

Executive Summary

In the spring of 2001, the Ontario Prevention Clearinghouse provided support from the Stroke Initiative, funded by the Ministry of Health and Long-Term Care (MOHLTC), for the development of the Ontario Heart Health Network's (OHHN) Continuation Working Group (CWG). The CWG was to include members of the OHHN Working Group as well as representation from various groups connected with the current Ontario Heart Health Program (OHHP) and/or chronic disease prevention.

The Continuation Working Group realized that the renewal of the OHHP funding was, in fact, an opportunity to take a bold step forward and proposed that the OHHP coalitions become a stable part of a more co-ordinated system to prevent chronic disease. The elements of this system are already in place. What are required are vision, co-ordination and stability. Such a system would be a world-leading innovation and could dramatically improve the health of Ontarians.

Due to strong and visionary leadership from governmental and non-governmental sectors, Ontario currently has a remarkable array of programs and initiatives targeted at chronic disease prevention. These elements could be even more effective, if they were less fragmented and functioned as part of a single system. The Continuation Working Group proposes a vision to build on our current situation and strengths in Ontario. This system would have provincial and local elements and would take a multi-factorial, multi-sectoral approach, based on partnerships and co-ordination among stakeholders.

Background

Heart Health Networks in thirty-seven regions across the province have developed and continue to develop innovative strategies and resources in physical activity, healthy eating and smoke-free living. Across numerous communities a common concern expressed is that disease-based initiatives can result in separate networks and initiatives for each specific disease. At the local level, it is the same people who come to each of the tables, working with the same risk factors.

As we move into the final year of the OHHP, we have the opportunity to assist in the development of a more co-ordinated system for chronic disease prevention that would provide effective use of our resources, avoid duplication and avoid overburdening community partners. The OHHP involves partners at the local and provincial levels including the public health units and community partners and a number of provincial partners.

Public Health Units

- perform a strong role in OHHP;
- report that heart health promotion was a high priority in 2000 (72% of health units);
- that have "very well co-ordinated" heart health activities increased from 45% to 75% between 1997 and 2000; and
- are supported in their chronic disease prevention mandatory program requirements by OHHP activities.

Community Stakeholders

- represent diverse backgrounds and expertise across the province;
- currently number 2,500 participating as partners; and
- require ongoing recruitment and strategies in order to maintain active participation and ensure coalition functioning.

Provincial stakeholders include the following:

- Ministry of Health and Long-Term Care;
- Provincial and Community programs and partners;
- Ontario Health Promotion Resource System (OHPRS) including the Heart Health Resource Centre (HHRC);
- Non-governmental Organizations (NGOs); i.e., Heart and Stroke Foundation;
- Ontario Heart Health Network; and
- Heart Health Provincial Partners Committee.

A number of provincial prevention strategies have been developed or are in the process of being developed to provide a framework for initiatives. Many of these strategies are being implemented at the community level through Heart Health Networks.

Stroke Strategy
 Diabetes Strategy
 Physical Activity Strategy

Cancer Prevention Strategies
 Ontario Tobacco Strategy
 Nutrition Strategy

Assumptions

If the heart health coalitions shut down in 2003 because of lack of funding, it would be difficult to recreate these coalitions at a later date; some of the demonstration project sites had difficulty recruiting partners after the HHAP funding stopped. The heart health coalitions and networks are needed to accomplish the provincial prevention strategies that have been developed or are being developed (nutrition, tobacco, diabetes etc.).

Guiding Principles

Discussion of Guiding Principles

A community-based delivery system for the prevention of chronic disease would include the following:

<p>Comprehensive community approaches that would be planned and implemented through local and provincial partnerships involving key stakeholders in a single co-ordinated system.</p>	<p>Community coalitions work with the cube that includes multiple risk factors, multiple approaches and multiple channels.</p> <p>We work with a broad range of partners (more than 2500 across the province).</p> <p>Delivery at the local level is important because Ontario communities are very diverse - each community is best able to determine what will work in their community.</p> <p>In order to do our best with limited resources, we want a single co-ordinated system at the local level (instead of separate coalitions for each strategy).</p>
<p>Primary prevention of disease and promotion of healthy living as the focus.</p>	<p>We will continue to focus on healthy lifestyles and primary prevention that addresses more than one chronic disease; e.g., heart health, stroke prevention etc.</p>

Local delivery systems that are supported by a provincial system.	The skills and capacity of the OHPRS is a valuable support to local coalitions. OHPRS is a group of resource centres that includes the Heart Health Resource Centre, The Health Communications Unit, the Ontario Prevention Clearinghouse etc.
Stable partnership arrangements between the province, provincial organizations and local communities.	Investment in partnerships has occurred at many levels. In order to have a stable system there needs to be continued partnership development between the province, provincial organisations and local communities.
Evidence-based approaches and innovation for continuing success.	Work that is based on good science forms the foundation of our work, yet we can continue to be creative and try new ways to respond to the needs of our communities.
Mutual accountability of communities and partners.	Coalitions need to have concise, realistic ways to obtain meaningful feedback about program goals. With limited resources, evaluation demands need to be balanced with other program responsibilities.
Integrated programs and messages within communities to deliver all chronic disease prevention strategies.	Coalitions can be a channel for multiple disease prevention strategies. Coalitions themselves would decide whether they would be able to expand. They would base their decision on the prevalence of the disease in that community, ability to mobilize and involve partners and community interest. Funds and supports need to be in place to foster and support the increased activity.

Key Elements and Recommendations

In the short term, the CWG requests that

- MOHLTC fund a sixth year of OHHP to prevent coalitions from winding down during the review of this proposal and completion of the program evaluation;
- A Chronic Disease Steering Committee be formed to plan and advise MOHLTC (recommendation 1);
- A working group be formed to research and develop recommendations about staffing especially the role of co-ordinator (recommendations 9 and 16); and
- A working group be formed to recommend ongoing reporting and evaluation requirements and develop user friendly tools (recommendations 5 and 12).

Overall, the Continuation Working Group recommends

1. The formation of a Chronic Disease Prevention Steering Committee to provide an equitable balance between the voices of community coalitions and provincial bodies.
2. The central technical support (e.g., training and consultation) provided by the Ontario Health Promotion Resource System (OHPRS) be maintained as an essential service to communities.

3. That OHPRS co-ordinate central program development (including the possibility of media campaigns) and disseminate prevention programs.
4. The use of a provincial brand for all centrally developed programs.
5. The development and use of a central activity reporting form that can be completed on-line to provide information about program activities to local communities and the Ministry. This form would replace the current system.
6. That MOHLTC develop a chronic disease health promotion strategy for Ontario to encompass the prevention components for cardiovascular disease (CVD), stroke, diabetes and cancer, while integrating the physical activity, tobacco and nutrition strategies.
7. The continuation of community coalitions as the base from which to plan and implement primary prevention of chronic disease initiatives.
8. That health departments, supporting community coalitions working in chronic disease prevention and health promotion, function in a stewardship role.
9. A problem-solving process to clarify the human resources requirements after 2003. This would include information about the co-ordinator role, administration/secretarial needs for the coalition, and the support needs of local NGOs and other partners.
10. The continuing development of regional networks to provide peer mentoring to community coalitions.
11. Continuing the joint planning process developed in the OHHP using a two-year planning cycle.
12. Designing a constructive evaluation process for local disease prevention programs.
13. Clarification of the roles and responsibilities of the major partners working at the local level.
14. Long term, stable funding from the MOHLTC to community coalitions engaged in health promotion. Stable funding enables a continuous and seamless transition to chronic disease prevention.
15. Continuation of the current level of in-kind contribution requirements.
16. That MOHLTC explore alternative funding models for the local co-ordinator as determined through a consultation process.
17. The availability of small funding grants to local communities engaged in innovative health promotion or disease prevention initiatives that target a specific disease (e.g., stroke) and may have the potential for provincial distribution.

1.0 BACKGROUND

In 1998, the Community and Health Promotion Branch and Public Health Branch of the Ministry of Health and Long-Term Care implemented the Ontario Heart Health Program to address the leading modifiable risk factors associated with cardiovascular disease. The OHHP is a five-year province-wide program with a budget of 3.4 million per year. Communities are required to provide \$2 of in-kind contributions for every \$1 of provincial funding. The funds are used by heart health community partnerships to plan and implement comprehensive, population-based chronic disease prevention and health promotion initiatives.

In response to a Ministry request, heart health programs in 37 local communities became involved in a sustainability planning exercise. Each community was required to submit a sustainability plan in March 2001 along with their Annual Activity Plans for 2001/2002. During sustainability training workshops, provided by the HHRC, and follow-up discussions on sustainability issues, members of the Ontario Heart Health noted that sustainability planning also needed to be on the agenda of provincial organizations interested in heart health. The link between sustainability at a local and provincial level could not be developed in isolation of each other.

The OHHN prepared a letter of intent proposing a framework from which a collaborative planning process could occur between local communities, provincial organizations and the Ontario Ministry of Health and Long-Term Care, all of whom have a vested interest in decreasing the burden from cardiovascular disease in this province. Members of the OHHN, based on input and consultation with the network collective, local communities and some partner organizations, developed a proposal.

In the spring of 2001, the Ontario Prevention Clearinghouse provided funding from the Stroke Initiative, funded by the Ministry of Health and Long-Term Care, to support the planning and implementation of the Continuation Working Group initiative. The CWG was to include members of the OHHN Working Group as well as representation from various groups connected with the current Ontario Heart Health Program and/or chronic disease prevention.

Continuation Working Group Mandate

The Ontario Heart Health Network mandated the Continuation Work Group to

- Propose ways to ensure the continuation and enhancement of the Ontario Heart Health Program currently being delivered by the Province of Ontario, local public health units and heart health coalitions beyond 2003;
- Identify ways to build sustainable partnerships between local health units, local heart health coalitions and the Ministry of Health and Long-Term Care; and
- Propose strategies incorporating stroke prevention within the OHHP in the short term and chronic disease prevention (i.e., cancer and diabetes) over the long term.

2.0 INTRODUCTION AND ASSUMPTIONS

As the Continuation Working Group began its work, it noted the following developments:

- The province was developing chronic disease strategies, notably for cancer, stroke, diabetes and asthma. Each of these strategies had a preventive component. Despite considerable overlap in the content of these preventive components, there was a tendency developing to have separate funding, infrastructure and accountability within each strategy. The mechanisms to resource and deliver these preventive components at the local level were not well worked out;
- A number of provincial Health Promotion Resource Centers were moving to more closely co-ordinate their activities into a single system;
- The province had a mature tobacco control strategy and was in the process of developing nutrition and physical activity strategies following similar models;
- The Ontario public health system through its Mandatory Health Programs and Services Guidelines had a mandate to develop and deliver a Chronic Disease Prevention Program; and
- Through the OHHP, there were in place 37 community coalitions to foster local partnerships to prevent heart disease and promote heart health.

In short, there exist at present, in Ontario, innovative strategies and resources to prevent chronic disease. These strategies have tended to be disease-based, and have resulted in a somewhat fragmented approach at the local level.

The Continuation Working Group realized that the renewal of the OHHP funding was, in fact, an opportunity to take a bold step forward and propose that the OHHP coalitions become a stable part of a more co-ordinated system to prevent chronic disease. The elements of this system are already in place. What are required are vision, co-ordination and stability. Such a system would be a world-leading innovation and could dramatically improve the health of Ontarians.

