cochrane Database of Systematic Reviews.

<http://www.cochrane.org/reviews/clibintro.htm>

Guidelines Advisory Committee (GAC)

Provides summaries of guidelines rated most highly by GAC and links to full text version of all available guidelines.

<http://gacguidelines.ca/>

Registered Nurses Association of Ontario's Nursing Best Practice Guidelines (NBPG)

Provides nurses guidelines for best practices in nursing client care.

http://www.rnao.org/bestpractices/about/bestPractice_overview.asp

Canadian Guide to Clinical Preventive Health Care

Guide for wide variety of preventive health interventions, using the evidence-based recommendations of the Canadian Task Force on Preventive Health Care (CTFPHC).

<http://www.ctfphc.org/>

Institute for Clinical Systems Integration (ICSI)

A collaboration of health care organizations providing evidence-based guidelines dedicated to helping identify and accelerate the implementation of best clinical practices.

www.icsi.org/

Appendix

Health Promotion and Disease Preventions Checklist

Identify patient needs and health promotion/disease prevention resources in the community

- Use screening tools to identify patients at risk of certain conditions
- Develop an inventory of community resources
- Identify gaps in local services

Develop HPDP programs to address patient needs

- Access evidence-based guidelines to direct HPDP activities
- Incorporate health promotion concepts into program planning
- Develop health promotion/disease prevention programs to address identified gaps
- Define a set of objectives that each program plans to achieve
- Develop your team - identify and communicate roles, responsibilities and tasks
- Develop strategies to link patients to community resources

Deliver health promotion and disease prevention programs including:

- Formal and informal opportunities to deliver HPDP programs
- Involving patients in setting personal goals
- Educating patients to become active participants in managing their health
- Outreach activities to reach patients that do not present in person
- Follow up with patients to invite them from screening, immunizations, etc.
- Develop reminder systems such as patient registries or case note stickers

Evaluate health promotion and disease prevention programs

- Develop indicators that measure objectives set out in the planning process
- Use indicators to monitor progress towards HPDP objectives
- Develop mechanisms to collect data
- Follow up with patients to determine if goals are being achieved
- Adjust programs and strategies as required to achieve objectives

References

Nine Steps to a Health Promoting Integrated Health System (IHS). Centre for Health Promotion: Toronto, 1998.

Section 4: Health Promotion and Disease Prevention. Appendix E: Primary Care Initiatives. Ontario Medical Association (OMA) Agreement.

National Preventative and Community Medicine Committee. Putting prevention into practice: A guide for the implementation of prevention in the general practice setting. 1st Edition. The Royal Australian College of General Practitioners: Australia, 1998.

Integrated health promotion: A practice guide for service providers. State Government of Victoria, Australia, Department of Human Services.

http://www.health.vic.gov.au/healthpromotion/resources_links/integrated.htm

