

Heart Health Orientation Workshop

Follow-up to 'Parking Lot Questions' posed at the HHRC Orientation Day-May 19th, 2004

The following are some answers to the questions posed at the orientation session on May 19th. We (Jennifer and Karima) contacted Brian Hyndman at the Health Communication Unit, Barb Riley and Sarah O'Brien at the Nutrition Resource Centre for their thoughts and added some of our own. Please also see the resource section at the back for further reading! If you would like further support, please contact Karima Kassam, 416 367-3313 Ext 236 or kkassam@opha.on.ca.

1. How successful has the Eat Smart! program been in Ontario?

"Depends how you're defining 'success'. As far as I know, the evaluation data collected on Eat Smart! is mostly monitoring/tracking stats (e.g., # of restaurants certified, etc.), rather than outcome measures of knowledge, menu choices and eating habits" -Brian Hyndman

According to Sarah O'Brien at the Nutrition Resource Centre, The Eat Smart! program has not been evaluated at a provincial level. However, a logic model has been developed and is available in hard copy, and a number of smaller studies have been completed. These include:

Eat Smart! Ontario's Healthy Restaurant Program: A Survey of Participating Restaurant Operators. Lesley A Macaskill; John J M Dwyer; Connie L Uetrecht; Carol Dombrow. Canadian Journal of Dietetic Practice and Research; Winter 2003; 64, 4, pg. 202

Eat Smart! Ontario's Healthy Restaurant Program: Focus Groups With Non-participating Restaurant Operators. John J M Dwyer; Lesley A Macaskill; Connie L Uetrecht; Carol Dombrow. Canadian Journal of Dietetic Practice and Research; Spring 2004; 65, 1; pg. 6

Additionally, a group in Thunder Bay evaluated the 'Eatsmart' dining guide in 2004 and found "approximately three-quarters of residents recognized the Eat Smart! Brand". The authors mention in their report that "several other health units have conducted evaluations of the Eat Smart! program, though as far as we know no reports have been published in PHERO. An optional module for Eat Smart! has been developed for the Rapid Risk Factor Surveillance System (RRFSS), so it is likely that many health units in Ontario have unpublished data regarding the success of their local Eat Smart! efforts. From personal communications, it seems that recognition of the Eat Smart! brand within those communities assessed is generally under fifty percent. To date, our chosen vehicle for disseminating Eat Smart! information has been a high-quality, glossy stand-alone dining guide containing a list of Eat Smart! qualified restaurants, distributed once annually via the local newspaper. However, this survey revealed that few of these dining guides are actually retained by members of the public, despite the

fact that the survey was conducted only 3 weeks post-dissemination. Instead, respondents indicated that the Yellow Pages would be a more intuitive and convenient vehicle. Smaller but still significant proportions of respondents indicated a preference for newspaper advertising and the internet. As a result of the survey, we are implementing a re-design of our dining guide to be published in the restaurant section of the Yellow Pages, a smaller less expensive newspaper advertisement, and more promotion of our website as a source of Eat Smart! information. These changes have reduced our production and distribution costs by approximately half and the funds saved will be used for more extensive promotion of Eat Smart!"

-source, Evaluation of the Thunder Bay Eat Smart! Restaurant Program Dining Guide, by Lee E. Sieswerda, B.Ed., M.Sc., Jennifer L. Bowen, B.Hec., RD and Shari Tremaine, B.Sc. April 30, 2004. Thunder Bay District Health Unit.

Some general background on Eat Smart!

Eat Smart! Ontario's Healthy Restaurant Program started 1997 as a partnership among the Ontario Ministry of Health and Long-Term Care, the Canadian Cancer Society (Ontario Division), the Heart and Stroke Foundation of Ontario, the Ontario Ministry of Agriculture, Food and Rural Affairs, Toronto Public Health, local health units, heart health program, the food service industry, & consumers. The program was launched provincially in 1999. The Workplace Cafeteria module and the School Cafeteria module were introduced in 2001.

The Eat Smart! program is managed provincially by the Nutrition Resource Centre at the Ontario Public Health Association with funding from the Ontario Ministry of Health and Long Term Care. Eat Smart! has two provincial partners, the Canadian Cancer Society (Ontario Division) and the Heart and Stroke Foundation of Ontario.

Eat Smart! is run by local public health units. 32 of the 37 public health units implement the Eat Smart! Restaurant Program and over 900 restaurants participating (number keeps increasing). There are currently about 18 public health units implementing the Workplace Program and School Program and approximately 45 participating workplace cafeterias and 45 participating school cafeterias (another 40 are in progress). However, it is expected that these numbers will increase as more public health units start to implement the program and expand the program in the coming months/years.