The underlying assumption of this report is that this is the direction in which the province of Ontario should be moving. Failure to renew the OHHP funding would be counterproductive to this direction. It would lead to increasing fragmentation and inefficiency at the local level. Termination of funding now would make it difficult, if not impossible, to recreate this local infrastructure at a later date.

This report will look first at the existing situation in the province of Ontario, with an emphasis on the Ontario Heart Health Program. It will then propose how these elements might be combined into a single chronic disease system, with the existing OHHP coalitions taking on an expanded mandate as a key element of the local infrastructure.

3.0 THE CURRENT SITUATION AND STAKEHOLDERS IN CHRONIC DISEASE PREVENTION IN ONTARIO

Local Stakeholders

Public Health Units

Public Health Units have performed a strong role in the OHHP. As part of the OHHP, 36 Boards of Health (public health system) and one hospital received funding to initiate the heart health program within their local communities.

Data from the provincial evaluation show that heart health promotion was a high priority within most (72%) of the health units in 2000. The priority given to heart health was sustained (55%) or increased (42%) from the previous year. Furthermore, in 1997, 45% of health units rated the level of co-ordination of heart health activities in the health unit as very well co-ordinated; in 2000, 75% rated the level of co-ordination as very well co-ordinated.² Heart Health Coalitions have become integrated into the work of the health units and have increased the capacity of health units.³

The Mandatory Health Programs and Services Guidelines (MHPSG) (MOHLTC, 1997), outline a variety of disease objectives, behavioral and policy objectives and requirements and standards for public health units. There are overlaps between the OHHP guidelines and the MHPSG, and many public health units are using their local OHHP activities to meet Chronic Disease Prevention MHPSG requirements.

Health Unit staff have mandated requirements and expertise to ensure high quality health promotion and primary prevention programming. Most ...community partners do not have the primary prevention mandate and many do not have the expertise. They rely on the Health Unit to be a leader and gatekeeper for quality programming.⁴

Community Stakeholders

The participation of community partners has been one key requirement in the OHHP. Community partners refers to volunteers and partner agencies from the community who participate in the heart health project. The stated expectation was that boards of health and their community partners would jointly develop the application and be actively involved in planning, implementing and evaluating the heart health project.⁵

Currently, the heart health coalitions involve approximately 2,500 local partners across the province including health units, voluntary health agencies, other coalitions/networks, education, recreation services and many more. The ongoing recruiting of volunteers and community partners and maintaining their active participation were identified as a two key issues for coalition functioning.⁶

² Results are from the provincial evaluation of the Ontario Heart Health Program, funded by the Ontario Ministry of Health and Long-Term Care.

³ Shea & company. Report on Community Capacity for Integration of Stroke Prevention in Selected Regions of Ontario, July 2001, 14.

⁴ Feedback from the Consultation Process: Review Guide for the Continuation Plan for 2003 and Beyond, January 2002.

⁵ Ontario Ministry of Health. Heart Health Program, Application Guidelines, 1997, 1.

⁶ Results are from the provincial evaluation of the Ontario Heart Health Program, funded by the Ontario Ministry of Health and Long-Term Care (Coalition Reflections).

Provincial Stakeholders

Ministry

The Community and Health Promotion Branch, the Public Health Branch and the Integrated Policy and Planning Division of the Ministry of Health and Long-Term Care provide leadership in health promotion and chronic disease prevention. MOHLTC engages in province-wide partnerships within the government and the not-for-profit sector, to ensure sound development of policies and programs in health promotion. The MOHLTC evaluates its system performance and supports communities with funding provincially and locally. Program development has evolved with other ministries such as the Ministry of Education, the Ministry of Citizenship, Culture and Recreation and the Ministry of Agriculture, Food and Rural Affairs to address health promotion and chronic disease prevention across sectors.

The MOHLTC was a key partner with provincial organizations and local communities in the design and implementation of the Ontario Heart Health Program. The OHHP builds on the public health system by providing funds to enable communities to work across sectors to address the risk factors associated with cardiovascular disease. The MOHLTC maintains its partnership at all levels to ensure its strategies continue to support corporate direction and the needs of Ontarians.

Provincial and Community Programs and Partners

Provincial and Community Programs are responsible for multiple-risk-factor health promotion programs and for developing the capacity of communities across the province to undertake health promotion and illness prevention initiatives. Programs include the following:

- The Ontario Heart Health Program is a \$17 million (\$3.4 million per year) provincial program to address the three leading modifiable risk factors (smoking, physical inactivity and unhealthy eating) associated with cardiovascular disease (see page 14);
- The FOCUS Community Program is a \$12 million (\$2.4 million per year) provincial program in 22 communities to prevent problems, including injuries, associated with alcohol and drug abuse. Preventing substance abuse among children and youth is a priority, with each project being asked to allocate one-third of their budget to activities directed at young people;
- The Health Promotion Program has the lead role for co-ordinating the Ontario Tobacco Strategy (OTS), a comprehensive province-wide initiative to reduce tobacco use;
- Active Ontario, implemented in 1998, is a joint partnership of the Ministry of Health and Long-Term Care, Ministry of Culture, Citizenship and Recreation and related non-governmental agencies such as the Ontario Physical Health and Education Association and Parks and Recreation Ontario;
- The Nutrition Program focuses on public education and social and environmental changes to facilitate the adoption of healthy eating practice by Ontarians. Partners include the Public Health Branch, Ministry of Agriculture, Food and Rural Affairs and related non-governmental organizations such as the Canadian Cancer Society, Ontario Division and the Heart and Stroke Foundation of Ontario; and
- The Health Promotion Program funds the Ontario Health Promotion Resource System comprised of fourteen resource centres and seven key associate organizations, to support and increase the capacity of communities to deliver health promotion programs by enhancing knowledge and skills.

Ontario Health Promotion Resource System and Heart Health Resource Centre

Provision for central technical support was assured during the OHHP by the inclusion of a resource centre specifically mandated to support the program: the Heart Health Resource Centre. The mandate of the HHRC is to enhance the capacity of public health agencies and their community partners from across the province to implement comprehensive, community-based heart health programs. During the first four years of the OHHP, the HHRC provided many services to the OHHP communities including

- 98 on-site consultations;
- 29 training events specific to the OHHP;
- responses to well over 1,000 queries; and
- co-ordination of eight OHHN meetings and two OHHN conferences.

The OHHP was further supported by other resource centres with either a generic mandate, such as The Health Communication Unit and the Ontario Prevention Clearinghouse, a risk-factor-specific mandate such as the Program Training and Consultation Centre or other mandates. Many of the 14 resource centres (that now comprise the OHPRS) provided services directly, collaboratively or indirectly to the communities of the OHHP.

The various organizations that make up the OHPRS have provided invaluable support to the heart health coalitions. The system provides opportunity for professional development and coalition development. We suggest that the process to access these services and a description of services each resource centre provides be communicated to all chronic disease prevention coalitions.⁷

Central support to the OHHP was also offered by agencies that were not resource centres but that had mandates that supported heart health programming, such as the Active Living Community Action Project (ALCAP). Some communities augmented their provincial technical support through locally available free or fee-for-service groups or consultants.

Recently, the Ontario Health Promotion Resource System was established representing a co-ordinated approach to planning, reporting, evaluation and service provision for all Ministry-funded resource centres. OHPRS is a co-ordinated group of organizations dedicated to enhancing the capacity of community health promotion practitioners to adopt and carry out effective health promotion practices. This system is still evolving.

Non-Governmental Organizations

NGOs have historically played an important role in chronic disease prevention in the province. They are involved in policy development, advocacy, research priorities, research funding, program development and implementation. They include Ontario Heart & Stroke Foundation (OHSF), Canadian Cancer Society – Ontario Division, Lung and Kidney associations and others.

Ontario Heart Health Network

The Ontario Heart Health Network is a provincial networking arm of the Ontario Heart Health Program. The OHHN is a vehicle created specifically to facilitate networking, sharing and learning among all those involved in community-based heart health programming. The Network facilitates partnerships between practitioners in

⁷ Feedback from the Consultation Process: Review Guide for the Continuation Plan for 2003 and Beyond, January 2002.

the field, the funders (MOHLTC), the researchers (Canadian Heart Health Initiative – Ontario Project CHHIOP), and the support agencies (e.g., HHRC, ALCAP).

The Heart Health Resource Centre is the secretariat of the OHHN. Along with co-ordinating meetings and participating in OHHN subcommittees, the HHRC provides funding for the OHHN, through its grant from the MOHLTC, and administers the funds of the OHHN.

The Heart Health Provincial Partners Committee (HHPPC)

The HHPPC, a committee of the MOHLTC, is a group of provincial organizations committed to improving and enhancing the health of Ontarians through a variety of programs and services. The committee includes representation from several members of the OHPRS and NGO stakeholders. The HHPPC has supported the goal of the Ontario Heart Health Program in a number of ways: providing advice and recommendations to appropriate party (ies) on the broader emerging issues and needs of heart health projects; consulting and making recommendations on provincial program priorities and issues; providing collective strategic advice to the Ministry of Health and Long-Term Care; and responding to emerging issues and needs of the local heart health projects.

The HHPPC has also initiated a process to move toward a broader role encompassing chronic disease prevention. This process will outline the future role of the committee in supporting continuation and enhancement of the OHHP.

The Ontario Heart Health Program

In 1990, the Ontario Ministry of Health established the Heart Health Action Program (HHAP), which provided funding and support to five community-based heart health demonstration sites. During the same year, health units from across the province were introducing heart health programs into their Healthy Lifestyles Programs.

*The evaluation of the HHAP concluded with 'cautious optimism'. An investment from the provincial government of approximately 60 cents per capita for five years stimulated the initiation and growth of a long-term process of community change in five diverse communities.*⁸

In 1998, the Ontario Ministry of Health and Long-Term Care (Community and Health Promotion Branch and Public Health Branch) implemented a five-year provincial heart health program to address the leading modifiable risk factors associated with cardiovascular disease. The OHHP builds on the public health system and partners with local non-governmental agencies such as the Heart and Stroke Foundation, the Canadian Cancer Society and the Lung Association to co-ordinate and deliver prevention activities.

Highlights as of October 1999⁹

- In the 1999/2000 fiscal year, the 36 funded projects provided a total of 727 activities.
- Communities contributed approximately \$10 million of in-kind contributions in the 1998/1999 fiscal year, exceeding the 2:1 match.
- Over 1,100 groups were members of heart health partnerships across the province.

⁸ The Heart Health Action Program. Final Evaluation Report, December 1995, xi.

⁹ Ministry of Health and Long-Term Care. Community and Health Promotion Branch; OHHP Summary Sheet, October 1999.

Highlights as of October 2001

- 97.5% of health units reported an increase in sharing of resources for heart health activities between the health unit and other community agencies.
- 90% of health units reported an increase in priority given to multiple-risk-factor programming within the health unit.
- Communities contributed over \$11 million of in-kind contributions in the 2000/2001 fiscal year.
- The average investment was 3.9 local dollars to every provincial dollar.
- Approximately 2,500 groups are members of heart health partnerships across the province.¹⁰

Provincial Strategies

Stroke Strategy

The stroke initiative introduced in 2000 provided funding to six Regional Stroke Centres (RSC) in Ontario. In most cases, the RSCs are in their early formation stages and may not be positioned to provide information about their mandates to their communities. Coalitions would benefit from information about the stroke strategy including clarification about the mandate of the stroke centres and expected working relationships with the heart health coalitions.

