



***The Active Living Coalition for Older Adults (ALCOA)
envisions a society where all older Canadians are living
active lifestyles thereby contributing to their physical
and overall well-being.***

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Active Living and Diabetes: Building on our Successes

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Welcome ALCOA Delegates:

On behalf of the ALCOA Executive and Guardians, I would like to welcome you to our national meeting and thank you for finding the time in your busy schedules to be able to attend. This national meeting is the culmination of a year of work relating to the prevention of type 2 diabetes in older adults. This project was made possible by funding available through the Public Health Agency of Canada. The components of the project included surveying older adults and service providers, gathering 'leading practice' programs, conducting three regional meetings in the west, central and eastern Canada, and now our national meeting. It is our hope at this meeting that we will be able to develop *National Recommendations for Action*, that ensure that all the good work done in this past year will continue to move forward, and eventually assist in the prevention of type 2 diabetes in older adults.

The consultants on this project must be recognized for their hard work and devotion. Not only did they ensure that the outcomes of this project would be achieved, but it was also very important that the final product was one of high quality and that it would be useful to the industry. Our sincere thanks to:

- ❖ Jane Larlee - Addison (Vancouver BC)
- ❖ Annette Penney - Maurer (Kitchener, ON)
- ❖ Patsy Beattie - Huggan (Charlottetown, PEI)

I hope you find this manual and the two day meetings to be informative and useful to you in your profession. We value your input and knowledge and are most appreciative of you sharing your time and expertise with ALCOA.

Sincerely,

Patricia Clark

National Executive Director



ENVIRONMENTAL SCAN OF COMMUNITY BASED INTERVENTIONS THAT ADDRESS PRIMARY PREVENTION OF TYPE 2 DIABETES IN OLDER ADULTS

February 2008

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INTRODUCTION

This environmental scan document contains resource information on programs that are currently being provided to older adults in various communities across Canada. These programs are considered to be making a difference to the health and well being of older adults in their quest to engage in active living in an attempt to prevent the onset of Type 2 Diabetes.

As part of the research in identifying leading practices of community-based interventions targeted at primary prevention of Type 2 Diabetes in older adults, a scan of programs across Canada was conducted. Consultants hired by the Active Living Coalition for Older Adults (ALCOA) in Western, Central and Atlantic Canada solicited the assistance of regional health and recreation service providers in collecting program information on leading practices in this area. Information sources included the Canadian Diabetes Association at the national and provincial levels, Coalition for Active Living (Federal Govt.) and other nongovernmental organizations such as the Heart and Stroke Association, Arthritis Society and Lung Association. Provincial sources included ministries of health, health authorities and/or departments in every province, community and family health clinics /centers, community senior's networks and community parks and recreation programs. Program descriptions were received through these channels and subsequently reviewed against the following best practice criteria which had been developed for the project. These criteria were determined through a review of existing literature on primary prevention of Type 2 Diabetes and to reflect the focus of the project.

Best Practices Criteria:

- Targets Older Adult Population (50+)
- Component of Physical Activity
- Focus on Primary Prevention
- Evidence-based
- At least one evaluation with positive outcome
- Includes a measurement tool
- Promotes personal or social change
- Implemented directly by provider
- Sustainable and/or partnered with another organization

Regional advisory committees with stakeholder and consumer representation were formed in each region. Consultation meetings with the committee representatives were held in Vancouver, Toronto, Moncton and Halifax to review and validate the information on the leading practices identified in the environmental scan process. During these meetings it was determined that many of the programs reviewed in this scan, while successful in engaging older adults, do not measure progress of participants or are not yet to be evaluated. As a result, and based on discussion about the term 'best practice' and the interpretation of the term, new terms were identified for the purposes of reporting. These terms were reviewed and agreed to by one of the regional advisory committees. Input provided by the regional representatives in ranking and identifying the programs has been summarized in the following 3 categories for the purposes of this resource document.

Leading, Promising and Complimentary Practices.

Leading

- A leading practice is recognized as one which meets all the criteria developed for this project (see criteria above).

Promising

- A promising practice program is recognized for the opportunity to become leading practice by making an adjustment to include an element such as measurement or evaluation.

Complimentary

- A complimentary practice is recognized as one which does not include physical activity but complements both leading and promising practices due to its focus on screening, nutrition, retirement, etc.

The environmental scan and this document are limited by the time available during this project. However, the document does provide a sample of programs currently in existence throughout Canada and provides a foundation for discussion of future programming for primary prevention of Type 2 Diabetes. The physical activity benefits and opportunities provided through the various programs outlined in this document will hopefully be a useful resource in assisting individuals living in healthy communities to reduce the incidence of Type 2 Diabetes.

DEFINITION OF TERMS

Active living	ALCOA members subscribe to the World Health Organization's (WHO) definition of active living as: A way of life in which physical, social, mental, emotional and spiritual activities are valued and are integrated into daily living.
Healthy eating	Healthy eating is about maintaining a healthy diet through choices about what to eat with the intent of improving or maintaining good health. This includes: balancing the foods you eat; eating breakfast; including at least 4 out of 5 food groups from Canada's Food Guide at each meal, and enjoying three meals a day, healthy snacks and plenty of water. In order to be more inclusive of the diverse ethnic populations in Canada, more options should be made under the various food groups in Canada's Food Guide to make allowances for ethnic preferences.
Diabetes	<p>Diabetes is a disease that interferes with the body's ability to properly use insulin, a hormone essential for the proper use of the energy contained in the food we eat. There are three primary types of diabetes: type 1, where the body makes little or no insulin; type 2, where the body makes insulin but cannot use it, and gestational diabetes, which arises during pregnancy. Over time, diabetes can lead to life-threatening and debilitating complications, such as hypoglycemia, cardiovascular disease, stroke, high blood pressure and lower limb amputations.</p> <p>A number of risk factors have been identified as contributing to diabetes. These include being a member of a specific population group, having a family member with diabetes, leading a sedentary lifestyle, being excessively overweight, poor eating habits and age. One of the population groups at highest risk is seniors: 10% of Canadians over the age of 65 have the disease, compared to 3% of those aged 35 to 64.</p>
Older adults	As set out in ALCOA's guides for health care professionals and individuals with diabetes, the criteria for an older adult will be a person who is 50 years of age or older.
Primary Prevention:	Prevention that is directed towards preventing the initial occurrence of disease or disorder (WHO). For the purpose of this project primary prevention includes activities designed to prevent the delay or the onset of Type 2 Diabetes in older adults through modifications of the environment and/or actions to address behavioural risk factors. (modified from the CDA)

Regional Advisory Committee	A committee in each region, (Western, Central and Atlantic Canada) made up of individuals who represent organizations who work with seniors, community groups, or individuals who design programs for seniors (e.g. municipal fitness directors).
National Advisory Committee	The Committee, comprised of 6 to 7 individuals, selected by the Executive Director and Past Chairman, and approved by the Guardians, will provide advice to the Project Leader (National Executive Director) during the term of the project.
Corporate members	These are members who are corporate organizations with an interest in the care and prevention of diabetes in older adults. Currently there are two corporate members: Aventis Pharma Inc. and Merck Frosst. Merck Frosst has agreed to appoint one of their staff to the National Advisory Committee. Aventis participation is yet to be determined.
Corresponding members	These are international, national, provincial or community associations and government, educational institutions, corporations or foundations who are interested in: furthering active living for older adults; promoting ALCOA materials and resources within their respective networks; and who volunteer on ALCOA task forces and Ad Hoc committees. There are currently 57 corresponding members whose role in this project is to assist with making connections and helping the consultants to collect data from older adults.
Roundtable members	Includes 23 members who oversee the strategic direction of ALCOA. Their role in this project will be to assist with making connections and helping the consultants to collect data from older adults.
Environmental scan	The goal of our environmental scans will be to locate organizations (regionally) who offer information, programs or services designed to address the care and/or prevention of diabetes in older adults. The types of organizations need not be limited to regional health authorities, health departments or types of health centres but can also include volunteer organizations, non-profit/charitable organizations and private sector businesses. A thorough environmental scan will adequately answer the question, <i>“What is out there in my region to address the care and prevention of diabetes in older adults?”</i> It will also assist in the identification of gaps in programs and services that exist for older adults with diabetes. “Ideal” diabetes care and prevention programs or services for older adults will have been in existence long enough to have a documented evaluation for effectiveness OR will have performed an evaluation in the past year and can make a statement about their outcomes.

Best practices	A scan across Canada, dealing with primary prevention of the initial occurrence of Type 2 Diabetes in older adults. Prevention programs may include informational pieces, outreach activities and programs, and process issues. Activities should be designed to prevent the delay or onset of Type 2 Diabetes in older adults through modifications of the environment and /or actions to address behavioural risk factors. The intervention could be multi-faceted but must contain at least one component designed to engage participants in some form of physical activity.
Leading Practice	A leading practice is recognized as one which meets all the criteria developed for this project (see best practice criteria in introduction).
Promising Practice	A promising practice program is recognized for the opportunity to become leading practice by making an adjustment to include an element such as measurement or evaluation.
Complimentary Practice	A complimentary practice is recognized as one which does not include physical activity but complements both leading and promising practices due to its focus on screening, nutrition, retirement, etc.
Key stakeholder	<p>Stakeholders are people who will have an interest in the outcome of this project and will be able to utilize the information to enhance or improve their current offerings to their members. They include individuals who currently work with seniors in any setting:</p> <ul style="list-style-type: none"> • organizations who offer programs or resources for seniors • community groups who offer programs or resources for seniors • programmers/directors at fitness facilities, such as private clubs, municipalities, employee fitness programs, not-for-profit who offer programs for seniors, or are interesting in offering programs in the future. • health care providers
Measurement tool	Survey, questionnaire, semi-structured or structured interviews designed to gather information or collect data. For the purposes of this project, tools will be designed to conduct a needs assessment of diabetes programs and services available throughout the regions.

Needs assessment

A method of locating diabetes resources to older adults in communities (within a region; a cataloguing of these resources which include programs, services, information and facilities/organizations offering such services. The goal of a needs assessment for this project is to identify (and measure?) the level of unmet needs (gaps) with respect to availability of programs, services and information available to address the care and prevention of diabetes in older adults. Identify distribution of such services and note any apparent gaps. Detection of differences and similarities in programs will be noted.

Terms of reference

This is a roadmap which describes the work needed to be done, when and by whom. The scope and constraints set out in this document determines the deliverables. Terms of reference will include: vision, objectives and scope of the project as well as who the stakeholders are and what their specific roles and responsibilities will be. A plan for resources and how the plans will be achieved is desirable as is a breakdown of the work with a structure and schedule in place.

BEST OR LEADING PRACTICES

BC Healthy Living Program - BC

Sponsoring Organization	Vancouver Coastal Health, British Columbia
Program Leader(s)	Maylene Fong
Target Population(s)	Ages 35 – 65 who are “well”, “well-at-risk” for chronic diseases or have “early/asymptomatic” chronic disease, and whose life circumstances include one or more of the following: low income; low education; new Canadian/immigrant; aboriginal peoples and socially isolated
Contact	Maylene Fong Tel: (604) 708-5255 Email: maylene.fong@vch.ca

Description

The program identifies population ‘at risk’ for developing high prevalence chronic disease in Vancouver Community and provides health screening and linkages to community resources. The program targets the three pillars of Healthy Living including: healthy eating, physical activity and tobacco reduction.

Highlights/Successes

- provided diabetes and health screening events in the community
- developing partnerships with the community and community leaders
- implementing a grant process to provide seed money for community initiatives

Challenges

- developing the partnerships and linkages with community takes time
- cultural and diversity issues

What makes this program innovative or a best/leading practice?

This program is unique in that it provides primary and secondary prevention for high risk populations that currently do not receive or have easy access to health education or services. The program’s goal is to partnership with community leaders, organizations to also enhance their capacity in the areas of healthy eating, increase physical activity and increase overall health awareness to prevent the development of chronic diseases. The program aims to reach population’s at high risk that are negatively impacted by social determinants of health.

Program Assessment

<p><i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i></p>	<p>Community & Public Health</p>
<p><i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i></p>	<p>Yes</p>
<p><i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i></p>	<p>The program will have an “Active Living Coordinator” position, whose role will be identifying and partnering with these community resources to link them back to the high risk population to access. One of our grants currently in progress has provided seed money to develop a walking program with volunteer leaders within a ethnic population.</p>
<p><i>Does it focus on primary prevention?</i></p>	<p>Yes</p>
<p><i>Is the program is evidence based?</i></p>	<p>Yes</p>
<p><i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i></p>	<p>Yes - glucose testing, B/P, BMI, and abdominal girth.</p>
<p><i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i></p>	<p>So far the evaluation of the program has mainly focused on our health screening which includes, glucose testing, B/P, BMI, and abdominal girth.</p>
<p><i>Does it involve an intervention to promote personal or social change?</i></p>	<p>Yes</p>
<p><i>Does the provider (organization) directly implement the program?</i></p>	<p>Yes</p>
<p><i>Is the program sustainable and/or partnered with another organization?</i></p>	<p>Yes</p>
<p><i>Are program leaders trained to deliver the program? (What type of training have they received?)</i></p>	<p>Yes</p>

The Chronic Disease Self Management Program - BC

Sponsoring Organization	<i>Each province has its own sponsoring arrangement.</i>
Program Leader(s)	<i>British Columbia: Patrick McGowan mcgowan@dccnet.com Yukon: Rebecca Fenton rainbow@northwestel.net Alberta: Elly Webster ewebster@chr.ab.ca Saskatchewan: Suzanne Sheppard Suzanne.sheppard@saskatoonhealthregion.ca Manitoba: Caitlin Keyzer ckeyzer@sogh.mb.ca Ontario: Durhane Wong-Rieger durhane@sympatico.ca Quebec: Deborah Radcliffe-Branch deborah.radcliffe-branch@muhc.mcgill.ca Nova Scotia: Susan Miles smiles@avdha.nshealth.ca New Brunswick: Beverly Greene Beverly.greene@gnb.ca Prince Edward Island: Laraine Poole lfpoole@ihis.org Newfoundland: Ann Colbourne Acolbourne@nl.rogers.com</i>
Target Population(s)	<i>Adults</i>
Contact	<i>Dr. Patrick McGowan Tel: (604) 940-3974 Email: mcgowan@dccnet.com</i>

Description

The Chronic Disease Self-Management Program (CDSMP) is a lay-led patient education program. Trained lay leaders meet with groups of 10-12 persons with chronic diseases for 2 ½ hours once each week for six consecutive weeks. Course participants are persons who are experiencing any type of chronic health condition; their significant others also are encouraged to attend. Although different chronic health conditions may have different physical impacts on a person's body, they often cause similar problems related to activities of daily living interaction with the health care system, communication with family and friends, and dealing with negative emotions such as fear, anxiety and depression. The program gives people confidence, information and skills to manage their health.

The CDSMP teaches the following content:

- how to develop a suitable exercise program
- cognitive symptom management
- healthy eating
- breathing exercises
- problem solving
- communication skills (with family, friends, and health care providers)
- use of medication; and how to deal with the emotions of chronic illness (anger and depression)

Highlights/successes

In the program, participants obtain new information, learn new skills and abilities, and develop new ways to manage and cope with chronic health conditions. Participants give and receive support from others who are experiencing similar health conditions. As well, they realize they are not alone and the difficulties they are experiencing are normal.

