

“OHHP - Taking Action for Healthy Living”

Reference Material

December, 2003

Table of Contents

	<u>Page</u>
1.0 Introduction	3
2.0 Rationale for the OHHP	3
3.0 Supports for the OHHP	7
4.0 Guidelines for Roles & Responsibilities	8
4.1 Taking Action for Healthy Living Partners.	8
4.2 OHHP Coordinator	9
4.3 Community Partnership Chairperson	11
5.0 Planning, Reporting & Evaluation	11
5.1 Overview of Approach	11
5.2 OHHP Objectives	12
5.3 Materials to Support Planning	17
6.0 Contact Information.	17

APPENDICES

- I: Glossary of Terms Used in the "Submission Package" and the "Reference Material"
- II: Acronyms
- III: Definition of Indices Used in Equity Adjustment Formula
- IV: OHPRS Members & Contact Information

1.0 Introduction

The Heart Health Resource Centre (HHRC) is pleased to provide you with this document, which represents the collaborative input of many local and provincial partners in the OHHP. This Reference Material provides additional information, intended to further assist OHHP Coordinators and Community Partnerships (CPs) in the completion of the *"OHHP – Taking Action for Healthy Living"* Submission Package due January 15, 2004. This document may also be of interest to various OHHP stakeholders as well as others such as academics and planners.

The content presented here is meant to clarify some of the larger notions related to the OHHP, provide a current context for the program, as well as an enhanced understanding of the OHHP Submission Package. Over time, this document may be updated or new information will be made available on the HHRC Web site.

Other documents complement this Reference Material. Readers are encouraged to consult:

- The OHHP "Submission Package", Ministry of Health and Long-Term Care (MOHLTC)
- The "Q & A" documents (MOHLTC)
- "Guidelines for the Completion of the Operational Plan" (MOHLTC)
- The HHRC Orientation materials
- The HHRC Web site (www.hhrc.net)
- The OHPRS Web site (www.ohprs.ca).

2.0 Rationale for the OHHP

The goal of the *"OHHP - Taking Action for Healthy Living"* is to prevent cardiovascular disease (CVD) and other chronic diseases such as Type-2 diabetes, stroke and some forms of cancer.

The *"OHHP - Taking Action for Healthy Living"* achieves this goal through collaborative partnerships between Ministry representatives, provincial organizations, Boards of Health/host agencies, other local community organizations, and volunteers, by implementing programs with a primary emphasis on physical activity, healthy eating, and smoke-free living, at the community level.

The link between the OHHP risk factors and the prevention of many chronic diseases is also recognized by the national Advisory Committee on Population Health (ACPH). Their discussion paper of June 10, 2002 entitled "Advancing Integrated Prevention Strategies in Canada: An Approach to Reducing the Burden of Chronic Diseases" outlines:

“There is a sound rationale for an integrated approach with an emphasis on addressing underlying causal factors. In our efforts to address chronic disease, we need to continue effective disease-specific activities. However, there are key conditions which support work to advance integrated chronic disease prevention at this time, namely: a strong foundation of experience, a growing evidence base, and emerging opportunities within jurisdictions and NGOs.

The integrated approach being proposed has four main elements. These elements capitalize on the opportunities created by existing prevention strategies and strengthen future efforts by placing emphasis on underlying conditions in collaboration with partners in the health system and with other sectors. The four elements are:

- ***Addressing the set of common risk factors:*** *Integrated strategies will target the set of common risk factors for major chronic diseases simultaneously through approaches that promote and support healthy living.*
- ***Recognizing and addressing the relationship between lifestyle choices and social conditions:*** *The most promising avenues for effective prevention focus on supporting healthy living in healthy conditions, based on an understanding of lifestyle choices within the possibilities and constraints of people's social conditions.*
- ***Consolidating prevention efforts within life settings:*** *Using life settings such as work, school or community is increasingly recognized as an effective way to reach target populations with integrated prevention action on multiple risk factors and across life cycles.*
- ***Engaging partners within and across the systems that impact health:*** *To optimize health gains coordinated intersectoral and interjurisdictional intervention is required, as well as horizontal linkages with other sectors (such as environment, housing, justice) that have a role in addressing underlying determinants of health.*

The potential benefits of integrated approaches include a reduction of the burden of disease and a contribution to the sustainability of health systems through increased efficiency and effectiveness of prevention efforts.”

Two aspects of the OHHP require special mention. The first is the partnership aspect. The *“OHHP - Taking Action for Healthy Living”* is a vehicle for collaborative, primary prevention efforts in Ontario communities. It provides resources for increasing the number and depth of joint and shared activities among community partners. OHHP is also a vehicle for innovation. Building on OHHP-Phase I and other heart health programs around the globe, *“OHHP - Taking Action for Healthy Living”* is intended to help us learn about how to do

health promotion in the dynamic and diverse Ontario environment. Some opportunities for innovation in this next phase include:

- working with non-traditional partners.
- addressing a multiple set of chronic disease outcomes by addressing a trio of common risk factors.
- evaluating innovative approaches to population health issues.
- public health “stewardship”¹ as opposed to leadership or ownership.
- balancing provincial direction and consistency with local priorities and flexibility.
- local-provincial partnerships and working committees.

The second aspect is addressing the relationship between health behaviours and conditions of living, notably, isolation, low income situations and other social conditions. The *“OHHP – Taking Action for Healthy Living”* is based on several key Guiding Principles that are outlined in detail in the Submission Package. One in particular that merits a deeper explanation is grounded in “inclusivity and accessibility”. Different approaches are needed in order to promote inclusion and accessibility across broad populations, including mixes of policies and programs that address health disparity. These approaches include precise targeting to the most vulnerable population as well as sensitivity to the interdependence between individual behaviour, socio-economic status and community/institutional resources.

Within the context of the OHHP, CPs are encouraged to direct their risk-factor based programming to those segments of their population that have been determined to be priorities, which may include those with less access to the basic determinants of health.

