An Introduction to

THE BETTER PROGRAM

Ontario Chronic Disease Prevention Alliance
October 7, 2021

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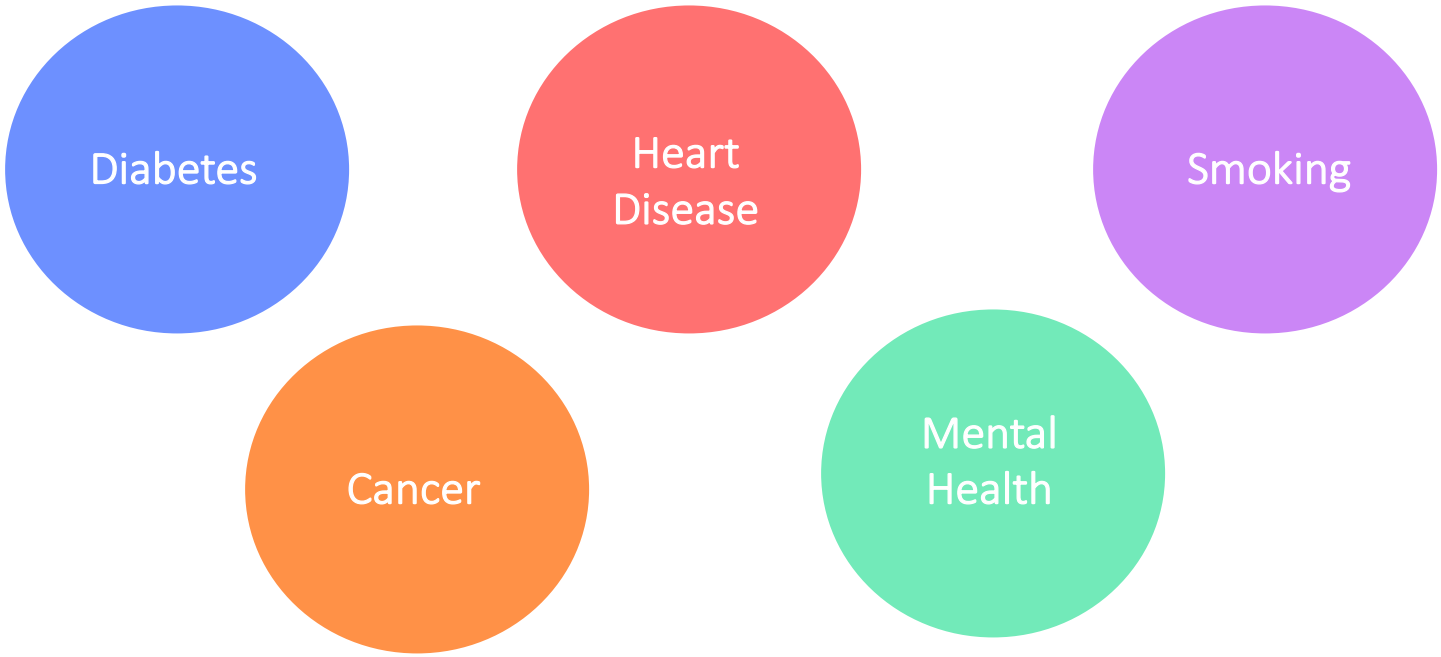
Context

- 3 out of 5 Canadians have a chronic disease[1]
- 1/3rd of cancers are preventable through modifiable risk factors[2]
- Family physicians lack time, resources & tools to address chronic disease prevention and screening
- There are a plethora of guidelines, many of which conflict or lack rigor