-source, Sarah O'Brien, Nutrition Resource Centre

2. What ARE the connections between theory and practice in heart health in Ontario?

"The OHHP was premised on the American heart health demonstration projects in Minnesota, Stanford, and Pawtucket, so it inherited all of the theoretical baggage of these initiatives. But to the best of my knowledge...decisions about practice seem to be based on the interests of the coalition partners, community priorities, mandate considerations, available time and resources, and what seems to have worked in other communities. There may be individual activities linked to theories (e.g., stages of change theory continues to be popular). However, I don't think the heart health coalitions

systematically consider the application of theories during their strategic planning sessions. "- Brian Hyndman

However, Barb Riley, who is conducting province-wide research on heart health programs in Ontario notes that theory has played a significant role in the development and conceptualization of heart health programs in this province. In her 2001 paper with Elliot, Taylor, Cameron and Walker, she states that diffusion (of innovation) theory "provided the rationale for focusing on the implementation stage of dissemination for" CHHI OP (2001: 26). Additionally, "socio-ecological approaches" to health promotion (including the ecological model) have been a significant factor influencing implementation of heart health promotion in this province. "A socio-ecological perspective provided the rationale for studying factors operating within the public health system and factors operating in the surrounding environment" (27).

So, some say health promotion theory has played a role, others say not so much. Additionally, there may be other theories at work in heart health, theories born in sociological, economic and political fields that speak to power and interest groups in coalition work. More importantly, what do you think?

3. What are we really talking about when we use the term 'population' in heart health?

"If you mean 'population health', then the rationale is that you'll get a bigger 'bang for your buck' from bringing about population-wide changes in health status (as opposed to directing your efforts towards 'high-risk' groups)...[see the] extensive literature critiquing the population health approach from Ron Labonte, Ann Robertson, Dennis Raphael et al." -Brian Hyndman.

Additionally and drawing on those cited above, I have always understood the term population health to mean more of top down, epidemiological (stats) driven approach to public health, an approach which has gained in currency this last decade and changed the face of health promotion in this country (see Robinson and Elliott 2000 for more).

Whereas a classic community health promotion initiative might start with a group of volunteers who want to work from the 'bottom up' to create a small community garden in the local parking lot for exercise, produce and a better sense of community, a population health approach would start by gathering stats on all the populations in the region and then planning an approach that best fits all the folks (not just those community gardeners). It is supposed to make more sense 'evidence-wise' and have more substantial 'outcomes', but sometimes a small, community-driven garden brimming with home grown vegetables and a sense of pride is just as vital. -Jennifer Poole

FYI - The World Health Organization notes a 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)

4. How does the CUBE model fit in the population health model?

(How do the two models work together given that population health looks at shifting the “bell curve”? The CUBE talks about identifying one group and working with that particular group in the areas of channels, risk factors, etc.)

Terrific to hear that such questions are being asked. And terrific to hear that the concept of 'bell curve' (shifting the mean value on various risk factors within the population) is part of the understanding of a population approach to prevention (i.e., population health). Only point that seems to need more explanation is that the cube is a useful framework that describes HOW to apply a population approach to prevention (i.e., how to achieve the shift in a population mean on blood pressure, smoking, etc). The cube represents a comprehensive approach to prevention. Even though one way to use the cube is to select one audience and develop interventions that address the other dimensions (channels, risk factors, etc), that is only one application of the comprehensive model. You might want to point out that Audience is one dimension of the cube. Therefore, a variety of audiences need to be addressed to be truly comprehensive". – Barb Riley

Additional Resources for further reading

These are the journal articles referenced in this follow-up document, and I've included a summary of what I consider to be one of the most useful. – Jennifer Poole

Labonté, Ron. (1995). *Population health and health promotion: What do they have to say to each other?* Canadian Journal of Public Health, 86(3):165-68.

Summary: The author asserts that much of what is claimed in the name of population health supports the concerns of health promotion. However he also argues that there are some assumptions that may be at odds with those in health promotion and that these assumptions should be debated. These concerns include population health's emphasis on epidemiological methods, its economic conservatism and its silence on ecological questions of overall economic scale. Labonté's discussion outlines how population health differs from health promotion in its underlying philosophy of approach.

Labonte, Ron and Robertson, Ann. (1996). Delivering the goods, showing our stuff: The case for a constructivist paradigm for health promotion research and practice. Health Education Quarterly 23(4):431-47.

Riley, Elliot, Taylor, Cameron and Walker (2001). On the HHRC website.

Riley, Barb, Taylor, Martin and Elliot, Susan J. (2001). Determinants of implementing heart health activities in Ontario: a social ecological perspective. Health Education Research, 16(4): 425-441.

Robertson, Ann. (1998). Shifting discourses on health in Canada: from health promotion to population health. Health Promotion International, 13(2): 155-166.

Robinson, Kerry and Elliott, Susan J. (2000). The practices of community development approaches in heart health promotion. Health Education Research, 15(2): 219-231