This strategy is illustrated in the following quote:

“Some programs, by their very success, widen the health status gap due to differences in the population. In one smoking cessation program it was found that the prevalence of smoking decreased mainly in adults with high education, increasing social differences. The increasing socio-economic status difference in cardiovascular mortality during the 1980’s was accompanied by a growing social difference in the prevalence of smoking.”²

Listed below are those determinants of health that Health Canada has suggested are basic to population health:

¹ Terms such as this are defined in Appendix 1: Glossary of Terms

²Lyons R & L. Langille. Healthy Lifestyle: Strengthening the Effectiveness of Lifestyle Approaches to Improve Health. Health Canada, Population and Public Health Branch, 2000, 35.

- Income & social status
- Social supports networks
- Education
- Employment & working conditions
- Physical & social environments
- Biology & genetic endowment
- Personal health practices & coping skills
- Healthy child development
- Health services.

History also plays an important role in understanding the rationale for the second phase of the OHHP. In 1986, Health Canada, in partnership with the provinces and the Heart and Stroke Foundation, began the Canadian Heart Health Initiative (CHHI), a federal/provincial strategy to tackle the major cause of death, health care costs, and disability in Canada.

The long-term health goals³ of this Initiative, patterned after a handful of large-scale intervention programs in the United States and Europe, were to:

- improve the heart health of Canadians,
- reduce premature cardiovascular morbidity and mortality,
- reduce the prevalence of preventable or controllable risk factors for CVD (smoking, high blood pressure, elevated blood cholesterol, diabetes, obesity and sedentary lifestyle),
- improve lifestyle behaviours associated with heart health, and
- improve working conditions, social and physical environments supportive of citizens in making heart-healthy behavioural choices.

Short-term health goals were to increase public knowledge and awareness of the causes and consequences of CVD, as well as to increase the knowledge and awareness of individuals at risk on how to control their CVD risk. In addition to long term health outcomes and behaviours (5 to 20 years), the provincial heart health programs aimed to influence the way communities support changes, as well as of governments and other organizations in developing healthy public policy. Thus, in addition to health goals the programs set health system's goals as the basis for accountability in the short term.

There were five phases of the CHHI, as outlined in the diagram below:

³ http://www.hc-sc.gc.ca/pphb-dgspssp/ccdpc-cpcmc/cindi/pdf/chhi-eval_e.pdf



As part of the CHHI strategy, Health Canada, through the National Health Research and Development Program, provided matching funds to all provinces to implement community based cardiovascular disease (CVD) prevention programs. This is the “Demonstration Phase” in the above diagram. The purpose of these programs was to demonstrate the efficacy of evidenced based public health approaches to preventing and reducing cardiovascular disease in the Canadian population and to build capacity in the public health system for planning and implementing effective provincial and community heart health interventions.⁴

Although Ontario's demonstration phase was funded provincially, it was carried out at the same time as, and contributed to, the CHHI Demonstration Phase. Five Ontario communities were selected based on the submission of community proposals and each undertook programming tailored to their community that met the provincial program goals of being able to:

1. enable communities to build their capacities for heart health promotion;
2. build an understanding of models of community organization; and
3. document key interventions and findings to disseminate to other communities in Ontario.

Main lessons learned from the HHAP phase⁵ that influence the direction of “OHHP - Taking Action for Healthy Living” include:

⁴ ibid

⁵ The Heart Health Action Program Final Evaluation Report, December 1995.

- The coalition approach taken represented a new way of working for public health and other community agencies. Therefore community organization and building capacity for planning and implementing comprehensive, community-based programs was a major focus.
- Programs developed elsewhere must be adapted to fit the local context. Even those designated as “recommended practice” cannot simply be transferred from one jurisdiction to another.

The model developed as a result of the HHAP served as a sound basis for heart health promotion in Ontario. The model included several components, including elements of community projects (e.g. mandate, structures, culture, research and evaluation, intervention design) and elements of services to support community projects (e.g. training, consultation, funding, info and educational resources). This preliminary model provided a starting point for planning for dissemination of heart health promotion province-wide (OHHP – Phase I).

Lastly, in terms of the history that has influenced the OHHP, is the Canadian Heart Health Initiative – Ontario Project (CHHIOP). This was undertaken to better understand the capacity of the public health system and community agencies to undertake heart health promotion, and the factors influencing local heart health promotion efforts. This research phase reinforced the need to strengthen capacity for local (heart) health promotion and to make effective programs available for local adaptation and use (ie. what works). More details on the CHHIOP project and its results can be found at http://www.hhrc.net/supports/ref_1.pdf.

3.0 Supports for the OHHP

OHHP CPs are asked to identify their training and support needs that would assist them in addressing the objectives they have set for themselves. The system of 15 resource centres, seven key associates and one secretariat known as the Ontario Health Promotion Resource System (OHPRS) supports health promoters/practitioners in Ontario who want to increase their capacity to effectively promote health. The OHPRS is funded by the MOHLTC. The services offered by the OHPRS include training, consultation, print and electronic resources (including the weekly Ontario Health Promotion Email Bulletin – www.ohpe.ca), networking opportunities and referrals to other sources of support as needed. Each of the members offers a different area of expertise and increasingly, the members are working together to offer coordinated services to clients. A full list of the OHPRS members can be found in Appendix IV along with a brief summary of the mandate for each centre. The OHPRS Web site also provides a means to discovering more about each resource centre – www.ohprs.ca.

While CPs can access any services from the OHPRS, their primary support is through the HHRC. The specific mandate of the HHRC is to enhance the capacity of the public health agencies or other host agencies and their community partners to implement comprehensive, community-based heart health programs. The HHRC uses five strategies to fulfil their mandate:

- Training.
- Consultation.
- Resource development and dissemination.
- Communication and coordination.
- Collaboration.

