Detailed Description of Activities by Age Group

Each section lists strategies and program activities as statements generated from the discussions. The number indicates the overall priority for the target group

Pregnancy to 2 years	
Program Activity	**Description**
1. Group education: pre & post natal classes parent and baby groups	• group counselling on general topics (dietitian, GP, social worker, and other allied health professionals) offered to all pregnant women. Basically taking 1 hour to get a consistent message across to many, for resource purposes. • pre & post natal classes focusing on healthy living, weight, physical activity & nutrition (in addition to typical pregnancy education); supplement with pregnancy & early parent walking group • group education on introduction of food to infants, healthy family eating habits, pregnancy nutrition, - shopping trips, cooking classes • comprehensive group education - prenatal, infant and toddler classes (nutrition, physical activity, mental health, opportunity for social networking) • parenting classes re: nutrition; encourage mom/dad to lead a healthy lifestyle as a good role model for kids • lifestyle programs to include babies / toddlers; offer daycare • at six month baby check visit, refer to a group class for introducing solids • pre-natal and toddler groups for support and discussions around healthy living • parenting groups - mothers/potential mothers - play groups, education sessions • mom/tot physical activity groups
2. Prenatal visit: 1:1 counselling with nurse/3rd trimester	• preconception counselling (folic acid, birth control pills, healthy lifestyle) • prenatal visit: screening (BMI) and prevention, info sheets re: healthy eating and activity in pregnancy, Canada's Food Guide, expected weight gain in pregnancy (tear-off pad) • counselling visit in third trimester, funded by government (breast feeding, options, delivery, post partum etc.) • longer appointment time with extra time devoted to assessment of knowledge needs and patient education • phone consultation for mothers with young children if cannot come in
3. Well baby visit	• group well-baby visits with practitioner and dietitian • well baby visit with focussed teaching/advice for that age group: infant nutrition handout, formula/starting solids. • verbal advice and knowledge transfer re: weight gain during well baby visits (include dietitian in these

	conversations)
4. Website/ recorded messages/apps	• website & other social media to increase accessibility for nutrition questions • YouTube & other social media to educate re: physical activity, play, games with young children • list / links to reliable web sites • self help • access to 'apps' or journals to better assess lifestyle, knowledge of health (tracking, monitoring) • have a recorded message running while people are on hold on the telephone • list of appropriate websites, videos and written advice • resources loan section at primary care office for those who don't have internet
5. Referral to dietitian, physical activity specialist	• automatic visit with dietitian and kinesiologist for every pregnant patient or family with a young child • assessment of patients understanding of nutrition, physical activity, weight management and motivation to change or maintain • automatic face-to-face meeting with dietitian during pre and post-natal visit: education re: how to make your own baby food, alternative diets e.g. vegan/vegetarianism and adequacy of these diets in meeting infant and toddler nutrition requirements • multidisciplinary patient care approach -referral to dietitian
6. Establish partnerships	• refer to other community resources for prenatal, infant and toddler group education if not available in FHT re: healthy eating, weight management, breastfeeding • parent and baby groups - coordinate with existing groups/services to provide info/education • drop-in groups at local centre such as Early Years Centre (EYC)- including rotating schedule with HCP • partnerships with Parks & Rec or community groups - they offer parenting group, FHT offers allied health professional (AHP) educator for health topics • have prenatal clinics at community recreation centres with concurrent exercise class/support and education group • establish linkages to community services, programs and resources (e.g. EYC, public health programs, support groups, prenatal or well baby visits)
7. New parent / family information package	• including community resources, supports and services (e.g. activities, programs, support groups, counselling, parenting advice, Early Years Centre, Good baby box, good food box etc) • connecting patients with groups • supportive breast feeding awareness: what's out there, community resources, groups
8. Good relationship with PCP	• ongoing discussion/advice, support at regularly scheduled appointments • PCP to capitalize on acute visit to touch on health promotion • awareness (during pregnancy): conversation with health care provider about current attitudes and