Cancer Prevention Strategies (Cancer Care Ontario)

At the request of the Ministry of Health and Long-Term Care, Cancer Care Ontario (CCO) has initiated a planning exercise to develop a long-term strategic plan for cancer prevention. This exercise will engage members of the Ontario Network for Cancer Prevention in the development of goals, objectives, strategies and tactics for primary and secondary prevention.

CCO and its major partners in cancer prevention (including the Canadian Cancer Society and the public health system) were active participants in the development of the Canadian Strategy for Cancer Control. It is likely that the Ontario strategy will be a more specific version of the national plan.

The national plan for cancer prevention advocated the integration of cancer prevention (i.e., primary prevention initiatives) with other non-communicable disease prevention strategies. Furthermore, it advocated that cancer prevention give priority to tobacco control, nutrition and physical activity promotion. It also suggested that collaborative structures be funded to advocate such integration and that there be an allocation of funds sufficient to deliver a potent and effective dose of population-based interventions across Canada.

In addition to this long-term planning exercise, CCO has engaged its provincial and regional networks for cancer prevention in a budget-planning exercise over the next three years. The product is a multiple-risk-factor reduction strategy that will also impact cardiovascular disease, chronic obstructive disease, diabetes and other major chronic conditions. The estimated cost for the start up of this important comprehensive strategy would be an additional \$17 million annually. All of this is consistent with the approach advanced by the Continuation Working Group.

Diabetes Strategy

¹⁰ Results are from the provincial evaluation of the Ontario Heart Health Program funded by the Ontario Ministry of Health and Long-Term Care, in progress.

In Ontario, diabetes is a significant chronic disease. Over 600,000 people have diabetes, and 60,000 new cases are diagnosed yearly. Furthermore, approximately 300,000 people in Ontario are unaware that they have diabetes¹¹. The prevalence of type 2 diabetes is increasing, and with an aging population and rising obesity rates, this trend is projected to continue.¹² A strategy for diabetes is currently being planned.

The risk factors for diabetes and cardiovascular disease are particularly similar although there is considerable overlap between the risk factors for diabetes, asthma, cancer, osteoporosis and stroke, especially with respect to the modifiable risk factors of diet and alcohol intake, tobacco use, physical activity level and Body Mass Index (BMI). The similarities between diabetes initiatives and the goals of other disease-prevention efforts suggest that a collaborative chronic disease prevention strategy, accounting for risk factors and the determinants of health, would be an efficient, cost-effective alternative.

Ontario Tobacco Strategy

The Ontario Tobacco Strategy (OTS), a comprehensive province-wide initiative to reduce tobacco use was first implemented in 1992. In 1998, the OTS was renewed in response to the report of an expert panel. The OTS now includes research, policy, public education and support for community action through a combination of province-wide and community initiatives. The legislative component is the Tobacco Control Act (1994) that sets new rules about selling tobacco to minors and smoking in public places. The program works closely with the Public Health Branch, Communications Branch and Legal Services Branch to implement and monitor the strategy.

Physical Activity Strategy

Active Ontario, implemented in 1998, is a joint partnership of the Ministry of Health and Long-Term Care, Ministry of Culture, Citizenship and Recreation and related non-governmental agencies such as the Ontario Physical Health and Education Association and Parks and Recreation Ontario. The goal of the strategy is to improve the reach and effectiveness of physical activity education programs in a variety of community settings such as schools, workplaces, homes, recreation and sports environments and the health system.

Nutrition Strategy

A Nutrition Strategy is under development and will be aimed at key community settings such as schools, workplaces and restaurants. Partners include the Public Health Branch, Ministry of Agriculture, Food and Rural Affairs and related non-governmental organization such as the Canadian Cancer Society, Ontario Division and the Heart and Stroke Foundation of Ontario.

¹¹ Ontario Ministry of Health and Long-Term Care, 1999.

¹² Victoria Nadalin, Primary Prevention of Type 2 Diabetes in Ontario: Policies, Research and Community Capacity Prepared for the Ontario Public Health Association with assistance from the Research and Prevention Units, Division of Preventive Oncology, Cancer Care Ontario, 2001.

4.0 A VISION OF A CHRONIC DISEASE PREVENTION SYSTEM AND STRATEGY FOR ONTARIO

Due to strong and visionary leadership from governmental and non-governmental sectors, Ontario currently has a remarkable array of programs and initiatives targeted at chronic disease prevention. The Continuation Working Group proposes a vision to build on our current situation and strengths in Ontario. This infrastructure would have provincial and local elements and would take a multi-factorial, multi-sectoral approach, based on partnerships and co-ordination among stakeholders.

We need to move toward a single, chronic disease prevention infrastructure in the province. This infrastructure would be based on existing pillars: the chronic disease prevention mandate and resources of the public health system; the coalitions of the Ontario Heart Health Program; the Ontario Health Promotion Resource System; provincial disease prevention strategies for heart disease, cancer, diabetes, stroke and asthma; and non-governmental organizations.

4.1 Guiding Principles

A community-based delivery system for the prevention of chronic diseases would include the following:

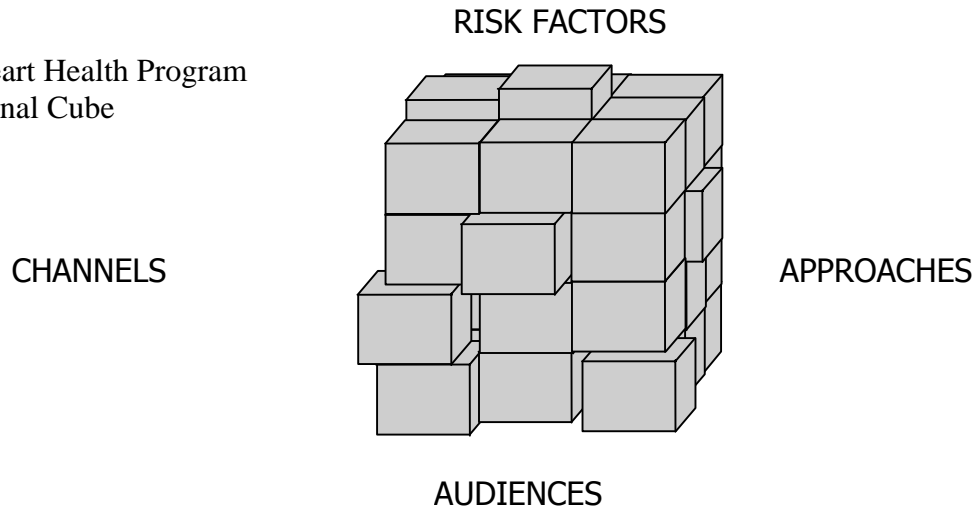
1. Comprehensive community approaches that would be planned and implemented through local and provincial partnerships involving key stakeholders in a single co-ordinated system;
2. Primary prevention of disease and promotion of healthy living as the focus;
3. Local delivery systems that are supported by a provincial system;
4. Stable partnership arrangements between the province, provincial organizations and local communities;
5. Evidence-based approaches and innovation for continuing success;
6. Mutual accountability of communities and partners; and
7. Integrated programs and messages within communities to deliver all chronic disease prevention strategies.

A community-based delivery system for the prevention of chronic diseases would include the following:

1. Comprehensive community approaches that would be planned and implemented through local and provincial partnerships involving key stakeholders in a single co-ordinated system.

In the OHHP, a multi-dimensional cube is used to illustrate the complexity of the comprehensive health promotion model. Different channels (e.g., restaurants or workplaces) provide access to selected audiences. Multiple approaches are used to modify the risk factors related to heart disease: poor nutrition, inactivity and tobacco use.

The Ontario Heart Health Program
Multi-dimensional Cube



From the local perspective, the current OHHP is a three-way relationship between local health units, community partners and the Ontario Ministry of Health and Long-Term Care. The Heart Health Benchmarking Project identified cornerstones of relationships between partners (See box below). These process indicators provide a guide for forming future partnerships with heart health coalitions.

Recommended Success Indicator

Strong sense of collaborative partnership

- Jointly developed mandates and plans;
- Comfort with and ownership of decision-making processes;
- Conflicts are recognized, addressed and resolved in an open, fair process;
- Sense of continuity, not burn out; and
- Partner satisfaction with continuity of co-ordination.

Other components:

- Partners are comfortable and feel involved in the planning process;
- Partners are satisfied with the level of (interpersonal) relationships among coalition partners; and
- Flexibility and effective communication.¹³

¹³ PHRED. Toward Benchmarking Heart Health Coalitions, April 2001.

Across Ontario, dynamic community coalitions have been formed as part of the OHHP and are in various stages of developing local capacity for health promotion. Early evaluation evidence shows that more than 2,500 partners are participating in the planning and implementation of heart health initiatives across Ontario. Delivery at the local level offers responsiveness to local strengths and health issues yet would be strengthened by a comprehensive vision.

What is needed is a single, co-ordinated, health-promotion delivery system to broaden existing community and regional coalitions and avoid duplication of resources. The large diversity of communities across Ontario necessitates local community planning. The HHAP evaluation identified that community ownership takes a long time to develop yet does increase the capacity of health units.¹⁴

2. Primary prevention of disease and promotion of healthy living as the focus.

At this time the Heart Health Coalitions may be unique within their communities by supporting the value of primary prevention. The need for health restructuring, an aging population and the increase in mortality to chronic diseases heighten the importance of communicating the health-promotion vision. Community coalitions are well positioned to provide the stewardship of the health-promotion vision at the community level.

Many OHHP community coalitions report focusing on the heart health risk factors of healthy eating, active living and smoking cessation rather than focusing on heart disease. These heart health risk factors are also associated with diseases such as cancer and diabetes. Several community coalitions report they have initiated a transition to include these diseases in their ongoing work.¹⁵

3. Local delivery systems that are supported by a provincial system.

The Ontario Health Promotion Resource System and other provincial supports have played an important role in providing education and development and consultation support to optimize strategies at provincial, regional and community levels.

*Training opportunities are a core service of a support system.*¹⁶

*Consultation is an important part of a support system, providing technical or programming expertise, and some administrative support to sites and to the central funders.*¹⁷

The role of OHPRS is valued at the community level and needs to continue and possibly expand into new roles. The OHPRS can promote enhanced communication and collaboration and can nurture excellence in health promotion while reducing duplication.

¹⁴ Shea & Company. Report on Community Capacity for Integration of Stroke Prevention in Selected Regions of Ontario, July 2001, 14.

¹⁵ CWG. Results from Review Guide Responses, January 2002.

¹⁶ Heart Health Resource Centre. The Heart Health Action Program. Final Evaluation Report, December 1995; 70.

¹⁷ Ibid; 72

4. Stable partnership arrangements between the province, provincial organizations and local communities.

The investment in partnership has occurred at many levels. The way individuals and organizations within local communities relate to the province and provincial organizations is the key to a stable system from which to achieve common program goals. During the OHHP, the Ministry and local communities developed a working relationship that is evolving into more than just funding for local health promotion efforts. Partnership arrangements, between the province and local communities, should be clarified and affirmed. There is a strong need to ensure that this relationship is clear and can endure beyond March 2003.

In local communities, a core of dedicated agencies and individuals has been recognized as an essential component of success. The elements that keep people together and build a sense of collective identity include history of successes and the commitment to a common vision.¹⁸

1. Evidence-based approaches and innovation for continuing success.

Ontario has taken the lead in Canada in developing community-based heart health primary prevention with the OHHP built on the experiences and evaluation from the HHAP. To continue development in health promotion, a balance is needed between evidence-based interventions and the importance of innovation. Ontario is a large, diverse province. Local community planning is needed to identify and shape prevention initiatives that work for specific communities. The use of best practices and innovative strategies can combine to ensure a flexible response to community needs.