The HHRC, in addition to providing significant direct support services to the CPs, is also the key link between the CPs and the various OHPRS members. To support this, the HHRC has developed a system to relay information to the communities on behalf of all OHPRS members so the communities are not inundated with information that is not readily apparent as to how it fits with the OHHP mandate. Likewise, CPs are encouraged to contact the HHRC first for their training and support needs. The HHRC will triage the requests and refer and assist the CP in accessing the services best suited to their needs.

To support CPs in creating their strategic and operational plans, the HHRC has posted several documents and links to their Web site. Several of these will provide background and context to the OHHP which may be particularly useful to new partners and coordinators.

As clients of the OHPRS, some or all CPs will be invited to participate in some system-wide programs. One example is an evaluation of quality and usefulness of services (especially those of the HHRC). Another is an evaluation of the impact of OHPRS services on capacity building, which likely involves surveys in 2005 and 2007.

4.0 Guidelines for Roles & Responsibilities

Much has been learned over the last ten years regarding the human resource elements that are critical to the success of the OHHP. To enhance the required elements included in the Submission Package, additional details have been provided here.

4.1 Taking Action for Healthy Living Partners

OHHP- Taking Action for Healthy Living is a partnership between the MOHLTC, the host agencies, and their community partners. The act of working together to support a common goal through partnership is at the core of this program.

Community Partnerships

The responsibility of the community partnership will be to:

- Share responsibility for decision-making.
- Achieve the project's overall goal(s) and objectives, including planning, implementing and monitoring/evaluating the project.
- Maximize resources to eliminate duplication in program delivery.
- Ensure the project is responsive to local values, perceptions and needs.
- Influence the practices of many people and organizations, thereby enhancing sustained change within the community.
- Provide a forum for broad community participation.
- Respond to needs and issues raised by the community in relation to heart health and chronic disease prevention.
- Link to broader provincial strategies and initiatives to create more alignment and produce an adequate "dose" for key messages.

Board of Health/Host Agency

The Board of Health/host agency has the following responsibilities:

- Accountability to the MOHLTC for use of provincial funds.
- Ensuring that funds are used according to OHHP Phase II guidelines.
- Providing core co-ordination and support to the community partnership.
- Participating actively in the community partnership's activities.
- Sharing decision making and leadership with other community partners.

Ministry of Health and Long-Term Care

Health Promotion and Wellness (HP&W), Public Health Branch, represents the Ontario Ministry of Health and Long-Term Care. The responsibility of the ministry is to:

- Integrate the OHHP within the MOHLTC strategic directions.
- Provide funds to the Board of Health/host agency.
- Ensure access to the OHPRS.
- Facilitate partnerships and planning at the provincial level.

4.2 OHHP Coordinator

Listed below are those functions that are considered to be universal to all OHHP Coordinators across the province (not necessarily an exhaustive list). These functions were developed using several sources of information: Terms of Reference from community partnerships; results of the input received at the OHHP June meeting; an analysis undertaken by the Toronto Heart Health Partnership; 1997 OHHP Guidelines; insights from the 2000 OHHP Benchmarking

Study; the HHAP final report; the 2003 OHHP Qualitative Study; as well as discussions that took place within the HRWG. It is recommended that these functions be reflected in the list of responsibilities for the OHHP Coordinator position that is included in the Submission. Sample Job Descriptions from some current OHHP Coordinators can also be accessed on the HHRC Web site.

Table 1: OHHP Coordinator Responsibilities

Accountability	<ul style="list-style-type: none"> o Maintain official records (documents, contributions-in-kind, reports) o Monitor Operational Plan (budget, timelines, outputs) against the strategic direction and original needs assessment (1998) o Process incoming invoices for expenditures o Gather contributions-in-kind and resource distribution numbers for inclusion in reports o Coordinate, collate and submit, on behalf of the CP, required provincial plans and reports, including the collation of contributions-in-kind from partners
Communication	<ul style="list-style-type: none"> o Link between local project work groups o Establish & maintain local communication vehicles o Initially deal with all incoming correspondence for the CP o Link between community partnership & Board of Health o Contact person for the provincial components (Ministry, Evaluation, OHPRS / HHRC, OHHN) o Link to OHPRS / HHRC consultants providing local service o Monitor, on a daily basis, postings to the HHRC "Heartlinks" list serv o Network with partners, OHHN and regional colleagues
Coordination	<ul style="list-style-type: none"> o Coordinate the local planning and evaluation process o Connect the necessary components of various project working groups and programs o Coordinate, with appropriate partners, local meetings and partnership-wide events o Coordinate submissions for any funding requests, proposals created by the CP o Coordinate the completion of surveys, requests for information coming to the CP o Secure additional technical or human resource assistance as needed for work groups and Steering Committee (e.g., HHRC consultants) o Coordinate the various aspects of a Volunteer Management program for partners and volunteers
Partnership Support	<ul style="list-style-type: none"> o Nurture the relationship with and between partners to maintain their participation

	<ul style="list-style-type: none"> o Work with CP Chair(s) to establish meeting details (agenda, timing, materials, consultants as required) o Provide CP with regular Operational Plan updates (budget, timelines, outputs) o Identify & facilitate access to training and learning needs of the partners o Ensure new partners are well oriented
Program Support	<ul style="list-style-type: none"> o Act as a technical resource and coach to local work groups, as needed (e.g., planning, evaluation, "recommended practices", specific risk factors) o Ensure local identity appears as necessary o Monitor inventory of local products (promotional items, program materials) o Implement program elements as assigned in the Operational Plan
Representation	<ul style="list-style-type: none"> o Ex-officio member of local project CP Steering Committee o Participate on relevant local community committees, groups, and coalitions on behalf of CP o Active participation in the OHHN o Active participation on regional HH groups, if they exist (OHHN regional groups, OHHP Coordinator meetings) o Attend HHRC provincial &/or regional training events o Participate in the OHPRS / HHRC evaluation, as requested

4.3 Community Partnership Chairperson

The role of Chairperson of the CP should be separate from the staff support role that the OHHP Coordinator fulfills, in accordance with standard "best practices"⁶ cited in the volunteer and coalition management literature. CPs are encouraged to make every effort to establish CP leadership from a member other than the Board of Health/host agency.

