2018-2019 Fiscal Year

WINDSOR
Family | Health | Team

HEALTH PROMOTION PLAN

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List of Abbreviations

Arthritis, Rehab and Education Program	AREP
Asthma Research Group Windsor-Essex County Inc.	ARGI
Canadian Mental Health Association	CMHA
Certified Respiratory Educator	CRE
Chronic diseases	CD
Chronic obstructive pulmonary disease	COPD
Client Centered Rehabilitation Questionnaire	CCRQ
Electronic Medical Record	EMR
Emergency Department	ED
Fibromyalgia Workshop	FM

Health Equity Impact Assessment	HEIA
Health Promoter	HP
Hypertension	HTN
International Classification of Diseases	ICD-9
Irritable Bowel Syndrome	IBS
Local Health Integration Network	LHIN
Ministry of Health and Long-Term Care	MOHLTC
Nicotine Replacement Therapy	NRT
Noncommunicable diseases	NCDs
Nurse Practitioner	NP
Osteoarthritis Workshop	OA
Patient Health Questionnaire	PHQ-9
Quality Improvement Plan	QIP
Quality Improvement Decision Support Specialist	QIDSS
Registered Dietitian	RD
Registered Nurse	RN
Registered Respiratory Therapist	RRT
Smoking Treatment for Ontario Patients	STOP
Social Worker	SW
St. Clair College	SCC
WECHC Partnership Advisory Committee	PAC
Windsor and Essex County	WEC
Windsor Essex Community Health Centre	WECHC
Windsor-Essex County Health Unit	WECHU
Windsor Family Health Team	WFHT
Windsor Squash and Fitness Club	WSFC

1.0 Executive Summary

The Windsor Family Health Team (WFHT) is a community governed non-profit corporation offering high quality primary health care for residents in Windsor and the surrounding area. It has an inter-professional group of health care practitioners, including family physicians, who provide health care in an integrated and respectful environment to help keep patients healthy before illness occurs.

The Health Promotion Plan focuses on chronic disease management and prevention, as it is the leading cause of death in Ontario.[1] To prevent and manage these diseases, four objectives were developed to improve patient outcomes through the eighteen programs and services currently offered at the WFHT.

The objectives consist of the following:

1. Target and mitigate the most prevalent chronic diseases at the WFHT by offering a sufficient number of programs and services to address these chronic diseases identified in the WFHT patient medical profiles and Windsor-Essex population.
2. Reduce the four key modifiable risk factors; tobacco use, alcohol consumption, physical inactivity and unhealthy eating.
3. Improve health equity by offering programs and services to meet the diversity of the WFHT's patient population identified in the most recent online learning preference survey and HEIA tool results.
4. Provide evidence-based programs and services that leverage community partnerships and resources.

Further work in promoting all the programs and services at the WFHT is expected to improve patient participation. The Health Equity Impact Assessment Tool, will continue to be applied to programs and services in hopes of supporting equity-based improvement planning and outlining special considerations for disadvantaged patients to reduce health disparities. It was also identified that cardiovascular conditions represent the most significant grouping of chronic diseases at the WFHT as it contributes to over 32% of diagnoses present in the WFHT patient's medical charts. In the future, the Congestive Heart Failure Self-Management Program will be rolled out at the WFHT, but this program is currently in pilot mode elsewhere and is not ready at the present time.

Upon analysis of the eighteen programs and services as seen in Section 6.0 of the report it was identified that two programs- Gender Journeys and Supermarket Tours- will be discontinued.

Health Promotion Strategy

In alignment with the WFHT Strategic Plan Report 2018-2022, the health promotion strategy strives to uphold the WFHT's mission to *providing access to primary health care through an integrated team approach* by supporting WFHT's vision for *Healthy Lives and Healthier Community.*[2] To accomplish this, the health promotion strategy focuses on chronic disease management and prevention. Chronic diseases are a significant burden to the Ontario healthcare system and represent nearly 80% of all deaths in the province[3]. Many of these diseases can be prevented by modifying four key risk factors; tobacco use, alcohol consumption, physical inactivity and unhealthy eating[4]. The WFHT's objective to mitigate these diseases is to target the aforementioned modifiable risk factors by promoting healthy behaviours in the WFHT's patient

population and in part, the Windsor-Essex community. The health promotion strategy will incorporate the Model of Health and Well-Being as seen in Figure 1 in conjunction with WFHT's Quality Improvement Plan (QIP) by applying the principles of the Health Equity Impact Assessment (HEIA) Tool.

For more information about QIPs please visit:
http://www.hqontario.ca/Quality-Improvement/Quality-Improvement-Plans.[5]

For additional information or to review the HEIA template please visit:
http://www.health.gov.on.ca/en/pro/programs/heia/tool.aspx[6]

The WFHT Model of Health and Wellbeing was adopted in June, 2014 as a strategic framework for a model of care.

Figure 1: The Model of Health and Well-Being

For additional information or to review The Model of Health and Well-Being please visit: ‘
https://www.allianceon.org/model-health-and-wellbeing[7]

1.1 Fundamentals of Programs and Services

The overall mission of the health promotion plan is summarized into four key objectives:

1. Target and mitigate the most prevalent chronic diseases at the WFHT by offering a sufficient number of programs and services to address these chronic diseases identified in the WFHT patient medical profiles and Windsor-Essex population.

2. Reduce the four key modifiable risk factors; tobacco use, alcohol consumption, physical inactivity and unhealthy eating.
3. Improve health equity by offering programs and services to meet the diversity of the WFHT's patient population identified in the most recent online learning preference survey and HEIA tool results.
4. Provide evidence-based programs and services that leverage community partnerships and resources.

2.0 Objective One: Prevalence of Chronic Diseases

Chronic diseases (CD), also referred to as noncommunicable diseases (NCDs), are long-term diseases that typically develop slowly over time which are rarely cured but can be treated.[8] CDs include arthritis, asthma, back problems, cancer, cardiovascular diseases, chronic depression, diabetes and respiratory diseases; worldwide, they are the leading cause of mortality.[9] [10] The Erie St. Clair LHIN identified chronic diseases to be significantly increasing in the region putting further stress on the healthcare system within the region. The Erie St. Clair population reports higher rates of arthritis, asthma, diabetes, hypertension, mood disorder, chronic obstructive pulmonary disease (COPD) and heart disease relative to the province.[11]

At present, the health care system has a reactive approach by addressing acute health conditions rather than chronic diseases.[12] This is unfortunate given that CDs can not only be managed but also prevented. WFHT's programs and services target the most pervasive chronic diseases as seen below in Table 2. The table categorizes the WFHT patients diagnosed with health conditions and ranks the diseases by proportion of patients affected. Chronic diseases are expected to continue to climb as Ontario's population is anticipated to grow to 16.9 million by 2031 with 25% of the population aged 65 and older.[13] It is therefore critical for the WFHT to mitigate and manage chronic diseases with our current population to be ahead of the expected rise.

2.1 WFHT Patient Population Profile and Top Health Conditions

As of July 19th, 2018, there are 6809 enrolled patients. To better target and implement the Health Promotion Plan it is important to understand the patient population and the most prevalent health conditions at the WFHT. At just over 17%, the age group between 30-39 is the most significant group at the WFHT as noted in Table 1. In general, 60.5% of the population is between the working-age group aged 20 and 59 with the total female population exceeds the male population by a margin of 2.4%. These metrics should be kept in mind when evaluating and developing new programs and services.