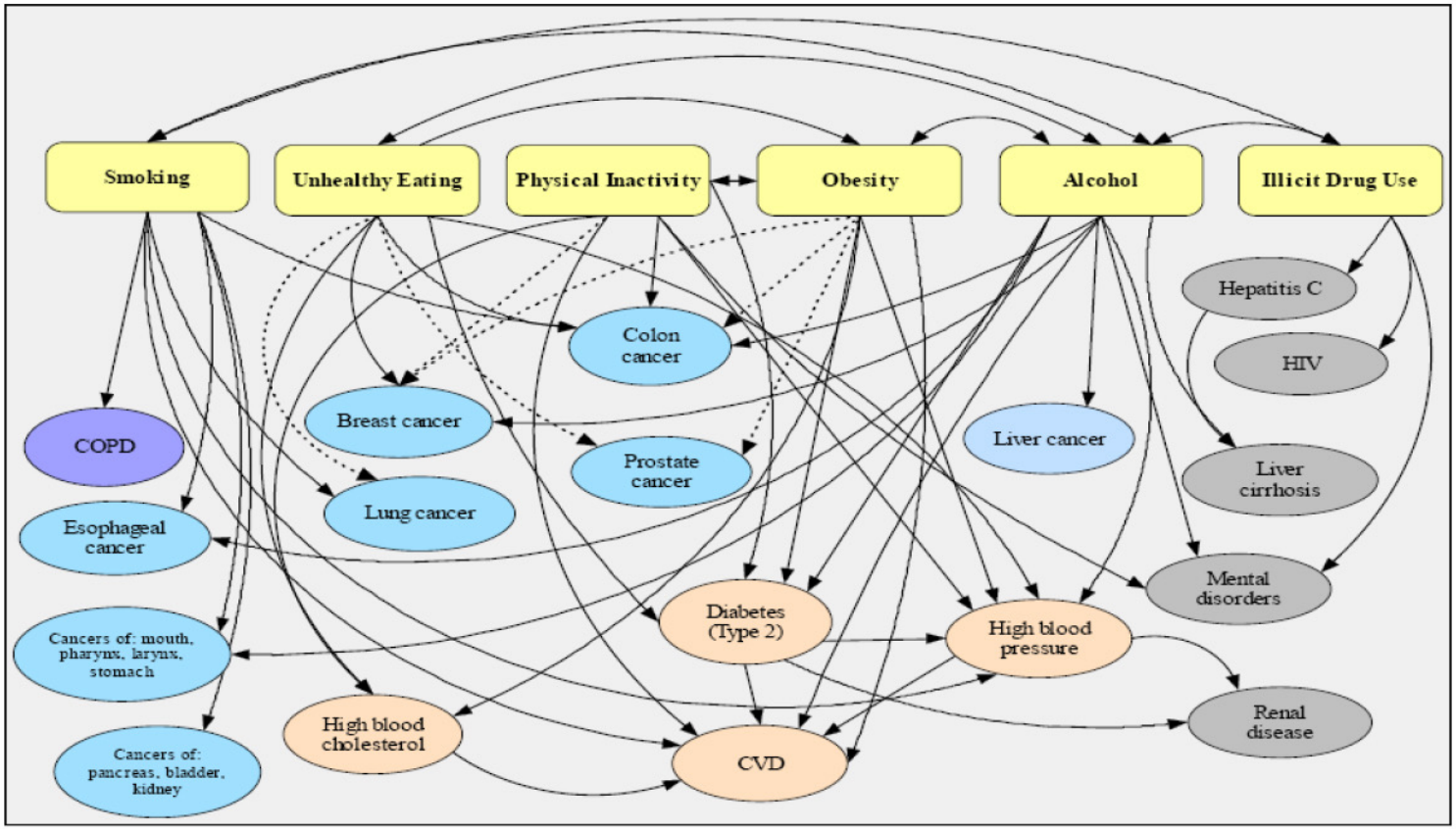
1. Public Health Agency of Canada. Fact Sheet: Government of Canada chronic disease initiatives [Internet]. Ottawa (ON); [modified 2011 Sep 19; cited 2013 Jun 24]
2. Global Toronto. New campaign aims to cut the risk of cancer in Alberta by half. 2014 May 9

Photo source: Retrieved from http://www.kore1.com/what-to-do-when-deciding-between-multiple-job-offers/www.kore1.com