6. Mutual accountability of communities and partners.

Coalitions need concise, realistic mechanisms to assure their communities and partners about program effectiveness and obtain meaningful feedback about program goals.

Compliance with reporting requirements must be part of the fiscal accountability structure. At the same time, reporting must be sufficient but not overly burdensome.¹⁹

With limited resources, evaluation demands need to be balanced with other program responsibilities. Clear accountability channels and governance need to be negotiated. Participation in evaluation that contributes to the scientific knowledge base needs to be balanced with time demands for program implementation.

7. Integrated programs and messages within communities to deliver all chronic disease prevention strategies.

Coalitions can be a channel for multiple-disease-prevention strategies at the local level. In partnership with key community stakeholders, decisions about programming would depend on prevalence of the disease, ability to mobilize and involve partners around the specific issue, community interest and/or awareness (or lack of) about the disease. Funding and supports need to be in place to foster and support the increased activity and messaging for specific diseases.

¹⁸ PHRED. Toward Benchmarking Heart Health Coalitions, April 2001, 13.

¹⁹ Heart Health Resource Centre. The Heart Health Action Program, Final Evaluation Report, December 1995; 74.

4.2 Provincial System

Issues and Rationale

One of the challenges of making the new chronic disease prevention system work will be to generate true multi-sectoral co-ordination and planning at the provincial level. To provide an equitable balance between the voices of community coalitions and provincial bodies, we recommend the formation of a Chronic Disease Prevention Steering Committee.

The central technical support provided throughout the OHHP has been helpful in providing training, information sharing and resources. The support is valuable and should be maintained through the OHPRS, while also adapting the support to better fit with local plans. An additional role for OHPRS may be to co-ordinate central program development or distribution of prevention programs. OHPRS has the capacity and is well positioned to plan, develop and disseminate high-quality resources efficiently and equitably across the province.

Many local heart health coalitions and co-ordinators have suggested the development of a common, provincial, program identifier (i.e., a logo or tagline). It has been suggested that coalitions need one brand in place to identify ALL provincial or central programs.

Finally, as the complexity and depth of health promotion increases across the province, there is a heightened need for good reporting of process and accomplishments. What is being proposed is the development of a central “activity report form” that could be accessed on-line to fulfill reporting and evaluation requirements.

Chronic Disease Prevention (CDP) Steering Committee

1. The CWG recommends the formation of a Chronic Disease Prevention Steering Committee to provide an equitable balance between the voices of community coalitions and provincial bodies.

The Steering Committee’s role would include responsibility for program requirements at the local level (e.g., types of reporting, provincial evaluation plans). The roles of various existing groups would be clarified through a consultation process, including the role of the Provincial Partners Committee and the HHRC.

The purpose of the CDP Steering Committee is to support the goals of the Ontario CDP Program by

- Providing advice and recommendations to appropriate party(ies) on the broader emerging issues and needs of CDP projects;
- Consulting and making recommendations about provincial program priorities and issues; and
- Providing collective strategic advice to the Ministry of Health and Long-Term Care and responding to emerging issues and needs of the local CDP coalitions.

This purpose is achieved through communication and networking, monitoring emerging trends and issues, facilitating provincial and local information exchange and supporting sustainability efforts.

Membership on the Steering Committee would include representation from the OHHN, OHPRS, provincial partners (including representatives from NGOs) and MOHLTC. Consideration should also be given to the degree and type of involvement of other ministries, including the Ministry of Education, Ministry of Culture, Citizenship and Recreation and Ontario Ministry of Agriculture, Food and Rural Affairs.

If there is a Chronic Disease Prevention Program in Ontario, there must be a body created with representation from all stakeholders to provide leadership and direction to community coalitions.

*Coalition members from both urban and rural coalitions should be included in the membership to represent the communities.*²⁰

Central Technical Support

2. The CWG recommends that the central technical support (e.g., training and consultation) provided by the Ontario Health Promotion Resource System be maintained as an essential service to communities.

*This support is vital to front line prevention workers as it allows us to do our work using supported, evidenced based tools and data.*²¹

The central technical support offered by the various provincial resource centres and other provincial bodies has been essential to the OHHP. In addition to the training and consultation support, other specific roles for the OHPRS might be to

- Facilitate joint planning for the stroke initiative within communities, to avoid duplication, expose gaps and target programming to create broader community ownership;
- Facilitate linkages with OHPRS support, to help some health units assess their infrastructures and organizational culture to adapt to a community-based chronic disease prevention program;
- Keep and increase linkages with all chronic disease prevention initiatives;
- Maintain risk-factor, disease-focused and skill-based training, information/resource provision and consultation; and
- Continue to facilitate communication and build relationships between various groups such as the Regional Stroke Centres and coalitions, in the context of stroke and chronic disease prevention.

The structure and function of OHPRS may need to be modified with a move to a chronic disease approach.

Central Program Development

3. The CWG recommends that OHPRS co-ordinate central program development (including the possibility of media campaigns) and disseminate prevention programs.

Effective prevention programs of the OHHP are being shared informally across the province, frequently through regional network meetings. There is an opportunity to improve provincial dissemination and to co-ordinate the development of new programs, as common needs surface. It may be worthwhile to co-ordinate some focused provincial programs and/or media campaigns, to be used for local planning issues and supported provincially.

Centralized program development would encourage inclusion of the best components from across the province to offer an efficient, cost-effective use of resources to develop high-quality programs. The move to more centralized program development would assist in promoting standardized health messages across the province.

Ongoing needs assessments are required to ensure new programs are responsive to the diverse priorities of communities in Ontario. New programs need to be flexible and allow for local adaptation in order to be useable in both urban and rural settings.

²⁰ Feedback from the Consultation Process: Review Guide for the Continuation Plan for 2003 and Beyond, January 2002.

²¹ Ibid.

Central program development would allow [this coalition] to focus on planning and implementation in the community, versus the enormous financial resources required for development costs. The challenge in this role would be that these programs are meeting actual needs in the community, recognizing some of the diversity between communities within regions and the province.

Support whatever it takes to promote efficient use of resources of high quality that are kept current and equitably distributed.²²

Common Program Identifier

4. The CWG recommends the use of a provincial brand for all centrally developed programs.

The provincial programs (Eat Smart, Summer Active etc.) do not currently have a unifying look. If communities were to implement and support provincial programs at the local level, it would be of value to have a common visual thread. This does not mean everything has to look alike, but that all resource, promotional or program materials would say, for example, “This is part of Ontario’s chronic disease/healthy living initiative” or “Promoting a Healthy Ontario”. The repetition of a common identifier builds a strong message about health promotion.

Local communities would still be able to use their own community logo; fostering local community program identity is important, but showing a connection across Ontario is important as well. The local coalitions can include the provincial brand on its materials in addition to local program identifiers to add synergy and interconnectedness.

The brand would also be useful if a provincial social-marketing initiative were to be implemented. To provide a timely response, the selection and use of the common identifier could be co-ordinated by OHPRS.

Reporting

5. The CWG recommends the development and use of a central activity reporting form that can be completed on-line to provide information about program activities to local communities and the Ministry. This form would replace the current system.

A user-friendly activity report form would be developed and the frequency of reporting requirements would be negotiated. The form would facilitate ongoing tracking and would replace existing forms.

The proposed central activity report form would be based on the elements of the cube and would include the in-kind contribution total for that period and other relevant information. This information would be entered into a database that could be accessed by local and provincial bodies.

Willing to do the reporting that’s necessary to keep accountability measures in place, but time and energy should be spent on direct services and not on having to do excessive amounts of reporting.²³

²² Two communities’ comments from: Feedback from the Consultation Process: Review Guide for the Continuation Plan for 2003 and Beyond, January 2002.

²³ Feedback from the Consultation Process: Review Guide for the Continuation Plan for 2003 and Beyond, January 2002.

Outputs from the data system would be available by risk factor, channel, audience and approach and would include other important information as defined by the partners.

Also, links to the Public Health Mandatory Program and Services reporting should be established. For example, recording the indicators that are attached to local coalition initiatives would serve a dual purpose of ensuring accountability to the Ministry and illustrating the cohesiveness of the public health practice with community groups.

There is a recognized need for ongoing research at various levels. Continuing the Heart Health Benchmarking process could be explored as a way of showing progress in coalitions. Also, data about specific needs in communities should be collected. Surveys need to be tied to the goals set locally and provincially and should be the “report card” of effectiveness of this and other programs across the province.

Roles and Responsibilities – Provincial System

6. The CWG recommends that MOHLTC develop a chronic disease health promotion strategy for Ontario to encompass the prevention components for CVD, stroke, diabetes and cancer, while integrating the physical activity, tobacco and nutrition strategies.

The following table illustrates the proposed functions for each of the organizations in the provincial system. As part of the policy direction and planning function for the Ministry, the committee recommends that MOHLTC develop a chronic disease health promotion strategy for Ontario. This would encompass prevention components for CVD, stroke, diabetes and cancer, while integrating the physical activity, tobacco and nutrition strategies.

FUNCTIONS	OHPRS	NGOs	MOHLTC	OHHN	Steering committee
Policy Direction	4	4	4	4	4
Planning	4	4	4	4	4
Evaluation	4	4	4	4	4
Co-ordination: - Networking and Referral - Information & Knowledge Exchange and Diffusion	4	4	4	4	4
Training & Consultation	4				
Central Programming	4	4	4	4	4
Funding		4	4		
Secretariat	4		4		
Best Practice	4				
Promotion of Policy Change		4		4	4

4.3 Local System

Issues and rationale

Community coalitions are engaged in promoting and supporting initiatives that enhance healthy behaviors and address the common risk factors. This would continue as the primary “service” in each community. A multiple-risk-factor approach would be used, and depending upon community health needs, “new” risk factors might be addressed.

Health units have contributed significantly at the local level and are positioned to continue this role. A stewardship role in the prevention of chronic disease and health promotion is supported.

The need to reconsider the current human resource requirements after 2003 is based on a number of perceptions and observations including high turnover of co-ordinators; inappropriate match of people to the co-ordinator position; inequities of full-time employee (FTE) allocation in local health units; and special staffing issues across the province.

During the most recent sustainability planning, some co-ordinators found it helpful to discuss plans at their regional networks to share ideas and solve problems together. Having plans reviewed by peers and HHRC coaches was particularly helpful because colleagues currently working in the field provided valuable support and advice. A peer mentoring and review process could provide timely support to coalitions.

Coalitions participated in planning, monitoring and evaluation of coalition projects with other partners. The process enabled coalitions to clarify their visions and plan collaborative activities based on their dedicated resources, credibility within the community and access to decision makers.

OHHP Coalitions

7. The CWG recommends the continuation of community coalitions as the base from which to plan and implement primary prevention of chronic disease initiatives.

Research has demonstrated that the involvement of ‘communities’ in health promotion and disease prevention programs is critical. Communities and their members need to acquire the capacity for stronger health promotion and disease prevention roles.²⁴

Funded by the OHHP, community coalitions have been formed in communities across Ontario. These coalitions, strengthened by contributions from partners with multiple mandates and broad expertise, have continued to build capacity for health promotion programming. Investment in these coalitions has come from local and provincial sources and can be sustained to form the base or infrastructure for chronic disease prevention and health promotion in Ontario.