The WFHT tracks patients' diagnoses through the International Classification of Diseases (ICD-9) system. A total of **4,208** WFHT unique patients or **62%** of the global WFHT population have at least one ICD-9 code associated with them. Due to comorbidities within the patient population there are **close to 22,000** ICD-9 coded health conditions. There are also over **18,000** health conditions that have no ICD-9 code associated with them through open text diagnosis. While the number of un-coded health conditions appears large, the Quality Improvement Decision Support Specialists (QIDSS) noted that a large portion of these un-coded health conditions do not require an ICD-9 code because one does not simply exist. In summary, Table 2 lists the top 10 sub-classification health conditions and the top three or more, most prevalent unique classification diagnoses within the sub-classification. Metabolic diseases (obesity and hyperlipidemia), mental

illness and hypertension and are the top three most pervasive sub-classifications at the WFHT. The data provides a benchmark to ensure the programs and services offered at the WFHT appropriately match the needs of the patient population. A further important statistic identified in Table 10 shows that cardiovascular conditions contribute to 32.9% of diagnoses present in the WFHT patient's medical charts. Consequently, cardiovascular conditions are the most significant grouping of chronic diseases at the WFHT.

Table 1: 2018 Patient Profile by Age Group and Gender

Age Group	Female	% Female	Male	% Male	Total	% Total
0-9	325	4.8%	334	4.9%	659	9.7%
10-19	353	5.2%	344	5.1%	697	10.2%
20-29	526	7.7%	419	6.2%	945	13.9%
30-39	640	9.4%	532	7.8%	1172	17.2%
40-49	481	7.1%	496	7.3%	977	14.3%
50-59	480	7.0%	545	8.0%	1025	15.1%
60-69	358	5.3%	381	5.6%	739	10.9%
70-79	223	3.3%	196	2.9%	419	6.2%
80-89	67	1.0%	63	0.9%	130	1.9%
90+	33	0.5%	13	0.2%	46	0.7%
Grand Total	**3486**	**51.2%**	**3323**	**48.8%**	**6809**	**100.0%**

Figure 2: 2018 Patient Profile

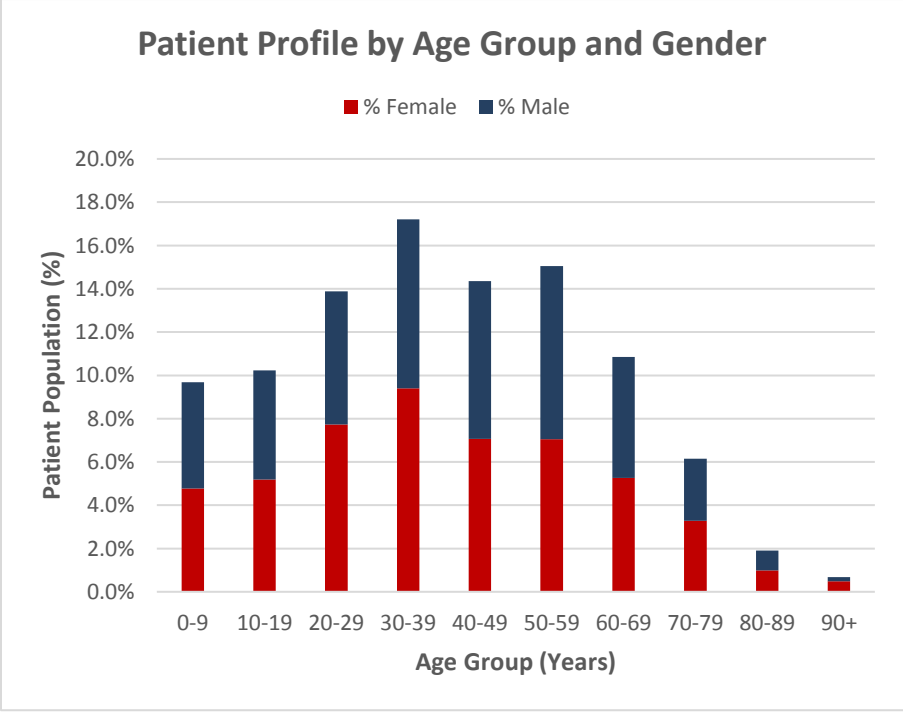

Table 2: WFHT Top 10 Health Conditions by Sub-Classification Description

Rank	ICD-9 Code Range	Sub-Classification Description	F	M	Total	%
1	**270 – 279**	**Other Metabolic Disorders and Immunity Disorders**	**1118**	**1010**	**2128**	**33.3**
	272.4	Other and unspecified hyperlipidemia	442	393	835	
	278.0	Overweight and obesity	447	356	803	
	272.0	Pure hypercholesterolemia	230	295	525	
	278.02	Overweight	147	109	256	
	277.7	Dysmetabolic syndrome X	87	132	219	
	272.2	Mixed hyperlipidemia	106	107	213	
	278.01	Morbid obesity	57	30	87	
	272.5	Lipoprotein deficiencies	33	52	85	
	274	Gout	23	59	82	
	272	Disorders of lipoid metabolism	33	43	76	
2	**300 – 316**	**Neurotic Disorders, Personality Disorders, and Other Nonpsychotic Mental Disorders**	**776**	**657**	**1433**	**22.4**
	300.0	Anxiety states	412	226	638	
	305.1	Tobacco use disorder	242	229	471	
	314.0	Attention deficit disorder of childhood	55	74	129	
	305.0	Nondependent alcohol abuse	16	68	84	
	300.02	Generalized anxiety disorder	43	34	77	
3	**401 – 405**	**Hypertensive Disease**	**569**	**593**	**1162**	**18.2**
	401	Essential hypertension	493	515	1008	
	405	Secondary hypertension	40	43	83	
	401.1	Benign essential hypertension	29	25	54	
4	**295 – 299**	**Other Psychoses**	**539**	**351**	**890**	**13.9**
	296.2	Major depressive disorder single episode	338	206	544	
	296.8	Other and unspecified bipolar disorders	75	51	126	
	296.3	Major depressive disorder recurrent episode	55	37	92	
5	**710 – 719**	**Arthropathies and Related Disorders**	**541**	**346**	**887**	**13.9**
	715.9	Osteoarthrosis unspecified whether generalized or local, site unspecified	398	256	654	
	715.0	Osteoarthrosis generalized	38	30	68	
	714.0	Rheumatoid arthritis	32	8	40	
6	**360 – 379**	**Disorders of The Eye and Adnexa**	**368**	**380**	**748**	**11.7**
	367.1	Myopia	183	186	369	
	367.0	Hypermetropia	73	97	170	
	367.4	Presbyopia	38	58	96	
7	**530 – 539**	**Diseases of Esophagus, Stomach, and Duodenum**	**361**	**297**	**658**	**10.3**
	530.81	Esophageal reflux	318	263	581	
	535.4	Other specified gastritis	20	6	26	
8	**490 – 496**	**Chronic Obstructive Pulmonary Disease and Allied Conditions**	**349**	**301**	**650**	**10.2**
	493	Asthma	267	191	458	
	496	COPD, not elsewhere classified	60	65	125	
	492	Emphysema	31	52	83	

9	**280**	**Iron deficiency anemias** (no sub-groups)	**492**	**135**	**627**	**9.8**
10	**249 – 259**	**Diseases of Other Endocrine Glands**	**283**	**315**	**598**	**9.4**
	250	Diabetes mellitus	240	272	512	
	257	Testicular dysfunction		32	32	
	256.4	Polycystic ovaries	20		20	

* Sub-classification descriptions based on 2015 ICD-9-CM Diagnosis Codes database (http://www.icd9data.com/2015/Volume1/default.htm)
* A patient is only counted once if the patient has multiple diagnoses within the same sub-classification (bold patient counts), but patients may have diagnoses from multiple sub-classifications.