Sessions are highly interactive with emphasis on strategies to help individuals manage more effectively. Content includes skills mastery (accomplished through weekly contracting to do specific behaviours and through feedback), and modeling (accomplished by lay leaders with chronic conditions), and leaders frequently use problem-solving strategies.

Challenges

Program leaders are recruited from the community and receive a four-day training to become a program leader. These leaders provide a commitment to implement two programs. As leaders personally experience chronic health conditions, the program needs to continually recruit and train new leaders.

What makes this program a leading/best practice?

Several assumptions underlie the program:

- people with chronic conditions have similar concerns and problems; people with chronic conditions must deal not only with their disease(s), but also with the impact on their lives and emotions;
- lay people with chronic conditions, when given a detailed leader's manual, can teach the CDSMP as effectively, if not more effectively, than health professionals; and the process or the way that the CDSMP is taught is as important, if not more important, than the subject matter that is taught.

All of these assumptions have been evaluated in published studies. In a five year research project, the CDSMP was evaluated in a randomized study involving more than 1000 subjects. This study found that people who took the program, when compared to people who did not take the program, improved their healthful behaviours (exercise, cognitive symptom management, coping and communications with physicians), improved their health status (self-reported health, fatigue, disability, social/role activities, and health distress), and decreased their days in the hospital.

Program Assessment

<p><i>Is this program focused on community, individual/family or public health?</i></p>	<p>Individual Community – builds community capacity</p>
<p><i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i></p>	<p>Yes</p>
<p><i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i></p>	<p>Yes</p>
<p><i>Does it focus on primary prevention?</i></p>	<p>Yes</p>
<p><i>Is the program is evidence based?</i></p>	<p>Yes – a comprehensive literature review found that self-management training is effective in helping people manage diabetes, asthma, hypertension, depression, and congestive heart failure (BC Office of Health Technology Assessment, 2002). Also, refer to following website: http://patienteducation.stanford.edu/bibliog.html</p>
<p><i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i></p>	<p>Yes – standardized measurement tools are used in 25 countries. Measurement tools used in evaluating impact in diabetes. Outcome and economic studies also conducted</p>
<p><i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i></p>	<p>Yes, see the bibliography at the Stanford Patient Education Research Center http://patienteducation.stanford.edu/bibliog.html Also, refer to BC website at www.coag.uvic.ca/cdsmp</p>
<p><i>Does it involve an intervention to promote personal or social change?</i></p>	<p>Yes</p>
<p><i>Does the provider (organization) directly implement the program?</i></p>	<p>Yes</p>
<p><i>Is the program sustainable and/or partnered with another organization?</i></p>	<p>Yes</p>
<p><i>Are program leaders trained to deliver the program?</i></p>	<p>Yes. The program is given by pairs of trained lay leaders who follow a scripted Leader's Manual. Each leader must successfully complete a four-day training workshop before he/she can lead the program. Ideally, leaders should take the program before they become leaders. Courses are delivered in community settings (senior centres, libraries and recreation centres).</p>

Healthy Alberta Communities - AB

Sponsoring Organization	Centre for Health Promotion Studies, School of Public Health, University of Alberta
Program Leader(s)	Heather Deegan, Project Coordinator
Target Population(s)	Communities throughout Alberta
Contact	Heather Deegan
	Tel: (780) 492-2064 Email: heather.deegan@ualberta.ca

Description

Healthy Alberta Communities is a community-based chronic disease prevention project based in four communities throughout Alberta, funded by Alberta Health and Wellness from 2004-2010. Project work is ultimately addressing the four leading causes of death; Type 2 Diabetes, heart disease, cancer and obstructive lung disease, which result from common modifiable lifestyle-related risk factors. The project is developing and implementing customized interventions based on extensive community consultation and citizen engagement in every step of activity, including stakeholder identification of community priorities and collaborative development and delivery of initiatives through intersectoral partnerships.

Primary prevention is the foundation of the Healthy Alberta Communities approach, by addressing the socio-environmental determinants of health. The overarching aim is to create environments in the four communities where *healthy choices are easier* (related to the three behavioural risk factors of physical activity, healthy eating and tobacco reduction). The WHO definition of “active living” is directly applicable to the overall approach of the Healthy Alberta Communities project, with an equal emphasis on physical activity and the other domains of social, mental, emotional and spiritual activities. Community development through capacity-building is a strong focus of project activity, with the expectation that short term investments through the resource contribution of the Healthy Alberta Communities project (staff time plus financial) will lead to sustained change in communities.

Highlights/Successes

Community Mile Project, St. Paul

The Iron Horse Trail has been an important mode of physical activity for community members, as well as a source of community pride to be a part of the provincial and national trails initiatives. St. Paul has adopted the *Community Mile Project* to expand the local trail system that will eventually encompass the entire town and permit a completed circuit for recreational activity that will be accessible at numerous entry points in residential and commercial locations around the town. The mayor has become a strong community champion for the *Community Mile Project* and has recently challenged local businesses and community members to make donations of funds that will be matched with municipal and provincial dollars. The Healthy Alberta Communities project has provided some money for publicity through local advertising, a Nordic walking poles workshop provided free for community members, and certificates of recognition for donors, as well as a community launch of the initiative. The publicity and other activities have garnered \$25,000 in local contributions in five short months, and recently a local business has encouraged its employees to achieve physical activity goals (steps/day), and in exchange the business will make regular financial donations to the *Community Mile Project*.

Mayor's Walk/Run, Redcliff (Medicine Hat)

The *Mayor's Walk/Run* in Redcliff (a community of 5,000 outside of Medicine Hat) emerged through discussions with community partners and residents regarding the components of a healthy, vibrant community. A key partner in the planning phase was the Town of Redcliff Community Services Department. Early in 2006 the concept of hosting an event to showcase local opportunities for physical activity began to develop. It was also identified that this event presented an opportunity to provide information about established community programs that support health. The overall goal of the event was to promote Redcliff as a vibrant community that is supportive of all facets of active living. Through discussion and research, the *Mayor's Walk/Run*, an established program through Recreation for Life, was selected as the community event that would achieve the overall goal.

The annual spring festival "Redcliff Days" presented an opportunity to hook the new *Mayor's Walk/Run* to an existing, long-standing community celebration. Healthy Alberta Communities provided some financial support and strong leadership and worked with partners to host the Redcliff *Mayor's Walk/Run* as a kick-off event to the 2006 Redcliff Days. It was a successful event that saw involvement of many community members, including management staff from the municipality, municipal leaders, and the Mayor. Organizations involved in sports and recreation volunteered time to assist with the event, and local business provided financial donations that assisted with costs.

The following year saw increased interest in hosting the *Mayor's Walk/Run* again, and at that time Healthy Alberta Communities handed the event organization and leadership to the community, taking more of a backseat role. When the community and partners took on a more active role in planning the event, the municipality made the decision to use the opportunity to showcase the Red Trail, a small Redcliff trail system that community members hold as a source of pride. The municipality earmarked some dollars to expand the Red Trail so it could accommodate the full 5k *Mayor's Walk/Run*, thereby exposing community members to a new, expanded trail and demonstrate the ease of access to physical activity in their community. Year two of the Redcliff *Mayor's Walk/Run* saw increased community participation and the citizens now have an expanded trail system to support active living in its various dimensions.

Challenges

- Respecting community's process for planning and development, on community's timeline, rather than imposing personal or project timelines.
- Dealing with, and incorporating (if possible) "community-wide crises" as they emerge so they don't overshadow careful planning and development of previous high-priority plans and activities.
- Understanding and working with complex and long-standing political undercurrents that dictate how partners work (or don't work) together.

What makes this program innovative or a best/leading practice?

The process for working collaboratively with community stakeholders to develop customized interventions utilizing a community capacity building approach. Community engagement at every step of the way fosters ownership and sustainability.

Program Assessment

<i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i>	Community
<i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i>	18 and older See description above.
<i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i>	Yes, see description above.
<i>Does it focus on primary prevention?</i>	Yes
<i>Is the program is evidence based?</i>	Yes
<i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i>	Yes
<i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i>	Yes, the overall approach is based on population health interventions for integrated chronic disease prevention as demonstrated in North Karelia Finland.
<i>Does it involve an intervention to promote personal or social change?</i>	Yes
<i>Does the provider (organization) directly implement the program?</i>	Yes
<i>Is the program sustainable and/or partnered with another organization?</i>	Yes
<i>Are program leaders trained to deliver the program? (What type of training have they received?)</i>	Yes. Education and skills development for community capacity building, community development and other training specific to respective interventions.

10 Weeks to a Healthy U Program - AB

Sponsoring Organization	Chinook Health, Lethbridge, Alberta
Program Leader(s)	Lori Chaki-Farrington/Sherri Sterling
Target Population(s)	Individuals who are at-risk or have been diagnosed with a chronic condition (including Diabetes)
Contact	Lori Charki-Farrington
	Tel: (403) 394 7763 Email: LChaki-farrington@chr.ab.ca

Description

The program is a 10 week exercise and education program for individuals who are at-risk or who have been diagnosed with a chronic condition. The purpose of the program is to help individuals develop self manage skills with respect to healthy eating and exercising. The program is overseen by a multidisciplinary team of healthcare professionals and is located in a community facility. Maintenance programs for individuals who “graduate” from the program are being developed through various partnerships in our community. The program is currently available in 1 urban and 3 rural sites within the health region.

Highlights/Successes

- Promotion of self-management
- Development of community partners
- Great outcome data
- Taken chronic condition treatment out of “silos”
- Use multidisciplinary treatment teams
- Promotion of “Common Messages”

Challenges

- Resources
- Ability to accommodate all eligible participants
- Initial “buy-in” from clients

What makes this program innovative or a best/leading practice?

The program follows best-practices based on current evidence. The common piece of exercise and healthy eating is generally no different across the chronic illness spectrum, so all groups are able to exercise and learn together – this eliminates the “silo” groupings and redundant lifestyle programs - this makes better use of limited resources. The program philosophy of self-management allows individuals to feel self confident that they are able to exercise at home. The program is able to accommodate more individuals who require this lifestyle intervention instead of creating longer wait lists for individuals to access disease specific programs that may only accommodate small numbers of eligible participants.

Program Assessment

<p><i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i></p>	<p>Community & Individual</p>
<p><i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i></p>	<p>The majority of the participants are older adults because of the age-nature of chronic illness and due to the time of day of the programs. The age range is currently 22-83 years with an average of 62 years.</p>
<p><i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i></p>	<p>The exercise program is progressive over the 10 weeks with the goal of 30 minutes of continuous exercise after 3 months, 60 minutes after 6 months, and a maintenance duration of 60-90 minutes at 1 year. Components of the program such as dynamic/static stretching, Home Support Exercise Program, and resistance exercises are taught to the individuals on a weekly basis and these components are integrated into their walking programs.</p>
<p><i>Does it focus on primary prevention?</i></p>	<p>Primary & Management</p>
<p><i>Is the program is evidence based?</i></p>	<p>Yes</p>
<p><i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i></p>	<p>Pre and post assessments are conducted on all individuals referred into the program. Measurements include Body Composition (height, weight, waist circumference), Endurance (6-Minute Walk), Functional (3 Meter Timed-Up-and-Go), and Self Perception of Health (SF 36 Health Survey).</p>
<p><i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i></p>	<p>The pre and post assessment data is kept in our health region's database for continual review and analysis. The region is looking to write a discussion paper based on the program findings.</p>
<p><i>Does it involve an intervention to promote personal or social change?</i></p>	<p>Yes</p>
<p><i>Does the provider (organization) directly implement the program?</i></p>	<p>Collaborative</p>
<p><i>Is the program sustainable and/or partnered with another organization?</i></p>	<p>Yes</p>
<p><i>Are program leaders trained to deliver the program?</i></p>	<p>Yes</p>

in motion Programs - SK

<i>Sponsoring Organization</i>	<i>Saskatoon Health Region (University of Saskatchewan, City of Saskatoon, ParticipACTION)</i>
<i>Program Leader(s)</i>	<i>Linda Martin, Director and Professional Leader, Linda.martin@saskatoonhealthregion.ca, 306.655.8153</i>
<i>Target Population(s)</i>	<i>Children and Youth, Workplace Wellness, Inactive Adults, Primary Prevention of Diabetes, Healthcare Professional Referral, Older Adults</i>
<i>Contact</i>	<i>Nancy Lackie</i> <i>Tel: (306) 655-8262</i> <i>Email: nancy.lackie@saskatoonhealthregion.ca</i>

Description

In motion is a comprehensive health promotion strategy to increase physical activity through partnerships, community awareness, targeted strategies, research and evaluation. The founding partners (a regional health authority, university, municipal government, and national physical activity promotion organization) work at a community level through multisectoral collaboration (e.g. industry and business community, media, community organizations, cultural agencies, school boards, policy makers). Part of ***in motion***'s vision is to serve as a model for provincial, national, and international initiatives. Based on numerous accolades and inquiries received for physical activity strategies, ***in motion*** has now packaged its expertise, experience, and resources into products and consultative services. As a result the ***in motion*** model has been shared with over fifteen Canadian communities.

Highlights/Successes

- The number of Saskatoon residents who report being active enough to receive health benefits increased 39 percent during ***in motion***'s first five years of operation
- 61% of residents recall seeing, hearing or reading about ***in motion***
- Have 124 ***in motion*** schools, 160 ***in motion*** workplaces, 50 Forever...***in motion*** older adult exercise programs occurring in congregate housing and community facilities, 5 diabetes screenings with ethno cultural populations, 40 family physicians trained (18 clinics involved) in PACE Canada with more than 380 patients counselled, 1037 beginner fitness programs offered with 5868 participants,
- Received \$1,755,000 over 5 years from CAHR/CIHR:
- Community Alliances for Health Research - a branch of the Canadian Institute for Health Research
- Largest physical activity research grant in Canada
- Collaborate with over 100 organizations (physicians/healthcare professionals, school divisions, business community, non-profit organizations, chronic disease groups, local media, community ambassadors)

- Built community capacity as shown by an increase in Laverack’s nine domains of community capacity

Challenges

- Limited resources to expand to other target areas
- Maintaining and nurturing partnerships

What makes this program innovative or a best/leading practice?

- Maintains a focus on physical activity for health benefits.
- Community-based
- Driven by four key components of building partnerships, creating community awareness, targeted strategies, measuring our success
- Built upon shared values of working together to improve health.
- Collaborative community partnerships at all levels.
- Uses existing program delivery systems and administrative structures.
- Community – University alliance.
- Evidence-based research

As a result of *in motion*’s success, the Saskatoon multi-sectoral team has become leaders in physical activity community mobilization sharing the *in motion* model with over fifteen communities across Canada. *In motion*’s consultation and resources enable cities and provinces to use such information to successfully increase participation in physical activity among their residents, and in the process, build capacity of their community to ensure effectiveness and sustainability of their physical activity health promotion programs.

