Project Evaluation Report

Integrating Chronic Disease Prevention with Primary Care in South East Community Health Centres: Building Capacity in Primary Care for Reducing Risk of Stroke in High Risk Populations

A project of the South East Community Health Centres Chronic Disease and Prevention Management Network, Funded by the Ontario Ministry of Health Promotion

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April 30, 2010

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1. Introduction

This report outlines results of an evaluation of the project "Integrating Chronic Disease Prevention with Primary Care in South East Community Health Centres: Building Capacity in Primary Care for Reducing Risk of Stroke in High Risk Populations". After setting the project background, the report outlines the evaluation methods, and summarizes the four unique approaches used by the project's four implementing community health centres (CHCs). The report then highlights project results at the provider, client and CHC level, and concludes with a list of lessons learned.

2. Project Background

"Integrating Chronic Disease Prevention with Primary Care in South East Community Health Centres: Building Capacity in Primary Care for Reducing Risk of Stroke in High Risk Populations", is a project of the South East Community Health Centres Chronic Disease and Prevention Management Network. The project was funded by the Ontario Ministry of Health Promotion in partnership with the Provincial Stroke Strategy for a period of two years, from April 2008 – April 2010. The project was implemented by four Community Health Centres in the South East LHIN including:

- Country Roads CHC (serving Portland and Rideau Lakes area);
- Gateway CHC (serving Tweed and area);
- Kingston CHC (serving Kingston, Greater Napanee and Stone Mills area); and
- Merrickville CHC (serving Merrickville, North Grenville and Smiths Falls).

The **overall purpose** of the project was to use the collective knowledge and expertise of the partners to increase the uptake of health promotion concepts and use of that knowledge by the interdisciplinary primary health care teams in the four CHCs in South East LHIN to:

- Identify clients at particularly high risk of developing chronic disease/stroke;
- Improve outcomes/reduce risk for those patients by providing the needed information, education supports and referrals, access for those clients to appropriate health promotion resources and opportunities that address their unique needs.

The project's main strategy was to build capacity for reducing risk of stroke and other chronic diseases through a team of Health Promotion Champions. The Champions worked directly with primary care provider teams in each CHC to introduce key health promotion and disease prevention messages, tools and best practices and to assist the teams to adapt new processes that fit local needs.

3. Evaluation Methods

The evaluation centred on both outcome and process components of the project using both quantitative and qualitative data. Using the project's draft evaluation framework document, evaluation methods included the following:

- Review and analysis of all project documentation including the project proposal, interim progress reports and group feedback forms
- Review and analysis of results from project evaluation tools including:

    - pre- and post- provider surveys
    - pre- and post- client surveys
    - project intervention chart summaries
- Review and analysis of indicators listed in draft evaluation framework including[1]:
    - % of primary care practitioners who are aware of community resources and supports related to health promotion and primary prevention of stroke
    - % of primary care practitioners who refer high risk clients to community prevention programs
    - % of clients surveyed who report increased awareness of risk factors and access to resources available to them
- Semi-structured interviews with health promotion champions, primary care providers and clients in each of four CHC sites (completed 21 interviews in total, including 7 clients)

The project developed three written tools in order to evaluate project results: the pre- and post- provider survey; the pre- and post- client survey; and the intervention summary. These tools were applied unevenly in the project and thus provide limited but important insights on project results. Further information on these tools, how they were used in the project, and their limitations is in Appendix A. Interview guides are included in Appendix B.

4. Four CHCs, Four Unique Approaches

4.1 Summary of Target Groups and Approaches

Each of the four CHCs used a unique approach to try to meet the project purpose. The four approaches are summarized below.

CHC	Target Group	Approach	Number of Clients
Country Roads	Men over age 40 and women over age 50 with already identified high blood pressure and high lipid profile and no recorded blood pressure or lipids in more than 12 months.	Use Purkinje database to identify clients who meet the target group profile. Contact clients by letter and phone. Invite them to a "Healthy Heart Clinic" where they meet first with an RN for health promotion, and then with a nurse practitioner or doctor. RN took measurements, discussed lifestyle changes and worked on self-management goals. The NP or doctor discussed test results, medications and risk factors. Book follow-up appointments with RN as requested.	48 (with approx. 30 clients booking followup appointments)

[1] In addition to these listed indicators, the Project Coordinator compiled data on the percentage of male clients over age 40 and female clients over 50 who in the last 24 months have had a blood pressure measurement and a fasting lipid profile, as well as the percentage of male and female clients over 18 with obesity screening in the past 24 months. These results are available in the final project report. Results suggest an increase in all indicators over the past two years. The increase can be attributed to a combination of factors, including an increase in the practice of screening, as well as improved reporting and improved data quality.

Kingston	Aboriginal men and women with various risk factors for stroke	Create a partnership with the Katarokwi Native Friendship Centre. With input from aboriginal facilitators, design culturally appropriate content and conduct six group sessions at the Friendship Centre, led by two aboriginal facilitators.	28 (Average number of participants over six group sessions)
Gateway	Men over age 40 and women over age 50 presenting with elevated blood pressure without diagnosis and/or treatment of hypertension	Plan the care pathway first with the local Chronic Disease Prevention and Management Committee. Complete blood pressure checks on all clients who come to the CHC. Inform clients who meet target group profile of the CHCs "Blood Pressure Program", give them a brief overview of modifiable risks, and send them home with a BP machine to log their results for two weeks. Thereafter, schedule four monthly appointments with RPN for health teaching and goal setting, followed directly by appointments with their physician. Also, have primary care providers refer targeted clients to a "Heart Healthy" group, running for four weeks. RPN runs group sessions, with the assistance of a nutritionist for one session.	42
Merrickville	Women over age 50 with already identified high blood pressure, high lipid profile, and obesity	Use Purkinje database to identify clients who meet the target group profile. Contact clients by phone and invite them to attend a five-session group program, including a one-on-one assessment. Design and lead group by an interdisciplinary team including a nurse, nutritionist, social worker, and community health worker.	5
			Total: 123

4.2 A Spectrum of Responses

As summarized in the chart above, the project used a variety of strategies to meet the project goal.

4.2.1 Traditional clinical approach

Country Roads CHC and Gateway CHC used the most traditional approaches, through their "Healthy Heart" and "Blood Pressure Program" clinics. Both sites emphasized linking with clients individually, first with an RN or RPN, and next with a physician or Nurse Practitioner.

4.2.2 Group versus individual approaches

Merrickville and Kingston used a group rather than individual approach (though Merrickville also made some late efforts to connect group program participants with their primary care providers.) Gateway supplemented their individual approach with two group programs.

4.2.3 Established clients versus outreach to at-risk cultural groups

Country Roads, Gateway and Merrickville all worked with clients who were already attached to the CHC. By contrast, Kingston did outreach to an at-risk cultural group who did not have previous involvement in the health centre. Kingston originally tried to target the Asian community, but because of lack of connections, were not successful setting up even an initial meeting.

Because of the Kingston health champion's previous connections with the Four Directions Aboriginal Centre at Queen's University and with the Katarokwi Native Friendship Centre, the project identified aboriginal people as potential target recipients for the program. However, making it work was not easy. Early on, Kingston's health promotion champion, a Registered Holistic Nutritionist and Food Educator, realized, *"Our ideas for how to deliver health training to aboriginal people were wrong."* With the input of aboriginal facilitators, Kingston transformed their group program to be appropriate for aboriginal beliefs and traditions.

The program was called, "I'm here, I'm Algonquin, and parts of me are magnificent: Creating culturally appropriate ideas for an action plan for your circle of life." Delivered at the Katarokwi Native Friendship Centre, each of the six sessions began with a meal made from traditional aboriginal foods. Participants sat in a talking circle without tables separating them from each other. People attended the program in family units rather than as individuals. Aboriginal-specific teaching videos from Lakehead University, sponsored by the Heart and Stroke Foundation, used images and teaching methods that the participants could identify with. Advance written registration didn't work – for the first session, four people signed up in advance and more than 30 attended.