	concerns about wt, nutrition and activity
9. Identification of high risk group	• identifying high risk group during the prenatal and well baby visit (e.g. psychosocial, GDM etc) - screening and refer to appropriate resources • special focus on the obese pregnancy patient. pre and post partum (e.g. nutrition, exercise, blood sugar screening)
10. Drop-in clinics (baby weigh-ins, parental support)	• drop-in clinics for baby weigh-ins and parental support • including screening
11. Provider education	• take a family based approach (need for more training for health care providers) • targeted education to health care providers
12. Screening for feeding issues (opportunistic and during wellness care)	• have a screening tool to flag feeding issues to be reviewed before next regular baby check and refer to an ongoing feeding issue class and from that class if needed then an individual session
13. Access to lactation consultant	• provide information about breast feeding support • promotion of breast feeding to facilitate maternal weight loss and baby's healthy weight gain • promote lactation consultation
14. Peer support group	• mentoring/buddy system e.g. patient run healthy diet info sessions for education, role model, recipe exchange, connecting keeners & non-keeners etc.
15. System navigation guide for patients	• creating care plan or map for prenatal to postnatal and infancy to help guide patient through the system
16. Ongoing support	• phone consultation for mothers with young children if cannot come in • follow-up component to group education for ongoing support
3 to 12 years	
Program Activity	**Description**
1. Parental education	• educate parents about importance of healthy eating and physical activity; engage them in exhibiting these behaviours (e.g. lead by example rather than "do as I say, not as I do"); information on healthy meal ideas • group education classes for parents (or one-on-one visits) - highlighting the risk of poor diet and inactivity as well as some solutions and guidelines they can implement in their homes • cooking classes parents and me - with nutrition teaching • highlight the importance of decreasing screen time, active commuting, and family activities together • provide list of healthy lower calorie snacks • empower parents to set limits and be in charge of parenting • parental education and involvement and role modelling

	• educate parents on nutritional label reading • healthy families • parental education for foodbanks, funding for recreational activities, healthy food box, other community resources
2. Routine check-ups / screening	• routine check-ups to identify problems with unhealthy eating habits/disorders, monitoring BMI, and fitness level • use proper growth charts (World Health Organization's charts) • establish well child visits (after the age of 4) that are funded in a similar model to the 18 mth well baby visit. They should ideally follow a provincially / nationally recognized format like the 18 mth WBV with involve- ment of at least one allied health professional, with some training for this particular age group. (red flags) • screening preschoolers w NutriSTEP and provide appropriate f/u within FHT to those identified at nutritional risk • routine screening and regular assessments of weight, lifestyle • modify the Rourke visit to include physical activity as a priority along with immunization. • Lifestyle Assessment forms as part of well-child visits • encourage regular visits with PCP, kids in this age often not seen. • capitalize on 4-5 yr old planned well kid visit • regular healthy family visits to FHT
3. Establish partnerships: schools / community groups	• community and / or school garden and cooking programs • partnering with schools/community partners with a goal to increase education re: fitness, physical activity and healthy eating/meal plans and cooking • partnering with Parks and Rec; community-based family focused sessions re: healthy family choices for nutrition and exercise • partnership with local schools, especially for geographic-specific FHTs - afterschool programs • healthy meals & snacks, milk programs at school, daycare, public health • put information on healthy food choices, snack ideas, lunch ideas and other community resources in school newsletters • merging of public health and primary care, with funding for interested health care providers to do mini presentations to schools etc. in the community focusing on age specific advice and goals. The idea is to differentiate fact from fiction, as there is a lot of misinformation out there • link with other community agencies to develop/facilitate joint programs (e.g. Public Health, DHU, Children's agencies etc)