Program Assessment	
<i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i>	See program description
<i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i>	Older Adults are one of three population groups targeted and one of six targeted strategies (see the program description for more detail).
<i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i>	The focus is physical activity and is incorporated through communications and marketing and targeted strategies.
<i>Does it focus on primary prevention?</i>	Yes
<i>Is the program is evidence based?</i>	Yes

Program Assessment

<p><i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i></p>	<p>Yes</p>
<p><i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i></p>	<p>Evaluation of in motion is an ongoing and critical process to the initiative. Of fundamental importance is the strategy's built-in program evaluation and University of Saskatchewan led research.</p> <p>in motion Physical Activity Baseline and Follow-up Surveys</p> <p>Physical activity levels and awareness</p> <p>The number of Saskatoon residents who report being active enough to receive health benefits increased 39 percent during in motion's first five years of operation</p> <p>Communications and Marketing Research and Evaluation</p> <p>Campaign recalls, surveys, focus groups</p> <p>76% recall seeing, hearing or reading about in motion</p> <p>Agreed that the message delivered by the in motion media campaign is effective</p> <p>They believe residents are more aware of the importance of physical activity</p> <p>However, it is difficult to identify exactly where or when they have received the message</p> <p>Targeted Strategy Evaluation</p> <p>ongoing evaluation and research of initiatives within all targeted community strategies</p> <p>Research</p> <p>Built community capacity as shown by an increase in Laverack's nine domains of community capacity</p>
<p><i>Does it involve an intervention to promote personal or social change?</i></p>	<p>Yes</p>
<p><i>Does the provider (organization) directly implement the program?</i></p>	<p>Yes</p>
<p><i>Is the program sustainable and/or partnered with another organization?</i></p>	<p>Yes and Yes</p>
<p><i>Are program leaders trained to deliver the program? (What type of training have they received?)</i></p>	<p>Yes</p>

Steppin' Out with Confidence - MB

Sponsoring Organization	Various Partners
Program Leader(s)	Vary from community to community
Target Population(s)	55 plus
Contact	Madeline Kohut
	Tel: (204) 940-8574 Email: Mkohut@wrha.mb.ca

Description

Peer lead walking program following same model as Steppin' Up with Confidence

Highlights/Successes

- Positive feedback.
- Development of walking clubs in many communities.

Challenges

- Identifying and recruiting peer leaders

What makes this program innovative or a best/leading practice?

This program is innovative and effective and based on best/promising practice. The program is delivered by various partners.

Program Assessment

<i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i>	On older adult/community
<i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i>	55 plus
<i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i>	Has physical activity model
<i>Does it focus on primary prevention?</i>	Health promotion
<i>Is the program is evidence based?</i>	Yes
<i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i>	No
<i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i>	Yes
<i>Does it involve an intervention to promote personal or social change?</i>	Yes
<i>Does the provider (organization) directly implement the program?</i>	Yes
<i>Is the program sustainable and/or partnered with another organization?</i>	Various community partners
<i>Are program leaders trained to deliver the program? (What type of training have they received?)</i>	Yes

Healthier Weigh - MB

Sponsoring Organization	Reh-Fit Centre
Program Leader(s)	Dale Kornelson (dietitian) Julie McPetrie(fitness consultant) Michelle Meade (project manager)
Target Population(s)	Obese adults
Contact	Michelle Meade Tel: (204) 488-8023 Email: michelle.meade@reh-fit.com

Description

The Healthier Weigh is a 16 week lifestyle-intervention program for obese adults facilitated by a registered dietician and fitness consultant. Focus is on lifestyle changes.

There are 10 weekly education and exercise classes designed to provide the participants with the information and tools to determine their personal food management and activity plan monitored by our program facilitators. During the last 6 weeks the participants work out at the facility independently, meet one-on-one with the dietitian to address any outstanding issues and see the fitness consultant regarding exercise-related questions. There are two option sessions arranged for the group-topics/activities selected are dependant on that groups area of interest. E.g. pilates, spin cycle class, yoga or Cravings and Binge Eating

The program includes pre and post assessment consisting of a blood lipid analysis, anthropometric measurements and a graded exercise tolerance test.

All participants are asked to workout at the facility a minimum of three times a week for the duration of the program.

Email contacts, and one-on-one appointments with the specialists provides an opportunity for the participant address personal issues and traditional stumbling blocks.

Program goals: Workout at the Centre a minimum of three times a week and lose 4.5kgs. Successful participants receive \$100.00 for attaining the program goals.

Participants are selected based on meeting the criteria of a BMI 30 or more; a keen desire to make a change in their lifestyle and the self-efficacy that they can make the change. They must agree make every effort to workout at the Centre for the full 16 week period and attend the 10 educational sessions.

Highlights/Successes

The feedback from the participants has been extremely positive.

To date there are over 50 people on the waiting list and calls are received on a daily basis. Graduates of the program have contributed to the referrals to this program.

Actually selecting participants has contributed to their desire to be chosen. In our experience, committed individuals contribute to the positive environment.

Graduates of the program have reinforced the merit of the financial incentive and attribute the amount of \$100.00 to being significant enough to encourage them to meet the attendance goals, which in turn helped them reach their weigh loss goals.

It is important to recognize that a fitness facility can be very intimidating to this population and the intent of Healthier Weigh is to help the participants to become more comfortable in a fitness environment. It has been great to see the participants and graduates of the program attend other activity/exercise classes at the Centre and in other locations.

By selecting individuals who are ready and keen, they in turn become a self administered support group. Participants have exchanged email addresses; have arranged to meet at the centre to workout together and to offer encouragement. Many met prior to the class and visit, exchange success strategies and generally offer support to one another.

The weight loss goal was purposely selected to maximize success, as well as make a strong statement about prudent weight loss should be a result lifestyle changes. A number of participants identified that as a result of this program they finally realized that they do need to make lifestyle changes and are far more aware now of the kinds of things they need to do to make those changes.

Within the first two groups there are graduates that have continued to be active and have lost more weight. There are examples of individuals who have lost over 60 pounds as a result of the program.

The next phase of the program will be a peer-led support group and there is already support from some of the graduates to assist in the development of that group.

Challenges

The biggest challenge has been the overwhelming response. More groups need to be run. Given our attendance expectations the program should not run over the summer therefore limiting our program year. Running simultaneous groups puts a stress on the operation and runs the risk of diluting the focus on the participants.

What makes this program innovative or a best/leading practice?

The selection process; the simple program goals tied to strong supports and incentives; peer support; and the right staff who are have the knowledge and skills to properly support and encourage a group of people typically challenged by an exercise environment.

Program Assessment	
<i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i>	Individual health
<i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i>	The program targets obese adults. The majority of applicants to date have been mid-to-older adults.

Program Assessment

<p><i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i></p>	<p>A significant aspect of the program is on improving quality and quantity of activity. All participants receive a pre- and post assessment involving a treadmill test which is used to screen for clinical problems as well as establish initial fitness levels and determine target heart rate training zones. Fitness Consultant meets with each participant individually to work with them on their personal activity program.</p> <p>Incentives have been built into the program to reward those who are active at the facility a minimum of three times a week. Participants are monitored and staff intervene if they determine someone is at risk for not reaching minimum attendance.</p> <p>All participants are also given a pedometer to track their daily activity.</p>
<p><i>Does it focus on primary prevention?</i></p>	<p>Yes. This program is directed at obese individuals. This population is at high risk for diabetes and heart disease. The assessment process is helpful in identifying/evaluating risk factor status. Participants can utilize the professional staff to help them to determine and reach their short term program goals.</p>
<p><i>Is the program is evidence based?</i></p>	<p>Yes. The length of program, selection tools, inclusion of assessments, goal-setting, intervention strategies, professional and group support, and financial incentives are designed to affect and reinforce personal change. Educational component is supported by current standards in dietary and exercise guidelines.</p>
<p><i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i></p>	<p>Health and Lifestyle Questionnaire, Self-Efficacy, Stages of Change tools are included with application package.</p> <p>Pre and post assessments includes blood lipid analysis (lipid profile, FBS) height, weight, resting and exercise EKG, blood pressure and heart rate and a graded exercise tolerance test.</p>
<p><i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i></p>	<p>Two cohorts of 12 people have completed the program; a third will be finished on February and a fourth has just started.</p> <p>In the first two groups 11 of the 12 have completed the program and 72% success in meeting the program goals.</p>
<p><i>Does it involve an intervention to promote personal or social change?</i></p>	<p>At this point the intervention is designed to promote personal change.</p>
<p><i>Does the provider (organization) directly implement the program?</i></p>	<p>Yes the Reh-Fit Centre directly implements the program.</p>
<p><i>Is the program sustainable and/or partnered with another organization?</i></p>	<p>The Centre has partnered with a corporate sponsor who has subsidized the program.</p>
<p><i>Are program leaders trained to deliver the program? (What type of training have they received?)</i></p>	<p>The program leaders are registered dietitians and fitness consultants with degrees in Exercise Sciences. The project leader also has ACSM and CSEP designation.</p>

Health Screening and Assessment and Consultations - MB

Sponsoring Organization	Reh-Fit Centre
Program Leader(s)	Variety of Professional staff(Lab Technologists, Physicians, Nurses, Dietitians, and Fitness Professionals)
Target Population(s)	Adults especially those who are moderate to high risk to exercise.
Contact	Michelle Meade Tel: (204) 488-8023 Email: michelle.meade@reh-fit.com

Highlights/Successes

Over the years the screening process has uncovered health issues (high blood pressure, elevated blood sugar levels, heart problems etc.), has inspired participants to make changes and provided them with the opportunity to track changes. Goals have been set utilizing the data and the tests themselves have provided an educational opportunity.

What makes this program innovative or a best/leading practice?

It is innovative because most facilities do not include this as part of their membership/entrance procedure. It is invaluable for the senior population as a health screen and educational opportunity. Having on-site specialists such as dietitians, exercise specialists and nurses available to advise the members over the duration of their membership has proven to be invaluable to the member's pursuit of their health and lifestyle goals, Prevention comes from knowledge and having specific data pertaining to their personal health history, then the expertise to advise is a very empowering tool.

Program Assessment	
<p><i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i></p>	<p>Individual health</p> <p>This service is included in the membership at the facility and non-members can access it for a fee.</p>
<p><i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i></p>	<p>All new members and participants must fill out the Health and Lifestyle Questionnaire prior to engaging in exercise at the Centre. We strongly recommend the assessment to everyone especially to non-cardiacs who are moderate to high risk to exercise (and males over 45 and females over 55).</p> <p>Those with heart disease must have an assessment on entrance to the program.</p> <p>After the assessment the individuals set up meetings with the staff to review results and determine their course of action.</p>
<p><i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i></p>	<p>The assessment includes a treadmill test which evaluates cardiovascular fitness and determines training heart rates. The foundation to our program is physical activity so invariably the members</p>

Program Assessment

	receive exercise advice and programs designed specifically for them.
<i>Does it focus on primary prevention?</i>	Yes. It evaluates blood pressure, lipid values, electrocardiogram at rest and during exercise, as well as weight/body mass and lung function. If elevated they are referred to their physician, or the appropriate professional (i.e. dietitian) or for further investigation.
<i>Is the program is evidence based?</i>	Yes. Consistent with best practise for level 5 medical fitness facilities.
<i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i>	Health and Lifestyle Questionnaire, assessments includes blood lipid analysis (lipid profile, FBS) height, weight, resting and exercise EKG, blood pressure, spirometry (lung function) and heart rate and a graded exercise tolerance test on treadmill. Results are forwarded to their personal physician for their records.
<i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i>	We have been conducting this assessment on thousands of people. As a result the participants have been able to track improvements, many have pursued professional advice to help them and have experienced positive changes.
<i>Does it involve an intervention to promote personal or social change?</i>	Personal change
<i>Does the provider (organization) directly implement the program?</i>	Yes the Reh-Fit Centre directly implements the program.
<i>Is the program sustainable and/or partnered with another organization?</i>	We are not partnered with any other organization for the screening and assessment on our members. We are partnered with the Winnipeg Regional Health Authority for our Cardiac Rehabilitation Program. Yes it is sustainable
<i>Are program leaders trained to deliver the program? (What type of training have they received?)</i>	We use professionals in their respective fields. Lab Technologists, Physicians, Nurses, Dietitians, and degreed Fitness Professionals.

Chronic Disease Prevention Initiative – MB

Sponsoring Organization	Brandon Regional Health Authority
Program Leader(s)	Nancy McPherson / Karen Burton
Target Population(s)	Adults – 30 to 59 years
Contact	Nancy McPherson
	Tel: (204) 571-8414

Description

The Brandon RHA continues to receive provincial funding for a chronic disease prevention initiative (CDPI). Funding is then transferred to Healthy Brandon, a community coalition, charged with overseeing the 5-year initiative aimed at reducing the burden of chronic disease in the Brandon region. Based on the findings of the 2004 comprehensive community health assessment, four core strategies have been developed to improve the health of residents in the region:

1. Active lifestyle strategy
2. Healthy eating strategy
3. Reduced tobacco use strategy
4. Stress management strategy

Four working groups were established with one group aligned with a specific core strategy. Funds from Healthy Brandon were then allocated based on their respective action plans.

Highlights/Successes

- Over 50 representatives from community agencies, businesses, not-for-profit groups and interested citizens gathered to plan how to make our community healthier.
- There have been many individuals come forward to work on specific projects that have not engaged with the various sectors before.
- The entire program is focused on modifiable risk factors for chronic diseases (cardiac, respiratory, renal, cancer) rather than duplicating efforts to address the same risk factors within the context of a specific disease.
- A Community Facilitator has been instrumental in providing valuable support to Healthy Brandon, the development of the four working groups, connecting with community residents, and liaising with the regional health authority and funding body.
- A wide range of activities / projects are available with the intent that one or more will appeal to all residents at some point.

Challenges

- Connecting with individual citizens who may be interested in participating.
- Allowing the structure and processes to evolve without creating a community-based bureaucracy.
- Developing strong working relationships with the business community.
- Addressing issues related to stress management in a meaningful way.

- There are three rural municipalities in the Brandon region but efforts tend to be directed towards the City of Brandon.

What makes this program innovative or a best/leading practice?

The shift in leadership from organization to community.

Program Assessment	
<i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i>	Community This program is targeting the 30 to 59 year population in the region. Workplaces were identified as a practical means of connecting with this population as well as a means to implement health-related policies and programs that will influence a positive cultural shift towards healthy living.
<i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i>	Given the target population (30-59 year olds), some older adults are involved in this program but the primary focus is not those over 50 years. Since several activities span many ages and stages such as Community Gardens and Family Fun Nights, all older adults are encouraged to participate.
<i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i>	Yes. One of the core trajectories is the Active Lifestyle strategy. Healthy Brandon in motion is the working group focused on increasing access to the necessary information, skills resources and supports to enhance physical activity at the community level.
<i>Does it focus on primary prevention?</i>	Yes.
<i>Is the program is evidence based?</i>	Yes. Evidence-based research has been gathered through various credible publications such as the Canadian Public Health Journal, professional associations and several provincial clearinghouses.
<i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i>	Yes. At a individual level, health screening clinics have been delivered in some workplaces with plans to deliver health screens / wellness clinic on local neighbourhoods in spring 2008. Health screens include several clinical measurement tools including blood pressure, blood sugar and cholesterol levels, height, weight, level of exercise, amount of tobacco use, etc. At a community level, each working group has identified key measures associated with specific activities to monitor.
<i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i>	No. Monitoring forms have been completed by each of the four working groups and submitted to the provincial funder but a report / summary has not been received to date. A 2-day CDPI Share & Learn workshop is scheduled for February 2008 as an opportunity for RHAs to come together and share their successes and challenges to date.

Program Assessment

Does it involve an intervention to promote personal or social change?

Yes, both. Each working group has developed an action plan (reviewed annually) that focuses on engaging residents in the region in healthy living activities / projects. Healthy Brandon is currently developing a social marketing strategy to influence a cultural shift throughout the region.

Does the provider (organization) directly implement the program?

No. All of the activities have been planned and implemented through partnerships with a variety of community residents, agencies and organizations. The Regional Health Authority is one player at the table and implements actions that are within its mandate, similar to the other agencies and organizations.