3.0 Objective Two: Risk Factors

While background risk factors (such as age or sex) may not be adjusted, many CDs can be prevented or managed through common modifiable risk factors, including the four fundamental risk factors (tobacco use, alcohol abuse, physical inactivity and unhealthy diet) and intermediate risk factors (such as elevated blood cholesterol or blood sugar levels).[14] The casual effect of these risk factors and how they contribute to chronic disease is seen in the chart below. Based on this evidence, the WFHT needs to ensure its programs and services target as many risk factors as possible to reduce chronic disease within the WFHT patient population and surrounding area. The *2016 Windsor Essex County Community Needs Assessment Report* also identified these risk factors as barriers to health in the community, further solidifying the WFHT commitment targeting the four key risk factors.[15]

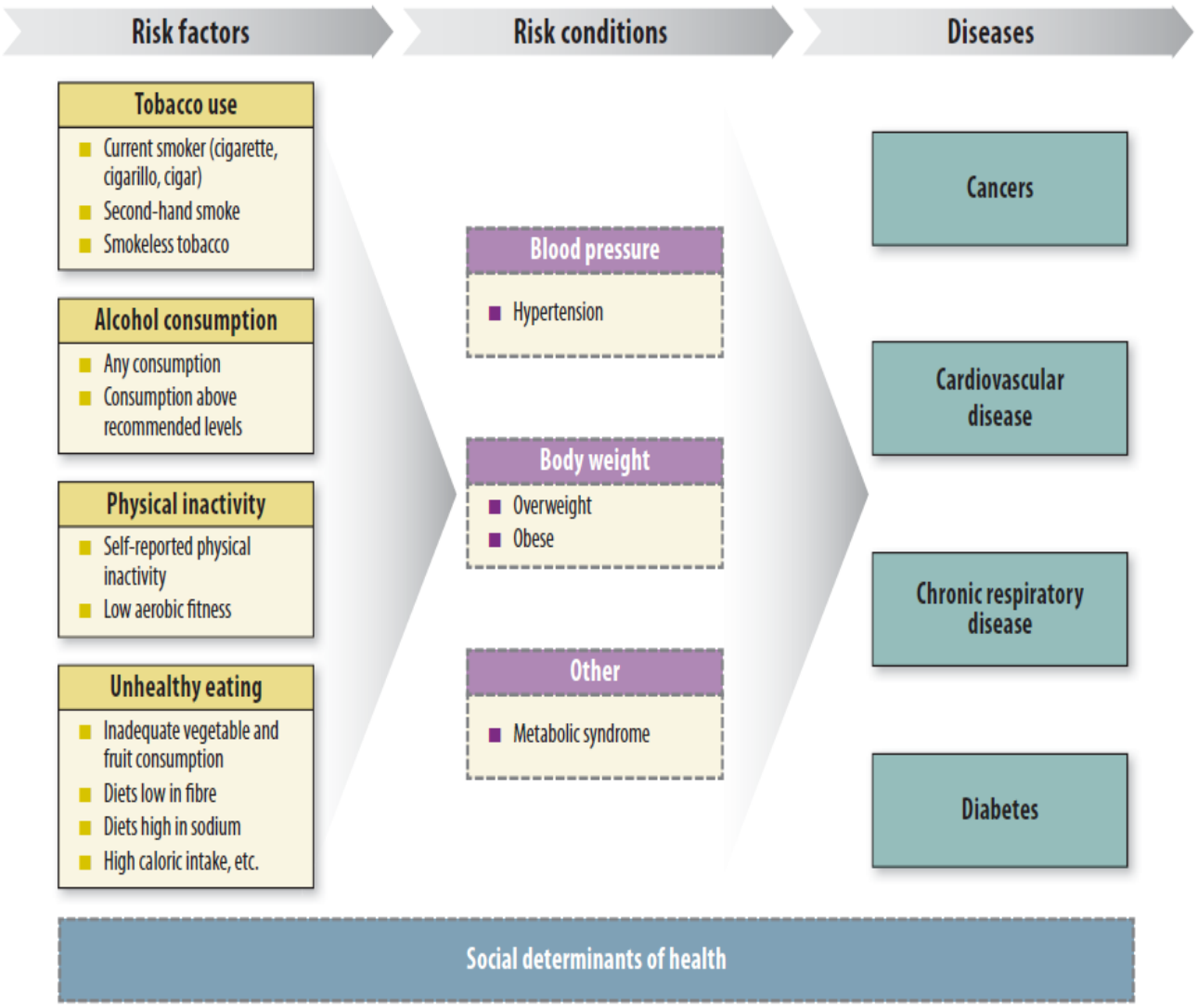

Figure 3: Link between chronic disease and risk factors[16]

4.0 Objective Three: Health Equity

Health equity and the associated social determinants of health also have an impact on the prevalence of CDs such as an individual's income, education, location or immigration/ethnic origin.[17] The risk factors to chronic diseases are not evenly distributed across sub-populations due to the varying social determinants of health. These inequalities may limit some at risk populations to receiving the optimal level of care they require.[18] The WFHT Health Promotion Plan seeks to recognize and understand the social determinants of health of its patient population to improve the healthcare provided. A vital tool to determining the underlying health inequities is the Health Equity Impact Assessment (HEIA) Tool.

4.1 Health Equity Impact Assessment (HEIA) Tool

A key quality dimension identified in the 2016-2017 Quality Improvement Plan (QIP) was to improve health equity with the objective of supporting this initiative through the WFHT's programs and services. Health equity was further recognized as a gap in the services provided by the WFHT as identified in the 2015 Be Well Survey.[19] As a result, a target was set to use the Health Equity Impact Assessment (HEIA) Tool when designing, implementing and evaluating programs and services and to specifically evaluate 25% of the current programs and services annually. The HEIA Tool was created by the Ministry of Health and Long-Term Care (MOHLTC) to provide organizations a framework to address health inequities by considering the needs of specific vulnerable populations. A HEIA helps to identify potential unintended impacts, which allow the opportunity for strategies to be developed to maximize the positive and minimize the negative. Five programs/services have currently had an HEIA completed including: Eat4Life, Cooking on a Budget Workshop, Women's Health Workshop, Stress Reduction and Management Workshop: Stressed Out, Depression Workshop: Winter Blues Buster and Gender Journeys.

5.0 Objective Four: Leveraging Partnerships

WFHT has a number of partnerships that mutually benefit and assist to implement the organization's mission to improve patient population care and wellbeing. Developing and enhancing partnerships fits the goals of the WFHT Strategic Plan 2018-2022. The intention is to remove redundant expenses from the healthcare system while simultaneously improving healthcare offerings through coordination of specialized services and programs that are delivered to the populations that need them.