4. Child targeted education; develop / incorporate healthy lifestyle literature, media, web for children	• education sessions for children re: healthy eating/cooking, developing good diet habit, promote PA • encourage children to monitor their own satiety -> child's self-esteem, self-efficacy • develop/incorporate healthy lifestyle literature or media appropriate to this age group • passive education: posters, pamphlets, website • poster in waiting room with picture of a normal weight adult, teen, child etc example aim for BMI of 25 (the goal is to have an impact on people's perception of what healthy looks like) • child targeted education: table-talks, games, videos while in waiting room - social media/ online PA tracker (game) for increasing PA and healthy eating • child friendly literature in waiting rooms (flyers, books, shows playing on waiting room TVs) • connect patients with local programming e.g. partnership with FHT and community fitness facility
5. Family education	• engage whole families in physical activity • group education classes around developing "competent" eating which would involve whole family • Healthy You focused on families (lifestyle balance program focussed on nutrition, PA) • group education focusing on the family unit /breakout for age appropriate activities • kids & parents involved in classes for cooking, shopping & school lunches quick and healthy
6. School programming; integrate into school system	• school programming - curriculum including nutrition, daily PA • educate school educators to promote policies re: appropriate choices for fundraising and for healthy "treat" days • integrate into school system - need formal linkages between PC and school boards -encourage walking, healthy snacks, reusable water bottles etc. • acknowledge and commend Board of Education for the decision and implementation of healthy eating practices within school cafeterias. • each FHT has funding and responsibility towards a few schools in the area (i.e. preventative teaching) • educate teachers/board of education about acceptance of healthy body weight and fostering healthy self-esteem; adopt no-tolerance policies for weight-related bullying • target schools- food choices for meals offered through school • help parent's lobby for increased gym/outdoor time at school
7. Provider education	• more PCP/allied health care provider education • support PCPs with awareness of resources available, increase confidence of PCPs to engage in conversations around healthy weights • promote healthy lifestyle rather than labeling/stigma of being overweight - an overweight child can still be healthy if they are eating well and are active • stronger focused approach by the health care providers (HCPs) - recognize that some kids are at risk!

	Take a non generic approach- individualized towards the high-risk kids • approaching physical activity outside of formal exercise- anything that reduces screen time • health care provider education sessions to increase provider knowledge & competency
8. Advocacy to government for community programs	• advocacy for national school meal program • advocate to government (Ministry of Ed, MCYS). Require governments to provide more funding for physical activity programs and access to healthy food • advocate for subsidizing healthy lifestyle choices • improved access to extracurricular activities or programs - promoting free/sustainable/ affordable activity within the community • support healthcare providers to influence marketing of fast foods, portion size
9. List of community resources / activities	• build awareness about community resources & programs like 4-H programs • list of resources/activities in the community with a list of the associated costs (-> awareness)
10. Develop EMR for plotting child growth	• EMRs need to plot where the child falls for BMI, blood pressure & growth curve • using EMR to increase screening of at risk population
11. Website	• FHT website with a parent section to access literature/resources re: healthy lifestyles for their children and families
12. Peer support groups	• social and peer support - connect patients with local programming e.g. partnership with FHT and community fitness facility
13 to 18 years	
Program Activity	**Description**
1. Routine check-ups / screening; well adolescent visit	• screening • yearly health review with focus on physical activity and weight • monitor mental health more in well kid check-ups which will pick up on emotional eating • routine check-ups to screen for BMI, level of activity, assessment of screen time, unhealthy relationship with food/eating disorders • regular mental health, substance use/ misuse check-ups • encourage regular well adolescent visit for screening, education • FHT sending out letters / calling pts in this age group to come in for an annual health examination. In that visit, school, weight, self esteem issues should be a focus, and potentially identified for further intervention using questionnaires • develop a screening tool to flag low self esteem / potential mental health issues related to obesity, those flagged then proceed to group lead by mental health worker and dietitian

	• make an effort to use any opportunity (visit for coughs and colds) to do HEADDS type of screening (or even have a simple questionnaire screen)
2. Work with schools	• physical activity mandatory in school • FHT health professionals working with high schools to have programs / sessions offered to interested students. - maybe even mandatory sessions that address the medico-psychosocial issues in this age group. • work with student councils to raise further awareness at school event on community options for physical activity and long term benefits of healthy lifestyle • nutrition education, food education and cooking as part of health class • FHT outreach with public health unit in high schools • partner with schools, public health and to do guest speaking sessions on body image, nutrition • after school activity programs (help from town to fund for underprivileged families)
3. Health promotion through social media; online support for adolescents	• health Promotion through media (i.e. TV, facebook, twitter) ... targeted social media/ apps to promote physical activity and healthy lifestyle - link with prizes, contests • online support - reliable web sites, and online support groups and access to HCP via online mediums • use of healthy eating advertisement on social networking sites • FHT website - adolescent section for information and resources related to healthy lifestyles • take advantage of social networking media to engage teens in conversations about healthy lifestyles: interactive websites, Facebook group, twitter • PA challenge - use online (i.e. endomondo) with prizes • create system for teens to email/text health care provider • provide online nutrition support/ chat room for questions with dietitian answering to dismiss myths
4. Teen group education	• develop handouts geared to this age group • cooking and grocery shopping classes just for teens or teens and parents together • encourage teenagers to adopt a routine regarding eating, sleep, and activity patterns while allowing them the freedom to choose their options for a routine • education surrounding healthy body images and self-esteem - foster the notion that you don't have to be thin to be healthy and just because you're overweight doesn't make you unhealthy • patient education & communications (physiology etc.) and solutions that are applicable to this age group • limit parental involvement with specific topics that teens may not feel comfortable sharing • cooking and physical activity groups and education surrounding disease prevention • offer meal prep group session with built in walking group for teens wanting to lose weight
5. Community resource information	• educate teens on various community resources- after school programs, sport programs, clubs in schools, encourage school-based cooking classes etc