Traditional Health Care Model



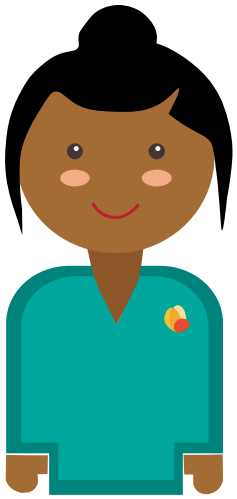
Reality



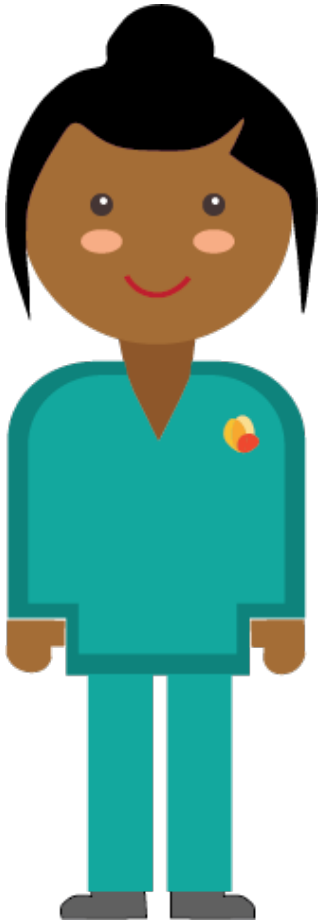
Haydon E, Roerecke M, Giesbrecht N, Rehm J, Kobus-Matthews M. (2006, March). Chronic disease in Ontario and Canada: Determinants, risk factors and prevention priorities: Summary of full report. Prepared for the Ontario Chronic Disease Prevention Alliance & the Ontario Public Health Association. Available from: http://ocdpa.ca/sites/default/files/publications/CDP-FullReport-Mar06.pdf

The BETTER Approach

- Focus on prevention and screening of cancer, diabetes, heart disease and associated lifestyle factors (diet, physical activity, smoking, and alcohol)
- Patients **40 to 65 years of age** are targeted
- Identifies an enhanced role in the primary care setting: the **BETTER Prevention Practitioner**™ who is informed by the **BETTER Toolkit**

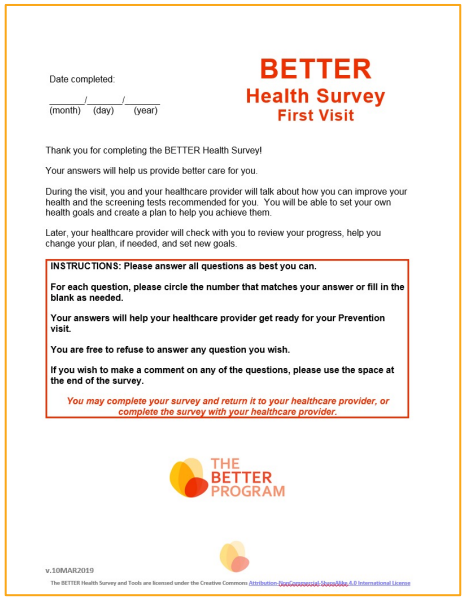


The BETTER Prevention Practitioner™



- A member of the practice (e.g. RN, LPN, NP, dietitian etc.) who has been trained to have specialized skills in chronic disease prevention and screening
- Completes a 2-day training session
- Someone who has dedicated time to have prevention visits with patients

The BETTER Tool Kit



BETTER
Health Survey
First Visit

Date completed:

_____/_____/_____
(month) (day) (year)

Thank you for completing the BETTER Health Survey!

Your answers will help us provide better care for you.

During the visit, you and your healthcare provider will talk about how you can improve your health and the screening tests recommended for you. You will be able to set your own health goals and create a plan to help you achieve them.

Later, your healthcare provider will check with you to review your progress, help you change your plan, if needed, and set new goals.

INSTRUCTIONS: Please answer all questions as best you can.

For each question, please circle the number that matches your answer or fill in the blank as needed.

Your answers will help your healthcare provider get ready for your Prevention visit.

You are free to refuse to answer any question you wish.

If you wish to make a comment on any of the questions, please use the space at the end of the survey.

You may complete your survey and return it to your healthcare provider, or complete the survey with your healthcare provider.