Is the program sustainable and/or partnered with another organization?

See comment above. The long-term success of this program is dependent upon strong partnerships and a commitment to healthy living throughout the region. A cadre of agencies and organizations contribute to the majority of activities / projects. Despite the donation of many resources by partner agencies, however, sustainability will only be ensured by the involvement of the business community due to their generous financial support.

Are program leaders trained to deliver the program? (What type of training have they received?)

Approximately half of the Healthy Brandon community coalition has engaged in a training opportunity thus far. For example, one member of the Active Lifestyle working group and the Community Facilitator participated in a three day in motion workshop, two members of the Reduced Tobacco Use strategy attended a dynamic conference out-of-province and on-going training workshops are available within the province. Locally, individuals will be trained in the spring to deliver health screens at the neighbourhood level.

Combined Fitness Program - ON

Sponsoring Organization **Canadian Centre for Activity and Aging**
Program Leader(s) **Certified Seniors' Fitness Instructors**
Target Population(s) **55+ community dwelling well older adults**
Contact **Clara Fitzgerald**
Tel: (519) 661-1604 **Email: cfitzge4@uwo.ca**

Highlights/Successes

The majority of participants improve on their follow up assessment the following year, the programs have been expanding and attendance is fairly consistent during all seasons. Over 420 active participants in the programs.

Challenges

Certain times of day are more popular than others when trying to meet the needs in the community. Participants pay fees as there is no core funding therefore, these are some barriers that we cannot meet. Transportation is starting to become an issue as well.

What makes this program innovative or a best/leading practice?

This evidence based program has the participants exercising within their ability and target heart zone while incorporating all components of functional mobility which is essential for the functional fitness of the participant to continue to be healthy and independent.

Program Assessment	
<i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i>	Community dwelling well older adults
<i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i>	YES
<i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i>	YES 2-3x a week for 75minutes in a fitness class Specialty stroke and dynamic balance classes are 1 hour in length
<i>Does it focus on primary prevention?</i>	YES/NO (some participant already have a condition)
<i>Is the program is evidence based?</i>	YES

Program Assessment

<p><i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i></p>	<p>YES all participants have a fitness appraisal on an annual basis</p>
<p><i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i></p>	<p>Ecclestone NA, Myers AM, Paterson DH. Tracking Older Participants of Twelve Physical Activity Classes Over a Three-Year Period. <i>Journal of Aging and Physical Activity</i>, 1998. 6: p. 70-82.</p> <p>Paterson DH, Govindasamy D, Vidmar M., Cunningham DA, Koval JJ. Longitudinal Study of Determinants of Dependence in an Elderly Population. <i>Journal of the American Geriatrics Society</i>, 2004(52): p. 1632–1638.</p> <p>Thomas SG, Cunningham DA, Rechnitzer PA, Donner AP, Howard JH. (1985). Determinants of the Training Response in Elderly Men. <i>Medicine Science Sports & Exercise</i>, 17(6):667-72.</p> <p>Cunningham DA, Rechnitzer PA, Howard JH, Donner AP. (1987). Exercise Training of Men at Retirement: A clinical trial. <i>Journal of Gerontology</i>, 42(1):17-23.</p> <p>Rice CL, Cunningham DA, Paterson DH, Rechnitzer PA. (May 1989). Strength in an Elderly Population. <i>Archives of Physical Medicine & Rehabilitation</i>, 70(5):391-7.</p> <p>Paterson DH, Cunningham DA, Koval JJ, St Croix CM. (1999). Aerobic Fitness in a Population of Independently Living Men and Women Aged 55-86 Years. <i>Medicine Science Sports & Exercise</i>, 31(12):1813-20.</p> <p>Stathokostas L, Jacob-Johnson S, Petrella RJ, Paterson DH. (1997). Longitudinal Changes in Aerobic Power in Older Men and Women. <i>Journal of Applied Physiology</i>, 2;781-9.</p>
<p><i>Does it involve an intervention to promote personal or social change?</i></p>	<p>YES</p>
<p><i>Does the provider (organization) directly implement the program?</i></p>	<p>YES, the Canadian Centre for Activity and Aging offers this program 25 times a week</p>
<p><i>Is the program sustainable and/or partnered with another organization?</i></p>	<p>YES UWO, SJHC</p>
<p><i>Are program leaders trained to deliver the program? (What type of training have they received?)</i></p>	<p>The instructors are certified seniors' fitness instructors</p>

Get Fit For Active Living - ON

Sponsoring Organization	Canadian Centre for Activity and Aging
Program Leader(s)	Certified Seniors' Fitness Instructors
Target Population(s)	55+ beginners to exercise or have not been exercising in recent years
Contact	Clara Fitzgerald
	Tel: (519) 661-1604 Email: cfitzge4@uwo.ca

Description

Get Fit for Active Living is an eight week education and exercise program designed to introduce older adults to the benefits of exercise and an active lifestyle. Each participant begins with a complete health assessment. The program consists of two aerobic exercise classes, one weight-training class and a one-hour education class each week. Participants learn how to get started on a regular exercise program, and about the importance of a healthy, active lifestyle for maintaining independence,

Highlights/Successes

The participants improve over the 8 weeks and 81% continue to exercise after the program is completed.

Challenges

Other areas that we have tried to implement the program had some financial issues and resource issues with space.

What makes this program innovative or a best/leading practice?

It gives the participant both a physical and knowledge based foundation to continue to implement structured exercise into their daily living routine.

Program Assessment

<p><i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i></p>	<p>Community dwelling seniors who would like to become more active</p>
<p><i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i></p>	<p>YES, designed for the 55+ seniors. Those who are younger than 55+ are welcome to attend</p>
<p><i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i></p>	<p>YES, 1 hour of strength training a week 2 hours of a combined cardiovascular, strength, balance and flexibility program Physical Activity is promoted during the 1 hour education session a week where the participants learn about physical activity, adherence, health eating and special conditions including diabetes</p>
<p><i>Does it focus on primary prevention?</i></p>	<p>YES, The benefits of exercise are covered in the Education Sessions</p>
<p><i>Is the program is evidence based?</i></p>	<p>YES Mar 2000-Mar 2003 pilot study</p>
<p><i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i></p>	<p>YES, strength, balance, flexibility</p>
<p><i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i></p>	<p>YES Jones GR, Wark G, Cyarto E, Boris J, Storry E. Evaluation Report: Canadian Centre for Activity and Aging's Get Fit for Active Living Program. 2004, Canadian Centre for Activity and Aging: London , ON . p. 19.</p>
<p><i>Does it involve an intervention to promote personal or social change?</i></p>	<p>YES discusses stages of behaviour change</p>
<p><i>Does the provider (organization) directly implement the program?</i></p>	<p>YES this is offered at the Canadian Centre for Activity and Aging for 8 weeks 5 times a year</p>
<p><i>Is the program sustainable and/or partnered with another organization?</i></p>	<p>Partnerships with Middlesex Healthy Living, Royal Bank Atlantic</p>
<p><i>Are program leaders trained to deliver the program? (What type of training have they received?)</i></p>	<p>YES, they are Certified Seniors' Fitness Instructors who then take the Get Fit For Active Living Facilitator Program</p>

Moving for Health - NL

<i>Sponsoring Organization</i>	<i>Eastern Health – Eastern Regional Wellness Coalition</i>
<i>Target Population(s)</i>	<i>Older women 50 plus however the membership age can be any adult any age</i>
<i>Contact</i>	<i>Sherry Kennedy Regional Coordinator, Eastern Health</i> <i>Tel: (709) 528-1211 Email: sherry@nf.aibn.com</i>

Description

This program is free and supports community volunteer leaders who have a passion and interest, to get the adults in their community moving for health.

This FREE program sponsored by the Eastern Regional Wellness Coalition supports the need to get Newfoundlanders more physically active and contributes greatly to the improvement of overall health and well being of those who participate.

By using the resources that currently exist in your community such as church halls, parish centres, schools, personal care homes and community centres and volunteer leaders who have a passion for physical activity your community can become a more active community.

The free resources provided by the program include a resource binder and video. In addition to site visits to groups, public health nurse recruit and are assigned as resource and as well Community Grant Program for equipment and Discretionary Funding from the Wellness Coalition provides healthy snacks in addition to promotional items provided to groups for events

Highlights/Successes

There have been many unexpected outcomes of the Moving for Health program. It's the social capital and the fellowship of women that provide the unexpected outcomes. These are only a few:

- Development of leadership skills that are transferred from this group to another group i.e. leader from Moving for Health started a Catholic Women's League
- Learning to read with assistance from retired teacher participants in this program to enable a member to become literate. This person then went on to become mayor of her town.
- Helping the larger community by donating monies to the various groups including churches, church halls, supporting youth to travel to Germany for World Youth Day, Walk for the Cure in association with the Canadian Cancer Society to support breast cancer survivors in Moving for Health group etc...
- Capacity in members by partnering with library so members can possess a library card to read up on wellness
- Social capital by supporting members in times of crisis i.e. by being the honour guard at funeral, calls, cards, and visits.
- Modeling physical activity for one's family by interactive play to increase children's physical activity level

- Healthy recipe exchange - try different way of cooking to reduce trans fats by trying healthier recipes
- Exercising together can become a family affair i.e. three generations in one family in one group
- Trying new things i.e. some members in their 70's are walking for exercise for the first time and enjoying it
- Incorporating exercises to support members with various conditions i.e. osteoporosis, Parkinsons etc...
- Increased health benefits by lowering of blood pressures, loss of weight, stress relief, better control of blood sugars, increased bone density etc
- Increased mobility i.e. in personal care homes many members have a greater range of motion

Challenges

- This program usually works best in a rural community as in an urban centre there are many options for the community to get physically active
- Volunteer leaders are a rare commodity in urban centres

What makes this program innovative or a best/leading practice?

The innovation is the how. It is the way in which we do our work. In the past we would tell people to be more physically active but that was NOT enough.

The Coalition provides development of personal skills in the leaders of the Moving for Health programs by offering free resources and support in the start up of a group. Through networking with other like groups to become an active community leaders in the area can be the needed motivation to keep leaders motivated.

As a coalition we needed to create supportive environments so that people have the opportunity to overcome the barriers to physical activity such as climate, lack of program, and or space etc.. There is an effort yearly to provide an opportunity for the leaders to connect and discuss what is happening in their neck of the woods. This always has been very motivational and successful.

The Coalitions have developed a policy called Community Grant program offers groups an opportunity to purchase equipment for the group and as well the Discretionary Fund provides healthy foods for an event. In addition, the Coalitions advocated for the community use of schools and in the last NL budget, Danny Williams said that insurance will no longer be a barrier for community groups to use schools.

Through reorienting health services community health nurses identify potential volunteer leaders who have an interest in physical activity. A number of groups who are mainly senior population receive their flu shot on site at the Moving for Health group.

The strengthening of community action includes the various Moving for Health groups who fund other causes such as: Walk for the Cure – Canadian Cancer Society, Jingle Bell Walk – Arthritis Society, World Youth Day Germany and Australia Rep funded from North River, donations to parishes, and schools for use of space, in addition to the Children's Wish Foundation, local charitable causes are a few of the fund raising types.

Most of all.....it is the social capital that moves people the most. The connectedness, the fellowship for a brain aneurysm survivor, breast cancer survivor, brain cancer survivor, supports those with Parkinson's, osteoporosis, and many other chronic diseases. It is the cards that say I care about you and your family in times of sadness and also times of celebration. We built moving for health for physical activity, but people stay because of the social capital.

Program Assessment

<p><i>Is this program focused on community, individual/family or public health?</i></p>	<p>Community</p>
<p><i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i></p>	<p>Yes definitely. In the era of Heart Health days in Newfoundland this coalition wanted to build on the successes of the current existing physical activity program in Harbour Grace under the leadership of Alice Blundon at St Paul's Fun and Fitness. (See right)</p>
<p><i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i></p>	<p>Yes. New Moving for Health groups in the community start out with a walking program with stretching added at the beginning and at the end of the program. Then over time the group will add therabands or resistance bands and use small weights to add variety. There are a number of groups, which include in their programs a cardio and floor exercises. Right three generations exercising together in Norman's Cove.</p> <p>In a personal care home there is a chair-stretching program supplemented. One Fifty Plus group added carpet bowling to the program men versus the women. Then after their version of Moving for Health they have a "scoff" a social tea and then a "scuff" to old time Newfoundland music.</p>
<p><i>Does it focus on primary prevention?</i></p>	<p>Yes</p>
<p><i>Is the program is evidence based?</i></p>	<p>Yes</p>
<p><i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i></p>	
<p><i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i></p>	<p>Many positive outcomes on many levels. There have been various evaluations:</p> <ul style="list-style-type: none"> Site visits Moving for Health profiles Evaluations from Orientation Workshops Surveys from leaders/co leaders
<p><i>Does it involve an intervention to promote personal or social change?</i></p>	<p>Yes</p>
<p><i>Does the provider (organization) directly implement the program?</i></p>	<p>Eastern Regional Wellness Coalition/Eastern Health</p>
<p><i>Is the program sustainable and/or partnered with another organization?</i></p>	<p>Community Partners for Space</p>
<p><i>Are program leaders trained to deliver the program?</i></p>	<p>Yes</p>

Education Program – Creative Retirement – MB

<i>Sponsoring Organization</i>	<i>Creative Retirement</i>
<i>Program Leader(s)</i>	<i>About 15 different individuals</i>
<i>Target Population(s)</i>	<i>50 – 90 years</i>
<i>Contact</i>	<i>Ingrid Wedlake</i>
	<i>Tel: (204) 949-2551</i>

Description

Creative Retirement offers various educational programs that provide information about fitness and health (nutrition sessions, heart health, Aging Eyes sessions, Exercises you can do at Home sessions, etc) . They also do some fitness classes (Tai Chi, Walking with Chi, Yoga, Walking the Labyrinth, Fushion, Walking Clubs, etc). We offer about 10 – 15 different sessions a term so it is difficult to list everyone.

Highlights/Successes

The Walking Club has probably had the most success as many people who were previously inactive have joined this program.

Challenges

Funding is the main challenge. It is very difficult to break even on fitness programs due to the high cost of facilities and instructors. Creative Retirement does not receive any funding for fitness programs so we must raise enough revenues to cover all the costs.

The second biggest challenge is getting inactive people to sign up for classes.

What makes this program a promising practice?

Most of our programs are lead by seniors, so they understand many of the challenges the participants face. We also offer a wide variety of programs and are constantly introducing new courses. CRM endeavours to work closely with seniors so we can offer programs they want.