	• develop list of community resources and post on FHT website • develop information pack for teenagers on physical activities in their region that they can do with their friends, getting fit, socializing and having fun • handout to give to teen with info on activities in their community (especially free options)
6. Youth Advisory Committee	• create Youth advisory committee that helps to develop programs/strategies to reach adolescents re: healthy lifestyles (can also help to run some programs as part of volunteer hours) • establish groups to participate in fundraising bike tour or walking challenge • develop teen working group to help shape and engage community initiatives for teens - empower them
7. Partner with Parks & Rec; community engagement (community groups, sports teams, clubs, youth drop-in centres)	• partner with local school, Parks & Rec - help run health promotion activities and competitions; have them be student led • offer support and guidance at the local middle/high school level concerning fitness/health/home ec. programs. • university / college prep groups "School Survival" (-> life skills for independence: cooking, planning, time management, diet etc.) • community engagement -> RD/AHP support in community groups, schools, sports teams, clubs, youth drop-in centres, screening • partnering with youth-focused/ youth-led groups such as eXpose, reality theatre etc. Focus on peer activities which target self esteem, PA and nutrition • partner with youth groups • partner up with True Sport (federal government) i.e. posters in waiting room, brochures promoting movement not necessarily organized sport/teams • co-involvement with local sports teams, coaching staff, Scouts to take healthy lifestyle outside of the rink, court or diamond • education campaign focused on where teens are at (bars, malls, community centres, wifi spots etc.) - make it fun but powerful • develop physical activity programs with other community agencies • organized sports teams - education campaign/tool for coaches on healthy eating/diet (e.g. professional development days)
8. Child and parent education together	• education for child and parents together on healthy eating and meal preparation • educate re: healthy eating and physical activity & engage parents in actively participating in these behaviours with their teenagers • parent education (similar to the previous target group 3-12 years)
9. Family support system ;	• family support system - healthy lifestyle of adolescent must be established through family norms as well.

parent groups	Teenagers are much more likely to adopt healthy habits if the home environment reflects it as well • offer support groups for parents on parenting tips for teens including topics on healthy lifestyle • promote family meals & eating together
10. Teenage peer support groups with peer leaders; volunteer opportunities	• offer volunteer opportunities (need volunteer hours for high school) to lead PA group etc • community advocacy volunteering opportunities that give PA (clean up the city) or nutrition education (Food Bank drive) • develop social support networks with trained peer leaders (as opposed to health professionals) • teenage peer support groups - cooking and physical activity groups
11. Access to specialized team services	• access to interdisciplinary health care team to address weight concerns (i.e., eating disorders, emotional eating ..to see family for group counselling)
12. Provider education – specific to age	• education for HCP on how to approach this topic with teens in a way that promotes healthy self esteem • training for HCP - motivational interviewing, choices and changes, etc • consistent messaging from FHT re: health at every size
13. Drop-in clinics	• make drop-in clinics open access at various hours to make convenient for them
18+ years Generally Healthy	
Program Activity	**Description**
1. Annual health exam review & assessment; screening	• add Fantastic Lifestyle Checklist at annual review and assessment • develop a holistic lifestyle assessment based on mental, physical, spiritual (rest), and emotional needs. Sleep assessments and guiding the patient towards individual health and wellness • 1:1 education • patient screening - weight, waist circumference, BMI, BP regardless of reason for visit and referral to the appropriate specialists (dietitian, kinesiologist, social worker) * must ensure input is quantification and measurable • routine check-up to screen for BMI, healthy eating (healthy portions, Canada's Food Guide), food issues/emotional eating, screening for chronic disease (HTN, diabetes, CVD risk, mental health issues). • annual health exam - talking about personal health risk factors - make it relevant • emphasis on annual health examination (AHE) - for those with 2 or more criteria: obesity + 1 other chronic disease marker, increase to monthly face-to-face visit (for 12 months) to motivate lifestyle change • use lifestyle screening questionnaire
2. Group education	• group work for similar demographics • group education - craving change, peer led group support, life skills (e.g. meal prep, cooking on a budget etc), walking groups etc