5.0 Planning, Reporting & Evaluating

5.1 Overview of Approach

In revising the planning, reporting and evaluation aspects of the *"OHHP – Taking Action for Healthy Living"*, the intent was to build on the strengths of the first phase while integrating improvements that are reasonable and manageable for

⁶ Should additional details regarding effective volunteer and partnership management be desired, the following Canadian toolkit is recommended: "Responsibility and Accountability: What Community-Based Programs Need to Know". 2002. FRP Canada. 613.237.7667. www.frp.ca ISBN 0-919051-41-3.

community partnerships. The adaptations were guided by the need to ensure that the resulting products and mechanisms put in place should:

- a) be supported by the three key partners in the *"OHHP - Taking Action for Healthy Living"* (the MOHLTC, the Board of Health/host agency, and the community partnerships).
- b) meet the programming, accountability and learning needs of local and provincial stakeholders.
- c) be coordinated with other planning, reporting, and evaluation being carried out at the local and provincial levels (e.g., Mandatory Program Indicator Questionnaires for public health).
- d) integrate planning, reporting and evaluation aspects.
- e) incorporate a learning agenda that builds on over a decade of high quality heart health work in Ontario, and that will advance (heart) health promotion in Ontario.
- f) be realistic within existing human and financial resources.

5.2 OHHP Objectives

The Strategic Plan required from each CP outlines several types of objectives:

- Population Objectives
- Capacity Objectives
- Programming Objectives
- Environmental Objectives

Within this document additional information is provided with respect to Population Objectives and Capacity Objectives.

Population Objectives

The Population Objectives describe the desired changes in the intended population with respect to the three risk factors. These objectives were created through the melding of the objectives currently within the "Mandatory Health Programs and Service Guidelines for Public Health in Ontario" and the objectives set through a collaborative process led by Cancer Care Ontario as part of the "Cancer 2020 Report". These two sets of objectives are outlined below in **Table 2**. Building on the similar elements of these current and practical was felt to be wiser than creating yet another set of objectives.

**Table 2:
Objectives from the MHPSPG & Relevant Cancer 2020 Objectives**

	Teen Smoking	Adult Smoking	Quitting Smoking	Exposure to Second-hand smoke	Smoke-free Space	<i>Fruit and Vegetable Intake</i>	<i>Physical Activity</i>	<i>Obesity</i>
Measure	Percent of teens who are current cigarette smokers	Percent of adults who are current cigarette smokers (ages 18 and older)	Percent of daily smokers who will make at least one attempt to quit smoking per year	Percent of Ontarians who will be exposed to second-hand smoke in the home and in private vehicles	Percent of public places (including bars, restaurants and gaming facilities) in Ontario that will be smoke-free	Percent of Ontarians who consume five or more servings of vegetables and fruits daily	Percent of Ontarians who participate in moderate to vigorous activity on most days of the week	Percent of Ontarians who are obese, as measured by a Body Mass Index over 30
Most Recent Estimate	CCO- 19% MHPSPG ⁷ – 13%	CCO – 26% MHPSPG- 22%	CCO-48% MHPSPG – n/a	CCO- 18% (children) and 25% adults MHPSPG – 31% (adults and youth)	CCO - 50% MHPSPG – 6%	CCO- 32% adults, 44% children over 12 years old MHPSPG – n/a	CCO- 34% MHPSPG – 41% adults 20+ 63% youth 12-19	CCO - Over 15% MHPSPG- 28% BMI>=27 adults (20-64)
Cancer 2020 Target	2%	5%	90%	Less than 1%	100%	90%	90%	10%
MHPSPG - 1997 Version	10% by 2005	15% by 2005	n/a	Increase proportion of smoke-free homes by 2010	100% by 2005	75% (4+) by 2010	40% - adults by 2010 60% youth by 2010 (include at least 30 min. mod. on most if not all days)	Slow the decrease of adults with healthy weight status by 2010
MHPSPG – Draft 12 – Jan. 2003	9% by 2010	14 % by 2010	n/a	26% by 2010	100% by 2010	75% by 2010	47% - adults by 2010 68% - youth by 2010 (as to PA Index – no #'s associated with guides)	23% adults with a BMI >= 27 by 2010 no #'s of children

⁷ MHPSPG estimates come from the 1996/1997 Ontario Health Survey and 1998 Municipal Bylaw Survey – most contained in draft 12 – not in 1997 version.

The **Organizational Capacity Objectives**

An OHPRS capacity survey is planned to take place in 2005 and 2007. The plan is to include an OHHP sample (or full population) as part of this survey. The capacity objectives listed in the table below should help CPs identify some meaningful capacities for them to strengthen in their communities.

Table 3: OHPRS Health Promotion Capacity Indicators

ASSESSMENT AND PLANNING:
1. Involve stakeholders/participants in the planning process
2. Ensure that the diversity of your community is reflected throughout the planning process
3. Develop appropriate and measurable objectives
4. Plan specific services/activities in French
5. Understand and apply theories to guide design and implementation of programs/activities (e.g., models of community or behaviour change)
6. Select valid and reliable sources of information on community needs, strengths and issues
7. Collect valid and reliable information on community needs, strengths and issues where insufficient information exists
8. Access relevant information on priority issues
9. Critically analyze research findings to identify practical program implications
10. Identify and analyze the social, cultural, economic and environmental factors affecting population health status
11. Develop proposals for funding
PROGRAM IMPLEMENTATION:
12. Involve stakeholders/participants in program implementation
13. Ensure that the diversity of your community is reflected throughout the