The program used a non-clinical approach, and did not measure or monitor health indicators such as lipid profiles, blood pressure, or body weight. Instead of an on-paper action plan, participants filled traditional leather medicine bags with cards that summarized health teaching and captured their goals in their own words. Each aspect of the program was mindful of traditional aboriginal beliefs and culturally appropriate messaging. Having aboriginal facilitators was critical to the program's success. One facilitator, a respected elder in the aboriginal community, commented,

> *"In chronic disease prevention and management, there's a big emphasis on peer-led training. But here, in our communities, everything is about connection. In the bigger picture, we want to connect to nature but most important, it's connection to people. The first question is, 'Who are you related to?' So if you're a white person trying to deliver knowledge, I can respect you. But you don't know anything about me and my body, because you're different." - Aboriginal Program Facilitator*

5. Highlights of Project Results

Each of the project's diverse approaches achieved significant results - for providers, for clients and for CHCs as a whole. While the freedom to be context specific is no doubt a strength of the project, four distinct approaches with four different target groups mean that it is not possible to "roll up" project

results across sites. Each site's approach had its distinctive strengths and challenges. Further, the project's evaluation tools, including the pre- and post- provider survey, the pre- and post- client survey, and the intervention summary were applied unevenly across sites and had significant limitations (see Appendix A for further detail).

With these limitations in mind, the following section highlights results that were common across several sites in three areas: results for providers; results for clients; and results for CHCs as a whole.

5.1 Results for Providers

Increasing the uptake of health promotion concepts and use of that knowledge by the interdisciplinary primary health care teams was the central purpose of the project. Results for providers were evaluated using two methods:

- Review and analysis of pre- and post- provider surveys
- Interviews with providers at each of the four sites (10 providers total including physicians, nurse practitioners, RPNs, nurses, and dieticians)

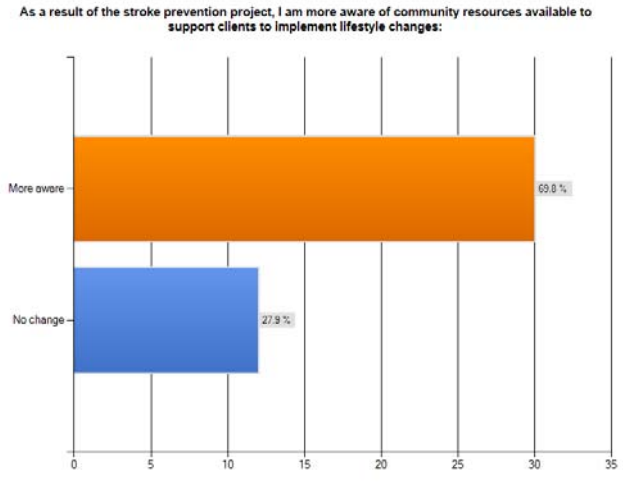
Highlights of the most significant results for providers are below.

5.1.1 Increased awareness of community resources

According to results from the post- provider survey, 69.8% (n=30) of respondents are more aware of community resources available to support clients to implement lifestyle changes as a result of the project. This result was also a common theme in interviews with providers as illustrated in the following quotes from physicians.

"We've been finding that [nurses] have been doing a good job of identifying other external resources – there are things I don't know about, and they've been doing a good job of plugging people in to external resources." - Physician

"I know medically what the patient needs, but they also need to get to access that, improve their motivation through education, and know that someone is there who knows all the resources. For physicians it's confusing, what was there six months ago is not there now. This is where I found the [health promotion champion] very valuable." - Physician



One of the most valuable things the network did was to develop a chronic disease risk reduction information toolkit and catalogue of resources. The basic toolkit had information and brochures on various risk factors, including information from the Heart and Stroke Foundation, the Canadian Cancer society, the Canada Food Guide, and other relevant resources. The intention was for each CHC to tailor this basic toolkit with more locally-specific resources. Health champions were actively using the toolkit in all sites with the exception of the Kingston CHC, where it is still to be rolled out. Kingston has made other efforts to ensure that providers are more aware of programs at the CHC.

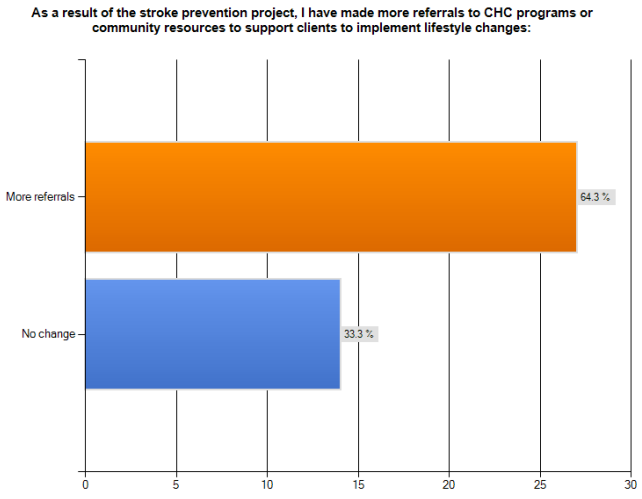
Gateway CHC took the most aggressive approach to organizing their available resources, and have a resource wall that has been culled, organized and updated. Before the project, they *"used to have a lot of stuff on racks that were never looked at."* Now, the resource wall display is current and frequently used by providers.

Working with volunteers, Country Roads CHC developed a 'Physical Activity Opportunities' brochure for their area, with information on how people can be more active in their community. The tool is well liked and used by providers at the centre.

In Merrickville and Country Roads CHC, use of the information toolkit continues to be mostly confined to the health champions. Country Roads CHC has seen an increase in the use of some written health promotion resources in the context of patient physicals. In future, Merrickville CHC would like to further develop a resource centre for primary care providers with access to information on community resources and supports.

5.1.2 Increased referrals to CHC programs or community resources

According to results from the post- provider survey, 64.3% (n=27) of respondents have made more referrals to CHC programs or community resources as a result of the project. This theme also arose repeatedly in interviews, as illustrated in the following quotes from various providers.



"We have learned to rely more on other paramedical players in the team. I don't have to be responsible for all the indicators, all the lifestyle changes. I can refer to other people and they can do their thing... It hasn't changed how I treat the patients in the situation. It's just that I am more aware of how I can get patients to access resources that might be helpful to them." – Physician

"I refer more to [the health promotion champion] now. I'm referring younger people with risk factors – smokers, people with high cholesterol, people who are overweight – more so that before…The net is cast wider." – Nurse Practitioner

"The project was centred around primary care, but it also involved the whole interdisciplinary team – social workers, dieticians and so on. This is not unusual for CHCs, but through the project, I have upped my referrals for sure." – Nurse

Referrals are not necessarily happening with equal force across sites, or with the same frequency across different care providers. One provider expressed, *"I think there's work to be done in terms of primary providers seeing value in our health promotion programs. I feel we don't get many referrals from primary care providers. We could have a lot more."*

When the provider survey is filtered for physician responses only, physicians report slightly lower numbers on increasing their referrals than overall respondents (57.1% compared to 64.3%).

5.1.3 No evidence of change on provider awareness of risk factors

The provider survey does not give any convincing evidence that awareness on modifiable risk factors was impacted by the project. In fact, overall responses show a slight decrease in awareness from the pre- to post- samples. Nor does the provider survey help show the project's impact on how often providers discuss risk factors with clients (answer response choices are different and therefore cannot be validly compared).