	• healthy weight loss, nutrition for cholesterol/blood pressure control, cooking groups, walking tours, supermarket tours, exercise • more interdisciplinary programs offered within the FHT, perhaps co-facilitated with 2 different disciplines • time management and stress management training
3. Medical diagnosis of 'obesity'	• make the diagnosis of 'obesity' an actual medical diagnosis, part of their medical history. Have visits dedicated to obesity / overweight, just like we would for hypertension (HTN) or diabetes (DM) • treat obesity more pro-actively, rather than re-actively (i.e. don't wait for diagnosis of DM/dyslipidemia/HTN to educate people about how their weight has contributed to these conditions) • make more aware of results in later life of obesity
4. Links to community education programs / resources	• provide links to community education programs that promote healthy eating and active lifestyles • provide info regarding walking groups or other group activities involving exercise • annual newsletter to patients discussing healthy lifestyle and identifying resources/supports/programs in community
5. Assess readiness to learn & goal setting	• assess readiness to learn & goal set with patient. • focus interventions on stages of change, start with their priority and have them build the confidence for sustainable changes • empower patients to decide what they want to do about their problem (personal goal setting with follow-up by HCP) • graded task assessment (breakdown the task to more achievable chunks)
6. Focus on behaviour and feelings not numbers	• shift focus away from numbers and more towards positive change (healthy lifestyle must be less "clinical" and more relaxed approach) • focus on behaviour and feelings
7. Develop survival package for living alone	• develop survival package for 'How to' survive your first year away from home; recipes quick and easy, healthy food choices, where to shop, calories in alcohol vs. water • meal planning for one - older seniors who live alone after spouse has passed away
8. Outreach for workplace wellness	• FHT outreach for workplace wellness programs • Healthy You in workplace • Partner with employers to allow FHT to come in to do screening clinics
9. Self-management support (individual or group)	• self-management groups for multiple chronic diseases • self-management support: individual or group or peer-led (Stanford) • consistent guided follow up (specific SMART short term goals with follow up) • self management at home- (i.e. using home blood pressure cuff, glucometer, etc.) • maintaining "passport to health" (include smart goals, barriers; record of health screening) to keep

	people focused on health promotion (can be paper or on-line)
10. Provider education	• training for HCP (eg. motivational interviewing, stages of change, conviction and confidence scaling, mental health screening) to influence behaviour change. • focus on moving through stages of change & motivational interviewing
11. Waiting room pamphlets, videos, website, messages, social media	• passive education tools (waiting room pamphlets, posters, videos, website, telephone on-hold message, etc) • take advantage of social media to engage in open conversation with dietitian and/or other health provider re: myths and misconceptions about healthy eating, physical activity, and chronic disease process and prevention • social media apps to promote self management • support from diet & activity tracking/coaching tools - i-phone or online
12. Provide navigation for SES marginalized to support networks	• providing navigation for socio/economical marginalized to support networks i.e. food shares, community gardens, subsidized fitness activities, etc. • recognition of low socioeconomic status as a barrier to good health. Facilitation of cooking class with linkage to food resources
13. Episodic visits for screening	• taking advantage of episodic visits to screen for early disease (high BP), health promotion (e.g. healthy weight loss & exercise for knee osteoarthritis), & prevention (assessment of activity level)
14. Scheduling flexibility	• scheduling flexibility • be more open in FHT with appts for health education physicals / paps in evenings so patients don't have to lose holiday time • offer existing group programs more often, in the evening to meet clients schedule, over lunch time
15. Improved access to activity supported by practice	• improving access to activity, funded or supported by FHT - e.g. group activity programs. • ministry funding for exercise / kinesiologist • access to physical activity program created within the FHT - would need funding for exercise physiologist
16. Exercise and diet prescriptions	• use prescription for exercise program (local parks, recreation parks, etc.) • have pre-printed exercise and diet prescriptions, handed to patients with obesity at visits to emphasize the acute and ongoing treatment of this condition
17. Partnering with community programs	• identifying resources (beyond the FHT) for lifestyle maintenance/change (internal and external) • community advocacy & partnering (supporting health care provider [HCP] to do so) for adequate food funding, housing, mental health supports, etc • Farmer's market in the parking lot with easily prepared recipes available using the food
18. Mental health support	• screening specialty populations (mental health) • more screening of obesity in mental health patients