implementation process
14. Address barriers to participation in programs/activities (e.g., promotion, child care, transportation, cost)
15. Develop and implement services/activities in French
16. Develop and implement health promotion policy options
17. Facilitate mutual support or self help, including small group development
18. Facilitate community development (e.g., conflict resolution; sharing power, nurturing relationships)
19. Deliver educational/behaviour change programs
20. Manage projects (e.g., human resources, finances, operations, monitoring the workplan)
21. Develop and implement health communications activities (e.g., social marketing campaign; working with the media, newsletters)
22. Demonstrate leadership skills
23. Recruit, co-ordinate and support volunteers
24. Build partnership and coalitions
25. Market the value and cost-benefit of health promotion in the community
26. Work with health service(s) to go beyond the traditional provision of clinical and curative services
27. Refer individuals and groups to health promoting organizations and sources of information on health-related issues
PROGRAM EVALUATION:
28. Collect information to assess implementation of health promotion programs/activities (e.g., tracking number and type of participants; documenting activities)
29. Collect information to determine if the health promotion activities are meeting

outcome objectives
30. Use evaluation findings to improve your health promotion programs/activities
SUSTAINABILITY AND TRANSFERABILITY:
31. Identify options for sustainability (e.g., securing funding; transfer to alternate organization)
32. Transfer skill sets and/or strategies (e.g., from one health issue to another; from one community to another)

5.3 Materials to Support Planning

To support the planning process, the HHRC has posted several documents on their Web site and provided links to other sites. In particular, the Logic Model workbook from The Health Communication Unit, the 1997 "Mandatory Health Programs and Service Guidelines for Public Health in Ontario", and examples of current strategic plans and terms of reference from OHHP CPs have been made available. In addition, scans of relevant "best practices" can also be found on the HHRC Web site.

6.0 Contact Information

Should you have any questions regarding the completion or submission of your Application, contact your MOHLTC Program Coordinator:

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“OHHP - Taking Action for Healthy Living”

Reference Material

Appendices

Appendix I: Glossary of Terms Used in the Submission Package and the Reference Materials

Activity: Several activities make up a program. Activities are usually time-limited and task-oriented. Using the workplace example, a Cafeteria program might involve the following activities: signage for tables, menu items, training for staff, and promotion to employees.

Approach: A potential health promotion strategy used within a program. Approaches include awareness raising, education, environmental support and policy change (Heart Health Resource Centre, 1998).

Awareness Raising: An approach that includes using health communication to increase general knowledge about healthy lifestyles (i.e., distribution of pamphlets/ booklets, mass communication campaigns, community events like contests or fairs).+

Cardiovascular Disease (CVD): Represents all diseases of the circulatory system, including: acute myocardial infarction, ischemic heart disease, valvular heart disease, peripheral vascular disease, arrhythmias, high blood pressure and stroke (The Changing Face of Heart Disease and Stroke, 2000).

Channel: Sites where activities are carried out and where you will reach your audience (e.g., schools, worksites, health care settings, etc.) (Heart Health Resource Centre, 1998).

Community: Within the context of the OHHP community is defined as the catchment area for the local Board of Health/host agency.

Community Capacity: A participatory process of developing a shared vision, leadership, resources and skills within communities and strengthening linkages, networks, and collective processes.*

Community Mobilization: Collective efforts carried out by communities which are directed towards increasing community control and improving health.

Community Partnership: Consistent with resources produced by the HHRC, such as the Sustainability Manual, "partnership" is meant to convey the most generic term possible for the group of organizational members and volunteers who come together to participate in the local "*OHHP – Taking Action for Healthy Living*" project.

Comprehensive: This term includes a number of dimensions with respect to heart health programs, including:

- The community involved in the process.
- Multiple risk factors being targeted.
- Multiple audiences.
- Multiple approaches are used to achieve objective.
- The synergy between programs.
- The strategies to promote sustainability (Heart Health Resource Centre, 1998).

Determinants of Health: The range of personal, social, economic and environmental factors, which determine the health status of individuals or populations.

Environmental Support: An approach that refers to changes in physical and social environments that help to create a healthy society and support healthy public policy (i.e., bike paths and walking trails, improved street lighting, etc.). Also includes indirect programming, where programs are directed to an audience that is responsible for supporting others (i.e., health professionals who promote healthy lifestyles to their clients).+

Evidence-based: Interventions are considered effective according to the best available information, which may include research data (from both quantitative and qualitative studies), theory and analogy (Barb Riley, RBJ Health Management Consultants).

Formative Evaluation: A method of assessing a program while the program activities are in the process of being formed. May involve collecting continuous feedback from participants in order to revise the program as needed. Formative evaluation also includes audience analysis and pre-testing, which is designed to assess the strengths and weaknesses of materials or strategies before implementation and permits necessary revisions before the full effort goes forward. Its basic purpose is to maximize the chance of program success before the communication activity starts (The Health Communication Unit).

FTE: Full-Time Employees or Equivalents.

Goal: What the program is designed to accomplish. There may be different levels of goals, i.e., project goals, program goals, long-term and short-term goals. In a Logic Model, the goal is the overall planned effect, impact or result.+

Health Promotion: The process of enabling people to increase control over and improve their health (Ottawa Charter for Health Promotion, World Health Organization, 1986).

Heart Health Benchmarking Process: Measuring and comparing the existing and emerging practices of organizations (e.g., health units) in order to identify those that achieve the best results (City of Ottawa Public Health, PHRED, Workshop “Benchmarking in Heart Health”, April 2001).

and

An ongoing, systematic process that seeks to identify and understand the recommended practices of others and customize such practices to one’s own setting (PHRED, 2001).

Impact Evaluation: Evaluates the impact that a program had on the participants or other stakeholders of the project. Impact evaluation goes a little further than outcome evaluation, in that in addition to measuring outcome it also measures what changes occurred as a result of those outcomes (Evaluating Health Promotion Programs, The Health Communication Unit).