Table 3: Onsite Partnerships with WFHT

Partnering Organization	Program(s) or Service(s) Offered
The Asthma Research Group Windsor-Essex County Inc. (ARGI)	• Atrial Fibrillation Program • Respiratory Self-Management Program • Congestive Heart Failure Self-Management Program • STOP program • Non-STOP smoking cessation

The Arthritis Society	• Arthritis, Rehab and Education Program (AREP) • Fibromyalgia Workshop (FM) • Osteoarthritis Workshop (OA)
Windsor-Essex County Health Unit and Partnering Community Primary Care Organizations: • City Centre Health Care – CMHA • Essex County Nurse Practitioner Lead Clinic • Harrow Family Health Team • VON Nurse Practitioner Lead Clinic – Lakeshore • Windsor-Essex Community Health Centre	• Eat4Life
St. Clair College (SCC) three campus sites: Main, Downtown and Thames • Provides access to healthcare services offered through a nurse practitioner (NP) and a registered nurse (RN) at all three campus sites and a clinical social worker (SW) at two of the sites.	• Choose to Lose – Staff Weight Loss Series

***Details regarding these program(s) or service(s) can be found in Section 7.0**

6.0 Windsor FHT Health Promotion Programs and Services (2018-2019)

Table 4: Program and Services Mix

	Health Condition	Success Indicator	Programs/Service
1	Chronic Pain	●	▪ Arthritis Rehabilitation and Education Program (AREP)
		●	▪ Fibromyalgia Workshop (FM)
		●	▪ Osteoarthritis Workshop (OA)
2	Heart Health	●	▪ Atrial Fibrillation Program
		●	▪ Health Failure Self-Management Program
		●	▪ Feel the Love: Heart Health Workshop (Part 1)
		●	▪ Feel the Love: Heart Health Workshop (Part 2)
3	Health Promotion	●	▪ Happy Feet
		●	▪ Health Links

		●	▪ Health Tapestry
		●	▪ Women's Health Workshop (Summer Wellness for Women)
4	Lung Health	●	▪ Respiratory Self-Management Program
5	Mental Health	●	▪ Depression Workshop- Winter Blues Buster
		●	▪ Gender Journeys
		●	▪ Stress Reduction and Management Workshop - Stressed OUT!
6	Nutrition/Obesity	●	▪ Cooking on a Budget
		●	▪ Eat4Life
		●	▪ Irritable Bowel Syndrome Workshop
		●	▪ St. Clair College Choose to Lose- Staff Weight Loss Series
		●	▪ Supermarket Tours (two)
7	Smoking/Addictions	●	▪ Smoking Treatment for Ontario Patients (STOP) & Non-STOP Smoking Cessation

● Slight adjustments needed
● Moderate adjustments needed
● Immediate adjustments needed

6.1 Chronic Pain Programs & Services

7.1.1 Arthritis Rehabilitation and Education Program

Criteria	**Description**
Program	With just over 10% of WFHT patients diagnosed with osteoarthritis and allied disorders, research indicates arthritis is a leading cause of disability and use of healthcare resources in Canada.[20] In order to reduce the impact of these disorders, WFHT in partnership with the Arthritis Society delivers the Arthritis Rehabilitation and Education Program (AREP) led by an Occupational Therapist. AREP provides a range of services for children and adults with arthritis, at no cost to clients with a valid Ontario health card number. Services include: Consultation and guidance on arthritis self-management; group education that includes information and management techniques for arthritis; and a customized arthritis service plan.

Objective(s)	To help people with arthritis to minimize the impact of this chronic disease on their lives. The focus is on teaching clients the skills to maximize their independence, enhance their mobility, and improve their self-esteem and self-confidence.
CD Targeted	Arthritis (osteoarthritis, rheumatoid), fibromyalgia, other arthritis related conditions
Risk Factors Addressed	Physical inactivity, unhealthy diet, joint stressors
HEIA Results	To be completed
Partnership(s)	The Arthritis Society
Frequency	AREP is offered throughout the year.
Promotion	Referrals are made through health professionals or via self-referral. WFHT health care providers complete and fax referral forms to the Arthritis Society.
Location	WFHT
Evaluation	As of October 1, 2018, the total target of 100 participants for this service has been exceeded. 99 participants from WFHT and the surrounding area have accessed the AREP program since April 1, 2018 (11 WFHT/88 non-WFHT) and 13 participants attended a Taking Charge of Fibromyalgia workshop, for a grand total of 112 participants. Surveys are distributed at the end of the programs. At present, 100% of the respondents indicated that they agree to strongly agree that they accomplished what they had expected in their rehabilitation program. 100% of the respondents indicated that they agree to strongly agree that they learned what they needed to know in order to manage their condition at home. In addition, 90% of the participants from the fibromyalgia workshop indicated they have a better understanding of their condition after attending the workshop, and 100% of the participants believed they have benefitted from the group.
Updates/Future Plans (2018-2019)	The partnership with the Arthritis Society will continue to support patients managing their arthritis and related conditions in the Windsor-Essex Community through the AREP. The need for this program/service in the future is also supported by the results from the WFHT's patient engagement focus group, which showed a continued interest regarding workshops and programs relating to arthritis and fibromyalgia. From a promotion perspective, the physicians should be reminded of the impact they have when referring patients to these programs/services as the Arthritis Society noted this increases patient participation. HEIA to be completed in the future.

6.2 Heart Health Programs & Services

7.2.1 Atrial Fibrillation Program

Criteria	**Description**
Program	A model for cardiovascular health care in the primary care setting, integrated with current chronic disease prevention and management strategies and patient-first provincial health initiatives. **The Atrial Fibrillation Program will provide patients with:** • Education and clinical evaluation related to the management and self-management of atrial fibrillation, with a focus on enhanced quality of life • Referrals to other health care providers as needed
Objective(s)	• Enhance the quality of life for people living with atrial fibrillation • Promote loyalty to atrial fibrillation best practices by incorporating evidence-based standards which reference international guidelines • Optimize the role of the interprofessional team members • Empower patients to gain control of their health by emphasizing self-management techniques
CD Targeted	Atrial fibrillation, hypertension, ischemic heart disease, sleep apnea, chronic kidney disease
Risk Factors Addressed	Stroke and bleeding risk, medication adherence, physical inactivity, alcohol consumption, tobacco use, falling, obesity, sleep disturbances, anxiety and depression, coping skills, health care utilization
HEIA Results	To be completed.
Partnership(s)	Asthma Research Group Windsor-Essex Inc. (ARGI)
Frequency	Offered throughout the year. The Pharmacist/ A-Fib Educator works two days per week at the WFHT for initial and follow-up appointments with referred patients.
Promotion	Referrals are made from WFHT health care providers
Location	FHT collaborative (WFHT, AFHT, HFHT)
Evaluation	The Atrial Fibrillation self- management program is in the early phases of implementation. Therefore, it is too soon to appropriately evaluate the effectiveness of the program.
Updates/Future Plans (2018-2019)	The Atrial Fibrillation Self- Management program will continue. Formal evaluation will commence January 2019 through Schulich School of Medicine. HEIA to be completed in the future.

7.2.2 Congestive Heart Failure Self-Management Program

Criteria	**Description**
Program	A model for cardiovascular health in the primary care setting, integrated with current CDPM strategies and patient-first provincial health initiatives. **The Congestive Heart Failure Self-Management Program will provide clients with**: • Comprehensive education • Medication reviews • Collaborative self-management action plans • Vaccinations • Diet and smoking cessation support
Objective(s)	• Patients will have the knowledge and tool to improve self-management skills and confidence • Improve access to Congestive Heart Failure program • Prevention: Targeted confirmatory diagnosis process for earlier disease intervention • Decrease healthcare utilization • Improvement in Health Status • Improve quality of life • Patient Satisfaction • Use of action plans • Improve in adherence to Canadian treatment standards – Medication Use
CD Targeted	Congestive heart failure, hypertension, hyperlipidemia, ischemic heart disease, cerebrovascular disease, peripheral vascular disease, obesity etc.
Risk Factors Addressed	Medication non-compliance, physical inactivity, alcohol consumption, tobacco use, unhealthy eating.
HEIA Results	To be completed.
Partnership(s)	Asthma Research Group Windsor-Essex Inc. (ARGI)
Frequency	This program will be offered throughout the year.
Promotion	Referrals will be made from WFHT health care providers
Location	FHT collective.
Evaluation	This program is still in the implementation stage and has not started seeing patients at the present time.
Updates/Future Plans (2018-2019)	The Congestive Heart Failure Self-Management program will be available to clients of the WFHT who have a diagnosis of CHF in the future. HEIA to be completed in the future.