Provider survey results do suggest that providers are more hesitant to discuss alcohol abuse with clients than any other risk factor. This finding was discussed with providers during evaluation interviews. To explain the provider survey results in this area, doctors expressed that:

> *"Brief interventions are easier to envisage for things like smoking and obesity than alcohol."*

> *"I don't tend to go into that a lot. I know it's important. There's a lot of denial there…There are so many risk factors, you just can't cover them all in a minute. This is why I found what [the health promotion champion] was doing was so valuable. If we went over everything with every patient, we'd never get everything done, it's too much."*

5.2 Results for Clients

Improving outcomes and reducing risks for clients at high-risk of stroke or other chronic disease is a central aim of the project. Project results for clients were evaluated using three methods:

- Review of pre- and post- client survey forms (Country Roads 10; Gateway 20; Merrickville 5)
- Semi-structured interviews with clients at each site (Total of 4 women and 3 men)
- Review of project feedback forms from group program (Gateway and Merrickville)

Highlights of the most significant project results for clients are below.

5.2.1 Increased awareness and behavior change on healthy eating and physical activity

According to client surveys, the most common changes for the majority of clients are on the level of awareness – for example, awareness of healthy levels of sodium/salt intake. However, a number of participants also noted in client surveys and expressed in evaluation interviews that as a result of the program, they had changed their eating habits, reduced their weight and increased their physical activity.

> *"I am a totally different person. I watch everything I eat. I've broken the sugar addiction. I'm reading labels again. I watch my salt intake. I joined the gym and work out five times a week. I walk whenever I can. It's like I have a new lease on life. I am 100% feeling fit and healthy. I feel alive. I feel like the years have been washed away from me." – Female Client*

> *"I've changed the way that I eat – mostly on salt." – Male Client*

> *"My eating has changed a lot for the better – lots of fruit and vegetables. I find that I go after the salt and the fat. I'm finding since I've lost the weight that I can garden better, do stairs better. I'm more active than I used to be… I'm really thrilled that I've lost weight." – Female client*

"It has helped us as a family. I'm looking at labels, I'm paying attention to what I'm buying. I keep a card on acceptable salt amounts in my purse and shop accordingly…"I've purchased new foods I've never eaten before, like tahini, and ground flax seed. I walk a minimum of three times a week with a friend. For me, making that commitment is huge. It's a different mindset – way better than it used to be." – Female client

"I learned that [even] minimal physical activity will improve our health, and that nutrition is so important. Garbage in, garbage out!" – Client on group feedback form

5.2.2 Self-management as an effective tool to promote lifestyle change

Several clients shared in interviews or on group feedback forms that the self-management approach, where clients choose and set individualized goals, has been an effective tool to promote lifestyle change – particularly when matched with follow-up appointments, support and accountability from their provider.

"Planning. The goal plan for the week. Holding yourself accountable. 'I will do this, this many times, this is my intent.' I had copies of the blank paper made and use them at home." – Female client

"It's a combination of a number of things I learned over the weeks. It started easy – just taking my blood pressure and getting the Canada Food Guide. The most important thing I got was the support from the [health promotion champion]. She sat with me and said, 'I'm going to help you with this'." – Female client

"Food is one thing that you have to consider. A lot of us aren't eating the right kinds of foods. Quitting smoking was the one I was most interested in. I'm working on the other things too…Since being part of the project, I think I am a bit more motivated now." – Male client

"A strength of the project is when the clients are very involved in the learning process, self-management" - Dietician

Kingston CHC used an innovative approach to self-management. Instead of using the Stanford Action Planning form, participants were given a traditional aboriginal leather medicine bag to store their goals, written on cards in their own words. When checking in weekly on people's progress on their goal-setting, the group also emphasized the question, "What did you learn?", rather than just, "Where you successful or not in meeting your goal?"

Not surprisingly, not all of the clients involved in the project were able to meet their self-management goals. One client noted, *"It seems simple, but I didn't meet my goal. It was hard to say I'm going to do this simple thing."* Another observed, ***"****Change is a tough one. Not because of the program, but because we're creatures of habit. We're set in our ways, we do what's familiar. Even though the program was excellent, old habits die hard."*

Nevertheless, for clients who were engaged in the project, the project seems to have achieved a high level of impact on client lifestyles using the self-management approach. For example, Country Roads CHC's intervention summary notes that of 48 clients who were engaged in the project and set self-management goals, only nine clients (19%) did not make their intended lifestyle change.

5.3 Results for Community Health Centres Ongoing Practice

The project intended not only to influence interdisciplinary primary health care teams and reduce risk for clients, but also to influence CHCs as a whole.

Project results on CHCs as a whole were evaluated through 21 interviews with providers, clients and managers.

5.3.1 Nurses empowered to do deeper health promotion

According to interviews with various providers including doctors, nurses, nurse practitioners, dieticians and others, the project has empowered nurses, including both RNs and RPNs, to do deeper health promotion. In fact, where the project has had its most significant and enduring impact on ongoing health promotion practices, it is because it has expanded the scope of practice for nurses and will maintain that past project completion. For nurses to be empowered to do health promotion in a more intentional way, they need the support of upper management and primary care providers, as well as time and resources. The following comments illustrate the result the project has had in terms of empowering nurses for health promotion:

> *"How do you get doctors to respect the work of the RPN? They are used to seeing them in a particular scope of practice. With this project, they begin to see the critical thinking and the health promotion they can bring. The RPNs can work in meaningful ways, in a way that supports physicians, and ultimately, the client." – Senior Manager*

> *"The nurses are taking a stronger lead in [stroke prevention]. They have a more structured approach. They have developed more skills in delivering health education to individuals, and we've reallocated some time to allow them to do it." - Physician*

> *"The project has really changed my practice. I focus more not on my agenda but on their agenda. We look at their goals and how they want to achieve them." - RN*

> *"Before, I wasn't always comfortable with what I should or should not be saying. Now, it's opened the door of 'Yes, we want you to do this health teaching.' We don't feel like we're stepping on toes. It's totally changed how I am with clients. Before I would feel, 'Should I or shouldn't I? What does the doctor want me to say?' Now, it's given me a broader comfort zone with health teaching… We have increased our awareness on health teaching. We've had a learning curve as well." - RPN*

5.3.2 New insights on doing outreach and working with at-risk cultural groups

The unique approach of the Kingston CHC led to new insights for everyone in the project on how to do outreach with at-risk cultural groups. The Kingston CHC was successful at breaking new ground with aboriginal people. Further, Kingston's rich experience with the aboriginal population helped others involved in the project to be more mindful of how they tailor programs for their own target populations. Kingston's project helped others see health promotion with a new lens, and opened up the possibility of creative, non-clinical and culturally appropriate approaches.

> *"The idea of building trust with clients, and working with sensitivity, is important for all of us. The work with aboriginal people is a magnifying glass for the rest of us." – Community health worker*

"It can change the lens of health promotion. All of the circular references, with the person at the centre, are wonderful. The idea of connection is so meaningful. We can use that in everything we do." – Senior manager

"If you're not able to understand where they are coming from, you're not going to reach them." – Aboriginal facilitator

5.3.3 Sustainability of project activities in various CHCs

All planned project activities have been completed with the allocated funding. Depending on the approach of various CHCs, the specific project activities have been more or less sustainable in the various health centres.

Gateway CHC has taken the most sustainable approach to project activities. From the start, the intention was to integrate project activities into the way the CHC operates, with the management view that "*if you use an 'add-on' approach or separate a program out, it will never be integrated*". Significant investment was given to the project planning stage using a team approach and working with the Centre's Chronic Disease Prevention and Management Committee. The Committee developed an algorithm to illustrate and guide program activities. The program was piloted with one RPN and one physician. Using learning from the pilot, the algorithm and other project tools were modified. Then the project was then rolled out to other RPNs at the Centre. Despite the completion of project funds, the activities that were started in the project will continue basically unchanged. As one provider expressed, *"It's embedded. The group piece will happen two times a year, the in office blood pressure program will continue".*

At Country Roads CHC, the health promotion champion continues to see clients from the Healthy Heart Clinic for follow-up, and has a greater number of referrals from others in the centre to do lifestyle counseling. Both primary care providers who were interviewed expressed their deepened appreciation of health promotion. One described her new practice of emphasizing self-management, and of booking back to back appointments with a nurse to receive more in-depth health promotion. In general, however, new health promotion approaches and use of project materials has been mostly restricted to the project's health promotion champion.