Indicators: Specific measures which indicate the point at which goals and/or objectives have been achieved. An indicator gives you the criteria to determine whether or not you were successful (The Health Communication Unit). Characteristic of an individual, population or environment which is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or population.*

Intermediaries: Health promoters/practitioners who work with the community, i.e., Boards of Health/host agencies, Community Partners, Community Health Centres, and others.

Local Project: Within the context of the OHHP, Phase II, refers to the collection of programs within a community that are funded by the MOHLTC and managed by a CP.

MHPSG: Mandatory Health Programs and Service Guidelines. The purpose of the standards is to set out the minimum requirements for fundamental public health programs and services targeted at prevention of disease, health promotion and health protection. These standards reflect broad aspirations for the health of all Ontarians and the important role of Boards of Health/host agencies in providing and/or ensuring relevant programs and services. Common chronic diseases listed in the MHPSG include heart

disease, stroke, cancer, chronic lung diseases (i.e. emphysema), diabetes, osteoporosis and many others (MOHLTC Web site).

Network: A group of individuals, organizations and agencies organized on a non-hierarchical basis around common issues, which are pursued proactively and systematically, based on commitment and trust.*

NGO: Non- Governmental Organization. Sometimes referred to as a voluntary or not-for- profit organization.

Objectives: Clear, realistic and measurable outcomes that are taken in order to reach an overall goal, within a given time period. Should identify how much of what should happen to whom by when. +

OHHN: Ontario Heart Health Network ~ the networking arm of the Ontario Heart Health Program.

HHAP: Ontario Heart Health Action Program ~ the Demonstration Phase conducted in five communities: Brant, Haldimand-Norfolk / East York / Ottawa-Carleton / Sudbury / York Region.

Outcomes: A change in the health status of an individual, group or populations attributed to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status.*

Outcome Evaluation: Evaluates what occurred as a result of a program and determines whether the program achieved its short- and long-term objectives. In its most rigorous form the design of an outcome evaluation can become very complex in order to rule out any other plausible explanations for the results (Evaluating Health Promotion Programs, The Health Communication Unit).

Policies: A formal statement or procedure within institutions (notably government) that defines priorities and parameters for action in response to health needs, available resources and other political pressures (World Health Organization).

Population-based approach: Involves the population as a whole rather than focusing on people at risk for specific diseases. It does not preclude the development of specific approaches to address the needs of specific priority groups. Key audiences are identified and interventions are designed to reach each group (World Health Organization).

Primary Prevention: Aimed at preventing disease before it occurs, through attempting to influence people to change their behaviour.

Process Evaluation: Focuses on programs that are already underway. Examines the procedures and tasks involved in providing a program, and seeks to answer the question: “What services are actually being delivered and to whom?” (Evaluating Health Promotion Programs, The Health Communication Unit).

Program: A well-organized series of activities designed to facilitate change in a well-defined target group⁸.

Program Evaluation: The systematic collection, analysis and reporting of information about a program to assist in decision-making (Guiding Principles for Program Evaluation in Ontario Health Units, 1996).

Recommended Practice: The set or sets of continually evolving actions and associated attitudes that are most likely to achieve health promotion goals in a given situation (Kahan and Goodstadt, University of Toronto).

Risk Factors: Behaviours that negatively impact on health in a general population (i.e., physical inactivity, unhealthy eating and exposure to tobacco smoke, stress).+

Secondary Prevention: Aims to stop or slow existing disease processes and their related effects through early detection and appropriate treatment. Also aims to reduce the occurrence of relapses and the establishment of chronic conditions through, for example, effective rehabilitation.*

Sequencing: Refers to the building of programs upon each other over time, in order to maximize population impacts. For example, for a particular audience, sequencing might be applied by focusing on awareness programs first, followed by skill building opportunities and environmental/policy programs.

Situational Assessment: A snapshot of the ‘present’ used to plan for future. It aids in setting priorities, learning more about a population of interest, anticipating trends and issues. Like a needs assessment, it focuses on community needs, but also considers broader social, economic, political and environmental contexts affecting needs.

⁸ This definition is consistent with that used in “What Works in Nutrition Promotion”, Nutrition Resource Centre and “International Scans for Best Practices in Heart Health”. Heart Health Resource Centre.

Skill Building: An approach that includes an opportunity for learning and skill development and/or some measure of behavioural change (i.e., classes and self-help groups, school programs, train-the-trainer programs).

Steering Committee: The generic term used to describe the smaller group of CP members who provide on-going, core, operational support to the local project. In specific CPs, this might be called a Management Team or an Executive Committee. It is typically comprised of 3-5 members, and often includes the Chair of the local CP, the OHHP Coordinator and a Board of Health/host agency representative.

Stewardship: The willingness to be accountable for the well-being of the organization by operating in service, rather than in control, of those around us (Peter Block, *Stewardship*, 1993). Within the context of the OHHP, Boards of Health/host agencies would also be accountable for the well-being of the CP.

Strategy: Refers to a group of programs that have the same goal, usually within a setting or a population. Strategies are often based on pressing issues or challenges affecting the achievement of the mission and vision, values and services. They describe a major area of responsibility over a 2-4 year period and usually require collaboration among stakeholders to ensure success, so therefore are usually tied to stakeholder needs and expectations in order to engage them. In the context of the OHHP, a CP might establish a Workplace strategy, a Youth Strategy or a Physical Activity strategy. Often the structure of work groups is based on these strategies.

Synergy: What happens when one program increases the impact of another (i.e., the whole is greater than the sum of the parts).

Targets: Population of interest or audience. The people in whom you want to see change take place.

Work Groups: The generic term used to describe the teams of people who manage the programs of the CP, sometimes referred to as sub-committees, task forces, or program teams.

+Source: *Comprehensive Heart Health Program Planning: June 1998*, Heart Health Resource Centre, OPHN

*Source: *Health Promotion Glossary*, World Health Organization, (WHO), 1998.