THE BETTER PROGRAM

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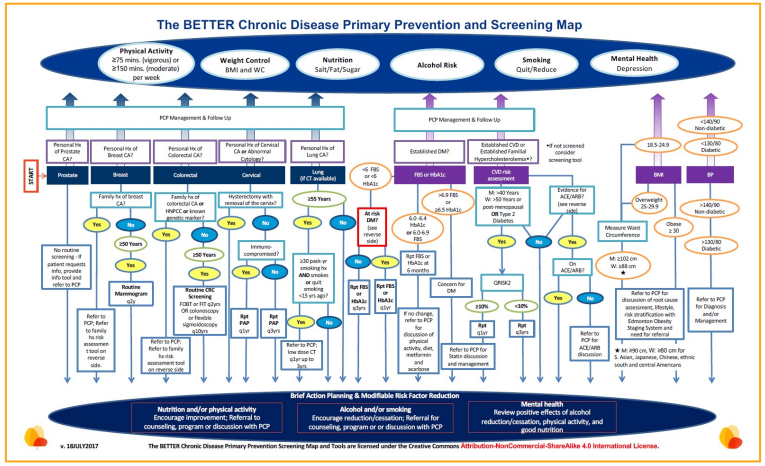

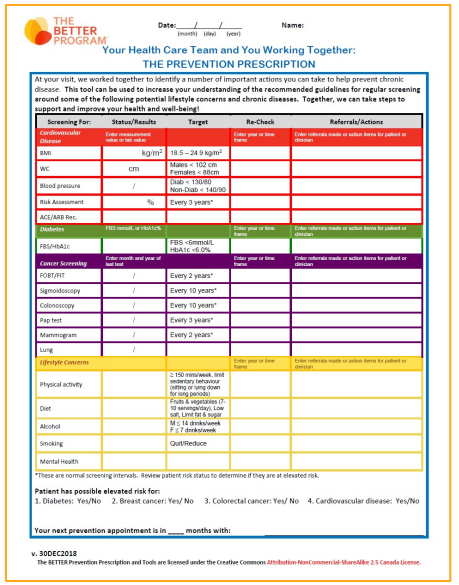

THE BETTER PROGRAM

Date: ____/____/____ Name:
(month) (day) (year)

Your Health Care Team and You Working Together:
THE PREVENTION PRESCRIPTION

At your visit, we worked together to identify a number of important actions you can take to help prevent chronic disease. **This tool can be used to increase your understanding of the recommended guidelines for regular screening around some of the following potential lifestyle concerns and chronic diseases. Together, we can take steps to support and improve your health and well-being!**

Screening For:	Status/Results	Target	Re-Check	Referrals/Actions
Cardiovascular Disease	Enter measurement value or lab value		Enter year or time frame	Enter referrals made or action items for patient or clinician
BMI	kg/m²	18.5 – 24.9 kg/m²		
WC	cm	Males < 102 cm Females < 88cm		
Blood pressure	/	Diab < 130/80 Non-Diab < 140/90		
Risk Assessment	%	Every 3 years*		
ACE/ARB Rec.				
Diabetes	FBS mmol/L or HbA1c %		Enter year or time frame	Enter referrals made or action items for patient or clinician
FBS/HbA1c		FBS <6mmol/L HbA1c <6.0%		
Cancer Screening	Enter month and year of last test		Enter year or time frame	Enter referrals made or action items for patient or clinician
FOBT/FIT	/	Every 2 years*		
Sigmoidoscopy	/	Every 10 years*		
Colonoscopy	/	Every 10 years*		
Pap test	/	Every 3 years*		
Mammogram	/	Every 2 years*		
Lung	/			
Lifestyle Concerns			Enter year or time frame	Enter referrals made or action items for patient or clinician
Physical activity		≥ 150 mins/week, limit sedentary behaviour (sitting or lying down for long periods)		
Diet		Fruits & vegetables (7-10 servings/day), Low salt, Limit fat & sugar		
Alcohol		M ≤ 14 drinks/week F ≤ 7 drinks/week		
Smoking		Quit/Reduce		
Mental Health				

*These are normal screening intervals. Review patient risk status to determine if they are at elevated risk.