Program Assessment

<p><i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i></p>	<p>It is focused on individuals.</p>
<p><i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i></p>	<p>Yes</p>
<p><i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i></p>	<p>Yes, Tai Chi, Walking with Chi, Labyrinth, Walking Clubs, Yoga, Fushion, half day educational sessions. They are promoted in our schedule that is mailed out to people. The schedules are also available at various sites throughout the city.</p>
<p><i>Does it focus on primary prevention?</i></p>	<p>Yes</p>
<p><i>Is the program is evidence based?</i></p>	<p>No</p>
<p><i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i></p>	<p>No</p>
<p><i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i></p>	<p>We cannot afford to hire a professional evaluator.</p>
<p><i>Does it involve an intervention to promote personal or social change?</i></p>	<p>No</p>
<p><i>Does the provider (organization) directly implement the program?</i></p>	<p>For some of the classes we do and for others we work in partnership with another group. We do not have any space for fitness classes, so we must work in partnership with fitness facilities, seniors clubs and community clubs.</p>
<p><i>Is the program sustainable and/or partnered with another organization?</i></p>	<p>Both.</p>
<p><i>Are program leaders trained to deliver the program? (What type of training have they received?)</i></p>	<p>All our leaders are trained in their field (i.e. nutrition, fitness)</p>

Take Charge Program - MB

Sponsoring Organization	North Eastman Health Association through the Chronic Disease Prevention Initiative
Program Leader(s)	Sue McKenzie (community member)
Target Population(s)	Individuals with Diabetes
Contact	Debbie Viel
	Tel: (204) 268-7431

Description

The program targets people who are at risk of developing chronic diseases related to inactivity and weight. The goal of the program is to give participants the knowledge, tools and practical experience to effect a positive change in the behaviour that is contributing to the risks. The project provides participants with up to date knowledge for healthy nutrition, and physical activity. The program is 2 x / week for 12 weeks. One session includes information and exercise and the second weekly session includes identifying, setting and reviewing goals, measuring success and managing barriers in a supportive environment.

Highlights/Successes

- Client satisfaction
- Behaviour change
- Increased fitness levels for participants

Challenges

- Ongoing funding
- Marketing the group to a target group
- Controlling for differing client abilities – example having clients who have very limited mobility in 1 group

What makes this program a promising practice?

- This program has been led by a community member who saw the need and has really “taken charge” of the program.
- The leader brings in experts as needed but is running a very successful peer led group.
- If we are to highlight one of our initiatives that should be a best practice – it is this one as it is unique and grassroots
- In her 1st group she has not had only older adults but this group could be a best practice for adults 50+

Program Assessment

<p><i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i></p>	<p>Yes all 3. It primarily focuses on the individual but through the individual education there will be success in family and community health.</p>
<p><i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i></p>	<p>It is not an exclusive program but there were older adults who did participate in the program</p>
<p><i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i></p>	<p>Physical activity options are reviewed and tried by the participants. The options focus only on those activities that can be done at home or easily done in the community.</p>
<p><i>Does it focus on primary prevention?</i></p>	<p>Yes</p>
<p><i>Is the program is evidence based?</i></p>	<p>Materials and approaches are identified as best practice through research and expert opinion and are used as the foundation of the program. Examples include 5 A's (Assess, advise, agree, assist and arrange) and the Canada's Guide for Physical activity</p>
<p><i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i></p>	<p>Yes – weight loss, blood pressure, changes in resting heart and self reported results</p>
<p><i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i></p>	<p>No formal evaluation has been submitted to NEHA as of yet. The leader reports that initially all but 1 of the participants had a very low fitness level and now any of the participants could join an aerobics class and do okay. She reported participants not being able to complete any sit-ups to being able to complete 16 on an exercise ball.</p>
<p><i>Does it involve an intervention to promote personal or social change?</i></p>	<p>Yes personal change for the participants</p>
<p><i>Does the provider (organization) directly implement the program?</i></p>	<p>Yes it is provider driven – it is a chronic disease prevention initiative supported by NEHA and offered through a community member with our support</p>
<p><i>Is the program sustainable and/or partnered with another organization?</i></p>	<p>It is supported by the CDPI funds through the North Eastman Health Association</p>
<p><i>Are program leaders trained to deliver the program? (What type of training have they received?)</i></p>	<p>Yes – the leader has formal training. Certified Fitness instructor</p>

Coeur en mouvement - QC

Organisme parrainant le programme	Fondation des maladies du Coeur du Québec
Leader(s) du programme	Anne Pelletier
Population(s) ciblée(s)	Toutes les populations
Contact	Francine Marin et Anne Pelletier
	Tél: (514) 871-8038

Description

Cœur en mouvement est un programme qui facilite la pratique de la marche dans des lieux sécuritaires et balisés. La distance parcourue par le marcheur est indiquée à intervalles réguliers. Les sentiers Cœur en mouvement sont présents dans 10 villes du Québec.

Quels ont été les points saillants / succès du programme?

Promotion de l'activité physique pour toutes les populations

Organisation d'activités de marche pour la Journée Nationale du sport et de l'activité physique

Mise sur pied d'un bulletin web où les gens peuvent partager leurs expériences et trouver de l'information sur la marche.

Quels en ont été les défis?

Trouver des moyens de promotion efficaces et peu coûteux pour faire connaître le programme.

Selon vous, qu'est-ce qui fait de ce programme un programme novateur ou un programme de pratique exemplaire/promettante?

Le programme est basé sur une approche simple, le développement des sentiers permet aux personnes de pratiquer à leur convenance. Les activités d'introductions permettent l'éducation de la population, ainsi que la supervision d'adulte ayant besoin d'un peu plus d'encadrement.

Évaluation du programme

<i>Est-ce que le programme est relié à la communauté, l'individu/famille ou à la santé publique? (si vous choisissez plus d'une catégorie, veuillez expliquer)</i>	Communauté, individu et famille
<i>Cible-t-il les aîné.e.s de 50 ans et plus? (S'ils ne sont pas principalement ciblé.e.s, comment sont-ils inclu.e.s?)</i>	Oui, des groupes d'initiation à la marche ont été développés sur ces sentiers afin d'aider les gens à pratiquer de l'activité physique sur une base régulière
<i>Renferme-t-il une composante d'activité physique? (Si oui, quelle est cette composante et comment le programme en fait-il la promotion?)</i>	Oui, la marche avec des pancartes à chaque 0,5 kilomètre
<i>Est-ce qu'il se concentre principalement sur la prévention primaire?</i>	Oui mais peut être aussi pour la prévention secondaire
<i>Est-il est fondé sur des données probantes?</i>	Oui, la marche est excellente pour la santé du coeur
<i>Est-ce qu'il utilise un outil de mesure, p.ex. prise du poids, du taux de sucre dans le sang, etc.?</i>	À l'aide des balises, les gens peuvent mesurer leur progrès en termes de distance
<i>A-t-il reçu au moins une évaluation avec des résultats positifs? (Quelles évaluations ont-elles été complétées et font un sommaire des résultats?)</i>	En cours
<i>Implique-t-il une intervention promouvant des changements personnels ou sociaux?</i>	Oui, la marche comme activité physique
<i>Est-ce que le prestataire de service (l'organisme) met en œuvre le programme lui-même?</i>	En collaboration avec la ville et divers autres partenaires du milieu
<i>Le programme est-il viable et/ou en partenariat avec un autre organisme?</i>	En collaboration avec la ville et divers autres partenaires du milieu
<i>Est-ce que le(s) leader(s) ont reçu de la formation pour donner le programme? (Quelle genre de formation a-t-elle été fournie?)</i>	Le programme consiste principalement à mettre en place des sentiers et à promouvoir la marche

Forums Santé / Health Forums - NB

Sponsoring Organization	L'Association Acadienne et francophone des aînées et aînés du Nouveau-Brunswick and Public Health Canada
Program Leader(s)	Art Richard
Target Population(s)	Francophone seniors of New-Brunswick (Minority)
Contact	Roger Doiron Email: aafan@nb.aibn.com

Description

L'Association acadienne et francophone des aînées et aînés du Nouveau-Brunswick organized 14 Health Forums on Diabetes Prevention for seniors 50+. Interactive booths and conferences by dietitians on healthy eating, by diabetes clinic health nurses and by physical activity professionals educated the participants on the risks and complications of diabetes and on health promotion. The interactive booths educated the participants on the health services available in their region. A variety of tests were done such as blood sugar and hypertension during the day. The health break focused on examples of healthy eating and healthy foods. The activities were sprinkled with a little humour between the conferences to lighten the load on the participants.

Highlights/Successes

- 14 Health Forums presented all across New-Brunswick
- Exceptional participation
- More than 1500 seniors attended as participants or as volunteers
- 140 health professionals participated in 14 Health Forums and in interactive booths.
- Many interviews with radio stations, television and news-papers to educate the public on diabetes prevention for seniors in New- Brunswick

Challenges

Many seniors live in isolated rural areas. It is more difficult to reach them.

What makes this program a promising practice?

- This project has a strong focus on prevention and not only on the treatment of diabetes. This is very important, as there is great need for prevention programs such as this one.
- Volunteers take an active part in the process in order to ensure continuity and follow-up of the project.
- The Health Forums focused on francophone seniors in our society including our rural areas who need it most. Seniors living in isolated rural areas don't often have the opportunity to participate in such a quality event which provides them with a team of health professionals, good advice, education and tools all in one day. Since travel is often a major obstacle in rural areas, the Health Forums provide a well-needed service to seniors and acts as a promotional vehicle to identify and promote the health services available in their immediate area.

- The AAFANB is a non-profit organization, which works in conjunction with various partners. For this project, over 100 partners worked together to ensure the success of the event. Using such an approach, the Health Forums can be organized at a much lower cost than what it would with government agencies. Our partners allow us to reach seniors who would be practically unreachable otherwise.

Program Assessment

<p><i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i></p>	<p>This program is focused on individuals aged 50+.</p>
<p><i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i></p>	<p>Yes</p>
<p><i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i></p>	<p>Yes, each Health Forum had a physical activity component. A conference on physical activity was presented at all 14 Health Forums and focused on exercise and education in regards to diabetes. The seniors attending the forums went through a series of specific exercises for seniors as well as an informal challenge on exercises and healthy eating in order to take their individual situation in hand.</p>
<p><i>Does it focus on primary prevention?</i></p>	<p>Yes</p>
<p><i>Is the program is evidence based?</i></p>	<p>Yes</p>
<p><i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i></p>	<p>Yes. A more in depth evaluation will be done six months after the Health Forums to measure changes in lifestyle with eating and exercise habits.</p>
<p><i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i></p>	<p>Evaluation questionnaires were distributed to the participants on the various activities of the Health Forum and the information given. The outcome was very positive.</p> <p>A random evaluation by telephone will be performed 6 months after the end of the Health forums to verify if there have been any changes in their physical activities and to healthy eating habits in regards to their health.</p>
<p><i>Does it involve an intervention to promote personal or social change?</i></p>	<p>Yes</p>
<p><i>Does the provider (organization) directly implement the program?</i></p>	<p>The provider organizes the Health Forums and the in depth evaluation only.</p>
<p><i>Is the program sustainable and/or partnered with another organization?</i></p>	<p>The AAFANB has 13 volunteer committees across New Brunswick. Some of these committees will ensure the sustainability of the Health Forums in the future. Some Health Authorities already started to organize their own Health Forums.</p>
<p><i>Are program leaders trained to deliver the program?</i></p>	<p>Trained health professionals delivered the conferences and health booths.</p>

Diabetes Program - NS

Sponsoring Organization	North End Community Health Centre
Program Leader(s)	Jessie Jollymore, Dietitian
Target Population(s)	Persons living with Diabetes in Inner City Community
Contact	Jessie Jollymore
	Tel: (902) 420-0303 Email: j_jollymore@hotmail.com

Description

This is an unique 8 week Diabetes lifestyle intervention program offered throughout the year at the North End Community Health Centre. It focuses on optimal self-management of Diabetes in regard to healthy eating, getting active, and coping with stress. It is tailored for challenges faced by many living in an Inner City community – limited finances, limited access to transportation, literacy issues, and limited supports. Nutrition deals education on guidelines for Diabetes and incorporates cooking with foods from the food bank and shopping to get the most from your dollars as well as in depth meal planning. Physical activity is tailored to what is available at affordable rates within the community and what can be carried out at home, working with personal challenges participants face. Enhancing coping skills is essential, especially in this marginalized population and the workshop is carried out by a nurse educator as well as community peers and participants are given resources available in the community for ongoing support / support groups. Quantitative and qualitative evaluations are completed pre and post as well as 1 month follow up by phone.

Highlights/Successes

The community has responded with ongoing positive feedback to having a more comprehensive longer running COMMUNITY program that enables participants to have the time to integrate the information into their daily lives for optimal self-management of their Diabetes and also that the program is so HANDS ON. They give ongoing feedback in evaluations that they have, for the first time, able to actually prepare better meals and know about what meal balancing and doing it on a budget, is really all about. The hand out are kept to a minimum, instead we have developed visuals, such a placemats with actual portion sizes on them, and participants find this works great. Also, that we have other community agencies and individuals involved, participants have been getting and keeping more active in their community and have more support networks to help them.

Challenges

Getting people to stay for the entire 8 weeks – need weekly incentives, therefore can be added cost

What makes this program a promising practice?

Delivering right in the community at various locations; allowing participants to take part in program delivery and addressing their unique concerns + challenges; catering the program that helps people living with Diabetes better manage in their “everyday lives” with hands on cooking / getting them doing physical activities and matching them up with already established community programs; it’s multi-disciplinary and involves health professionals within the North End Community Health Centre as well as community members and organizations.

Program Assessment

<i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i>	Individual
<i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i>	Target population = 40 plus
<i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i>	Yes. Also healthy eating and stress management
<i>Does it focus on primary prevention?</i>	Yes
<i>Is the program is evidence based?</i>	yes
<i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i>	Pedometer / weight/ blood pressure / blood sugars test
<i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i>	Yes – increased social networks ongoing / slight weight reductions/ improved blood pressure/ slightly improved HbgA1C
<i>Does it involve an intervention to promote personal or social change?</i>	Yes – Personal change
<i>Does the provider (organization) directly implement the program?</i>	Yes
<i>Is the program sustainable and/or partnered with another organization?</i>	Yes it is sustainable and is partnered with other organizations within community such as YMCA, family resource centres, North End Community Health Centre, tenant's Association
<i>Are program leaders trained to deliver the program? (What type of training have they received?)</i>	Yes – staff and community members – given program overview + expectations

North End Walkers - NS

Sponsoring Organization	North End Community Health Centre
Program Leader(s)	Jessie Jollymore
Target Population(s)	Older Adults 45 years to 90 years of age.
Contact	Jessie Jollymore
	Tel: (902) 420-0303 Email: j_jollymore@hotmail.com

Description

This presentation presents an innovative program that addresses social, cultural, and economic determinants of health. Under the leadership of our Registered Dietitian, Jessie Jollymore, at a small inner city community health centre, a weekly “walking wellness group” was formed four years ago to address health issues and health promotion for older adults. In looking for possible solutions to increase physical well-being and healthy eating practices, the idea of creating local walking routes and starting a walking/cooking club was born. The benefits extend beyond increasing physical and nutritional well-being to experiencing a stronger sense of community, building increased social networks, and having a lot of fun in the process. As a group of 32 regular participants they start out with a weekly walk for 45 minutes, walking through their own mapped out community routes, wearing their bright yellow t-shirts and pedometers. The walkers then come back to the health centre and prepare a healthy lunch together and sit down and enjoy the meal while tallying their steps. For every million steps they walk, sponsorship of \$500.00 is obtained through various fundraising efforts and donations, and the group then puts the money into community projects. To date, they have walked close to 7 million steps. Collectively over the past year, the group of 32 has lost more than 120 lbs and made many healthy eating changes. They have improved their social networks, started their own scholarship fund for the community, held community events, and feel as though they are role models for healthy living and making a difference in their community. This group is now recognized across Nova Scotia and recently has been chosen by the Heart and Stroke Association as the Nova Scotia Champions for walking.