Kingston CHC organized their aboriginal group program as a standalone project to meet an unmet need. Kingston CHC is examining the option of repeating the group program at another Native Friendship Centre and on the nearby Native Reserve. Project materials may also be adapted and used by the Southern Ontario Aboriginal Diabetes Initiative (SAODI). Kingston will also make an effort to transfer learning from the project into its other CHC programs. The health promotion champion plans to continue the partnership with the Katarokwi Friendship Centre by giving a regular large-batch cooking class with aboriginal foods.

Merrickville CHC recognizes the value of the group program, but without additional funding, does not anticipate having adequate nursing hours to support its continuation.

6. Lessons Learned

The project's process and results have revealed a number of important lessons.

1. **Provide consistent upper management support and attention**

It seems obvious, but consistent upper management support and attention is important for project success. Several of the CHCs got off to a slow start in terms of organizing and implementing project activities as other important demands in the various CHCs took focus away from the project. Several CHCs also experienced transitions and gaps in management support during the project time period. As a result, project activities were sometimes pressed into a tight timeframe and those who were tasked with leading project activities sometimes felt isolated and unmoored, as revealed by the following comments.

> *"There wasn't much direction at the beginning of the project. We were told, find a champion. Other than that, you had to figure what you were doing on your own. I had no guidance from my manager, and no oversight once I started."*
>
> *"There wasn't enough focus or attention given to the project in the beginning."*
>
> *"If you're going to take on a project of this magnitude, make sure you have the resources to do it. And don't keep changing the key players. If you have someone designated at two days a week to support the project, they can't be called out to other work."*

2. Involve primary care providers at the front end to get their input and ownership

> *"Our reality here and in most health care settings is that the primary providers are the tail that wags the dog".*

CHCs with the most enduring project results involved primary care providers from the beginning to get their input and ownership into the project and how it would unfold. CHCs that did not engage their primary care providers early experienced more resistance, less buy-in, and less impact across the CHC as a whole. Reflecting back on what they would do differently, two project leaders commented:

> *"If I could do it all over again, I would do a better roll out than we did. I'd have a meeting and tell all the providers, this is what it's about, this is what we think will work, but what do you think? I'd get buy-in and input from the providers, and then take that info and decide. I would like their input, which I didn't get."*
>
> *"Ideally, we would have liked to see primary providers saying to their clients, we have this program that I think would benefit you. The primary care providers made it quite clear they have no desire to participate in this if they aren't really consulted."*

3. Consider an integrated sustainable approach rather than an "add-on" approach to new health promotion project activities

Many CHCs manage multiple short-term projects from various funders as a way to fulfill their mandates. When new projects are added, staff sometimes experience new demands as an additional burden on their already stretched time and responsibilities. CHCs that plan the integration of project activities into ongoing practice may have more sustainable results than those who use project funding to add-on a pilot project that may not be repeated.

> *"We wouldn't have been able to do it without the money – the time to integrate the principles and support the employee… [But] there's no point in doing a project if you're not going to integrate it."*

4. Empower nurses to work to their scope of practice as health promoters

The project had the most impact, and will have the most enduring impact, where nurses (both RNs and RPNs) are empowered practically with the time, resources and support to integrate intentional health promotion into their daily work. Despite this insight and the clear positive impact on client outcomes, not all CHCs are able to move in this direction. As one nurses commented:

> *"I'm much more useful as a nurse in this role as a health promoter, but the reality it is, our structure doesn't support it."*

5. Embrace an interdisciplinary team approach

An interdisciplinary approach is known as one of the hallmarks of a community health centre. Nevertheless, working it out in reality can be a challenge.

> *"Primary care tends to take precedence over everything else. They always strive to take an interdisciplinary approach, but it was new for many of us to work in this way."*

One of the identified strengths of the project was the interdisciplinary team approach. Where the project was able to maximize the strengths, knowledge and skills of physicians, nurse practitioners, nurses, dieticians, social workers and other providers, the potential for deeper impact with clients grew. As one nurse commented, *"Working with my teammates was a huge strength. The more minds you can put together, the more creative you can be."*

6. Use a regional approach to add value to project design and implementation

Project participants who participated in monthly network meetings involving all four CHCs appreciated the regional approach and believed it added to project effectiveness. Having a view into the Kingston CHC project – which had a significantly different target group and approach – was considered particularly interesting and valuable. The following quotes illustrate these themes:

> *"The monthly network meetings kept us all on track. It kept us in touch with the other CHCs so we weren't working in silos" – Nurse*

> *"It was good to work as a network, see the different approaches and work as a team to see how you could get over barriers… The Kingston CHC project made you see you need to be mindful of your target group." – Senior Manager*

7. Develop good evaluation tools at the design stage – keep them useful and consistent

The project's evaluation tools were of mixed value both because of their design limitations, but also because they were not applied evenly across sites. Evaluation tools are best developed at the design stage, are attached to clearly defined results and indicators. A future project would benefit from greater investment at the design stage in order to develop evaluation tools for both immediate and intermediate results. Good evaluation tools are easy to use and serve project participants and leaders by giving them information to make good decisions and deepen impact.

8. Integrate learning from outreach and programming to at-risk populations

The project demonstrated that outreach and program development for at-risk cultural groups has difficult challenges and exciting rewards. Some of the lessons learned from the Kingston experience with aboriginal people included:

Project Design and Developing Partnerships

- Use the connections you already have to deepen partnerships with potential partner organizations
- Make your connections with potential organizational partners and participants face-to-face
- Be mindful of mistrust that may exist, and be patient to grow the relationship
- Get the key players – for example the facilitators – involved as early as possible.
- Understand where the population gets their funding from now to deliver this health promotion message
- Call your program something creative – not "Stroke prevention education"

Group Program Development and Implementation

- Tailor program materials and approaches to people's cultural beliefs and traditions – this may involve throwing away preconceived notions on how a health promotion program "should" look. *"We might have all our information ready, only to be told that we had to tip it upside down."*
- Adapt traditional health promotion tools to be more culturally appropriate - for example, the Stanford action plan sheet adapted to the aboriginal medicine bag
- Use aboriginal facilitators to advise on and deliver program content – and be prepared to pay them for their time and efforts
- Do not expect people to sign up in advance – count on people who have relationships of trust with potential participants to invite them in person. "*The attitude is, don't plan for way down the road, because you don't know what is going to happen. I don't want to promise that I am going to come, because I don't want to break my promise."*
- Expect people to attend programs in family units, with children, parents, grandparents. In aboriginal culture. In terms of childcare, *"They believe that mothers and grandmothers are providing quality child care. To insinuate otherwise, because they do not have college degrees, can be offensive."*
- Use visual teaching methods – for example culturally appropriate videos
- Use concrete take-aways (like medicine bags) rather than paper handouts
- Consider scheduling the session for two and a half hours, to reduce the rush from the meal
- Set up the room so people are encouraged to sit in a circle and engage in one conversation – remove extra tables
- Tell people in advance about blood pressure checks during the group program – make sure people are prepared and take away any element of surprise
- Do not neglect the opportunity to link and inform participants of what is going on at the health centre

Monitoring and Evaluating Results

- Consider people's literacy levels and that written evaluations may not be appropriate
- Use one on one interviews with as many participants as you can to get specific information on things like people's linkages to providers and their concerns about stroke
- Use a talking circle to understand what people have learned and how they are living it out

7. Conclusion

“Integrating Chronic Disease Prevention with Primary Care in South East Community Health Centres: Building Capacity in Primary Care for Reducing Risk of Stroke in High Risk Populations” achieved significant results for providers, clients and CHCs as a whole. The unique approaches of each of the four CHCs mean results are uneven, with each CHC having its distinctive strengths and challenges. As a result of the project, the majority of providers increased their awareness of community resources for stroke prevention as well as their referrals to CHC and community programs. Many participating clients made important lifestyle changes, especially in the area of healthy eating and physical activity. Clients who embraced a self-management approach and had the support of their health care providers were spurned on to make these changes. The effective outreach to the aboriginal population in Kingston and the development of a culturally appropriate health promotion program was a particular highlight, with rich learning for other CHCs. The most enduring impact of the project is in CHCs who have had consistent upper management support, have engaged primary care providers from the start, have taken an integrated approach, and have empowered nurses with time and resources to work more intentionally as health promoters.