Patient has possible elevated risk for:

1. Diabetes: Yes/No 2. Breast cancer: Yes/ No 3. Colorectal cancer: Yes/ No 4. Cardiovascular disease: Yes/No

Your next prevention appointment is in ____ months with:

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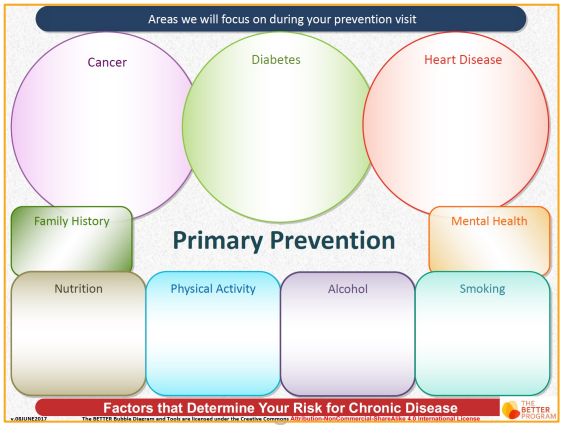
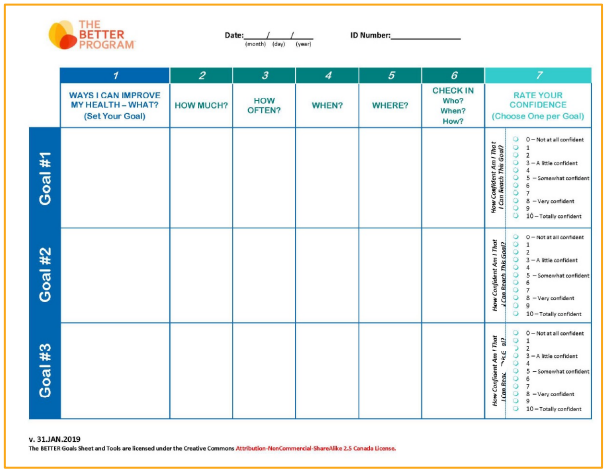




THE BETTER PROGRAM

Date: ____/____/____ ID Number:_____
(month) (day) (year)

	1	2	3	4	5	6	7
	WAYS I CAN IMPROVE MY HEALTH – WHAT? (Set Your Goal)	HOW MUCH?	HOW OFTEN?	WHEN?	WHERE?	CHECK IN Who? When? How?	RATE YOUR CONFIDENCE (Choose One per Goal)
Goal #1							How Confident Am I That I Can Reach This Goal? ○ 0 – Not at all confident ○ 1 ○ 2 ○ 3 – A little confident ○ 4 ○ 5 – Somewhat confident ○ 6 ○ 7 ○ 8 – Very confident ○ 9 ○ 10 – Totally confident
Goal #2							How Confident Am I That I Can Reach This Goal? ○ 0 – Not at all confident ○ 1 ○ 2 ○ 3 – A little confident ○ 4 ○ 5 – Somewhat confident ○ 6 ○ 7 ○ 8 – Very confident ○ 9 ○ 10 – Totally confident
Goal #3							How Confident Am I That I Can Reach This Goal? ○ 0 – Not at all confident ○ 1 ○ 2 ○ 3 – A little confident ○ 4 ○ 5 – Somewhat confident ○ 6 ○ 7 ○ 8 – Very confident ○ 9 ○ 10 – Totally confident

v. 31JAN.2019

The BETTER Process

Patient invited for prevention visit

Patient fills out Health Survey

Prevention Practitioner Prepares for visit

Prevention Visit

Patient linked to resources

The BETTER Trial

Overall Objective:

To improve prevention and screening in primary care for cardiovascular disease, diabetes, cancer and their associated lifestyle factors for patients aged 40-65.