7.2.3 Heart Healthy Workshops (Feel the Love Parts 1 & 2)

Criteria	**Description**
Program	The Heart Health Workshops provide education on major risk factors that can lead to heart disease or recurrent cardiovascular events and tips to decrease risk of CVD. **Feel the Love: Healthy Heart Workshop Part 1:** The RD and NP will discuss heart health issues that will focus on blood pressure, heart healthy eating, and physical activity. **Feel the Love: Healthy Heart Workshop Part 2:** The RD and SW will discuss heart health issues that will focus on heart healthy eating, physical activity, and stress management. There are many risk factors that can be controlled to reduce the risk of heart disease. With nearly 2.4 million Canadians aged 20+ living with ischemic heart disease, education regarding how to reduce the risk is vital; especially given it is the second leading cause of death in Canada.[21] Specifically, through healthy behaviours, nearly 80% of premature heart disease and stoke can be prevented.[22] With 15% of WFHT's patients diagnosed with essential hypertension and nearly 23% diagnosed with disorders of lipid metabolism, heart health education is fundamental for positive health outcomes.
Objective	To improve patient knowledge about nutrition and exercise for a healthy heart upon completion of the workshop.
CD Targeted	Hypertension, hyperlipidemia, ischemic heart disease, cerebrovascular disease, peripheral vascular disease, mental health.
Risk Factors Addressed	Alcohol consumption, tobacco use, physical inactivity, stress and unhealthy eating
HEIA Results	To be completed.
Partnership(s)	n/a
Frequency	Once a year
Promotion	WFHT Facebook page, WFHT waiting room TV screen and posters and display screens in providers rooms.
Location	WFHT
Evaluation	These workshops are scheduled to be completed in February and March 2019. The following questions will be asked to evaluate each workshop: 1) % of participants with who self-report increased knowledge after workshop. 2) % of participants who state information was presented effectively. 3) % of participants who self-identify as satisfied after workshop. 4) % of participants who responded they can apply the information they learned.

Updates/Future Plans (2018-2019)	TBD, upon completion of the workshop. HEIA to be completed.

6.3 Health Promotion Programs & Services

7.3.1 Happy Feet

Criteria	**Description**
Program	A Non-competitive walking group at Jackson Park. Walkers of all levels, motivations, skills and goals to come together to motivate and support each other and have fun. An eight week drop in program, that consists of one 30-minute walk per week that is open to WFHT patients and all community members.
Objective(s)	To promote physical activity, while also increasing social connectedness.
CD Targeted	Obesity, mental health
Risk Factors Addressed	Physical inactivity, social isolation
HEIA Results	To be completed.
Partnership(s)	N/A
Frequency	May 9th to June 28th 2018; Offered on Wednesdays - 12:15pm
Promotion	WFHT Facebook page, TV screen in WFHT lobby, posters in providers exam rooms, advertisement on the Shared community calendar.
Location	Jackson Park
Evaluation	The Happy Feet Walking program ran on a weekly basis from May 9th 2018- June 27th 2018. Happy Feet brought together clients of the WFHT not only to exercise, but to also help them achieve a personal goal and engage in a social event on a weekly basis. Clients who participated in the program expressed that they liked how they were able to go at their own pace and did not feel pressured to keep up with other participants. Happy Feet participants also expressed how much they looked forward to the group meeting each week and actually planned to continue walking together following completion of the program. All participants surveyed indicated that they would like to be contacted if a Fall session of Happy Feet is offered. Feedback from the evaluation surveys: 1. 100% of the participants were satisfied with the walking group 2. 100% of the participants felt they had both health and social benefits 3. 100% of the participants achieved a personal goal

	4. 100% of the participants would recommend this program to others Suggestions for improvement included 1. longer walks 2. morning walking time so that the temperature isn't too warm
Updates/Future Plans (2018-2019)	The Spring Session of Happy Feet was a success. The next session of Happy Feet with run from September 12th- October 31st 2018. HEIA to be completed.

7.3.2 Health Links

Criteria	**Description**
Program	The Health Links approach to care is a collaborative, integrated, person-centred approach that focuses on enhancing and coordinating the care of individuals living with multiple chronic conditions and/or complex needs. The goal of the Health Links approach to care is to create seamless care coordination for this patient population and ensure greater equity for all individuals, so that people with chronic and/or complex care needs are able to reach their highest level of health—or full health potential. Through Health Links, WFHT clients who are currently living with the greatest healthcare needs are offered support with care coordination by utilization of case managers, coordinated care plans and coordinated case conferencing.
Objective(s)	- Connect clients living with the greatest healthcare needs to a case manager - Establish a coordinated care plan for each Health Link Client - Improvement of the client's baseline confidence score rating
CD Targeted	Various depending on client
Risk Factors Addressed	Various depending on client
HEIA Results	To be completed
Partnership(s)	Erie St. Clair LHIN
Frequency	On going
Promotion	Clients who qualify (based on specific criteria) will be contacted directly and offered the program.
Location	Windsor Family Health Year
Evaluation	Health Links is currently in the early phases of implementation within the Windsor Family Health Team. Identification of 45 WFHT clients who could potentially benefit from the Health Link's approach to care have been identified but have not yet been began to work with the case

	manager. Therefore, it is too soon to appropriately evaluate the program at the present time.
Updates/Future Plans (2018-2019)	The Health Links approach to care will continue on with the Windsor Family Health Team. Care Coordinators from the Erie St. Clair LHIN will be working with the WFHT to help coordinate care and provide case management to clients who have been identified. HEIA to be completed in the future.

7.3.3 Health TAPESTRY

Criteria	**Description**
Program	The Health TAPESTRY approach to care intertwines clients, volunteers, healthcare providers and technology to help improve clients' quality of life & help people stay healthier for longer in the places where they live. Health TAPESTRY creates connections between trained health care volunteers, inter-professional health care teams, novel technology and community engagement through improved system navigation. Health TAPESTRY volunteers capture client information in the client's home via health tapestry technology and send the information to healthcare providers within the WFHT. This information is then utilized by the healthcare team within the WHFT to help improve the client's quality of life. Health TAPESTRY is a research project that is being conducted through McMaster University, Department of Family Medicine.
Objective(s)	Improve client's quality of life Help clients stay healthier for longer in the places where they currently live
CD Targeted	Various, depending on client
Risk Factors Addressed	Various, depending on client
HEIA Results	To be completed
Partnership(s)	McMaster University, The Windsor Essex Compassion Care Community
Frequency	On going
Promotion	Clients who qualify (based on specific criteria) will be contacted directly and offered the program.
Location	Windsor Family Health Year
Evaluation	Health Tapestry is currently in the early phases of implementation within the Windsor Family Health Team. 181 WFHT clients were identified as potential candidates for the Health Tapestry program. Each of these 181 clients received a phone call, and from this group,

	90 clients expressed interest and were mailed a welcome package and consent form. To date 51 clients have signed consent to participate in the program. Although the recruitment process of WFHT clients who could potentially benefit from participating the Health Tapestry program has occurred, but clients have not begun meeting with community volunteers. Therefore, it is too soon to appropriately evaluate the program at the present time.
Updates/Future Plans (2018-2019)	Health Tapestry will continue on in the upcoming months. Health Tapestry Volunteers will begin to work with the clients who have consented to participate in the study, and the WFHT will begin to have regularly scheduled huddles to review reports submitted from volunteers. HEIA to be completed in the future.