A coalition that oversees the planning, implementing and evaluation of lifestyle-related programming in a specific geographic area avoids overlap, duplication and competition. Resources are shared and maximized.²⁵

²⁴ Lyon R, Langille L. Healthy Lifestyles: Strengthening the Effectiveness of Lifestyle Approaches to Improve Health. Health Canada, April 2000, 39.

²⁵ Feedback from the Consultation Process: Review Guide for the Continuation Plan for 2003 and Beyond, January 2002.

Failure to renew the OHHP funding would be counterproductive to this direction. It would lead to increasing fragmentation and inefficiency at the local level. Termination of funding would make it difficult, if not impossible, to recreate this local infrastructure at a later date.

OHHP coalitions are involved implicitly in broader chronic disease prevention, since they focus on risk factors that are linked to a number of serious diseases such as cancer and diabetes. However, there is some evidence from a sampling of coalitions that some have explicitly included the prevention of other diseases in their mandates.

From a sample of 21 OHHP sites, information was collected about the current mandates.²⁶

- Twelve sites (57%) indicated that they have expanded programming beyond a specific heart health approach. Other diseases with associated risk factors that were addressed in programs included stroke, cancer and chronic disease prevention.
- Six sites (29%) have formally expanded their coalitions to include other diseases. These are either cancer or diabetes or both in two cases.
- Eight sites (38%) are considering expanding to other diseases or to a chronic disease approach. Of these, five are considering a broader chronic disease mandate.

Information from the review of the draft working paper demonstrated that the majority of respondents supported their community coalition continuing, with a chronic disease prevention approach. One site did not support and one was undecided about this approach.²⁷

The heart health coalitions have evolved and many have become quite expert in coalition development and programming.²⁸ To maintain this local capacity, ongoing funding for coalitions is essential to maintain a continuous local base for chronic disease prevention programming.

Furthermore, as part of the continuation process, the CWG recommends consultation with those sites that have expanded their coalition mandate, in order to learn from their experiences.

Health Unit Role

8. The CWG recommends that health departments, supporting community coalitions working in chronic disease prevention and health promotion, function in a stewardship role.

Local health units have a strong role in the OHHP and should continue to be pillars of a community chronic disease prevention program after March 2003.

Health units, through community links, have a role in protecting the public from disease and providing the community with optimum health opportunities for which no other agency has a clear mandate. As the major agency with dedicated resources for health promotion in most communities, the health unit has relatively more resources to contribute to both chronic disease prevention activities overall and to joint coalition activities in

²⁶ Rosenbaum C. (personal communication) from data collected for the Report on Community Capacity for Integration of Stroke prevention in Selected Regions of Ontario, July 2001.

²⁷ CWG. Results from Review Guide Responses, January 2002.

²⁸ Shea & company. Report on Community Capacity for Integration of Stroke Prevention in Selected Regions of Ontario, July 2001, 15.

particular. Furthermore, while other agencies, businesses and NGOs may focus on a single disease, a single risk factor or a specific population, public health is the one agency with the broad mandate of chronic disease prevention.

Due to its specific mandate of chronic disease prevention, as well as a specific requirement to participate in community coalitions, the health unit has a strong interest in both initiating and supporting strong, effective, community coalitions. Because of this mandate, it is in the interest of the health unit to work with and support a single coalition rather than to provide support for heart health as well as other disease-based coalitions.

It is important for the health unit that this important position within the coalition be translated into a philosophy of stewardship not control. Experience has shown that coalitions are most effective when health units provide core co-ordination and support and participate actively in coalition activities but share decision making and leadership with other community partners. This will facilitate other partners increasing their involvement and commitment over time.

In order to achieve local success, it is recommended that health units be guided by the following indicators:

- Health unit decision makers are seen as supportive of the coalition;
- Co-ordinator is seen as working for the whole coalition not just the health unit;
- Health unit is seen as a collaborative partner who accepts decisions made by the community coalition;
- Health unit planning and programming is seen as integrated into and complementary to coalition activity; and
- Health unit is seen as one member of the coalition.²⁹

Health units can lead from behind and nurture a stronger community effort by empowering others.

Additional elements of the health unit's role can include³⁰:

Fiscal agent: As a recognized transfer agency, health units are equipped and experienced in managing community funds and could continue in this role after 2003. However, a partner could handle this role if acceptable to the Ministry.

Staff Support: The health unit should be willing to assign additional staff where and when possible, to support the projects that are jointly planned with the community and the coalition. It is much more efficient and effective to work with a number of partners on an activity than to try to do a specific intervention in isolation of community involvement.

Secretariat: The health unit can effectively perform secretariat functions including production and booking of meetings, circulation of agendas, distribution of minutes, etc. Within some areas of the coalition working groups, this function can and should be shared with other partners.

Maintenance of Best Practices: With provincial links and experienced, trained staff, the health unit can act as a source of expertise, up-to-date information and links to keep coalition activities on the cutting edge and avoid duplication and inefficiencies. This will include being a key link to the resources provided by the OHPRS.

²⁹ PHRED Partners. Towards Benchmarking Heart Health Coalitions: Developing a Systematic Process for Documenting and Enriching Community/Health unit Partnerships, April 2001, 21.

³⁰ The various roles and functions performed by the Health Departments should be counted as an in-kind contribution.

Evaluation: While there will frequently be evaluation expertise in the community, the health unit can play a role in co-ordinating data collection, doing analysis for the coalition and reporting to the Ministry.

Co-ordination and the Co-ordinator Role

9. The CWG recommends a problem-solving process to clarify the human resources requirements after 2003. This would include information about the co-ordinator's role, administration/secretarial needs for the coalition and the support needs of local NGOs and other partners.

As part of the original funding, community partnerships (usually the health unit in-kind contribution) were expected to allocate one full-time staff position to co-ordinate the local heart health project. The expectation that this requirement would be fair and equitably applied across the province was not realistic. For larger health units with a large number of staff and managers, the requirement was feasible; designating FTEs to support the local OHHP activities was not a problem. In smaller health units, allocating one FTE was actually (or perceived to be) depleting already limited health unit resources.

The large geographic area of some health departments made it unrealistic for one person to perform the co-ordinator's role, even though this is the best way for delivery in most communities. The way the co-ordinator's role is implemented after 2003 should provide options for the diversity of needs across the province. The way of allocating one (or more) FTEs needs to be examined in order to reach Northern communities.

It was recognized in the Heart Health Action Program and reinforced in the Ontario Heart Health Program that a co-ordinator with dedicated time to devote to coalition functioning is essential to coalition success. This seems to work best in most communities when the co-ordinator is a health unit employee with clear accountability to the whole coalition.

There is a recognized need to examine the co-ordinator's role, the complexity of the role requirements, and the organizational policies in local situations. Further, other needed supports such as administration and the staffing of NGOs and other partners needs to be clarified.

We propose that a consultation process be conducted to clarify the role of the co-ordinator and supports for the co-ordinator and coalition. The existing co-ordinators, public health units, community partners and coalitions, the Ministry and provincial partners need to be part of this consultation process in order to develop the options that reflect the local community needs.

Establishment of a Peer Mentoring

10. The CWG recommends the continuing development of regional networks to provide peer mentoring to community coalitions.

Currently there are many mechanisms in place to assist local communities in developing realistic plans for their programs.

- 1) The Heart Health Resource Centre provides program planning, evaluation and sustainability training to co-ordinators and community partners.
- 2) Local plans are developed in partnership with local organizations. This process brings community expertise into the planning process while providing an opportunity for the community to be directly connected to the OHHP.

- 3) Finally, there is a feedback process on the Annual Plans of each heart health coalition. This is a process established by MOHLTC to support heart health coalitions in their planning. Plans are reviewed externally with Ministry input.

To support the planning process, peer mentoring is recommended. Peer mentoring would be

- Conducted through Regional Network membership as a group (with coalition participation, if feasible).
- Facilitated by a coach or consultant from the HHRC.
- Recognized as part of the planning process, with feedback occurring when plans are being developed.
- Co-ordinated jointly by the HHRC and the Regional Networks.

Peer mentoring would provide local programs with an opportunity to learn about other initiatives occurring in the region and may facilitate more joint projects and resource sharing. This process may also enhance consistency across the regions and provide feedback to coalitions, prior to beginning implementation of initiatives. Further benefits include the support to community co-ordinators from their peers and provide an opportunity for continued team building within regions.

Joint Planning

11. The CWG recommends continuing the joint planning process developed in the OHHP using a two-year planning cycle.

The planning process used in the OHHP contributed to the development of joint planning, which contributed to building a social network and a partnership agreement in communities. The planning process contributed to both efficiency and effectiveness and should be maintained.

Experience from the community coalitions shows that one year is too short a time frame; it is recommended that the planning process occurs every two years, with a suggestion for coalitions to re-visit the plan for revision and updating as needed by their communities.

Formative Evaluation

12. The CWG recommends designing a constructive evaluation process for local disease prevention programs.

There is interest in exploring the use of an evaluation process to promote innovation and continuous growth of local heart health coalitions. The intent would be to conduct formative evaluation with local coalition members and staff to improve their local programs. The assessments should yield practical, yet sometimes critical, advice about the organization, function and activities of the coalition. In order to be useful for local communities the evaluation process must be supportive of local program development and growth, involve communities in an open and transparent process and not be burdensome. It is recognized that the resource requirements for evaluation need to be balanced against the full slate of work undertaken by the community coalitions.

This constructive process for the evaluation of local chronic disease prevention programs is being proposed to address two needs. The first is to promote coalition development. The second is to ensure accountability to the Ministry of Health and Long-Term Care by evaluation that is scientifically rigorous and state of the art.

Roles and Responsibilities – Local System

13. The CWG recommends clarification of the roles and responsibilities of the major partners working at the local level.

The following table outlines possible roles for the Public Health Department, Community Stakeholders and the Coalition.

	Public Health Department	Community Stakeholders	Coalition
Policy Direction	4	4	4
Planning	4	4	4
Evaluation	4	4	4
Co-ordination	4		4
Programming	4	4	4
Fiscal Agent	4		
Fiscal Management			4
In-kind Contribution	4	4	
Secretariat	4		
Best Practice	4		
Promotion of Policy Change	4	4	4

4.4 Funding Model

OHHP Funding Base - Stability of the Vision

14. The CWG recommends long term, stable funding from the MOHLTC to community coalitions engaged in health promotion. Stable funding enables a continuous and seamless transition to chronic disease prevention.

The Application Guidelines for the OHHP state, “*Additional funding will not be available from the Ministry of Health for continuation of local projects beyond the duration of the Heart Health Program.*”³¹ This statement, along with experiences in sustainability workshops, has created intense concern in some coalitions about future program viability.

Whereas the core provincial funding provided the stimulus for effective planning and for stability of key roles and avoided the conflict of competing for fundraising dollars in local communities, the current uncertainty about funding is creating problems. The impending loss of funding affects the recruiting and sustaining of partners, who may interpret this loss as the lack of provincial commitment to the initiative. Without a stable base, positions can not be made permanent, possibly affecting the quality of staff and contributing to increased staff turnover.

Two key learnings from the Ontario Heart Health Action Program were that, “funding is a core service of an enabling system”³² and “management structures for local collaborative projects must have autonomy over use of funds.”³³

*The funding has encouraged the broader community to be committed and involved in changing the culture. Lifestyle change takes years to see results. It takes a community to raise our children. The funds provided leverage to secure creative and innovative in-kind resources from our community.*³⁴

Significant evidence demonstrates that although prevention funding is a small piece of the health budget, it is cost effective in the long term. To ensure continuous, seamless transition to chronic disease prevention, the request is for long-term, stable funding from the MOHLTC to community coalitions engaged in health promotion. Heart health coalitions in many communities have the capacity to co-ordinate the health message being given by partner agencies and advocate for change in public policy. This existing infrastructure is a logical base from which to build the new chronic disease prevention system.