Appendix A - Project Evaluation Tools

1. Pre- and Post- Provider Survey

The pre- and post- provider survey was given to providers at the beginning and end of the project. The survey asked providers about their awareness of risk factors and community prevention resources, as well as their typical practice in response to risk factors with their clients.

The survey was completed by a variety of providers including physicians, nurse practitioners, registered nurses, social workers, dieticians and so on. The numbers of completed provider surveys are below:

Site	Pre- Provider Survey Completed November 2008	Post- Provider Survey Completed March/April 2010
Country Roads CHC	13	12
Gateway CHC	9	11
Kingston CHC	12	9
Merrickville CHC	9	11
Total	**43**	**43**

The pre-provider survey and the post-provider survey are not identical. Therefore, they cannot be validly compared. For example, the pre- survey has one unique question and the post- survey has two unique questions. Each tool uses different categories/language to distinguish service providers. The pre-survey has several opportunities to provide open ended comments, while the post- survey has none. And perhaps most significantly, the answer response options are different in each tool. As a result, the pre- and post- provider surveys have limited value in terms of evaluating project outcomes.

Results of the pre- and post- provider survey are in Appendix C.

2. Pre- and Post- Client Surveys

The client survey (see Appendix D) monitored self-reported knowledge and behavior in four areas: healthy eating, physical activity, health status, and habits/social well being. The survey was given to a client when they first entered the project, and when they were completed project activities. The tool was not used at the Kingston CHC, but was used at Country Roads (10), Gateway (20) and Merrickville (5) CHCs.

The client survey has limited value when trying to judge overall project effectiveness for several reasons. First, it was completed by just over a quarter of project participants (35 out of 123 participants). Second, results of client surveys have been rolled up into site totals and thus cannot be analysed on a one to one basis. Finally, the way the client survey is designed, it cannot be analysed to produce a percentage of clients who report increased awareness of risk factors and access to resources, as envisaged in the project's draft evaluation framework.

3. Intervention Summary

The intervention summary (see Appendix E) was a chart created by the project to track impact on clients. The chart included information on whether or not the client was screened, if risk factors were identified and information was distributed, if the client was formally engaged (self-management goals

set, attend group, attend clinic etc.), if the client was referred to a CHC program or another community resource, and if the client had implemented lifestyle change or had their risk factor reduced.

The tool was used unevenly in the project – for example, fully and with individual client details at Merrickville CHC, fully with limited detail at Country Roads CHC, modified and with the first round of clients only at Gateway, and not at all at Kingston CHC. As a result, it is not possible to roll up results of the intervention summary to get a full picture of the project. As designed, the tool is more useful as a "check list" for health promotion champions rather than a robust record of project outcomes.

Appendix B – Interview Guides

Interview Questions for Coordinators

1. In your own words, how would you describe the project's main goal?
2. How effective do you believe the project has been at achieving this goal?
3. How has the project changed the way you and others at your CHC both understand and do "health promotion" in your daily work?
4. In your view, what have been the greatest strengths of the project?
5. In your view, what have been the greatest weaknesses of the project's approach?
6. If you could do the project all over again in your CHC, what would you change? Consider the project's design, implementation and monitoring.
7. What recommendations do you have for improving community supports and opportunities for clients at high risk of stoke?
8. Funding for this project is now officially over. What activities and approaches will continue? What will not?
9. What advice would you give to another CHC in a different context who is beginning a similar project?

Interview Questions for Primary Care Providers

1. In your own words, how would you describe the project's main goal?
2. How effective do you believe the project has been at achieving this goal?
3. How has the project changed the way you screen clients to identify people at high risk for developing chronic disease including stroke?
4. How has the project changed the way you give education and counseling to your high-risk clients about the importance of reducing risk of chronic diseases (for example, education about healthy diet and weight, healthy activity and exercise, smoking cessation, responsible alcohol use etc.)?
5. How was the project changed the way you connect clients to appropriate resources in the CHC and your broader community that help reduce risk of chronic disease?
6. Has the project helped you identify barriers and challenges that may prevent clients from accessing ongoing self-care/health promotion programming? If so, how?
7. What recommendations do you have for improving community supports and opportunities for clients at high risk of stoke?
8. As you know, there are various modifiable risk factors for stroke. Among care providers, results of the project survey show that there is more hesitation to discuss alcohol abuse with clients than any other risk factor. Does this resonate with your experience? Why do you think this might be so?
9. How has the project changed the way you and others at your CHC both understand and do "health promotion" in your daily work?
10. What advice would you give to another CHC in a different context who is beginning a similar project?

Interview Questions for Clients

1. How you are involved in this community health centre?
2. As you might know, you've been involved in a stroke prevention project that the health centre is doing. Can you tell me how you first got connected to the project?
3. What are the most helpful things you have learned about how you can improve your own health and prevent having a stroke?
4. Over the past year, have you made any changes in your own life – for example to what you eat, how you are physically active, how you drink or smoke - as a result of your involvement with the health centre on stroke prevention? If so, what?

5. Have people at the health centre introduced or connected with other community programs, activities or supports to help you make these changes? If so, what has your experience been like with these programs?
6. What do you **like best** about the way this health centre worked with you to improve your own health and prevent strokes?
7. What did you **not like** about the way this health centre worked with you to improve your own health and prevent strokes?
8. Thinking not just about your own experience, but about everyone…in your opinion, what do you think is the most important thing a health centre can do to help other people improve their health and prevent strokes?

Interview Questions for KCHC Aboriginal Project Facilitators/Coordinator

1. In your own words, how would you describe your project's main goal?
2. How effective do you believe the project has been at achieving this goal?
3. Describe some of the challenges you have faced in engaging the aboriginal population in and around Kingston.
4. What have been the most effective strategies you have used to engage the aboriginal population?
5. In your view, what have been the greatest strengths of the project?
6. In your view, what have been the greatest weaknesses of the project?
7. If you could do the project all over again in your CHC, what would you change?
    - At the project design level
    - At the project implementation level
    - At the project monitoring level.
8. How effective has the project been at improving outcomes/reducing risk for aboriginals at high risk of stroke or chronic disease? How do you know?
9. What recommendations do you have for improving community supports and opportunities for aboriginal clients at high risk of stoke?
10. Funding for this project is now officially over. What activities, approaches and connections will continue in the coming months and years? What will not?
11. How has your experience in this project changed the way you and others at your CHC both understand and do health promotion in your daily work?
12. What advice would you give to another CHC in a different context who is beginning a similar project?

Appendix C – Results of Pre- and Post- Provider Surveys

Stroke Identification Prevention Survey POST

1. Overall, how aware were you of the eight modifiable risk factors for chronic disease prior to reviewing the list in the inset today?

	Response Percent	Response Count
not at all aware	2.3%	1
somewhat aware	27.9%	12
fully aware	69.8%	30
answered question		43
skipped question		0

2. Overall, how aware were you, prior to reviewing the list in the inset today, of the main population groups (especially the four racial groups) at increased risk for chronic disease?