Appendix II: Acronyms

CDC	Centers for Disease Control and Prevention
CDP	Chronic Disease Prevention
CDPAC	Chronic Disease Prevention Alliance of Canada
CHHI	Canadian Heart Health Program
CWG	Continuation Working Group
ACPH	Advisory Committee on Population Health
BMI	Body Mass Index
CCO	Cancer Care Ontario
CHC	Community Health Centre
CHHIOP	Canadian Heart Health Initiative– Ontario Project
CP	Community Partnership
CVD	Cardiovascular Disease
FTE	Full Time Equivalent
GWG	Governance Work Group
HHAP	Heart Health Action Program
HHPPC	Heart Health Provincial Partners Committee
HHRC	Heart Health Resource Centre
HP&W	Health Promotion and Wellness
HRWG	Human Resource Work Group
HSFO	The Heart and Stroke Foundation of Ontario
MHPSG	Mandatory Health Programs and Services Guidelines
MOH	Medical Officer of Health
MOHLTC	Ministry of Health and Long-term Care
MPIQ	Mandatory Program Indicator Questionnaire
MTR	Ministry of Tourism and Recreation
NGO	Non Government Organization
OCDPA	Ontario Chronic Disease Prevention Alliance
OHHN	Ontario Heart Health Network
OHHP	Ontario Heart Health Program
OHPRS	Ontario Health Promotion Resource System
OHS	Ontario Health Survey
PHB	Public Health Branch
PHRED	Public Health Research and Education Departments
PREWG	Planning, Reporting & Evaluation Work Group

Appendix III: Definition of Indices Used in Equity Adjustment Formula

Funding for OHHP, Phase I, was based on the following health and service cost indices.

Health Indices

Tobacco Use

Data from the 1990 Ontario Health Survey (OHS) were used to identify the proportion of regular smokers aged 12 and over. The modifier for individual board of health areas was calculated by dividing the board of health area prevalence by the provincial prevalence.

Unhealthy Eating

Data from the 1990 Ontario Health Survey (OHS) were used to calculate the proportion of the population aged 12 and over with fat intake higher than 30% of calories. The modifier for individual board of health area was calculated by dividing the board of health area prevalence by the provincial prevalence.

Physical Inactivity

Data from the 1990 Ontario Health Survey (OHS) were used to calculate the proportion of the population aged 12 and over who were identified as inactive in the physical activity index. This represents an energy expenditure of less than 1.5 kcal/kg/day. The modifier for individual board of health areas was calculated by dividing the board of health area prevalence by the provincial prevalence.

Service Cost Indices

Geographic Dispersion

This measures the dispersion of the population within board of health areas. A series of concentric zones at multiples of 30 km from the head office of the board of health were marked and census subdivisions (CSD) were classified by zone. Weights were applied to the population figures within zones dependent upon the number of zones they were away from the head office. Data from the 1991 census were utilized. The modifier used in the funding formula is the same as the one used in the "Towards Equitable Funding for Public Health" document (Ministry of Health, Public Health Branch, April, 1996).

Home Language

This describes the proportion of the population whose home language is not English. It consists of two components: home language neither English nor French and home language French. Each component was calculated by dividing the proportion of the board of health's population with that language characteristic by the proportion for the province. Transformations were then

performed on the standardized data for each component due to skewed distributions. The final modifier was calculated by adding the two components together and subtracting the value of 1.00. The modifier used in the funding formula is the same as the one used in the "Towards Equitable Funding for Public Health" document (Ministry of Health, Public Health Branch, April, 1996).

APPENDIX IV: OHPRS Members & Contact Information

Alcohol Policy Network (APN)

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

Phone: 416-367-3313 / 1-800-267-6817

APN facilitates the development of policies that prevent problems associated with alcohol use and promote the health, safety and well-being of individuals and communities across Ontario. APN monitors developments in alcohol policy and prevention research, disseminates timely information and best advice, promotes knowledge and skill development and facilitates networking and collaboration.

Association to Reduce Alcohol Promotion in Ontario (ARAPO)

<http://www.apolnet.org/arapo.html>

Phone: 416.367.3313

ARAPO's members share the goal of promoting public health and safety by reducing the impact of alcohol advertising, promotion and sponsorship through education, policy and community action.

Best Start - Ontario's Maternal, Newborn and Early Child Development Resource Centre

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

Phone: 416-408-2249 / 1-800-397-9567

Best Start supports community health professionals across Ontario working on health promotion initiatives to enhance the health of mothers and babies. Best Start helps enhance community capacity to develop and implement population based, community-wide, comprehensive initiatives that address the range of risk factors associated with low birth weight babies.

Best Start provides many of its services in French, as well as English.

Consumer Health Information Service (CHIS)

http://www.tpl.toronto.on.ca/uni_chi_index.jsp

Phone: 416-393-7056

CHIS helps people gain greater control over their own health through access to health information. CHIS also supports the provision of health information to public libraries.

Council On Drug Abuse (CODA)

<http://drugabuse.ca/>

Phone: 416-763-1491

The mission of CODA is to prevent and reduce substance abuse through education, with a primary focus on youth and those associated with youth.

Curriculum & School-Based Health Resource Centre (CSBHRC)

<http://www.ophea.net/>

Phone: 416-426-7265

The CSBHRC supports the effective implementation of the Health and Physical Education Curriculum across Ontario. CSBHRC also supports the development and implementation of curriculum and school-based programming in various risk factor and health promotion topic areas.

FOCUS Resource Centre (FRC)

<http://www.frcentre.net/>

Phone: 613-531-3895 / 1-888-433-3181

FRC supports the FOCUS Community Projects across Ontario. FOCUS Community Projects do alcohol and drug abuse prevention programming, including harm reduction. Under the leadership of the Centre for Addiction and Mental Health, FRC builds on the resources and expertise of partner agencies to provide seamless service delivery to the 22 FOCUS sites.