In the current partnership between the province, local health units and local community partners, it is evident from the In-kind Contribution Reports that the current level of funding has generated a large local investment in chronic disease prevention.

What is needed is ongoing base funding from the province at a similar level as under the current OHHP. This funding should be designated for the support of chronic disease prevention initiatives that are collaboratively planned, implemented and evaluated at the community level by local health units and community partners. As with the current OHHP, this funding would be allocated to the community partnerships.

³¹ Ontario Ministry of Health. Heart Health Program Application Guidelines, June 1997, 5.

³² Heart Health Resource System. The Heart Health Action Program, Final Evaluation Report, December 1995, 48.

³³ Ibid, 51.

³⁴ Feedback from the Consultation Process: Review Guide for the Continuation Plan for 2003 and Beyond, January 2002.

*The previous 5 years were successful. Since we are already attracting members at the local level from the various chronic disease based organizations, it is a natural progression.*³⁵

In-kind Funding

15. The CWG recommends the continuation of the current level of in-kind contribution requirements.

One of the innovative and supportive pieces of the current OHHP has been the in-kind requirement. Having to match the provincial funds 2:1 has not only leveraged local resources toward heart health programs but the calculation of the in-kind contributions has helped local health units and community partners gauge and value the input of others.

Even recognizing an underreporting bias in in-kind reporting, for every dollar provided by the Ministry, the average community contribution is \$3.90.

- For the fiscal year 1998/1999, reports showed a total of \$9,817, 092 of in-kind contributions (an average ratio of 2.99 to 1).
- For the fiscal year 1999/2000, a total of \$10,805,942 of in-kind contributions has been recorded (an average ratio of 3.48 to 1).
- For the fiscal year 2000/2001, although some reports are outstanding, the average in-kind contributions have been 11,008,058 with the average ratio being \$3.90 to 1.

NOTE: These preliminary results are from the provincial evaluation of the Ontario Heart Health Program, funded by the Ontario Ministry of Health and Long-Term Care.

This component should remain in the next program design for most communities. Many communities stated that the current formula of \$2 in local resources to every \$1 from the provincial level was realistic. However, because of the diversity in local resources and limited existing social capital in some communities, special considerations need to be given to this program component.

Work is needed to clarify in-kind contributions at the community level and to find easier tracking methods.

Additional Funding Considerations

16. The CWG recommends that MOHLTC explore alternative funding models for the local co-ordinator as determined through a consultation process.

The role of the local co-ordinator is challenging yet appears to be critical for program success. In some communities the co-ordinator position has worked well. In others, there have been difficulties caused by numerous factors. CWG recommends a problem-solving process to examine the issues around staffing as well as exploring alternative models of funding for the local co-ordinator.

17. The CWG recommends the availability of small grants to local communities engaged in innovative health

³⁵ Feedback from the Consultation Process: Review Guide for the Continuation Plan for 2003 and Beyond, January 2002.

promotion or disease prevention initiatives that target a specific disease (e.g., stroke) and may have the potential for provincial distribution.

While the interest and resources may exist at the local level to plan and deliver chronic disease prevention initiatives, the support to focus on disease-specific interventions varies across communities. After 2003, we recommend that each community submit its plan for chronic disease prevention interventions based on healthy eating, physical activity and smoke-free living and build into their plan opportunities to deliver disease-specific interventions. The disease-specific interventions would be linked to “enrichment” funding. At the community level, this would mean weaving disease-specific interventions into the overall community plan, rather than starting up a whole new initiative.

Some examples of this approach include the following:

- The development of a health professional training session/workshop on physical activity and its role in stroke prevention, to be conducted during Stroke Awareness Month in June (also Summer Active time). All stroke prevention messages could be worked into the workshop, but the benefits of physical activity in stroke prevention would be the training focus. The Heart and Stroke Foundation and the Regional Stroke Centres as well as the community partners in recreation and fitness could team up to plan and deliver this event (using enrichment funding to help support the initiative).
- The development of a newspaper insert on “*5 to 10 a Day*” (using base funding), but insert a two-page spread on the role eating more fruit and vegetables has in cancer prevention (using enrichment funding).
- The coalition could support a municipal smoking by-law initiative. A major by-law initiative requires many partners to work together from their own corners of the community to rally citizen and political support. The coalition’s contribution could be the disease-prevention aspect of the by-law, freeing other groups to focus on other issues such as economic impact, worker health and child health (using enrichment funding).

Enhanced provincial funding, greater than the current level of support, would be needed to address specific disease initiatives. The method of assessing and supporting these local initiatives would be developed through a future consultation process although the communities have clearly stated they would not be interested in lengthy application processes.

These initiatives would be for cancer, stroke, diabetes and heart disease.

The evaluation report from the HHAP demonstration phase states

CVD prevention requires a long-term investment. The HHAP sites have started a community change process that must be continued to realize long-term impacts. Most of the energy, effort and research concerning community health promotion coalitions has been directed to methods and techniques for forming and developing them. Relatively little attention during the last several years has been devoted to if, when, and how coalitions terminate, and the effects of termination on the participating organizations and communities. The instability created in 1994 in the HHAP sites (when the sites were nearing the end of the demonstration period and the external funding situation was highly ambiguous) raises questions about necessary supports (external and /or within communities) to ensure heart health initiatives continue in each community.³⁶

³⁶ Heart Health Resource Centre. The Heart Health Action Program, Final Evaluation Report, December 1995; 24.

Summary of recommendations

In the short term, the CWG requests that:

- MOHLTC fund a sixth year of OHHP to prevent coalitions from winding down during the review of this proposal and completion of the program evaluation;
- A Chronic Disease Steering Committee be formed to plan and advise MOHLTC (recommendation 1);
- A working group be formed to research and develop recommendations about staffing especially the role of co-ordinator (recommendations 9 and 16); and
- A working group be formed to recommend ongoing reporting and evaluation requirements and develop user friendly tools (recommendations 5 and 12).

Overall, the Continuation Working Group recommends the following:

1. The formation of a Chronic Disease Prevention Steering Committee to provide an equitable balance between the voices of community coalitions and provincial bodies;
2. The central technical support (e.g., training and consultation) provided by the Ontario Health Promotion Resource System be maintained as an essential service to communities;
3. That OHPRS co-ordinate central program development (including the possibility of media campaigns) and disseminate prevention programs;
4. The use of a provincial brand for all centrally developed programs;
5. The development and use of a central activity reporting form that can be completed on-line to provide information about program activities to local communities and the Ministry. This form would replace the current system;
6. That MOHLTC develop a chronic disease health promotion strategy for Ontario to encompass the prevention components for CVD, stroke, diabetes and cancer, while integrating the physical activity, tobacco and nutrition strategies;
7. The continuation of community coalitions as the base from which to plan and implement primary prevention of chronic disease initiatives;
8. That health departments, supporting community coalitions working in chronic disease prevention and health promotion, function in a stewardship role;
9. A problem-solving process to clarify the human resources requirements after 2003. This would include information about the co-ordinator's role, administration/secretarial needs for the coalition, and the support needs of local NGOs and other partners;
10. The continuing development of regional networks to provide peer mentoring to community coalitions;
11. Continuing the joint planning process developed in the OHHP using a two-year planning cycle;
12. Designing a constructive evaluation process for local disease prevention programs;
13. Clarification of the roles and responsibilities of the major partners working at the local level;
14. Long term, stable funding from the MOHLTC to community coalitions engaged in health promotion. Stable funding enables a continuous and seamless transition to chronic disease prevention;
15. Continuation of the current level of in-kind contribution requirements;
16. That MOHLTC explore alternative funding models for the local co-ordinator as determined through a consultation process; and
17. The availability of small funding grants to local communities engaged in innovative health promotion or disease prevention initiatives that target a specific disease (e.g., stroke) and may have the potential for provincial distribution.

ATTACHMENTS

- A. Glossary of Terms
- B. Summary of the Feedback from the Consultation Process
- C. Summary about Information Needed for Planning
- D. Highlights from Additional Supporting Research and Documents
- E. Resolutions and Letters of Support

A. Glossary of Terms

ALCAP: The Active Living Community Action Project (ALCAP) supports physical activity leaders through Community Facilitators who increase awareness about active living, conduct training, encourage collaboration between groups and support the planning and implementation of active living programs. Ontario Physical and Health Education Association (OPHEA) manages ALCAP on behalf of the Active Ontario strategy (OPHEA website).

Approach is the health promotion strategy used in the program. Approaches include awareness raising, education, environmental support and policy change. (Heart Health Resource Centre, 1998)

Best Practice in health promotion is 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)

Channel includes sites where the activities take place; e.g., schools, worksites and health care settings. (Heart Health Resource Centre, 1998)

Comprehensive: This term includes a number of dimensions with respect to heart health initiatives. It includes the following:

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

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

Formative Evaluation is a method of assessing a program while the program activities are forming or happening. It focuses on process. Formative evaluation may involve collecting continuous feedback from participants in a program in order to revise the program as needed.

Formative evaluation includes audience analysis and pre-testing. Pre-testing is designed to assess the strengths and weaknesses of materials or strategies before implementation. It 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.

Health Promotion: **Health promotion is the process of enabling people to increase control over and improve their health. (Ottawa Charter for Health Promotion WHO, 1986).**

HHAP: Heart Health Action Program.

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)

or

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

Indicators are specific measures indicating 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. (Health Communication Unit)

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 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 website)

NGO: Non- Governmental Organization.

OHSF: The Ontario Heart and Stroke Foundation.

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: Is aimed at preventing disease before it occurs. Secondary Prevention involves the early detection of disease, either when it produces symptoms or before symptoms are noticed. (Towards An Integrated Stroke Strategy for Ontario, 2000).

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).

Stewardship Role: When health units provide core co-ordination and support and participate actively in coalition activities but share decision making and leadership with other community partners.

B. Summary of the Feedback from the Consultation Process

Condensed responses³⁷

Responses were returned from 35 community coalitions* (Toronto counted as 2). The number of reviewers ranged from 2 to 17 with the average being about 8 participants per review. Reviewers were identified generally as being coalition members (steering committee and working group members) and public health. Some respondents listed the coalition members as representing their constituents. These included associations such as Heart & Stroke; Cancer Care Ontario; Canadian Diabetes Association; School Boards; Hospitals; District Health Councils; Universities; Colleges; Emergency Services; a First Nations Organization etc.

*(missing: 3)

SUMMARIZED RESPONSES:

1. Guiding Principles :

A community-based delivery system for the prevention of chronic diseases would include the following: # of

	supporting
1. Synergistic multi-factorial and multi-sectoral approaches that would be planned, developed, implemented and evaluated through local and provincial partnerships involving key stakeholders in a single co-ordinated system.	29
2. Primary prevention and healthy lifestyles as the focus.	30
3. Local delivery systems that are supported by a provincial population health system.	32
4. Partnership arrangements between the province, provincial organizations and local communities that are clarified to ensure continuous development and planning of a stable system.	31
5. Both evidence-based approaches and innovation for continuing success.	32
6. Accountability to its communities and partners.	32
7. Integrated programs, messages and delivery of all chronic disease prevention strategies.	31

Summary of ratings and comments

- | |
|--|
| <p>1. One of the challenges of making the new chronic disease prevention system work will be to generate a true multi-sectoral co-ordination and planning at the provincial level. To provide an equitable balance between the voices of community coalitions and provincial bodies, we recommend the formation of a Chronic Disease Prevention Steering Committee. Do you support the development of a Chronic Disease Prevention Steering Committee?</p> |
|--|

Support: 33 Do not support: 2

Summary of comments:

- Membership needs to be representational – balanced – reflect local communities
- Committee would need a clear role
- Support improved communication and collaboration- minimize duplication
- Avoid extra layer of bureaucracy

³⁷ A complete document listing individual comments is available upon request.