	• focus on mental health support for severe obesity
19. EMR long term tracking of changes	• interactive tool via EMR to illustrate effects of lifestyle modification, track impact of small clinical changes, patient education
20. EMR screening of specialty groups	• screening specialty populations (mental health, smokers, menopause, families with kids) • screen for patients in this group who quit smoking and gain weight • screen for menopausal weight increases • EMR screening for high risk to develop chronic disease and earlier intervention • medication review - look for weight contributing meds
21. Disease prevention focus programs within current disease programs	• group education surrounding healthy eating and physical activity and how this is important for preventing onset or further development of chronic disease • hands on seminars / workshops / groups re: healthy eating, meal preparation and also for physical activities for different age groups • group education (different topics related to lifestyle; physical activity, nutrition, self management, time management, stress management etc..) • education re: link of obesity, lack of exercise to cancer and ED not just the well known cardiovascular disease and diabetes • offer short intervention 1 or 2 sessions on specific health topics to engage and educate and prepare patients to make changes
22. Integration with specialist programs e.g. bariatric clinics	• be knowledgeable about specialized treatment options: medical and surgical bariatric clinic network option in Ontario.
23. Adding expertise in PA and diet to team	• exercise specialists, kinesiologist specialists, staff etc. • FHT to advocate for funding of kinesiologist and dietitian
18+ years Medically Complex	
Program Activity	**Description**
1. Self-management group support programs; SMART goals	• increase awareness & availability of self management programs • educating pt they are responsible for their health not their doctors • self management & empowerment to change • assessing readiness, engage clients in goal setting, empower clients to self-manage • promote self management & SMART goal setting - e.g. Stanford self management workshop, motivation interviewing and patient centred goals or planning • help patients understand the value of SMART goals and address barriers • realistic goal setting related to the pt's abilities - "something is better than nothing"; assess readiness for

	change • goal setting with focus on things the patient can control directly (PA and nutrition)
2. Community resource package	• make patients aware of existing services in the community and how to access • information package - community resources, programs, groups, supports and services • patient handout for community services, programs designed for complex needs (Heart Wise exercise programs)
3. Emphasize impact of obesity on Q of L and ADL	• physicians placing emphasis on impact of obesity on quality of life and impact on activities of daily living, on top of the medical benefits • emphasizing "realistic" and sustainable goals for patients with consensus from MD, NP, RD etc • focusing on a patient's perception of health and well being, along with specific lab #s (i.e. not looking at lab numbers in isolation). Motivating people to eat healthy and exercise to feel good and be more functional and not necessary to have their cholesterol down to ZERO. • establish targets towards functionality and quality of life. Create specialized plan/goals for individual needs (e.g. acknowledge financial barriers) • emphasis on quality of life (QOL) and functioning; educate regarding the significant benefits obtained with even small increments of change in nutrition and physical activity
4. Routine visits for chronic disease check-ups	• routine check-ups to assess BMI, monitor activity level and healthy eating. • regular visits do not always have to be by physician • routine visit for chronic disease management (Diabetes, HTN, dyslipidemia) • make use of annual appts with PCP to review risks, readiness to change, mental health and motivation • provide monthly visits: rotate between primary care professional for motivational support for lifestyle change with booster sessions of 1 to 2 group sessions for physical activity and nutrition goal setting, SMART goal.; this needs to be ongoing
5. Case-management to navigate system	• offer system navigation help • case management /pt care navigator to monitor progress (labs, lifestyle modifications, risks) and provide social supports • create care map and plan with patient to help them navigate the system and know where to go for support • case-management to navigate complexity of illnesses (& specialists); Educate re: combined effects of meds, mood, fatigue and effect on weight; Involve a variety of team members as appropriate
6. Disease specific education	• disease specific education and goals • interdisciplinary education sessions targeted towards specific needs (diabetes, cholesterol, physical limitations etc)