	Response Percent	Response Count
not at all aware	4.7%	2
somewhat aware	55.8%	24
fully aware	39.5%	17
answered question		43
skipped question		0

3. How aware are you of the community prevention resources and supports related to health promotion and primary prevention of chronic disease available to your clients?

	Response Percent	Response Count
not at all aware	0.0%	0
somewhat aware	55.8%	24
fully aware	44.2%	19
answered question		43
skipped question		0

4. Overall, how often do you discuss and recommend community prevention programs and supports to your clients with chronic disease risk factors (ie smoking, alcohol use, physical inactivity and unhealthy nutrition)?

	Response Percent	Response Count
always	23.3%	10
often	53.5%	23
sometimes	20.9%	9
rarely/never	2.3%	1
answered question		43
skipped question		0

6. If smoking is a risk factor for my clients, I evaluate their willingness to quit:		
	Response Percent	Response Count
always	34.9%	15
often	53.5%	23
sometimes	9.3%	4
rarely/never	0.0%	0
answered question		43
skipped question		0

8. If obesity is a risk factor for my clients, I evaluate their willingness to lose weight:		
	Response Percent	Response Count
always	18.6%	8
often	62.8%	27
sometimes	16.3%	7
rarely/never	0.0%	0
answered question		43
skipped question		0

7. If low physical activity is a risk factor, I evaluate their willingness to increase activity:

	Response Percent	Response Count
always	30.2%	13
often	55.8%	24
sometimes	11.6%	5
rarely/never	0.0%	0
answered question		43
skipped question		0

8. If alcohol abuse is a risk factor, I evaluate their willingness to reduce or stop drinking:

	Response Percent	Response Count
always	27.9%	12
often	39.5%	17
sometimes	16.3%	7
rarely/never	14.0%	6
answered question		43
skipped question		0

8. If high blood pressure is a risk factor, I evaluate their willingness to work with lifestyle changes and medication to help:

	Response Percent	Response Count
always	44.2%	19
often	41.9%	18
sometimes	9.3%	4
rarely/never	2.3%	1
answered question		43
skipped question		0

10. As a result of the stroke prevention project, I am more aware of community resources available to support clients to implement lifestyle changes:

	Response Percent	Response Count
More aware	69.8%	30
No change	27.9%	12
answered question		43
skipped question		0

11. As a result of the stroke prevention project, I have made more referrals to CHC programs or community resources to support clients to implement lifestyle changes:

	Response Percent	Response Count
More referrals	64.3%	27
No change	33.3%	14
answered question		42
skipped question		1

12. This survey was completed by a service provider at:

	Response Percent	Response Count
Country Roads Community Health Centre	27.9%	12
Gateway Community Health Centre	25.6%	11
Kingston Community Health Centres	20.9%	9
Merrickville District Community Health Centre	25.6%	11
answered question		43
skipped question		0

13. This survey was completed by a:

	Response Percent	Response Count
Health promoter	4.9%	2
Registered Public Health Nurse	7.3%	3
Physician	19.5%	8
Nurse Practitioner	22.0%	9
Registered Nurse	26.8%	11
Social Worker	7.3%	3
Respiratory Therapist	4.9%	2
RD	7.3%	3
answered question		41
skipped question		2

14. Other written comments	
	Response Count
	10
answered question	10
skipped question	33

Indicator: % of Men over age 40 with a BP measurement in a 24 month period

Description of indicator: % of men over 40 years of age who had a blood pressure measured and recorded in a 24 month period.

Criteria: result comment (contains BP); encounter date (between begin date and end date); result code refid (equal to 30640); gender (equal to male); age (greater than 40); status (equal to active); resource type (physician or NP)

Timeframe: 24 month period - April 1, 2008 to March 31, 2010

Numerator: Primary care male clients, with an active status, over 40 years of age who had a BP measurement recorded in a clinical note using Purkinje.

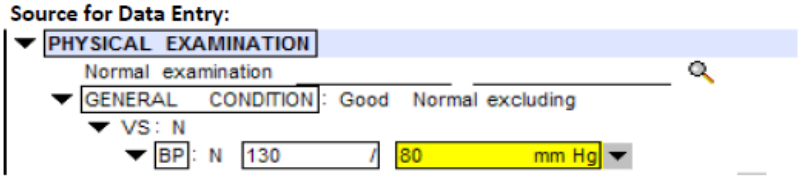
Denominator: Primary care male clients, with an active status, over 40 years of age.

Calculation: Numerator divided by denominator times 100.

Inclusion Criteria: Active, primary care male clients over 40 years of age with a recorded BP in a 24 month period.

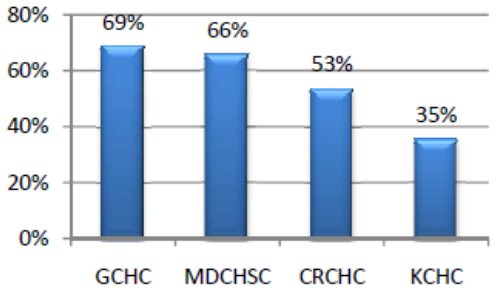
Exclusion Criteria: Non-primary care male clients, male clients 40 years of age and less, all female clients; all inactive clients and clients who are solely registered to a personal development group or community initiative.

Source for Data Entry:



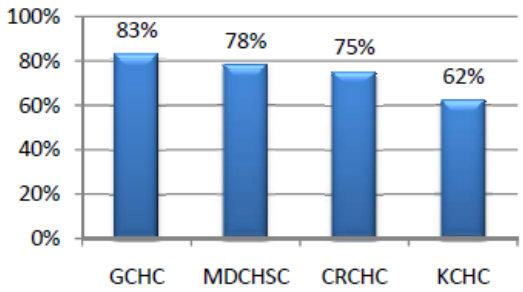
Timeframe: Oct 1 2007 to Sept 30 2009

	Num	Den	YTD
GCHC	758	1104	69%
MDCHSC	741	1131	66%
CRCHC	567	1063	53%
KCHC	324	918	35%



Timeframe: April 1 2008 to March 31 2010

	Num	Den	YTD
GCHC	859	1041	83%
MDCHSC	818	1052	78%
CRCHC	723	969	75%
KCHC	445	715	62%



Additional Notes/ Impact Analysis:

Results have increased for all CHC's as a result of two main factors:

1) as of April 1st, 2009 SE CHC's were recording notes electronically (BP and obesity information) and

2) improvements have been made to the denominator in the query from the previous indicator report. Previously the denominator was based on all CHC clients. For this report we restricted it to primary care clients only. i.e registered to a NP or physician.

Reporting Issues Identified:

KCHC and MDCHSC have an NP that registers early years and street health clients as well. In the future we need to determine a way to exclude those clients. In addition, a large portion of clients visiting the Street Health Centre are there for crisis intervention only and general assessment/vital signs. Due to the nature of the clientele and services offered BP and other vital signs are not taken.

Indicator: % of Woman over age 50 with a BP measurement in a 24 month period

Description of indicator: % of women over 50 years of age who had a blood pressure measured and recorded in a 24 month period.
Criteria: result comment (contains BP); encounter date (between begin date and end date); result code refid (equal to 30640); gender (equal to female); age (greater than 50); status (equal to active), resource type (physician or nurse practitioner)

Timeframe: 24 month period - April 1, 2008 to March 31, 2010

Numerator: Primary care female clients, with an active status, over 50 years of age who had a BP measurement recorded in a clinical note using Purkinje.

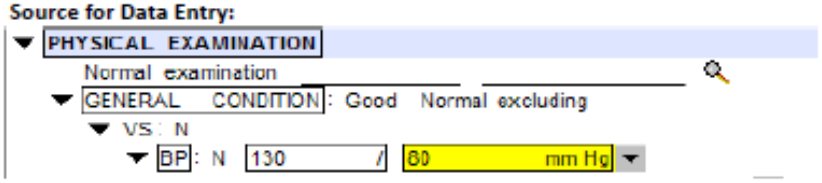
Denominator: Primary care female clients, with an active status, over 50 years of age.