- Need strong leadership at the provincial level & resources
- Clear message about prevention

2. Central technical support (e.g. training and consultation) has been provided by various resource centres (HHRC, THCU, OPC etc.) of the Ontario Health Promotion Resource System (OHPRS). Do you support the continuation of the current OHPRS role?

Support 34 No not support 1

Summary of comments:

- Support has been essential and want it to continue
- System needs to be streamlined with an improved access and improved point of entry
- Identification of future needs and ways to respond to them need to be developed.
- Reduce duplication

3. An additional role for OHPRS may be to co-ordinate central program development (including the possibility of media campaigns) and distribution of prevention programs. Do you support a central program development and distribution role for OHPRS?

Support 33 Partial Support 1 Do not support 1

- Benefits include:
 - Opportunity to have cost effective program development and evaluation
 - Efficient use of resources for high quality program development.
 - Coordinated media campaigns
 - Multilingual programs
- Criteria – based on real community needs, sensitivities and issues
 - Opportunity for flexible adaptation locally – i.e., not mandated
- Concern about coordination and time needed to do something provincially

4. It has been suggested that coalitions need one brand in place to identify ALL provincial or central programs. Do you support the need for a provincial identifier for program materials?

Support 30 Partial support 1 Undecided 1 Do not support 3

- **Provincial identifier good marketing strategy, promotes unity**
- Adds to credibility of program; Adds to visibility of program -- promote recognition of programs.
 - More efficient (1 vs37)
 - Yet, value local identify and autonomy – need flexibility to include “own”
 - Process must avoid bogging down in provincial bureaucracy

5. As the complexity and depth of health promotion increases across the province, there is a need for good reporting of process and accomplishments. There have also been suggestions for a user-friendly form. We are proposing a central “activity report form” that could be accessed

on-line to provide necessary program information to document for reporting and evaluation requirements. Do you support the development of an on-line activity report form for monitoring progress ?

Support 33 Undecided 1 Do not support 1

Summary of comments:

- User friendly – KISS (keep it simple..)
- **Compiled information needs to be useful both locally and provincially**
- Not an add on to existing reports
- Update every 2 months too frequent
- Not all HU have IT support

Local system

6. In most communities, coalitions have the capacity to promote and support initiatives that enhance healthy behaviors and address the common risk factors. This existing infrastructure is a logical base from which to build the new chronic disease prevention system. Do you support the continuation of your community coalition for chronic disease prevention?

Support 32 1/2 Undecided 1 1/2 Do not support 1

Summary of comments:

- Able to build on existing accomplishments, capacity of current coalition (will take years to rebuild if disband and lose momentum)
- Need to plan/ build capacity to move in this direction
 - need to clarify mandate of health department, mandatory programs, coalition etc.
 - Need specific funding to do this
 - Transition may be difficult
- Makes sense with risk factor approach

7. Health units have contributed significantly at the local level. A stewardship role in prevention of chronic disease and health promotion is supported. Do you support the continuation of the health unit in the role as described?

Support 32 N/A 1 Do not support 2

Summary of comments:

- Synergy with Health Departments mandate and strengths
- Health Departments have infrastructure and skills – but must buy in

8. A number of ongoing roles for health units are suggested. Do you support health units performing the following roles?

Fiscal agent:	Support	[31]	Do not support [3]
Coordination/program	Support	[32]	Do not support [2]
Secretariat:	Support	[33]	Do not support [1]

Maintenance of Best Practices: Support [31] Do not support [3]

Evaluation: Support [29] Do not support [4]

9. There is a need to reconsider the current human resource requirements after 2003. A problem-solving process is suggested to develop recommendations about staffing. Do you support a problem solving process to develop recommendations about the coordinator role and staffing for chronic disease prevention at the community level?

Support 33 Not sure 2

Summary of comments:

- Look at staffing issues & coordinator – roles and responsibilities
- Start with communities where it has worked well
- Work load on coordinator “maxed” – need to consider needs if role expanded
- Local needs i.e. North need to be considered

10. The regional networks have been found to be a useful forum to share ideas and problem solve together. A peer mentoring and review process is suggested to provide support and advice to coalitions in a timely manner. Do you support the development of a peer mentoring and review process at the regional network level?

Support 26 Support in part 2 Do not support 7

Summary of comments:

- Support regional networks and peer mentoring but not necessarily having review from peers
- Reviews need to be timely
- Peers may be from matched communities outside of regional networks
- Time constraints and current skills (re mentoring) need to be considered
- Concept requires elaboration

11. The joint planning process enabled coalitions to clarify their visions and plan collaborative activities based on their dedicated resources. The recommendation is to conduct planning every two years, with a yearly update. Do you support the continuation of the joint planning process to be done every 2 years, with yearly updates?

Support 30 ½ Do not support 4½

Summary of comments

- Longer time frame for planning useful
- Would give more time for implementation (planning and reporting is taking a lot of time)
- Important to have process indicators/checks and balances in place

- Still must have flexibility based on community – to remain sensitive to community needs

12. A process for external review, including site visits by experts in community-based chronic disease prevention is being proposed. The intent would be to provide formative evaluation to local coalition members and staff in their efforts to improve their local programs. Do you support an external review process for chronic disease prevention coalitions?

Support 22 Unsure 7 Do not support 6

Summary of comments:

- Useful for identification of best practices & dissemination – or future funding requests
- Evaluators must have knowledge of local program e.g., familiar with demographics, agency partners etc.
- Must be timely and constructive

Concern about interpretation of local differences, who “expert” reviewers are, time required and costs

Funding

13. To ensure continuous, seamless transition to chronic disease prevention, the request is for long term, stable funding from the MOHLTC to community coalitions engaged in health promotion at a similar level under the current OHHP. This funding should be designated to support chronic disease prevention projects, which are collaboratively planned, implemented, and evaluated at the community level by local health units and community partners. As with the current OHHP, this funding would be allocated to the community partnerships. Are you interested in seeking ongoing stable funding for your coalition with the conditions above?

Interested 34 Not interested 1 (From telephone interviews: interested 3*)

Summary:

- Ongoing, stable funding necessary for building community partnerships and for long term planning
- Prevention strategies are by their very nature long term initiative and therefore require sustained, stable funding for projects to be effective
- Continuity important – avoid gap in funding
- Sustainability requires stable and ongoing funding
- Too time consuming to keep applying for funding
- Need to be able to convince Ministry of cost effectiveness of long term prevention dollars

* one community reported being interested only if reporting is simplified; another community reports interested in continuing as a heart health coalition

14. The CWG is suggesting additional provincial funding to support alternative models for the local coordinator (to be developed in a future consultation process). Do you support exploring different funding amounts for different communities?

Support 29 Unsure 5 Do not support 1

Summary of comments:

- Recognize provincial diversity – need to consider population – hot spots, geography, other blocks

- to successful implementation
- Need a fair formula or criteria

15 Another funding suggestion is for specific provincial funding to be allocated to support disease specific initiatives such as for cancer, stroke, diabetes, and heart disease. Do you support the suggestion for communities to seek additional provincial funding for specific disease prevention initiatives?

Support 19 Not sure 5 Do not support 11

Summary of comments:

- Application process needs to be streamlined with funding accessible to all
- Need disease specific data – and used to support requests
- Easily accessible \$\$ - available twice a year to ‘grow programs’ - quick turn around time
- Disease specific initiatives can lead to fragmentation – prefer healthy lifestyle perspective
- Could lead to competition for dollars – with larger HU having more staff to write proposals
- Could lead to return to disease silos

16. The recommendation is that the in-kind program requirement would remain as with the current OHHP. Do you support the continuation of the 2: 1 in-kind requirement?

Support 30 Do not support 5

Summary of comments:

- useful reflection of community commitment
- encourages volunteerism and participation – coalition building
- tracking needs to be simplified
- 2:1 is difficult for some communities (i.e., Small, North etc)
- “smoke and mirrors” – most is from Health Unit
- too time consuming to track

C. INFORMATION NEEDED FOR PLANNING
- Summary January 25, 2002 -

Heart Health Community Coalitions were asked to complete the following questions when reviewing the Continuation Working Group’s Draft Continuation Plan for 2003 and Beyond. Responses were received from 35 community coalitions; two separate responses coming from Toronto. The three coalitions not completing the review guide were asked about their future plans by telephone.

Has your coalition broadened its programs beyond a specific heart health approach?

	#	%
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Yes	15	39.5
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Additional diseases coalitions are addressing:	#	% of 'expanded' coalitions
Cancer	13	87%
Diabetes	8	53%
Stroke	6	40%
Osteoporosis	3	20%
Lung disease	1	7%

No [19*]

* one coalition is preparing to broaden and include diabetes

Is your coalition in favor of broadening the program to a chronic disease approach in the future?	#	%
Yes	33	87 %
No	1	3 %
Uncertain	1	3 %
Missing	3	8 %

Comments:

- With resources (training & resources and funding to do disease specific initiatives) - *multiple responses*
- If there is flexibility in diseases
- Provided strategic planning is in place along with appropriate staff.
- Providing the reporting process is made easier. More programs mean more work so if this is the way we need to spend less time on the administrative side and/or we need more staff or the staff have to prioritize and let some of their other work go.
- Challenge is how to do it.
- One partner said no – info will not be specific enough for audience to pay attention
- This inclusive, comprehensive focus would assist in avoiding duplication of programs, messages, partners

Has your coalition broadened to risk factors other than tobacco, nutrition and active living?	#	%
Yes	21	55.3
No	14	36.8
Missing	3	7.9

Which risk factors:	#	%
Stress	19	50.0
Poverty, social exclusion/environmental supports	2	5.3
Alcohol	1	2.6
Healthy weights	1	2.6
Overall wellness	1	2.6

What resources or supports do you need either at the provincial or community level to move from a heart health focus to one encompassing other chronic diseases?

	#	%
A visioning and long term planning session about chronic disease prevention	28	73.7
Information and resources on stroke* prevention – needs, gaps, best practices, plans and access to resources	23	60.5
Information about local stroke incidence* and what physicians and health professionals know about stroke prevention.	24	63.2
Professional and public education about stroke* and community supports	22	57.9

Other:

- *also for other chronic diseases (cancer, diabetes, osteoporosis) – *multiple responses*
- Why the focus on stroke? *multiple responses*
- Need someone to facilitate a community meeting where all NGO and potential players are invited to hear about this new way of funding chronic disease prevention / need to avoid putting off partners at the community level. *multiple responses*
- but information needs to be manageable in terms of volume -
- Not applicable because we don't support the broadening or expansion of the coalition.
- We would need additional funding support to do a disease specific prevention initiative.
- Need data on specific populations/ We need an assessment of our community and more statistics in order to be able to strategically determine the priorities for our area. – *multiple response*
- Organized resource centre
- Consistent messaging across the province that doesn't confuse the public or create disease "turf" wars -
- A planning session about participating with the stroke strategy.
- - Also to place more emphasis on stress as this continues to be a commonly cited ailment in the community & is addressed by our partners. / Diabetes is the biggest issue in our community
- A more holistic appreciation of the benefits of healthy lifestyle;
- The planning session on chronic disease prevention should address advocacy/ policy development

issues.