Heart Health Resource Centre (HHRC)

<http://www.hhrc.net/>

Phone: 416-367-3313 / 1-800-267-6817

HHRC provides support to Ontario communities who are planning, delivering and/or evaluating comprehensive community-based heart health strategies. HHRC fosters networking and communication between peers through the Ontario Heart Health Network as well as its newsletter and e-mail discussion list.

National Clearinghouse on Tobacco and Health (NCTH)

<http://www.ncth.ca/NCTHweb.nsf>

Phone: 613-567-3050 / 1-800-267-5234

NCTH offers a comprehensive inventory of critical information for health intermediaries and other professionals in the field of tobacco control.

Nutrition Resource Centre (NRC)

<http://www.nutritionrc.ca/>

Phone: 416-367-3313 / 1-800-267-6817

The NRC helps nutrition practitioners across Ontario to implement nutrition programs and strategies in a health promotion context. NRC supports the implementation of provincial nutrition programs, facilitates networking and information sharing, and provides updates about key developments in the field of community nutrition.

Ontario Drug Awareness Partnership (ODAP)

<http://sano.camh.net/odap/index.htm>

Phone: 416-489-8301

The mission of ODAP is to raise awareness of the effects of alcohol and other drugs by encouraging and supporting drug awareness initiatives throughout Ontario. Key activities of ODAP include setting the theme for the annual Drug Awareness Week Campaign, developing and distributing products to support this campaign, and coordinating communication between Drug Awareness Committees throughout Ontario through a quarterly newsletter, website and annual symposium.

Ontario Healthy Communities Coalition (OHCC)

<http://www.healthycommunities.on.ca>

Phone: 416-408-4841 / 1-800-766-3418

OHCC works with the diverse communities of Ontario to strengthen their social, environmental and economic well-being. Educational materials, newsletters, a website, a monthly e-bulletin and annual conferences are co-ordinated through the Central Office in Toronto. Regionally-based Community Animators provide information, training, consultation and linkages to support local efforts to create healthier communities.

Services are provided in both English and French.

Ontario Prevention Clearinghouse (OPC)

<http://www.opc.on.ca>

Phone: 416-408-2249 / 1-800-263-2846

OPC has a multidisciplinary focus on prevention and health promotion activities across the province. OPC facilitates and empowers individuals, groups and

communities to work towards the realization of their social, emotional, physical and environmental health and wellbeing.

Services are provided in both English and French.

Ontario Self-Help Network

<http://www.selfhelp.on.ca/>

Phone: 416-487-4355 / 1-888-283-8806

The Ontario Self-Help Network is a program of the Self-Help Resource Centre. The goals of the program are to support the development of self-help groups, networks, organizations and centres in Ontario and promote the use of self-help strategies across Ontario. Services include information and referrals, workshops, a tool kit, a directory, and more.

Ontario Tobacco-free Network (OTN)

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

Phone: 416-922-2238 / 1-866-922-2238

OTN is an interagency network consisting of the Canadian Cancer Society Ontario Division, the Heart and Stroke Foundation of Ontario, and the Ontario Lung Association. The OTN supports a network of local tobacco-free councils, coordinated by public health staff and community volunteers, in their tobacco work throughout Ontario. The OTN also works to raise awareness of tobacco control activities and issues within their member health agencies.

Ontario Tobacco Research Unit (OTRU)

<http://www.otru.org>

Phone: 416-595-6888

OTRU is a network that fosters and conducts research, monitoring and evaluation contributing to programs and policies to eliminate tobacco-related health problems in Ontario.

Ontario Tobacco Strategy Media Network

<http://www.media-network.org/>

Phone: 416-217-1275

The Ontario Tobacco Strategy Media Network increases positive media coverage of tobacco issues and to facilitate media relations for [Ontario Tobacco Strategy](#) Partners. Key functions include tracking the news and providing daily updates,

summaries and talking points; producing background documents, draft op. eds., letters to the editor, etc.; and providing media relations training workshops.

Parent Action on Drugs (PAD)

<http://www.parentactionondrugs.org>

Phone: 416-395-4970

PAD works to prevent drug abuse among youth through education of parents, youth, service providers and the community. PAD also provides support to families of adolescents with substance abuse problems.

Physical Activity Resource Centre (PARC)

<http://www.ophea.net/parc/>

Phone: 416-426-7120

The Physical Activity Resource Centre was developed to provide support to Physical Activity Promoters in Public Health. PARC provides training and consultation, networking and referrals, and resource and information dissemination services. These services are intended to support capacity building and learning opportunities. The services of the Physical Activity Resource Centre are available to Physical Activity Promoters working in Public Health across Ontario.

Program Training and Consultation Centre (PTCC)

<http://www.ptcc.on.ca/>

Phone: 519-571-9870 (Kitchener) / 1-800-363-7822 (Ottawa)

PTCC provides training and consultation services to enhance the capacity of Ontario communities to implement effective community-based tobacco use reduction strategies. PTCC is a resource centre of the [Ontario Tobacco Strategy](#).

Smoking and Health Action Foundation (SHAF)

<http://www.nsra-adnf.ca/>

Phone: 416-928-2900

SHAF conducts public policy research and education designed to reduce tobacco-related disease and death. Through its evidence-based research on topical issues in tobacco control, SHAF has provided a crucial bridge between academics, policy-makers in government, and the wider health community.

SHAF is the sister organization of the Non-Smokers' Rights Association.

The Health Communication Unit (THCU)

<http://www.thcu.ca>

Phone: 416-978-0522

THCU at the Centre for Health Promotion, University of Toronto provides training and support in health communication, health promotion planning, evaluation, policy change, and sustainability. THCU's goal is to increase the capacity of community and public health agencies to plan for, conduct and evaluate a wide range of health promotion programs (within a comprehensive and population-based approach).

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