Calculation: Numerator divided by denominator times 100.

Inclusion Criteria: Active, primary care female clients >50 years of age with a recorded BP in a 24 month period.

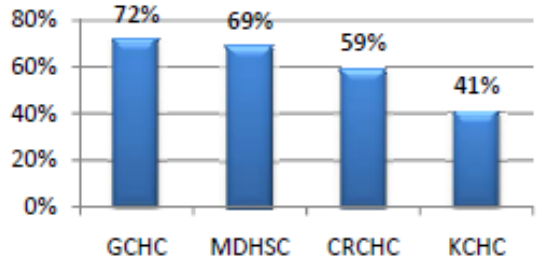
Exclusion Criteria: Active, non primary care female clients, clients 50 years of age and less, male clients; all inactive clients, and

Source for Data Entry:



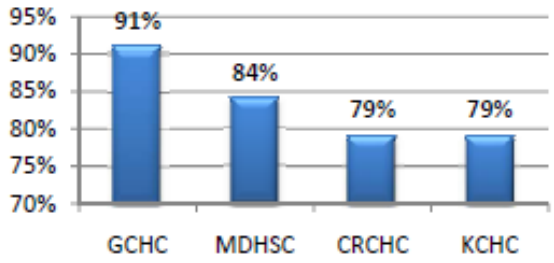
Timeframe: Oct 1 2007 to Sept 30 2009

	Num	Den	YTD
GCHC	667	922	72%
MDCHSC	739	1069	69%
CRCHC	563	962	59%
KCHC	289	705	41%



Timeframe: April 1 2008 to March 31 2010

	Num	Den	YTD
GCHC	753	827	91%
MDHSC	787	936	84%
CRCHC	677	853	79%
KCHC	353	446	79%



Additional Notes/ Impact Analysis:

Results have increased for all CHC's as a result of two main factors:

1) as of April 1st, 2009 SE CHC's were recording notes electronically (BP and obesity information) and

2) improvements have been made to the denominator in the query from the previous indicator report. Previously the denominator was based on all CHC clients. For this report we restricted it to primary care clients only. i.e registered to a NP or

Reporting Issues Identified:

KCHC and MDCHSC have an NP that registers early years and street health clients as well. In the future we need to determine a way to exclude those clients. In addition, a large portion of clients visiting the Street Health Centre are there for crisis intervention only and general assessment/vital signs. Due to the nature of the clientele and services offered BP and other vital signs are not taken.

Indicator: % of Men over age 40 with a lipid profile in a 24 month period

Description of indicator: % of men over 40 years of age who had a lipid profile measured and recorded in a 24 month period.

Criteria: resultcode description ml1 (contains HDL); result creation date time (between begin date and end date); gender (equal to male); age (greater than 40); status (equal to active), resource type (physician or nurse practitioner)

Timeframe: 24 month period - April 1, 2008 to March 31, 2010

Numerator: Primary care male clients, with an active status, over 40 years of age who had a lipid profile measured and recorded in a clinical note using Purkinje.
Denominator: Primary care male clients, with an active status, over 40 years of age.
Calculation: Numerator divided by denominator times 100.

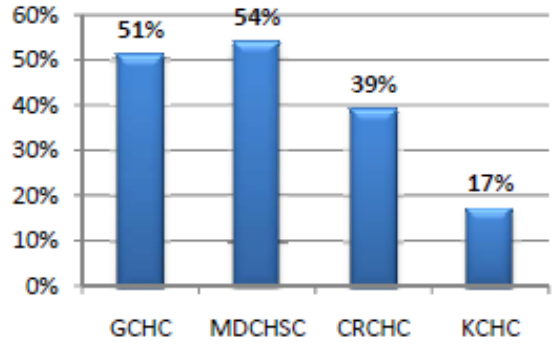
Inclusion Criteria: Active primary care male clients over 40 years of age with a recorded lipid profile in a 24 month period.

Exclusion Criteria: Non-primary care male clients, 40 years of age and less, with or without a lipid profile in a 24 month period; all female clients; all inactive clients.

Source for Data Entry: Based on HL7 Lab Data received electronically from MDS or entered manually.

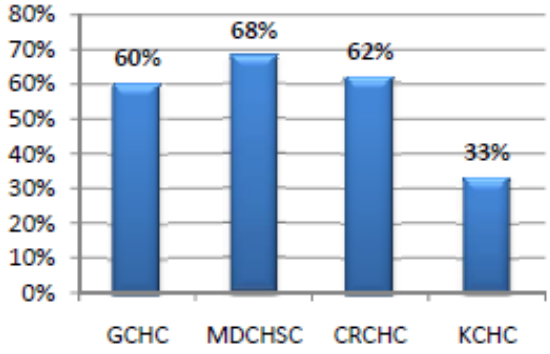
Timeframe: Oct 1 2007 to Sept 30 2009

	Num	Den	YTD
GCHC	564	1104	51%
MDCHSC	608	1131	54%
CRCHC	413	1063	39%
KCHC	158	918	17%



Timeframe: April 1 2008 to March 31 2010

	Num	Den	YTD
GCHC	622	1041	60%
MDHSC	715	1052	68%
CRCHC	600	969	62%
KCHC	238	715	33%



Additional Notes/ Impact Analysis:

Results have increased for all CHC's as a result of two main factors:

1) as of April 1st, 2009 SE CHC's were recording notes electronically (BP and obesity information) and

2) improvements have been made to the denominator in the query from the previous indicator report. Previously the denominator was based on all CHC clients. For this report we restricted it to primary care clients only. i.e registered to a NP or physician.

Reporting Issues Identified:

KCHC and MDCHSC have an NP that registers early years and street health clients as well. In the future we need to determine a way to exclude those clients. In addition, a large portion of clients visiting the Street Health Centre are there for crisis intervention only and general assessment/vital signs. Due to the nature of the clientele and services offered BP and other vital signs are not taken.

KCHC started using eLabs in July 2009 and the Street Health Centre only started using eLabs April 2010. Going forward results based on eLabs will improve.

Indicator: % of Woman over age 50 with a lipid profile in a 24 month period

Description of indicator: % of women over 50 years of age who had a lipid profile measured and recorded in a 24 month period.

Criteria: resultcode description ml1 (contains HDL); result creation date time (between begin date and end date); gender (equal to female); age (greater than 50); status (equal to active), resource type (physician or nurse practitioner).

Timeframe: 24 month period - April 1, 2008 to March 31, 2010

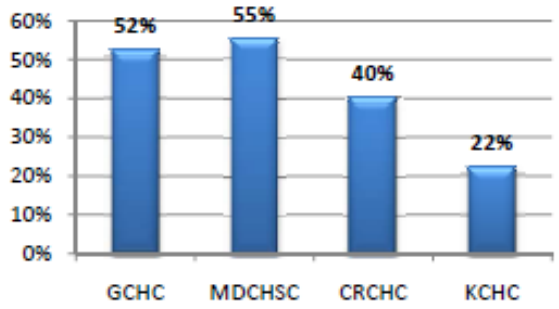
Numerator: Female clients, with an active status, over 50 years of age who had a lipid profile measured and recorded in a clinical note using Purkinje.
Denominator: Female clients, with an active status, over 50 years of age.
Calculation: Numerator divided by denominator times 100.

Inclusion Criteria: Active, female clients over 50 years of age with a recorded lipid profile in a 24 month period.
Exclusion Criteria: Female clients 50 years of age or less, with or without a lipid profile in a 24 month period; all male clients; all inactive clients.

Source for Data Entry: Based on HL7 Lab Data received electronically from MDS or entered manually.