7.3.4 Women's Health Workshop- Summer Wellness for Women

Criteria	**Description**
Program	The Summer Wellness for Women workshop focuses on women's health throughout the summer months. During this 90 minute workshop. A WFHT Social Worker (SW), Registered Dietitian (RD) and Registered Practical Nurse (RPN) all provide education on nutrition, mental health, and sun safety for women during the summer months.
Objective	To increase women's knowledge of mindfulness for stress management, nutrition for weight management, and Sun safety and skin care protection, upon completion of the workshop.
CD Targeted	Mental health and obesity
Risk Factors Addressed	Alcohol consumption, tobacco use, Stress, physical inactivity and unhealthy eating, sun safety
HEIA Results	Completed in July 2018
Partnership(s)	Windsor Squash and Fitness Club (WSFC).
Frequency	Once a year
Promotion	Workshop flyers are posted on the WFHT website, on the workshop board, at Windsor Squash and Fitness Club, at community agencies and throughout Jackson Park Health Centre.
Location	WFHT
Evaluation	The Summer Wellness for Women was offered on May 24, 2018 from 1:30-3:00pm. It was a collaborative health promotion workshop, with a holistic foundation. The workshop provided evidence-based education about sun safety, weight management nutrition, and stress management with a summer focused theme. Teaching format included PowerPoint, information packages, brainstorming and group discussion, case examples, as well as interactive mood management and relaxation exercises practiced as a group. 15 participants signed

	up, 13 participants attended, and 13 participants completed the evaluation The program was offered in the WFHT training room and was 90 minutes in length. All participants either agreed or strongly agreed that the program increased their knowledge, they were satisfied with the workshop and that they are likely to use the tools they learned. 12 out of 13 participants were satisfied with the length of program, and all participants were satisfied with the group size, program leaders, location and presentation topics. Post evaluation comments from attendees included: "*Excellent job to the presenters! All well spoken, great delivery and knowledgeable".* *"I wouldn't change anything, it was great and so glad you did it".* *"Maybe offer a focus on elderly groups in the future. I really enjoyed this seminar".*
Updates/Future Plans (2018-2019)	The Women's Health Workshop will be offered in the next fiscal year. Details regarding guest speakers and topics are TBD. HEIA completed July 2018

6.4 Lung Health Programs & Services

7.4.1 Respiratory Self-Management Program

Criteria	**Description**
Program	WFHT in partnership with the Asthma Research Group Windsor-Essex Inc. (ARGI) provides on-site services through a Registered Respiratory Therapist (RRT)/Certified Respiratory Educator (CRE) to patients with COPD and/or asthma. **The Respiratory Self-Management Program:** • Provides Spirometry testing for both accurate diagnosis per best practice, and for monitoring disease progression • Ensures patients have a correct diagnosis on file by diagnosis per best practice, and for monitoring disease progression • Maintains or improves current level of lung function for program participants • Encourages those with chronic lung diseases to receive flu and/or pneumovac vaccinations • Reduces patient Health Service Use • Ensures lung health program patients have a complete action plan as per best practices • Provides Smoking Cessation counselling • Identifies patients who are in poor control to schedule appointment with a team member COPD is an important health condition to target given it is associated with one of the leading causes of emergency visits in Erie St. Clair.[23] Asthma is also an important condition to target given that early

	management of asthma may prevent the development of COPD[24] and 6.5% of WFHT patients are diagnosed with this condition. The on-site RRT/CRE also provides smoking cessation assistance, which is beneficial given that smoking is attributed to over 80% of all COPD cases.[25]
Objective(s)	Patients will have the knowledge and tools to improve self-management skills and confidence. • Improve access to Respiratory self-management program • Prevention: Targeted confirmatory diagnosis process for earlier disease intervention • Decrease healthcare utilization • Improvement in Health Status • Improve quality of life • Patient Satisfaction • Use of action plans • Improve in adherence to Canadian treatment standards – Medication Use
CD Targeted Risk Factors Addressed	COPD, asthma and emphysema Tobacco use
HEIA Results	To be completed
Partnership(s)	Asthma Research Group Windsor-Essex Inc. (ARGI)
Frequency	The RRT/CRE works one day a week at the WFHT for initial and follow-up appointments with referred patients.
Promotion	Referrals are made from WFHT health care providers
Location	WFHT
Evaluation	**COPD** 1) Percentage of patients with an objectively confirmed diagnosis. (Reported Quarterly)- 71% 2) Percentage of patients with an action plan. (Reported Quarterly)- 80% 3) Percentage of patients who have had smoking cessation intervention. (Reported Quarterly) 100% 4) Percentage of patients who were offered and received an influenza vaccination. (Reported Quarterly) – NA/71% 5) Percentage of patients who were offered and received a pneumovax immunization. (Reported Quarterly)- NA/71% 6) Percentage of patients taught inhaler techniques. (Reported Quarterly)- 95% 7) Percentage of patients who received education on: pathophysiology, exacerbations, medications, and breathing techniques. (Reported Yearly)- NA 8) Improvement in CAT score by 2 points in GOLD classification B and D. (Reported Yearly)- NA

	9) Decrease in Annualized Health Service Use (ED visits and Hospitalizations) by GOLD classification (Reported Yearly).- NA **Asthma** 1) Number of patients with an objectively confirmed diagnosis. (Reported Quarterly) 50% 2) Number of patients with an action plan. (Reported Quarterly) 88% 3) Number of patients who have had smoking cessation intervention. (Reported Quarterly) -100% 4) Percentage of patients who were offered and received an influenza vaccination. (Reported Quarterly) NA/67% 5) Percentage of patients taught inhaler techniqes. (Reported Quarterly) 100% 6) Percentage of patients who received educaton on: pathophysiology, exacerbations, medications, and triggers. (Reported Yearly) NA
Updates/Future Plans (2018-2019)	The Respiratory Self-Management program will continue on for 2018/2019. HEIA to be completed in the future.