Highlights/Successes

The walkers have raised money, through donations and setting up their own “Wishing Well” campaign that people would throw a penny in the mini well and make a wish. Through these efforts, the walkers have put a swing set in their local city playground, held a community Spring Fair, held 2 High teas at a nursing home in their community, and held a Christmas party for local veterans and sing throughout their community for various functions. The community recognizes the walkers now weekly with tooting their horns and waving as well as having them featured on local newscasts. Being chosen by Heart and Stroke as the Nova Scotia Walking Champions this year has also been a great highlight. The walkers all feel they are positive role models in their community and are greeted warmly wherever they go in this community.

Challenges

Getting through the first year and trying to find ways to keep motivation going. Once the walkers felt connected and were enjoying themselves so much, they just show up...EVERY week for 4 years!

What makes this program a promising practice?

Strong community capacity building – we believe in the power of contribution in continuously reaching out to our community and also having them involved in projects with us; the value in building relationships; and finding new and unique ways to deliver the program that are meaningful to everyone and make sure that everyone has A LOT of FUN. It is amazing what humour can accomplish!

Program Assessment	
<i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i>	Individual
<i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i>	Not restricted to 50+
<i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i>	Yes
<i>Does it focus on primary prevention?</i>	Yes
<i>Is the program is evidence based?</i>	
<i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i>	Pedometer based
<i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i>	Yearly evaluations completed. Participants have yearly check ups with their Physicians at this health centre. Improved blood pressures/ weight loss/ improved glycemic control have all been reported and recorded.
<i>Does it involve an intervention to promote personal or social change?</i>	Yes – Personal change
<i>Does the provider (organization) directly implement the program?</i>	Yes
<i>Is the program sustainable and/or partnered with another organization?</i>	The Halifax Community Health Board was the initial sponsor for first year and the NECHC and participants themselves keep this sustainable – i.e. Have “penny fundraisers”
<i>Are program leaders trained to deliver the program? (What type of training have they received?)</i>	Have “leaders” within walking group that lead with walks and fundraising efforts. Training given by Dietician at NECHC

Heart&Stroke Walkabout™ - NS

Sponsoring Organization	Heart and Stroke Foundation of Nova Scotia with support from NS Health Promotion and Protection and Ecology Action Centre
Program Leader(s)	Local community Walkabout leaders
Target Population(s)	All sedentary Nova Scotians
Contact	Fran Dunn, Physical Activity Coordinator, Heart and Stroke Foundation of NS
	Tel: (902) 423-7682 x 316

Description

Heart&Stroke *Walkabout*™ aims to get feet back on the street and walking back in the minds of Nova Scotians. The goal of the initiative is to support Nova Scotians to accumulate 30-60 minutes of walking for recreation or active transportation, most days of the week. There are many components to the initiative including access to affordable pedometers, an innovative/interactive website (www.walkaboutns.ca), a social marketing campaign, a rewards and recognition program, and policy/advocacy supports for walkable communities. Our vision is to inspire a culture of walking in Nova Scotia.

Highlights/Successes

- Launch of the initiative in Oct -07
- Launch of the Website in Oct-07
- Development of a comprehensive Leader Handbook and supporting marketing tools (poster and rack cards) completed in Jan-08
- Trained 45 leaders across the province in February-08

Challenges

None to date

What makes this program a promising practice?

Walkabout, since its inception, strives to empower individuals and communities to engage in walking for the tangible and intangible benefits. Engaging so many stakeholders from various levels in the Ecological Model, as well as the innovative resources, tools, and supports for these stakeholders, is worthy of a promising practice designation.

Program Assessment

<p><i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i></p>	<p>Public Health</p>
<p><i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i></p>	<p>Moving forward, promotional materials, information, and supports will be developed for target populations including a including older adults</p>
<p><i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i></p>	<p>Yes – we are supporting Nova Scotians to accumulate 30-60 minutes of walking for recreation or active transportation on most days of the week.</p>
<p><i>Does it focus on primary prevention?</i></p>	<p>Yes – physical inactivity as a modifiable behavioural risk factor.</p>
<p><i>Is the program is evidence based?</i></p>	<p>Yes</p>
<p><i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i></p>	<p>Yes – pedometers are used to collect data on activity levels, inspire individual and group progress, and in future inform a rewards and recognition program. The website also provides participants with a resource to track their progress on-line.</p>
<p><i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i></p>	<p>Walkabout was launched in October-07. The next step in the evaluation framework is to evaluate the Walkabout leader handbook, orientation workshop, and supports (winter -08). Through back-end analysis and feedback, we know that participants appreciate and use the website resource and will be engaged further with the roll out of the rewards and recognition component and social marketing campaign.</p>
<p><i>Does it involve an intervention to promote personal or social change?</i></p>	<p>Yes – both. We are supporting a culture shift that must include personal and social change supported through an Ecological Model approach.</p>
<p><i>Does the provider (organization) directly implement the program?</i></p>	<p>No – we orient, provide tools, and support volunteers and stakeholders to implement the program at whatever level they choose to engage it (leader, advocate, champion)</p>
<p><i>Is the program sustainable and/or partnered with another organization?</i></p>	<p>This initiative is informed by a logic model and three year strategic plan and funding.</p>
<p><i>Are program leaders trained to deliver the program? (What type of training have they received?)</i></p>	<p>Yes – Walkabout leaders can participate in a two hour workshop including orientation to the website, leadership skills, safety checklist, provincial walking route inventory, use of pedometers for motivation and reward, and more.</p>

PEI Stepping Out Program - PE

<i>Sponsoring Organization</i>	<i>PEI Active Living Alliance</i>
<i>Program Leader(s)</i>	<i>Community/Workplace/School Volunteers</i>
<i>Target Population(s)</i>	<i>All Islanders</i>
<i>Contact</i>	<i>Lynn MacInnis</i>
	<i>Tel: (902) 569-7688</i>

Description

PEI Stepping Out is a pedometer based intervention designed to increase the activity levels in Prince Edward Islanders. It is supported by the Department of Health and implemented by the PEI Active Living Alliance.

Highlights/Successes

There have been over 10,000 Islanders that have taken part in a Stepping Out Program in communities, school, and workplaces all across the Island.

Challenges

Challenges have been to communicate the benefits to all individuals, also the cost of evaluating the program.

What makes this program a promising practice?

This program is innovative in the way that it not only uses a pedometer to motivate individuals to become more active, but it also offers healthy living information to encourage a lifestyle change. This program can be considered a best/promising practice due to the fact that pedometer based walking programs have been proven to deliver positive benefits through national and international evaluations.

Program Assessment

<p><i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i></p>	<p>Individual</p>
<p><i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i></p>	<p>Yes, but the program is not targeted for a specific populations, it is designed to suit all demographics.</p>
<p><i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i></p>	<p>Yes walking is the physical activity component and it is promoted by wearing a pedometer which counts daily steps, which in turn encourages the individual to set goals and increase their daily steps. There is a nutritional component as well.</p>
<p><i>Does it focus on primary prevention?</i></p>	<p>Yes</p>
<p><i>Is the program evidence based?</i></p>	<p>Yes this is an evidence based program due to the establishing of a baseline (steps per day at the beginning) and your daily steps at the end of the program. These are monitored on a tracking sheet.</p>
<p><i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i></p>	<p>The pedometer is your measuring tool.</p>
<p><i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i></p>	<p>Yes. All evaluations have been positive. PEI Stepping Out has been evaluated by Dr. Catherine Tudor-Locke and Dr. Cathy Chan and the findings have been extremely positive.</p>
<p><i>Does it involve an intervention to promote personal or social change?</i></p>	<p>Yes – Personal change</p>
<p><i>Does the provider (organization) directly implement the program?</i></p>	<p>No</p>
<p><i>Is the program sustainable and/or partnered with another organization?</i></p>	<p>The program is partnered with the Department of Health. The sustainability of this program would be challenging but possible.</p>
<p><i>Are program leaders trained to deliver the program? (What type of training have they received?)</i></p>	<p>Yes they receive one on one direction on how to deliver the program.</p>

Fit for Life - PE

Sponsoring Organization ***The U.P.E.I. Chi-Wan Young Sports Centre and CARI (Capital Area Recreation Inc.) are partnering to offer this program at the CARI Centre on the U.P.E.I. campus.***

Target Population(s) ***Individuals 50 years of age and older***

Contact ***Angela Marchbank***

Tel: (902) 566-0606

Description

Fit for Life is a 12-week program designed to encourage seniors to enhance their physical fitness through the use of flexibility, strength and cardio training. Participants receive an initial fitness assessment, a 12-week membership at the U.P.E.I. sports centre, a three-month pass to the CARI Pool, a program design specifically for their needs, access to all the programs, classes and facilities at the Sports Centre and a training log to record progress.

Highlights/Successes

Too early to know yet since this is the first offering of this program.

Challenges

This is the initial offering of the program so the main challenge has been to make the target population aware of the program and to produce participation by an appropriate number of individuals. While the price is moderate – \$160.00 – it's still not within the range of many low-income seniors. Even those who can afford it will have to analyze whether it's good value for the money. This, in turn, may depend on how frequently and how well individuals use the opportunities available to them.

What makes this program a promising practice?

The flexibility of working either with other seniors in joint initiatives or joining other groups composed of a variety of people of all ages, combined with the flexibility to choose your activities, set your own schedule, etc.

Program Assessment

<p><i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i></p>	<p>All fitness and wellness programs at UPEI are focused first on students, staff and faculty. However, we also focus on community and provide access to our programs by community members.</p>
<p><i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i></p>	<p>Yes</p>
<p><i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i></p>	<p>Because the program provides participants with full entry to the facility's fitness, exercise and aquatic centres and to the full range of programs and classes offered, each individual can determine his or her own level and variety of activities. These could range from weight lifting to swimming to squash to exercise groups to use of the walking track, etc.</p>
<p><i>Does it focus on primary prevention?</i></p>	<p>Yes</p>
<p><i>Is the program is evidence based?</i></p>	<p>Yes</p>
<p><i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i></p>	<p>Tests for flexibility, agility and endurance. Individual program designed based on results of assessment and individual goals and activity preferences.</p>
<p><i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i></p>	<p>Participants will be asked to complete a brief evaluation form at the end of the program.</p>
<p><i>Does it involve an intervention to promote personal or social change?</i></p>	<p>Assessment and personal program design along with participants willingness to change lifestyle will lead to personal change.</p>
<p><i>Does the provider (organization) directly implement the program?</i></p>	<p>The assessment and program design is provided for participants. However, it is up to the participants to partake in the physical fitness opportunities provided at the facility.</p>
<p><i>Is the program sustainable and/or partnered with another organization?</i></p>	<p>Partnership between CARI pool, UPEI Sports Centre and UPEI Wellness Initiative. Program will be offered two times per year which will be based on demand for the program.</p>
<p><i>Are program leaders trained to deliver the program? (What type of training have they received?)</i></p>	<p>The Personal Trainer, fitness instructors and fitness centre staff have trained and certified staff.</p>

Pathway to a Healthier Lifestyle - NL

<i>Sponsoring Organization</i>	<i>Federation of Newfoundland Indians/Health Canada</i>
<i>Program Leader(s)</i>	<i>Barbara A. Lannon, Diabetes Coordinator</i>
<i>Target Population(s)</i>	<i>Aboriginals</i>
<i>Contact</i>	<i>Barbara Lannon, Diabetes Coordinator</i>
	<i>Tel: (709) 489-8420 Email: Barbara@fni.nf.ca</i>

Description

Pathway to a Healthier Lifestyle promotes Diabetes awareness and prevention. This is done by promoting healthy nutrition and physical activity as two very important ways of prevention and management. The program, throughout the year, has several activities such as weight loss/physical activity challenge, youth and elder survival night along with presentations that enables them to be active and learn about healthy nutrition.

Highlights/Successes

This program provides several activities in promoting physical activity in the prevention and management of diabetes. These activities included a physical activity/weight loss challenge. This challenge encouraged the members to participate in simple physical activity to better their lives.

Challenges

Because of the large geographical areas that are dealt with sometimes it is hard to get members to participate in the programs available to them. Weather, transportation can be a barrier.

What makes this program a promising practice?

This program offers free activities to people who otherwise would not be able to participate in the program. Not only are the activities free but the coordinator goes to the areas to have the activities, the members do not have to go to her.

Program Assessment

<p><i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i></p>	<p>This program focuses on all aspects. The community: to ensure that everyone understands the importance of proper nutrition and exercise as a preventative method to the onset of diabetes. Individuals/family: helping individuals as well as family understand about proper nutrition and physical activity being an important part of their daily routine. Public Health: Health Care Professions working alongside the diabetes coordinator to present the information in relation to complications, risk factors and signs and symptoms of Diabetes.</p>
<p><i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i></p>	<p>This program is targeted at Aboriginals throughout central and western Newfoundland including children aged 5 – 10, youth from 11 – 17 as well as older members from 18 and up.</p>
<p><i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i></p>	<p>The physical activity can be one of many activities which the program offers such as Physical activity/weight loss challenge – members documenting any activity – walking, running, line dancing, gardening, raking leaves, walking the dog, etc..., youth elder survival night – elders show the youth how to survive in the wild.</p>
<p><i>Does it focus on primary prevention?</i></p>	<p>Yes. The primary focus for “Pathway to a Healthier Lifestyle” is Healthy Nutrition and Physical Activity to assist in the prevention of Diabetes.</p>
<p><i>Is the program is evidence based?</i></p>	<p>Yes, many of our activities such as the Physical Activity/Weight Loss Challenge had booklets which documented the amount of weight when the challenge began as well as their weight at the end of the challenge.</p>
<p><i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i></p>	<p>Many of the activities provided by the program include using measurement. i.e. – booklet for the challenge, Health Care professions will assist members with testing the blood sugar as well as weight.</p>
<p><i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i></p>	<p>Since this program began over 7 years ago more members have registered for the activities which are available to them. We have found that offering the programs to the rural areas enables people to participate in simple, free, activities which in the long term benefit them in the prevention and management of diabetes.</p>
<p><i>Does it involve an intervention to promote personal or social change?</i></p>	<p>Yes. This program promotes the members to change their lifestyle for the better.</p>
<p><i>Does the provider (organization) directly implement the program?</i></p>	<p>Yes</p>
<p><i>Is the program sustainable and/or partnered with another organization?</i></p>	<p>Yes, Health Canada, Health Care Professionals, Community Organizations work together to promote the program</p>
<p><i>Are program leaders trained to deliver the program?</i></p>	<p>Yes, our partners all have health care backgrounds, (i.e. RN)</p>

COMPLIMENTARY PRACTICES

The Coach Approach - BC

<i>Sponsoring Organization</i>	<i>Interior Health Region BC and YWCA/YMCA</i>
<i>Program Leader(s)</i>	<i>YMCA/YWCA trained staff</i>
<i>Target Population(s)</i>	<i>Adults</i>
<i>Contact</i>	<i>Adriane Long</i>
	<i>Tel: (250) 765-5916 ext. 100 E-mail: along@ymca-ywca.com</i>

Description

A research-proven activity support system specifically designed to help non-exercisers, or starter and stoppers, to build a long-term commitment to active living.