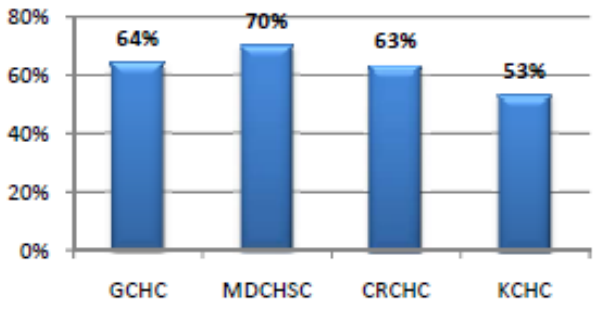
Timeframe: Oct 1 2007 to Sept 30 2009

	Num	Den	YTD
GCHC	475	922	52%
MDCHSC	590	1069	55%
CRCHC	387	962	40%
KCHC	157	705	22%



Timeframe: April 1 2008 to March 31 2010

	Num	Den	YTD
GCHC	528	827	64%
MDHSC	654	936	70%
CRCHC	537	853	63%
KCHC	238	446	53%



Additional Notes/ Impact Analysis:

Results have increased for all CHC's as a result of two main factors:

1) as of April 1st, 2009 SE CHC's were recording notes electronically (BP and obesity information) and

2) improvements have been made to the denominator in the query from the previous indicator report. Previously the denominator was based on all CHC clients. For this report we restricted it to primary care clients only. i.e registered to a NP or physician.

Reporting Issues Identified:

KCHC and MDCHSC have an NP that registers early years and street health clients as well. In the future we need to determine a way to exclude those clients. In addition, a large portion of clients visiting the Street Health Centre are there for crisis intervention only and general assessment/vital signs. Due to the nature of the clientele and services offered BP and other vital signs are not taken.

KCHC started using eLabs in July 2009 and the Street Health Centre only started using eLabs April 2010. Going forward results based on eLabs will improve.

Indicator: Clients over age 18 with obesity screening in 24 month period

Description of indicator: % of clients over 18 years of age who had obesity screening done and recorded in a 24 month period.

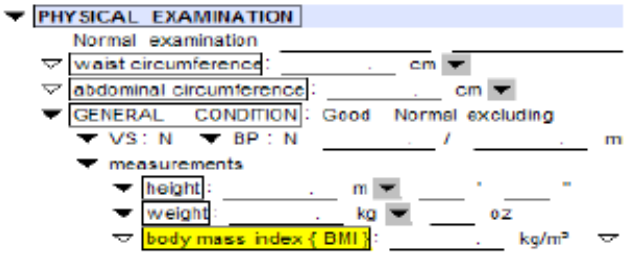
Criteria: resultcode description ml1 (contains abdominal circumference); result comment (contains body mass or waist); date range (between begin date and end date); age (greater than 18); status (equal to active), resource (NP or Physician.

Timeframe: 24 month period - April 1, 2008 to March 31, 2010

Numerator: Primary care Clients, with an active status, over 18 years of age who had obesity screening done and recorded in a clinical note using Purkinje.
Denominator: Primary care clients, with an active status, over 18 years of age.
Calculation: Numerator divided by denominator times 100.

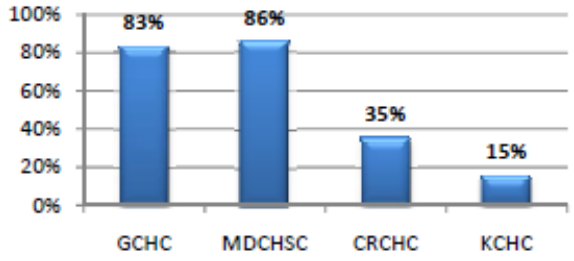
Inclusion Criteria: Active, clients over 18 years of age with recorded obesity screening in a 24 month period .
Exclusion Criteria: Active, clients, 18 years of age and less, with or without obesity screening in a 24 month period; all inactive clients.

Source for Data Entry:



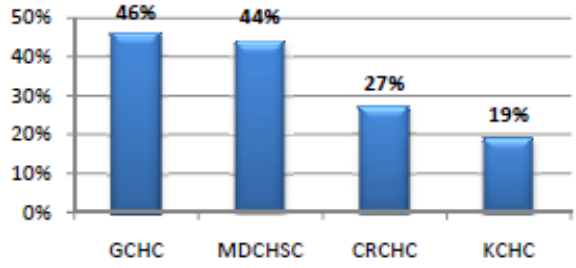
Timeframe: Oct 1 2007 to Sept 30 2009

	Num	Den	YTD
GCHC	2458	2946	83%
MDCHSC	3410	3959	86%
CRCHC	965	2752	35%
KCHC	432	2873	15%



Timeframe: April 1 2008 to March 31 2010

	Num	Den	YTD
GCHC	1369	2991	46%
MDHSC	1551	3491	44%
CRCHC	740	2,767	27%
KCHC	559	2884	19%



Additional Notes/ Impact Analysis:
Results have decreased at GCHC, MDCHSC and CRCHC. The previous query reported in November referred to the total number of visits for obesity screening in the numerator, therefore the results were inflated. SEISUG modified to query so it only extracted unique primary care clients that received obesity screening, therefore new results are more accurate.

Reporting Issues Identified:
KCHC and MDCHSC have an NP that registers early years and street health clients as well. In the future we need to determine a way to exclude those clients. In addition, a large portion of clients visiting the Street Health Centre are there for crisis intervention only and general assessment/vital signs. Due to the nature of the clientele and services offered BP and other vital signs are not taken.

Appendix D – Client Survey

Self Rank Your Lifestyle & Well Being

Healthy Eating	Not True	Rarely True	Neutral	Somewhat True	Very True
I choose high fibre foods often	☐	☐	☐	☐	☐
I watch my portion sizes most of the time	☐	☐	☐	☐	☐
I limit the amount of fat I eat	☐	☐	☐	☐	☐
I incorporate fruit and vegetables into my diet	☐	☐	☐	☐	☐
I am aware of my sodium/salt intake and it is at a healthy level	☐	☐	☐	☐	☐
I am aware of and follow Canada's food guide	☐	☐	☐	☐	☐
Physical Activity					
I Participate in physical activity 5 times a week (other than daily work)	☐	☐	☐	☐	☐
When I am active, it is for at least 15-20 minutes continuously	☐	☐	☐	☐	☐
I plan my day to include physical activity	☐	☐	☐	☐	☐
I try to improve my fitness level	☐	☐	☐	☐	☐
Health Status					
I am aware of my blood pressure	☐	☐	☐	☐	☐
I know my target blood pressure	☐	☐	☐	☐	☐
I know my blood cholesterol levels	☐	☐	☐	☐	☐
I know my target blood cholesterol levels	☐	☐	☐	☐	☐
I have been tested for diabetes	☐	☐	☐	☐	☐
I am at a healthy body weight	☐	☐	☐	☐	☐
I am aware of my medical family history	☐	☐	☐	☐	☐
Habits / Social Well being					
I am smoke free	☐	☐	☐	☐	☐
I am aware of healthy alcohol consumption guidelines	☐	☐	☐	☐	☐
I follow healthy alcohol consumption guidelines	☐	☐	☐	☐	☐
I know when I am under stress	☐	☐	☐	☐	☐
I can cope with stress in a positive way	☐	☐	☐	☐	☐
I have a stable income and adequate food and housing	☐	☐	☐	☐	☐
I am a positive Healthy role model for my family and friends	☐	☐	☐	☐	☐
I have a network of support in my family and friends	☐	☐	☐	☐	☐

Appendix E – Intervention Summary

Date	Client #	Screened	Risk Factor Identified	Information Tool kit distributed	Formally engaged SM Goals set, attend group, attend clinic etc	Referred to CHC program (list)	Referred to community resource (list)	Lifestyle Change Implemented	Risk Factor Reduced