6.5 Mental Health Programs & Services

7.5.1 Depression Workshop-
Winter Blues Buster: A practical workshop for boosting your mood

Criteria	**Description**
Program	A 90-minute psycho-educational workshop, hosted by a Social Worker, about Seasonal affective disorder (SAD) and/or depression and symptom reduction and mood management for participants who are experiencing mild to moderate levels of depression/SAD. **The Winter Blues Buster Workshop will:** • Focus on signs and symptoms of SAD/depression, origins and coping skills. • Educate participants on how to integrate healthy mood management skills into their daily functions. • Include a power-point presentation, Behavioral Activation exercise, SMART goal setting, Cognitive restructuring and mindfulness techniques and interactive group discussions. • Assist participants in improving their confidence in their ability to cope and manage symptoms of depression. With 11% of the WFHT population diagnosed with an anxiety disorder and 9% diagnosed with a major depressive disorder, the

	Depression and Anxiety Programs provide a supportive opportunity in an area traditionally underserviced.[26]
Objective(s)	To improve awareness of the implications of depression as well as strategies to improve mood and boost confidence in one's ability to cope, upon completion of the workshop.
CD Targeted	Depression and Seasonal Affective Disorder
Risk Factors Addressed	Alcohol consumption, tobacco use, physical inactivity and unhealthy eating
HEIA Results	February 2018
Partnership(s)	N/A
Frequency	Once a year
Promotion	The Shared Community Calendar, WFHT Facebook page and WFHT waiting room TV display, posters and computer displays in provider exam rooms.
Location	WFHT
Evaluation	Winter Blues Buster was offered as a practical skill based, interactive workshop that focused on Behavioural Activation, SMART Goal Setting and Cognitive Restructuring to improve motivation and mood. Teaching format included PowerPoint, information packages, brainstorming and group discussion, as well as interactive mood management and relaxation exercises practiced as a group. 12 participants attended. The program was offered in the WFHT training room and was 90 minutes in length. All participants either agreed or strongly agreed that the program increased their knowledge, they were satisfied with the workshop and that they are likely to use the tools they learned. 11 out of 12 participants were satisfied with the length of program and group size, and all participants were satisfied with the program leaders, location and presentation topics. 10 out 12 participants shared examples of what they learned: 5-minute rule, coping tools, take care of yourself before others, set small goals and short time frames, journal, follow your plan not your mood technique, how interactive the workshop was. Post evaluation comments from attendees included: "*Length of time was perfect". "would like more activities". "Add vitamin list to eating chart".*
Updates/Future Plans (2018-2019)	The Winter Blues Buster Workshop will be offered in the next fiscal year. Details regarding guest speakers and additional topics are TBD. HEIA completed February 2018.

7.5.2 Stress Reduction and Management- Stressed OUT!

Criteria	**Description**
Program	A 90-minute psycho-educational workshop, hosted by a Social Worker and Registered Practical Nurse, about stress reduction and management for participants who are experiencing moderate to severe levels of stress, which is impairing their quality of life. **The Stressed OUT! Workshop will:** • Focus on signs and symptoms of stress, origins and coping skills. • Educate participants on how to integrate healthy stress management skills into their daily functions. • Include a power-point presentation, relaxation techniques and interactive group discussions. Chronic stress can increase heart rate and blood pressure, which may lead to cardiovascular disease and/or mental illness.[27] With over 19% of the WFHT patient population diagnosed with neurotic disorders, personality disorders, and other nonpsychotic mental disorders and nearly 15% diagnosed with essential HTN-, opportunities for stress management strategies may be beneficial for avoiding many serious health concerns. The 2016 Community Needs Assessment Survey indicated that 40.7% of WEC responders noted education or information about stress management would be appreciated with specific support for dealing with stress and coping skills.[28]-
Objective	To improve awareness of the implications of stress, self-awareness, as well as strategies to improve their confidence in one's ability to cope, upon completion of the workshop.
CD Targeted	Hypertension, IBS and co-morbid mental disorders
Risk Factors Addressed	Alcohol consumption, tobacco use, physical inactivity, unhealthy eating, mental Health
HEIA Results	February 2018
Partnership(s)	N/A
Frequency	Once per year.
Promotion	The Shared Community Calendar, WFHT Facebook page and WFHT waiting room TV display, posters and computer displays in provider exam rooms.
Location	WFHT
Evaluation	Stressed Out was offered as a practical skills based, interactive workshop that focused on mindfulness practice, health lifestyle changes and management, SMART Goal Setting and Cognitive Restructuring to improve motivation and mood. Teaching format

	included PowerPoint, information packages, brainstorming and group discussion, as well as interactive stress management and relaxation exercises practiced as a group. 13 participants registered, and 10 participants attended. The program was offered in the WFHT training room and was 90 minutes in length. All participants either agreed or strongly agreed that the program increased their knowledge, they were satisfied with the workshop and that they are likely to use the tools they learned. All participants were satisfied with the length of program and group size, and all participants were satisfied with the program leaders, location and presentation topics. 8 out 10 participants shared examples of what they learned: Tips for mental health fitness, relaxation techniques, how to release stress, how to handle stress, ACE/achieve Connect Enjoy as a goal, self compassion, mindfulness exercise Post evaluation comments from attendees included: "*Great teachers". "Everyone had time to give input".*
Updates/Future Plans (2018-2019)	The Stressed Out Workshop will be offered in the next fiscal year. Details regarding guest speakers and additional topics are TBD. HEIA completed February 2018.

7.5.3 Gender Journeys

Criteria	**Description**
Program	The Gender Journeys is a meeting group that was adapted from the Gender Journeys program delivered by the Sherbourne Health Centre (Toronto, Ontario). It is a monthly drop-in group for young adults (aged 16-25) who are exploring their gender identity or struggling with what their gender identity means to them and their lives. Led by a peer facilitator, participants have access to trans-competent support. An estimated 0.5% of the Canadian adult population is transgender and research indicates these individuals are a medically underserved population.[29] Research also shows that transgender individuals are at an increased risk for stress (related to minority status), depression, suicide and HIV and other sexually transmitted infections.[30]
Objective	To provide information and support needed for individuals who identify as transgender or gender questioning to broaden knowledge and/or make informed decisions about their personal gender journey.
CD Targeted	Co-morbid mental disorders
Risk Factors Addressed	Alcohol consumption, physical inactivity, unhealthy eating and health equity
HEIA Results	Completed in 2016
Partnership(s)	N/A
Frequency	Monthly drop-in one-and-a-half hour sessions.
Promotion	Referrals are made from WFHT/SCC heath care providers, self-referrals and other community partners (ex. Teen Health,

	endocrinologist's offices and CMHA). The group is promoted through WFHT Facebook page, Lobby TV displays, posters and displays in provider exam rooms and the Windsor Trans Resources website.
Location	WFHT
Evaluation	No data was received from this program as the volunteer facilitator resigned.
Updates/Future Plans (2018-2019)	Gender Journeys has been put on hold at the present time as the peer facilitator resigned, and no other appropriate candidate was found to assume the position. Also, the new W.E Trans Support clinic is now available and provides several different Trans support groups within the community that WFHT clients can access for additional support.

6.6 Nutrition/Obesity Programs & Services

7.6.1 Cooking on a Budget

Criteria	**Description**
Program	The Cooking on a Budget is a 90-minute workshop that assists individuals who are living on a strict budget or living alone to learn a variety of ways to prepare nutritious meals. The WFHT's RD, in collaboration with a cook from a local bakery, presents and demonstrates how to prepare healthy, nutritious meals on a budget. Participants are invited to taste test prepared foods. Recipes and education handouts (low fat cooking, simple cooking and eating healthy) will be provided for all participants. Research has shown that individuals from higher-income groups have better access to health information and apply it more often than lower-income groups.[31] This is significant given 17.5% of the Windsor Essex population live on low-income, compared to the provincial average of 13.9%.[32] Therefore, targeting disadvantaged low-income populations may help to prevent health inequalities from widening. According to The 2016 Community Needs Assessment Survey, 54% of WEC responders rate affordable healthy food options as the top issue that needs to be addressed to improve the health of their family and/or community.[33] Results from WFHT's patient engagement focus group also showed participants voiced an interest for workshops pertaining to food and cooking classes.
Objective	To educate and increase patient's knowledge for preparing nutritious meals on a budget upon completion of the presentation.
CD Targeted	Obesity

Risk Factors Addressed	Unhealthy eating, health equity (low-income)
HEIA Results	Completed in 2016
Partnership(s)	Nana's Bakery owner/cook, Doug Romanek.
Frequency	Once a year. One-and-a-half-hour workshop.
Promotion	WFHT Facebook page, WFHT waiting room TV screen and posters and display screens in providers rooms.
Location	Nana's Bakery, 2936 Dominion Blvd, Windsor.
Evaluation	This workshop has previously had a great turnout. The workshop is scheduled to be held in November 2018. The following questions will be asked to evaluate the workshop: 1) % of participants with who self-report increased knowledge after workshop. 2) % of participants who state information was presented effectively. 3) % of participants who self-identify as satisfied after workshop. 4) % of participants who responded they can apply the information they learned.
Updates/Future Plans (2018-2019)	TBD, upon completion of the workshop.