Includes a series of six 30-minute one-on-one appointments over six months with your own Wellness Coach who will:

- work with you to set and achieve short-term goals
- help you develop plans to overcome your typical activity barriers
- teach you techniques and skills proven to help you stick with activity on a long-term basis
- let you choose whatever type of activity you'd like to try, and will inform you of the various activities available throughout Central Okanagan

Program Assessment

<p><i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i></p>	<p>Individual</p>
<p><i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i></p>	<p>Adults Those with physician diagnosed cardiovascular related chronic conditions (e.g. diabetes, kidney disease, hypertension) and: Have an interest in getting started or re-engaging in exercise Have had difficulty maintaining activity goals in the past Are medically stable, therefore have physician approval to exercise on their own or in beginner level activity programs</p>
<p><i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i></p>	<p>Yes</p>
<p><i>Does it focus on primary prevention?</i></p>	<p>Yes</p>
<p><i>Is the program is evidence based?</i></p>	<p>Yes</p>
<p><i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i></p>	<p>No</p>
<p><i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i></p>	<p>yes</p>
<p><i>Does it involve an intervention to promote personal or social change?</i></p>	<p>Yes</p>
<p><i>Does the provider (organization) directly implement the program?</i></p>	<p>Yes</p>
<p><i>Is the program sustainable and/or partnered with another organization?</i></p>	<p>Yes</p>
<p><i>Are program leaders trained to deliver the program? (What type of training have they received?)</i></p>	<p>Yes</p>

Community Pulmonary Rehab Group - BC

Sponsoring Organization	Vancouver Coastal health and St Paul's Hospital
Program Leader(s)	Health Care Providers
Target Population(s)	Older Adults
Contact	Maylene Fong
	Tel : (604) 708 5285 E-mail: maylene.fong@vch.ca

Description

The Community Pulmonary Rehabilitation Pilot Project is a community-based education and exercise program to help patients develop chronic disease self-management skills. Designed by chronic disease staff at Vancouver Coastal Health and St. Paul's Hospital, this project sought to:

- teach self-management skills
- increase patient knowledge of their condition
- encourage regular use of a prescribed exercise program
- help patients decrease worsening of symptoms

Client-directed education and self-management support were key principals behind the design and implementation of this program. Staff presented educational topics (e.g. breath control, medications, energy conservation, etc.) and facilitated discussion between participants (staff and patients), incorporating concepts such as goal-setting, self-mastery, and role-modeling.

Highlights/Successes

This six-week program on pulmonary rehabilitation has proved effective for the participants, in that it increased people's awareness of their condition, as well as their skills, motivation and confidence to better manage their health concerns. The structure of the program (frequency, scheduling, topic), location (in a local community-based facility), and exercise classes were all helpful elements, but it is the underlying philosophy of client-directed education facilitated by health professionals, and skill of the facilitator that clearly formed the base of its success.

The informal yet structured format of the education sessions, and carefully monitored exercise classes were both significant for people's sense of safety and comfort in the program. The interactive, group-based education and client-directed goal-setting were also vital to people's absorption and learning of this new information. Finally, it was the caring atmosphere, tone of mutual respect, encouragement and giving a sense of hope that were key factors in people's motivation to attend, and maintain new health behaviours.

As noted in other community-based health education groups, there are many benefits to these kinds of programs, not only for the patient but also for the wider community, as patients learn more about their health and share this information with others. The combination of community-based groups, self-management principles, and client-directed education continues to be a powerful and positive model for VCH services, and it is hoped that this pilot project will support extension of this model into future strategies.

Challenges

There was strong concern expressed by a participant regarding the increased tendency for healthcare services to charge a fee. As reflected in other seniors' focus groups (e.g. arthritis), people recognize that health care resources are dwindling, but some seniors also feel that they have paid into this system for most of their lives, and deeply resent now having to pay for services in which they have invested for so long. Some sort of financial support for this program would mean a lot to this population.

What makes this program a complimentary practice?

As noted in other community-based health education groups, there are many benefits to these kinds of programs, not only for the patient but also for the wider community, as patients learn more about their health and share this information with others. The combination of community-based groups, self-management principles, and client-directed education continues to be a powerful and positive model for VCH services, and it is hoped that this pilot project will support extension of this model into future strategies.

Program Assessment	
<i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i>	Individual and public health
<i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i>	Yes
<i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i>	Yes
<i>Does it focus on primary prevention?</i>	Yes
<i>Is the program is evidence based?</i>	Yes
<i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i>	No
<i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i>	Yes this program is in the pilot stage
<i>Does it involve an intervention to promote personal or social change?</i>	Yes
<i>Does the provider (organization) directly implement the program?</i>	Yes
<i>Is the program sustainable and/or partnered with another organization?</i>	Yes partnerships with community recreation staff have been recommended
<i>Are program leaders trained to deliver the program? (What type of training have they received?)</i>	Yes

Senior's Day - YT

Sponsoring Organization	ElderActive Recreation Association
Program Leader(s)	Bill Simpson
Target Population(s)	Seniors & Elders 55 plus
Contact	Bill Simpson
	Tel: (837) 633-5010 Email: wgsimpsom@klondiker.com

Description

Seniors are encouraged to come to the centre on a drop in basis on Wed. between 10 am and 3 pm. Their daily entry fee is subsidized by ElderActive recreation Association. They are encouraged to participate in any or all of the activities we are offering at the centre, also they can use any part of the games centre and its programs any time that day. We also try and arrange to have something there for lunch for those who want to stay for some of the afternoon activities.

Highlights/Successes

The activities we are promoting are slowly building in number of participants.

Partnering with the City owned Games Centre and the ability to subsidize their daily passes have both been positive.

Challenges

We still have trouble convincing some Seniors & especially Elders to come out and try some of our activities.

Transportation for some.

What makes this program a complimentary practice?

Whitehorse hosted the 2007 Canada Winter Games this year and as a legacy of the games we are fortunate to have a recreation facility second to none. We were able to partner with the City owned Games Centre as they were looking for clients for the slack daytime hours and we were looking for a place to do some of our indoor activities. So far it seems to be a good partnership as the staff at the centre are very accommodating, they set up & put away & store all our equipment. So far we have been able to subsidize the participants daily entry fee to the centre, this is very much appreciated by the seniors.

Program Assessment

<p><i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i></p>	<p>Individual</p>
<p><i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i></p>	<p>Yes</p>
<p><i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i></p>	<p>We offer Carpet Bowling, Floor Shuffleboard, Washer Toss, Rattlesnake at the present time. We are looking into the possibility of having indoor lawn bowling this winter as well.</p> <p>Other activities Seniors can participate in that day is swimming, aqua fit program, walking track, Seniors fitness class, indoor golf driving range, weight & exercise room, table tennis.</p>
<p><i>Does it focus on primary prevention?</i></p>	<p>Focus on Active Participation</p>
<p><i>Is the program is evidence based?</i></p>	<p>No</p>
<p><i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i></p>	<p>No</p>
<p><i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i></p>	<p>There have been no formal evaluations done to date.</p>
<p><i>Does it involve an intervention to promote personal or social change?</i></p>	<p>No</p>
<p><i>Does the provider (organization) directly implement the program?</i></p>	<p>Yes</p>
<p><i>Is the program sustainable and/or partnered with another organization?</i></p>	<p>Yes</p>
<p><i>Are program leaders trained to deliver the program? (What type of training have they received?)</i></p>	<p>Yes</p>

Elders in Motion – A fitness program for seniors - NT

<i>Sponsoring Organization</i>	<i>NWT Recreation and Parks Association in partnership with Yellowknife Health & Social Services Authority</i>
<i>Program Leader(s)</i>	<i>Jo Russell</i>
<i>Target Population(s)</i>	<i>Older Adults</i>
<i>Contact</i>	<i>Jo Russell</i>
	<i>Tel: (867) 920-6552 Email: Joanna_Russell@gov.nt.ca</i>

Description

A leader's manual for community recreation leaders or other interested community members that provides the information to guide a class of older adults through a series of light stretch & strength exercises. The exercises are chair-based and use Thera-Bands® or body weight. The program package includes a participant's handout as well.

This program was initially put forward in order to address a lack of qualified fitness professionals in most NWT communities. Recreation Coordinators and Community Health Representatives have indicated an interest in offering this type of program, but do not have a background in this type of work and asked for guidance in creating a safe program.

The program that is under development consists of a leader's manual and participant's handouts. Each package will be distributed with strips of red Thera-Band®.

The leader's manual has background information, PAR-Q, PARMED-X, consent form examples as well as detailed descriptions of the movements involved in the exercises and colour photographs of the exercises. The participant's handouts are designed to be photocopied. They have black & white pictures and abbreviated descriptions of the exercises. They are designed to be provided to participants who have already gone through the program with a leader and wish to try it on their own.

Highlights/Successes

Still under development, although focus tests have had good feedback

Challenges

Finding older adults to model the exercises.

What makes this program a complimentary practice?

Evidence shows that a light stretch and strengthen program is a good way to increase bone density and muscle mass for older adults. This helps prevent injury due to falls and increases balance and mobility. Other jurisdictions have similar programs, such as "OsteoFit" (BC), "The Rural Route to Active Aging" (Alberta), "Active Independent Aging" (Ottawa), and "Stand-up!" (Quebec).

Program Assessment

<i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i>	Community & Individual
<i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i>	Yes. The program is to show a leader how to take a group of apparently healthy older adults through a group exercise program
<i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i>	Focus is stretch & strengthen, as active living and ultimately to assist in fall prevention.
<i>Does it focus on primary prevention?</i>	Yes
<i>Is the program is evidence based?</i>	Under Review
<i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i>	No
<i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i>	We are still in the development phase of this project. The feedback from the pilot tests has been positive, and shows that there is a need for this type of "Train the Trainer" model.
<i>Does it involve an intervention to promote personal or social change?</i>	Yes
<i>Does the provider (organization) directly implement the program?</i>	Yes
<i>Is the program sustainable and/or partnered with another organization?</i>	Yes
<i>Are program leaders trained to deliver the program? (What type of training have they received?)</i>	Yes

Better Body Bob - NT

Sponsoring Organization	Yellowknife Health and Social Services
Program Leader(s)	Jo Russell or Melanie Wiebe
Target Population(s)	Adults in the workforce
Contact	Jo Russell
	Tel: (867) 920-6552 Email: Joanna_Russell@gov.nt.ca

Description

An 8 week workplace wellness program that focuses on modifiable heart health risk factors. Specifically the program is designed to increase physical activity (walking) and consumption of fruits and vegetables. Participants complete a fitness assessment from the *Canadian Physical Activity, Fitness and Life Style Approach, 2007* as well as a food group frequency questionnaire at the beginning and end of the program. This allows us to determine if fitness and healthy eating have increased. During the program participants record weekly blood pressures, bi-weekly weights, waist girths at the program start and end, and whether they received a flu shot in a "Better Body Passport". Additionally, weekly food and physical activity records and health quizzes are completed by participants. All activities are voluntary but for each activity completed participants receive "Better Body Bucks" which are used for a silent auction. The auction is the final activity and includes several gift certificates as well as fitness or healthy food prizes. Participants will be asked to complete a final evaluation of the program.

Highlights/Successes

This is the first session so evaluations have not yet been completed. Over 50% of YHSSA staff are participating.

Challenges

Currently to program is only in the pilot stage and we are not yet sure of the outcome. Additional staffing will be required in order to keep the program going.

What makes this program a complimentary practice?

This program focuses on physical activity, healthy eating, healthy waist girths, blood pressure monitoring, as well as increasing health knowledge. The program is an intervention for the workforce in the workforce; meaning that people do not have to give up their evenings or weekends to learn about health; they can positively influence their health while at work.

Program Assessment

<p><i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i></p>	<p>Individual</p>
<p><i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i></p>	<p>The program is focused on individuals in the workforce and as such all participants are adults. Although older adults are not focused on specifically, there are several employees over the age of 50 years. Additionally, the program modifies behaviours in order to improve health including diabetes prevention.</p>
<p><i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i></p>	<p>Low impact activities such as walking; however, any type of physical activity the participant feels they can safely accomplish is acceptable.</p>
<p><i>Does it focus on primary prevention?</i></p>	<p>Yes</p>
<p><i>Is the program is evidence based?</i></p>	
<p><i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i></p>	<p>During the program, participants record weekly blood pressures, bi-weekly weights, waist girths at the program start and end, and whether they received a flu shot in a "Better Body Passport".</p>
<p><i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i></p>	<p>This is the first session so evaluations have not yet been completed. Over 50% of YHSSA staff are participating.</p>
<p><i>Does it involve an intervention to promote personal or social change?</i></p>	<p>Yes</p>
<p><i>Does the provider (organization) directly implement the program?</i></p>	<p>Yes</p>
<p><i>Is the program sustainable and/or partnered with another organization?</i></p>	<p>Yes</p>
<p><i>Are program leaders trained to deliver the program? (What type of training have they received?)</i></p>	<p>Yes</p>

Take Charge Program - MB

Sponsoring Organization	North Eastman Health Association through the Chronic Disease Prevention Initiative
Program Leader(s)	Sue McKenzie (community member)
Target Population(s)	Individuals with Diabetes
Contact	Debbie Viel Tel: (204) 268-7431

Description

The program targets people who are at risk of developing chronic diseases related to inactivity and weight. The goal of the program is to give participants the knowledge, tools and practical experience to effect a positive change in the behaviour that is contributing to the risks. The project provides participants with up to date knowledge for healthy nutrition, and physical activity. The program is 2 x / week for 12 weeks. One session includes information and exercise and the second weekly session includes identifying, setting and reviewing goals, measuring success and managing barriers in a supportive environment.

Highlights/Successes

- Client satisfaction
- Behaviour change
- Increased fitness levels for participants

Challenges

- Ongoing funding
- Marketing the group to a target group
- Controlling for differing client abilities – example having clients who have very limited mobility in 1 group

What makes *this program a complimentary practice?*

- This program has been led by a community member who saw the need and has really “taken charge” of the program.
- The leader brings in experts as needed but is running a very successful peer led group.
- If we are to highlight one of our initiatives that should be a best practice – it is this one as it is unique and grassroots
- In her 1st group she has not had only older adults but this group could be a best practice for adults 50+

Program Assessment

<p><i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i></p>	<p>Yes all 3. It primarily focuses on the individual but through the individual education there will be success in family and community health.</p>
<p><i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i></p>	<p>It is not an exclusive program but there were older adults who did participate in the program</p>
<p><i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i></p>	<p>Physical activity options are reviewed and tried by the participants. The options focus only on those activities that can be done at home or easily done in the community.</p>
<p><i>Does it focus on primary prevention?</i></p>	<p>Yes</p>
<p><i>Is the program is evidence based?</i></p>	<p>Materials and approaches are identified as best practice through research and expert opinion and are used as the foundation of the program. Examples include 5 A's (Assess, advise, agree, assist and arrange) and the Canada's Guide for Physical activity</p>
<p><i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i></p>	<p>Yes – weight loss, blood pressure, changes in resting heart and self reported results</p>
<p><i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i></p>	<p>No formal evaluation has been submitted to NEHA as of yet. The leader reports that initially all but 1 of the participants had a very low fitness level and now any of the participants could join an aerobics class and do okay. She reported participants not being able to complete any sit-ups to being able to complete 16 on an exercise ball.</p>
<p><i>Does it involve an intervention to promote personal or social change?</i></p>	<p>Yes personal change for the participants</p>
<p><i>Does the provider (organization) directly implement the program?</i></p>	<p>Yes it is provider driven – it is a chronic disease prevention initiative supported by NEHA and offered through a community member with our support</p>
<p><i>Is the program sustainable and/or partnered with another organization?</i></p>	<p>It is supported by the CDPI funds through the North Eastman Health Association</p>
<p><i>Are program leaders trained to deliver the program? (What type of training have they received?)</i></p>	<p>Yes – the leader has formal training. Certified Fitness instructor</p>

SCREEN Toolkit – ON

Program Leader(s)	Heather Keller
Target Population(s)	Older Adults
Contact	Heather Keller Tel: (519) 824-4120 ext 52544

Description

This cd toolkit promotes successful screening of older adults in the community. SCREEN (Seniors in the community risk evaluation for eating and nutrition) versions I and II are provided in their various forms (self, interviewer, French, English, abbreviated). End users purchase a copyright licence to use all materials on the cd in their practice/site (Fee is \$65.00). In addition to the screening tools are tips on use, scoring, developing an ethical screening program etc. Users are also pointed to the Bringing Nutrition Screening to Seniors program and its materials to promote ethical implementation.