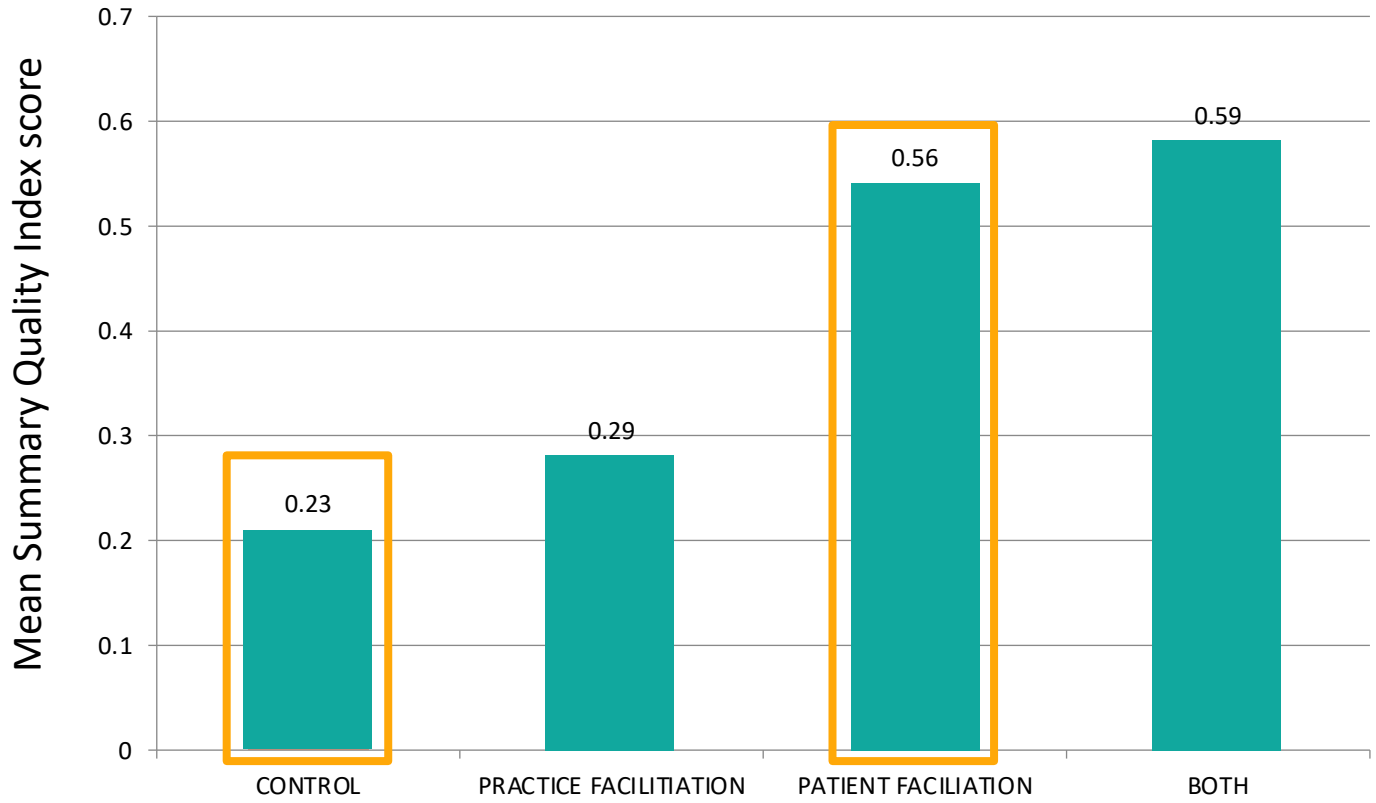
Specific Objectives:

To determine if:

- a practice-level **Practice Facilitator** intervention is effective
- a patient-level **Prevention Practitioner** intervention is effective

The BETTER Trial

Results:



Grunfeld E, Manca D, Moineddin R, Thorpe KE, Hoch JS, Campbell-Scherer D, Meaney C, Rogers J, Beca J, Krueger P *et al*: **Improving chronic disease prevention and screening in primary care: results of the BETTER pragmatic cluster randomized controlled trial**. *BMC family practice* 2013, **14**(1):175.