	• education on specific disease and treatment plan, including their role and responsibilities in the treatment plan • evidence based risk reduction - secondary prevention
7. Individual / family / support person education	• individual / family education. Empower patient and family through education of disease process, treatment options and self-care • help patients understand that medications, treatments are only part of the solution • offer education information in a variety of ways: written, oral, web based ...cognitive therapy • assess readiness to learn and motivation for change then tailor education and resources to the patient • group session (support) for family and/or pts; chronic disease groups dealing with coping strategies which will enhance chances at weight loss • offer 'Craving Change' groups to all FHTs on a regular basis or similar cognitive behavioural therapy (CBT) programs (4 week CBT group) gear teaching to individual, family and support persons • review supports (family, friends, community, and professionals), help to identify additional supports. Involve and plan with supports when appropriate and as necessary
8. Access to mental health / social work	• timely access to mental health/social work for patients struggling with mental health issues • pain and depression management -- need to help this particular target group
9. Peer led self-management support groups	• self-management support peer led - Stanford Model particularly useful here • patient-led priority setting for conditions and treatment approaches; let the patient decide at all times • group sessions in disease specific areas (leverage existing peer support groups) • support groups (those with similar conditions) - patients see they are not alone and can learn from one another • peer-led education/ support groups so that people can identify • create on-line support groups for patients that our allied health professionals can check in on
10. Internal referrals	• internal referrals (i.e. diabetes educator, chiropodist, social work, heart health etc)
11. Integration of practice group programs	• integration of other group programs within FHT (e.g. DM group, heart health, etc.)
12. Assessment by PT / kinesiologist to encourage mobility	• encourage mobility - offer assessments by physiotherapist/kinesiologist and screening by physician (ECG)

13. Improved interdisciplinary collaboration	• interdisciplinary collaboration to address all of the patients needs, not just in silos • Case conferencing with patient and all professionals involved in patient's care to ensure all barriers and challenges are identified to enable effective goal setting
14. Screening for mood / depression	• routine check-ups to screen for mental health issues • screen for mood, regular counselling to address impact of chronic disease on patients and family • assess for DSM IV, diagnosis, (focusing on mood disorder)
15. Home visits	• home visits for complex patient - especially if getting to clinic is difficult; assess home for PA opportunities, diet, safety & supports, etc (holistic home assessment)
16. Group exercise programs	• group exercise program geared towards this population group (Tai chi, aquafit, etc)
17. Disease prevention focus programs within current disease programs	• expanding programs to include people who are at risk for that disease - more focus on prevention. (e.g. leverage existing diabetic, HT, cardiac rehab programs)
18. Obesity as a medical diagnosis	• making sure, obesity is part of their complex medical history, and an important determinant when we prescribe treatment and diagnose new medical issues
19. Develop "health passport"	• develop a "health passport" which keeps lab data, medications, BP etc for patients to keep and review on each visit
20. Partner with community services, agencies	• maximize relationships with other centres in the community to pool resources rather than doubling up, making it easier for the patient to navigate • linkage to community programs and services/resources (i.e. CCAC Chronic Disease Program, Geriatric Program, DECNET, Weight Management Programs) • partner with community services, agencies, retirement homes, Parks & Rec
21. Provider education	• health care provider (HCP) education • regular updates with specialist for staffs increase in knowledge concerning chronic diseases • train health care providers in Motivational Interviewing and implement in office visits when patient presents as ambivalent or hopeless
22. Electronic follow-up – communication	• more use of electronic follow-up, email, web site etc • use EMR technology to invite patients with chronic disease for an assessment by a HCP • medication reviews (wt contributors etc.)