Highlights/Successes

There is considerable interest in nutrition with older adults and having some guidance for potential end users has helped to support appropriate, ethical nutrition screening of older adults.

Challenges

Unfortunately many communities do not have sufficient funds or political will to be involved in prevention efforts such as nutrition screening. Without a political will followed with sufficient funding, screening of older adult risk continues to be ad hoc.

What makes this program a complimentary practice?

Toolkit promotes ethical screening and is readily usable by practitioners.

Program Assessment

<p><i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i></p>	<p>All categories- targeted to community providers who will screen risk in individual seniors. As public health is involved in secondary prevention, this program would be useful to all health units.</p>
<p><i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i></p>	<p>Yes</p>
<p><i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i></p>	<p>No</p>
<p><i>Does it focus on primary prevention?</i></p>	<p>No- focused on secondary prevention, finding seniors at risk nutritionally</p>
<p><i>Is the program is evidence based?</i></p>	<p>YES</p>
<p><i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i></p>	<p>YES- SCREEN- a valid and reliable nutrition risk screening tool</p>
<p><i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i></p>	<p>Several validation/reliability studies.</p>
<p><i>Does it involve an intervention to promote personal or social change?</i></p>	<p>This is not a focus of the toolkit, although ethical screening which would involve referral and follow-up is a natural extension of screening.</p>
<p><i>Does the provider (organization) directly implement the program?</i></p>	<p>YES</p>
<p><i>Is the program sustainable and/or partnered with another organization?</i></p>	<p>Yes</p>
<p><i>Are program leaders trained to deliver the program? (What type of training have they received?)</i></p>	<p>The toolkit provides this guidance.</p>

EatRight Ontario – Dietitian Advisory Service - ON

<i>Sponsoring Organization</i>	<i>Ontario Ministry of Health Promotion</i>
<i>Program Leader(s)</i>	<i>Dietitians of Canada (DC)</i>
<i>Target Population(s)</i>	<i>Residents of Ontario – both consumers and health professionals</i>
<i>Contact</i>	<i>Helen Haresign</i> <i>Tel: (416) 977-0849 ext 205</i>

Description

Consumers and health intermediaries can connect with a Registered Dietitian (RD) to receive answers to their nutrition and healthy eating questions at no cost to user, through

- 1-877-510-510-2 a toll free telephone line open 9am to 5pm, Monday to Friday
- Email service on web site at www.ontario.ca/eatright

Service is available in both official languages; as well as many other languages.

Highlights/Successes

- users of service have provided positive feedback – saying service is easy to access; advice is trustworthy, easy to understand, and relevant
- service is used by all ages; and by people all over Ontario
- service makes it easy to access advice of RD for free
- advice is personalized

Challenges

- service is new, so it is important to build awareness

What makes this program a complimentary practice?

- free, easy access to trusted nutrition advice that is personalized for each individual by a qualified practitioner (Registered Dietitian)
- healthy eating is an important factor in promoting health and preventing chronic disease
- nutrition mis-information abounds – so this service provides easy access to advice that is personalized and that you can trust

Program Assessment

<i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i>	Individual
<i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i>	Service is available to all residents of Ontario. As client connects with a Registered Dietitian (RD) she will answer questions and adapt nutrition advice for individual person, in consideration of age, gender, lifestyle, etc.
<i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i>	No specific physical activity component. However, physical activity is stressed as an element of nutrition advice provided.
<i>Does it focus on primary prevention?</i>	Yes
<i>Is the program is evidence based?</i>	Yes
<i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i>	No
<i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i>	Evaluation is underway. Service has been positively received by a wide variety of users.
<i>Does it involve an intervention to promote personal or social change?</i>	Yes Direct contact with a RD
<i>Does the provider (organization) directly implement the program?</i>	Yes Service implemented by DC.
<i>Is the program sustainable and/or partnered with another organization?</i>	Ministry of Health Promotion and Dietitians of Canada launched service in July, 2007. It is being piloted throughout 2008.
<i>Are program leaders trained to deliver the program? (What type of training have they received?)</i>	Yes

Healthy Eating is in Store for You (HESY)™ - ON

Sponsoring Organization	Canadian Diabetes Association and Dietitians of Canada
Program Leader(s)	Sharon Zeiler (CDA), Lynda Corby (DC)
Target Population(s)	People at risk for chronic disease (eg Type 2 Diabetes) and the general population
Contact	Sharon Zeiler, Senior Manager, Nutrition Initiatives and Strategies, Canadian Diabetes Association Tel: (416) 408-7086

Description

HESY is a nutrition label education program designed to empower people at risk for chronic disease to read, understand, apply the nutrition information available on food product labels to enable them to make healthier food choices.

Highlights/Successes

The program has been well used by many health intermediaries and was also used by teachers with junior high and high school students.

Challenges

Maintaining the website without extra funding has been a challenge.

What makes this program a complimentary practice?

Having the material web-based so that it is accessible and easily available to all has been one unique aspect of the program. As well, when the program was created, 9 health promotion groups and industry were involved in the Advisory Committee that created and then tested all parts of the program. Participation has been all across the country and from the north to the south. The program has been very well received wherever it has been used. Just this year, some of the HESY materials were translated into Chinese, Punjabi, and Spanish—groups at high risk for chronic disease.

Program Assessment

<p><i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i></p>	<p>The program is focused on the individual/family—but has been used in a variety of settings to many different audiences.</p>
<p><i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i></p>	<p>The program is targeted at people at risk for chronic disease. The primary audience is not older people, but the information and messages are applicable to this population.</p>
<p><i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i></p>	<p>No, this program focuses on label reading.</p>
<p><i>Does it focus on primary prevention?</i></p>	<p>Yes, the program focuses on healthy eating which is one factor in the primary prevention of chronic disease.</p>
<p><i>Is the program is evidence based?</i></p>	<p>Yes, the program is evidence based.</p>
<p><i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i></p>	<p>The program has gone through an extensive evaluation and there is a Virtual Grocery Store “game “ with a score that is part of the HESY materials.</p>
<p><i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i></p>	<p>Yes, the program has been thoroughly evaluated and the evaluation is online at the HESY website.</p>
<p><i>Does it involve an intervention to promote personal or social change?</i></p>	<p>There is education to promote healthier behaviours.</p>
<p><i>Does the provider (organization) directly implement the program?</i></p>	<p>No, the HESY resources were created for health intermediaries to use with the target populations.</p>
<p><i>Is the program sustainable and/or partnered with another organization?</i></p>	<p>The program was created by and is sponsored by CDA and DC. The program elements are all on the HESY website, which is self-serve. The website is maintained by the 2 sponsoring organizations.</p>
<p><i>Are program leaders trained to deliver the program? (What type of training have they received?)</i></p>	<p>In the initial phases of HESY, we did train program leaders. The funding for this has ceased, but there is a training module on the HESY website.</p>

NOVA SCOTIA 55+ Games - NS

Sponsoring Organization	NS 55+ Games Society
Program Leader(s)	Pete Nordland, Vivian Wright, Leona Grant, Larry Armstrong, Eileen Borgel & 20 or so Directors from across the province.
Target Population(s)	All NS citizens aged 55 or better
Contact	Peter Nordland Tel: (902) 638-8009

Description

The NS 55+ Games are aimed at keeping adults active, mentally, physically and socially, into their golden years. Although the provincial games are held bi-annually, the Society is endeavouring to have each region of the province (6) hold similar games at both zone (local communities) and regional levels on an annual basis. The provincial games consist of approx. 20 activities ranging from the active sports such as hockey, curling, bowling and golf to the more passive pursuits of bridge, cribbage, scrabble and 45's. Participants in the provincials have the opportunity to represent Nova Scotia at the Canada 55+ Games.

Highlights/Successes

Just the fact that we have been able to put together two relatively successful provincial events with attendance increasing substantially between the first and the second. Seeing the look of pride on many faces when a medal is hung around their neck, or watching a 94 year old lady kicking up her heels on the dance floor in the evening is priceless.

Challenges

- Getting the word out. Nova Scotia, like all of the Maritime provinces, is mostly rural, and letting people know that our Society exists and what our aims are has been a challenge. You can advertise all you want, but in the end it is "word of mouth" that will attract the masses. This will take time, but it certainly appears to be heading in the right direction.
- Lack of corporate sponsorship. We have been blessed with fantastic support from both the Nova Scotia and federal governments, but it would be nice to get a major sponsor on line. Perhaps now that we have shown that this is a viable program, we may have better luck in the future.

What makes this program a complimentary practice?

I believe the main selling point is that it is run by 55+ people for 55+ people. It is run solely by volunteers. I also believe that our emphasis on the importance of the social aspect of the games during the evenings, whether it be by an entertainer or a sing-a-long or a dance, allows all participants to mingle with everyone else and not just those that they meet on the 'playing field'.

Program Assessment

<p><i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i></p>	<p>Community, although it is aimed at bringing all communities together in a fun but competitive environment on a bi-annual basis</p>
<p><i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i></p>	<p>Yes – 55+</p>
<p><i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i></p>	<p>Yes – physical activities may include: badminton, bowling, curling, golf, hockey, slo-pitch, swimming, track & field and tennis. If there is sufficient interest in any of these activities, then they are offered at the games.</p>
<p><i>Does it focus on primary prevention?</i></p>	<p>Yes – our premise is that the more active that one is, the healthier they remain and the less likely to require medical attention.</p>
<p><i>Is the program is evidence based?</i></p>	<p>Yes – by the smiles on people’s faces!</p>
<p><i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i></p>	<p>No</p>
<p><i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i></p>	<p>We have now held two NS 55+ Games, 2005 & 2007. The 1st games attracted 154 participants, the 2nd games 245 attended. Feedback from both sets of games was mostly positive, and what little criticism was received was positive. It definitively appears that the games are here to stay.</p>
<p><i>Does it involve an intervention to promote personal or social change?</i></p>	<p>Yes – Personal & social. Many people are afraid to break out of their own personal comfort zone, but we find that if we are able to get them involved at least once in the games, they are likely to return and bring some of their friends with them.</p>
<p><i>Does the provider (organization) directly implement the program?</i></p>	<p>Yes – the first two provincial games were implemented by the Society; however, for 2009, the town of Yarmouth has volunteered to host the games, and it appears that several other communities are getting in line for future games.</p>
<p><i>Is the program sustainable and/or partnered with another organization?</i></p>	<p>Yes - Canadian Senior Games Association</p>
<p><i>Are program leaders trained to deliver the program? (What type of training have they received?)</i></p>	<p>No – our Directors are volunteers from all walks of life who know the value of living an active lifestyle and are willing to devote considerable time to promoting and organizing these games at all levels.</p>

The Singing Kitchen - NL

Sponsoring Organization ***The Town of Branch (municipality)***

Target Population(s) ***Older adults***

Contact ***Priscilla Corcoran Mooney***

Tel (709) 227-4140

Description

A weekly community meal hosted by the Town of Branch with the goals of creating an inclusive environment and increasing food security for residents. Cost: age 55 +: Free and under 55: \$2/meal. Meals were delivered to those who could not attend. Meals were cooked by teams of women, 6/team. An average of 140 people attended each meal which is followed by sharing circle where songs, recitations, recipes, jokes are shared.

Highlights/Successes

60% of population of community attended each meal, social groups mixed and mingled at each meal, culture and history shared, community spirit and connection nurtured, intergenerational learning between older women and younger women in kitchen

Challenges

Recognising that mental health issues may prevent residents from attending, ensuring meals were nutritious and ensuring sustainability

What makes this program a complimentary practice?

The Singing Kitchen was able to combine so many secrets of health: food security enhanced social environment, volunteerism, team building, connection, culture. This program is as important to our residents as anything we have ever done as a council.

Program Assessment

<p><i>Is this program focused on community, individual/family or public health? (If you choose more than one category, please explain)</i></p>	<p>The primary focus is community health. Community inclusion and community wellness are two strategic directions for the Town of Branch.</p>
<p><i>Does it target older adult (50+) population? (Is the program specifically targeted at Older Adults? If not, how are they included?)</i></p>	<p>Yes, funding was granted by the New Horizons program and our goals were to make sure older adults had a good meal and an opportunity to socialize regularly.</p>
<p><i>Does it have a component of physical activity? (If yes, What is the component of physical activity and how is promoted?)</i></p>	<p>Physical activity was not a big part of the program but this year, we have introduced The Hall Walkers Club for older adults in Branch</p>
<p><i>Does it focus on primary prevention?</i></p>	<p>In some ways, this initiative has had a primary prevention focus since it taught participants the value of healthy eating, socialization...good food, good company.</p>
<p><i>Is the program is evidence based?</i></p>	<p>We are now in our second year and have taken lessons learned into the Singing Kitchen this year.</p>
<p><i>Does the program use a measurement tool? (e.g. taking blood sugar, weight, etc.)</i></p>	<p>No</p>
<p><i>Has it had at least one evaluation with a positive outcome? (What evaluations have been completed and summarize the findings?)</i></p>	<p>We completed evaluations, formally and informally thought and received rave reviews</p>
<p><i>Does it involve an intervention to promote personal or social change?</i></p>	<p>The sense of community that has been realized has caused our community to move forward as a community, as team looking towards a bright future. It has also taught Branch and other municipalities that councils have a responsibility for both social and economic development.</p>
<p><i>Does the provider (organization) directly implement the program?</i></p>	<p>Yes, working with a team of volunteers/</p>
<p><i>Is the program sustainable and/or partnered with another organization?</i></p>	<p>It has to be sustainable! We will sue revenue from the kitchen and hopefully, more funding from government and other partners to keep it going.</p>
<p><i>Are program leaders trained to deliver the program? (What type of training have they received?)</i></p>	<p>No.</p>

REFERENCES/RESOURCE

- 3.1 Merck Frosst Survey Fact Sheet: Insight into Canadians Living with Type 2 Diabetes – A Survey of People living with Type 2 Diabetes and Physicians
- 3.2 The social determinants of the incidence and management of type 2 diabetes mellitus; are we prepared to rethink our questions and redirect our research activities? Dennis Raphael, York University
- 3.3 The Health of Canadians – CCSD's Stats & Facts (Canadian Council on Social Development)
- 3.4 A Review of Relationships between Active Living and Determinants of Health. Jim Frankish, UBC

Website Articles:

- 3.5 Educational disparities in health behaviors among patients with diabetes: the Translating Research into Action for Diabetes (TRIAD) Study – Andrew Karter
<http://www.biomedcentral.com/1471-2458/7/308/prepub>
- 3.6. 2004/2005 Office of the Auditor General of British Columbia Preventing and managing Diabetes in British Columbia found at: <http://bcauditor.com> (89 page report)
- 3.7. BC Healthy Living Alliance Physical Activity Strategy March 2007 found at: www.bchealthyliving.ca (35 page report)
- 3.8 Saskatchewan Health: The Provincial Diabetes Plan –
“Supporting Saskatchewan People to achieve their best possible well-being.”
<http://www.publications.gov.sk.ca/details.cfm?p=12043>