- The terms “health promotion” and “disease prevention” should be clarified.
- Guidance should be provided on how to most effectively reach high- risk populations (ex: low income).

Do you have a Regional Stroke Centre (RSC) in your community?	#	%
Yes	10	26.3
No	24	63.2
Missing	4	10.5

If yes, has your coalition had contact with the RSC ?	#	%
Yes	9	90
No	1	10

Is your coalition working with other community coalitions e.g. Cancer coalition?	#	%
Yes*	18	47.4
No	16	42.1
Missing	4	10.5

* Examples: Interagency Council for Smoking and Health, Diabetes Prevention Project; Regional Cancer Network;
Local Breast Health coalition; Nutritional Partnership; Active Living Network

Is your coalition preparing or offering programs for the primary prevention of diabetes?	#	%
Yes	11	28.9
No	20	52.6
Missing	7	18.4

D. Highlights from Additional Supporting Research and Initiatives

The following documents provide support for a population based primary prevention approach being delivered at the local level. These are listed as additional support to the local and provincial initiatives and strategies discussed in the working paper (pages 11-16).

A Report on Plans and Priorities. 1999-2000 Estimates. Health Canada

The “challenges will require not just more money but a substantial rethinking of how health services are delivered in Canada.” (p.9) Business Line 2: Promotion of Population Health (PPH) identifies five strategies to promote health. One of these strategies is to improve health and health care through public empowerment, consumer participation and better communication. This strategy includes developing more effective working relationships with the voluntary sector and engaging citizens “in enhancing the health system and the health of individuals in their communities” and promoting healthy lifestyles.(p. 50)

http://www.hc-sc.gc.ca/english/pdf/estimates/1999-2000_rpp.pdf

Primary Prevention of Type 2 Diabetes in Ontario: Policies, Research and Community Capacity;

Prepared for the Ontario Public Health Association, Victoria Nadalin; with assistance from the Research and Prevention Units, Division of Preventive Oncology, Cancer Care Ontario
September 2001

A review of the diseases of diabetes, asthma, cancer, heart disease, osteoporosis and stroke show considerable overlap in the risk factors, especially modifiable risk factors. Further there are a number of commonalities in the prevention strategies. Due to the similarities between diabetes initiatives and the goals of other disease prevention efforts, a collaborative chronic disease prevention strategy accounting for risk factors and the determinants of health is recommended. This approach, with the health of Ontarians as its endpoint, is recognized as an efficient, cost effective, streamlined alternative.

Canadian Strategy for Cancer Control; Priorities for Action; January 2002

The vision of the Canadian Strategy for Cancer Control (CSCC) is to reduce the expected number of Canadians being diagnosed with cancer, reduce the severity of the illness, enhance the quality of life of those with cancer and reduce the likelihood of dying from the disease. Primary prevention is one of five priorities for action. The objective for primary prevention is to establish a national, provincial/territorial and municipal primary prevention system to address population based risk factors for cancer and other chronic diseases, by augmenting the collaboration among chronic disease constituencies.

Other priorities for action include standards and guidelines; re-balancing focus to improve resources and systems for delivery; human resource planning; and research priorities.

<http://209.217.127.72/csccl/pdf/CSCCActionPlan2002.PDF>

A Cancer Prevention System for Canada. Canadian strategy for Cancer Control: Prevention Working Group, January 2002.

Principles stated for a cancer prevention system include:

1. Population-based public health approach that takes into consideration the determinants of health.
2. Integrated and coordinated to enhance collaboration with other major disease prevention efforts.
3. Focus on community capacity building with strong linkages.
4. Accountability to ensure performance meets standards.
5. Sustainability by building on existing networks and other infrastructure elements.

These linkages document the direction being pursued by the Canadian Strategy for Cancer Control and the Canadian Chronic Disease Prevention Alliance.

http://209.217.127.72/csccl/pdf/finalpreventionJan2002_e.PDF

Canadian Heart Health Initiative: Process Evaluation of the Demonstration Phase: Conference of Principle Investigators of Heart Health, December 2001.

This comprehensive paper describes the Canadian Heart Health Initiative and the results from the demonstration phase. The following were identified as factors for success (pg. 40):

- Community “ownership” of projects;
- Clearly defined goals, direction and roles;
- Well-planned participatory evaluation process;
- Flexible training programs and technical support designed to benefit the community over the longer term;
- A supportive policy environment;
- Health economic conditions;
- Geographical accessibility;
- Wise use of volunteer services;
- Contribution of in-kind resources;
- Access to long-term funding;
- Written standards and criteria for funding.

MOHLTC Initiatives and Reports

Healthy Pregnancy and Child Development Initiative

Using a population health approach, health units have received funding for a Healthy Pregnancy and Child Development Initiative in collaboration with existing services, programs and organizations that will establish and /or strengthen collaborative, multi-sector community-based projects in the area. The project targets people planning pregnancies, expectant parents, and families and caregivers of children aged 0-6 years.

Injury and Family Abuse Prevention

Using a population health approach, health units have received funding for an Injury and Family Abuse Prevention Initiative to develop a multi-sector coalition and 4 year plan to address childhood injury (0-6 years of age) and family abuse prevention (directed toward children 0-6 years of age and/or pregnant women).

A Public Dialogue on Health Care. A Report To The Ministry of Health And Long-Term Care. Executive Summary, January 2002.

A survey was mailed to homes across Ontario in August 2001. The results are reported from over 400,000 respondents. One conclusion states: "... Issues that the public would like to see addressed are not just human resource ones that improve access or improve service and that speak to less stressed staff or a focus on service standards, but also include prevention and early detection of illnesses. From the perspective of the Ontario public, these are the three principles that the health care system should build around." (Executive summary; 22)

A Proposed Model for the Prevention and Control of Chronic Diseases: Analogies from Communicable Diseases. K Lee; K. Rottensten. PHERO; 10/27/01; 305-311.

The authors state the need for a model for the "systematic prevention and control of chronic diseases" in part due to chronic diseases are now the leading causes of mortality and morbidity. They discuss the principles used for communicable diseases and propose these principles may be applicable for a chronic disease prevention model.

E. Resolutions and Letters of Support

2001 aPHa RESOLUTION NO. A01-4

OPHA resolution and amendment – 2001 (hard copy only)

OPHA letter final (to Minister)

2001 aPHa RESOLUTION NO. A01-4

TITLE: **Continuation of funding to ensure sustainable heart health promotion programming in Ontario**

SPONSOR: Health Promotion Ontario (Public Health)

WHEREAS cardiovascular disease and other chronic diseases continue to be the major causes of morbidity and mortality in Ontario;

WHEREAS the recent *Health Care in Canada Survey, 2000* indicates that 91% of Canadians support greater emphasis on health promotion

AND FURTHER that the *Report on the Health Status of Residents of Ontario* (Public Health Research, Education and Development Program, February 2000) has called for:

1. adequate resourcing of prevention programs and
2. balancing the availability of treatment services with prevention efforts

WHEREAS disease prevention programming is compatible with the established role of public health;

AND FURTHER that Boards of Health in Ontario continue to be the most appropriate agent to play a lead role in mobilizing community partners, planning and implementation of cardiovascular disease prevention programs;

WHEREAS the provincial heart health strategy provides a framework for action enhancing the capacity of the community to develop and sustain comprehensive, integrated community-based heart health and food security strategies;

AND multi-risk factor programming supported by the Ontario Heart Health initiative takes a broader chronic disease prevention approach that also impacts diabetes, cancer and asthma through such programs as Eat Smart and tobacco use prevention policy and programs;

WHEREAS coalitions with adequate and consistent financial and human resources over a long term have proven to be an effective means of multi-sectoral action

AND capacity and momentum in integrated heart health and food security strategies are entering a stage where success is just beginning to have a demonstrated impact;

WHEREAS the Ministry of Health is only one funder in the process with health units and community partners contributing at least 2/3's of the program support and

WHEREAS jointly managed provincial funds have been a major catalyst to this local contribution; and

WHEREAS without continuity of provincial funding, the capacity of community partners to sustain local program coordination and implementation would be compromised;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (ALPHA) and the Ontario Public Health Association (OPHA) urge the Ministry of Health and Long Term Care to provide sustainable funding to the Provincial heart Health Strategy;

AND FURTHER, that the Ministry of Health and Long Term Care support policy and program strategies which prevent cardiovascular and other chronic diseases in the population, including a provincial resource system which ensures access by public and community health professionals to on-going research, training and support.

January 8, 2002

The Honourable Tony Clement
MPP Brampton West
Minister of Health and Long Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

RE: Concern about Termination of Ontario Heart Health Program

Dear Minister Clement

The mission of the Ontario Public Health Association (OPHA) is to strengthen the impact of people who are active in community and public health through Ontario. OPHA achieves this through education, advocacy, issue identification, public health expertise, and consultation in public and community health. OPHA represents the collective interests of approximately 3,000 individuals in public and community health through individual and constituent society memberships.

At its recent annual general meeting, the membership of OPHA voted to express its support of the Ontario Heart Health Program (OHHP) and to express concern regarding the Program's upcoming termination.

The OHHP, launched in 1998, is a \$17 million (\$3.4 million per year for five years) provincial program designed to address the three leading modifiable risk factors (smoking, physical inactivity and unhealthy eating) associated with heart disease. Since the program's inception, public health and community partners have been working together in 37 health unit areas across the province to promote healthy living, provide behaviour change opportunities, build supportive environments and influence healthy policy. The current OHHP structure facilitates an impressive return for investment by leveraging involvement of community partners and by reducing the burden of illness and treatment costs for chronic disease. The OHHP currently offers approximately 500 activities across Ontario.

-2-

Under the current OHHP guidelines, communities must invest a minimum of \$2 for every \$1 contributed by the MOHLTC. During the 1998/99 fiscal year, communities contributed over \$10 million as in-kind support and by the 2000/01 fiscal year, the community contribution increased to \$11 million. This represents an average investment of 3.9 local dollars for every one provincial dollar.

The OHHP also provides an opportunity for community partner and volunteer involvement. In the 1998/99 fiscal year over 1,100 groups were members of the heart health partnerships across the province. This grew to 2,500 groups by 2000/01 fiscal year.

The OHHP has the capacity to become the system by which all chronic disease prevention messages including cancer, diabetes, stroke as well as heart disease, are delivered. An integrated approach reduces the duplication of effort at the local level, maximizes opportunities for joint initiatives and respects the unique programming needs of each disease prevention area. This reduces the competition for limited community resources while promoting a comprehensive and integrated approach to healthy living and disease prevention.

OPHA would appreciate your assurances that the OHHP will not be terminated and that sustainable funding will be made available. The OHHP communities are planning for their final year right now, and unless funding is extended many communities will commence terminating their activities. **Immediate action is necessary to prevent this loss.**

Yours truly,

Connie Uetrecht
President, Ontario Public Health Association

Copy:

- Dr. Colin D’Cunha, Chief Medical Officer of Health and Director, Public Health Branch, MOHLTC
- Andrew Papadopoulos, Executive Director, Association of Local Public Health Agencies
- Karen Bays, Chair, Continuation Working Group, Ontario Heart Health Network (City of Ottawa Health Department)