Patient Perspectives

"[A] very thorough reading [of] my complicated medical history on my 1st visit…[the BETTER Program] needs to be a permanent part of health care"

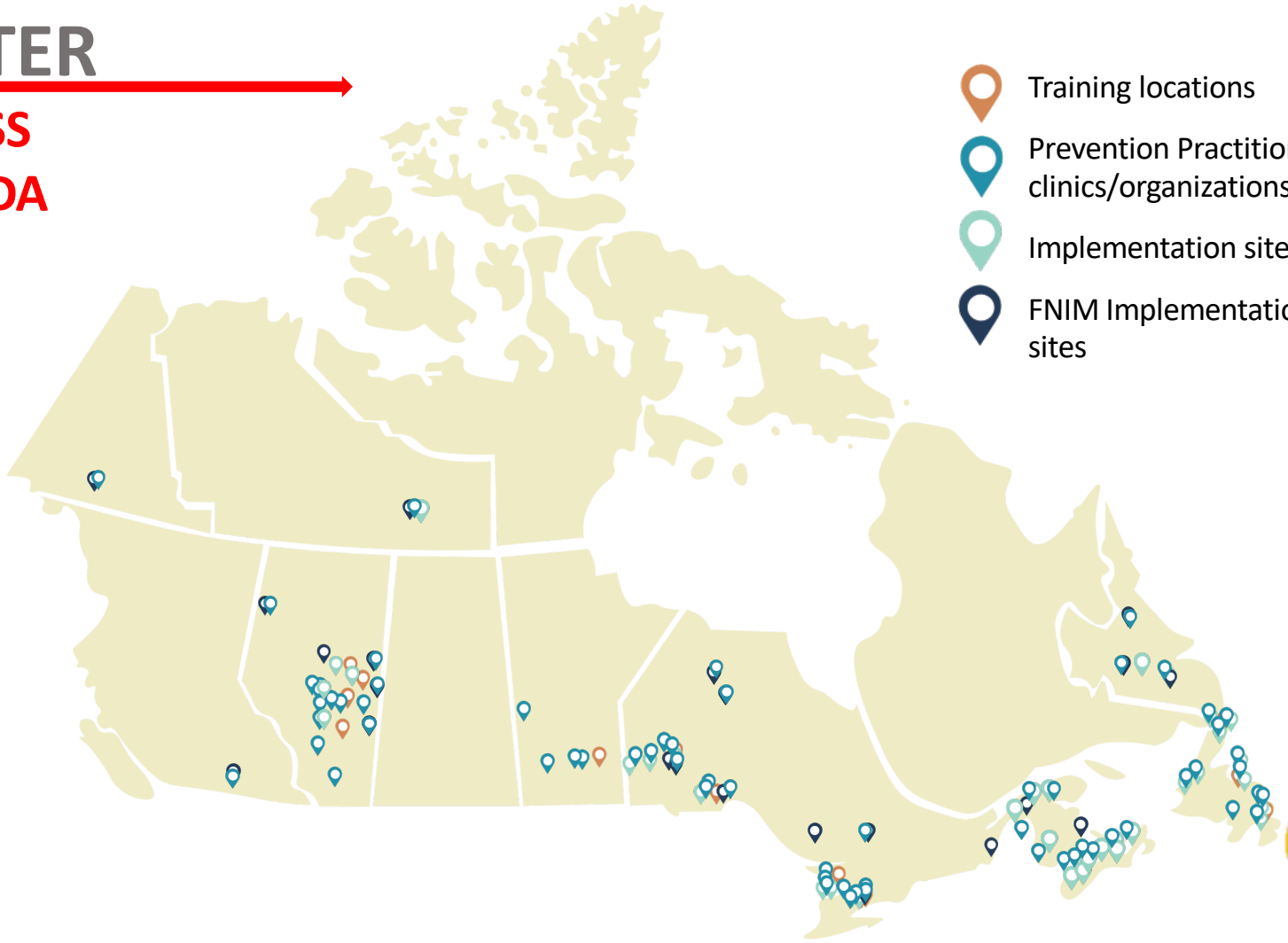
"It was nice to have someone look at the big picture regarding my health and develop a plan for me to go forward. Wish I had someone look from a prevention nature long before this. Bravo!"

"[the prevention visit was] personal, not rushed. She listened. She provided information that was relevant to me"

BETTER in Canada

BETTER

ACROSS CANADA



Questions?

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