7.6.2 Eat4Life

Criteria	**Description**
Program	Eat4Life is a nine-week healthy lifestyle program which promotes healthy eating, exercise and healthy behaviours to members of the Windsor-Essex County community. The program was developed by a primary care and public health partnership (via Registered Dietitians) to improve healthy lifestyle habits of Windsor-Essex County residents, as part of a comprehensive obesity reduction strategy for the region. The first Eat4Life module of three is complete. The WFHT will be offering module two to participates who have previously completed Module one. Module two will have a focus on weight loss and mindful eating. **Eat4Life:** • Provides members with information on nutrition, behaviour change, physical activity and goal setting with a pre and post evaluation survey. • Classes are offered on a weekly basis; each class is 2 hours • Provides participants with a binder, pen and weekly handouts. • RD shares current knowledge on healthy eating, and the Clinical Social Worker guest speaker addresses behaviour change • Participants will also have the opportunity to participate in a grocery store tour.

Objective	To increase participants knowledge on healthy eating and physical activity by ≥70% post program.
CD Targeted Risk Factors Addressed	Overweight and obesity Alcohol consumption, physical inactivity and unhealthy eating
HEIA Results	Completed in 2016
Partnership(s)	City Centre Health Care – CMHA, Essex County Nurse Practitioner Lead Clinic, Harrow Family Health Team, VON Nurse Practitioner Lead Clinic Lakeshore, Windsor-Essex Community Health Centre and the Windsor-Essex County Health Unit
Frequency	Once a year at WFHT. Nine-week program.
Promotion	City Centre Health Care, the Cardiac Wellness program, the Bariatric Assessment program at Hotel Dieu Grace Healthcare, the WECHC Partnership Advisory Committee (PAC) listserv, WFHT Facebook page and WFHT waiting room TV display.
Location	WFHT
Evaluation	Eat4Life Module Two is scheduled to begin in Jan 2019. The following questions will be asked to evaluate the workshop: 1) % of participants with increased knowledge measured through survey evaluation by obtaining a score ≥70% post program. 2) # of participants who finish 9-week program.
Updates/Future Plans (2018-2019)	TBD, upon completion of the workshop.

7.6.3 Irritable Bowel Syndrome Workshop

Criteria	**Description**
Program	The Irritable Bowel Syndrome (IBS) is a 90-minute workshop designed to provide support and tips to manage IBS symptoms. An NP and RD co-present this workshop. Group support talk will be offered at the end of the session so patients can talk and learn from one another. With 3.2% of WFHT's patient population diagnosed with IBS, it may appear as a low percentage, however; Canada has one of the highest rates in the world at roughly 14% of the Canadian population.[34] With only about 40% of IBS sufferers seeking medical attention[35], the workshop offers an opportunity for IBS awareness for management and treatment options.
Objective	To improve patient self-care and IBS awareness upon completion of the workshop.
CD Targeted	Irritable bowel syndrome
Risk Factors Addressed	Alcohol consumption, physical inactivity and unhealthy eating
HEIA Results	To be completed
Partnership(s)	N/A

Frequency	Once a year
Promotion	WFHT Facebook page, WFHT lobby TV displays, posters and computer displays in provider exam rooms and on the Shared Community Calendar.
Location	WFHT
Evaluation	The IBS workshop is scheduled for October 30th 2018. The following questions will be asked to evaluate the workshop: 1) % of participants with who self-report increased knowledge after workshop. 2) % of participants who state information was presented effectively. 3) % of participants self-identifying as satisfied after workshop. 4) % of participants who responded they can apply the information they learned.
Updates/Future Plans (2018-2019)	TBD, upon completion of the workshop. HEIA to be completed in the future.

7.6.4 St. Clair College: Choose to Lose – Staff Weight Loss Series

Criteria	**Description**
Program	The Choose to Lose program facilitates change towards a healthy lifestyle (healthy eating, exercise and behaviour modification) through regular communication with an RN to improve overall health in addition to weight management for St. Clair College staff. Participants will meet with RN for a half hour for individual counselling at week one then will meet weekly for "check-in" follow-up visits. Lunch and Learns are booked throughout the ten-week program during the lunch hour for participants to increase their knowledge about nutrition, exercise and behaviour change. A nutritious lunch will be served. Anthropometric measurements will be conducted at week 1 and again at week 10.
Objective(s)	• To increase weight loss and/or decrease waist/hip measurement upon completion of the program. • To increase knowledge of nutritious food choices by at least 1 point using the "Healthy Eating Questionnaire" upon completion of the program. • To increase positive behavioural changes towards a healthier lifestyle upon completion of the program.
CD Targeted	Obesity
Risk Factors Addressed	Physical inactivity and unhealthy eating
HEIA Results	To be completed
Partnership(s)	St. Clair College

Frequency	Ten-week program offered at the Main site (offered in both January and spring each year) and at the Downtown and Thames campuses (offered in January).
Promotion	The three RN's promote their program to staff at each of their respective campuses.
Location	Three St. Clair College sites: Main, Downtown and Thames.
Evaluation	63 % of participants lost weight and/or decreased their waist/hip measurement by end of program. 44 % of participants had an improvement by at least 1 point on the "Healthy Eating Questionnaire". 100 % of participants expressed satisfaction with content of program. 24 participants started the Choose to Lose program and 5 participants did not complete the program.
Updates/Future Plans (2018-2019)	The popularity of this program has been observed over the years and therefore Choose to Lose will be offered in 2018-2019 across all three-campus sites. HEIA to be completed.

7.6.5 Supermarket Tours

Criteria	**Description**
Program	The WFHT RD offers two supermarket tours at the local grocery store.
Objective(s)	To provide updated knowledge to participants with a focus on management of three chronic diseases: diabetes, cardiovascular disease and hypertension.
CD Targeted	Diabetes, cardiovascular disease and hypertension
Risk Factors Addressed	Unhealthy eating
HEIA Results	To be completed
Partnership(s)	N/A
Frequency	Two tours are held in November and March to celebrate Diabetes Awareness Month and Nutrition Month, respectively.
Promotion	City Centre Health Care, the Cardiac Wellness program, the Bariatric Assessment program at Hotel Dieu Grace Healthcare, the WECHC Partnership Advisory Committee (PAC) listserv and WFHT Facebook page.
Location	Real Canadian Superstore 2430 Dougall Ave.
Evaluation	---
Updates/Future Plans (2018-2019)	This program has been discontinued as local supermarkets now have their own internal dietitians working to support community members that WFHT clients can access.

6.7 Smoking/Addictions Programs & Services

7.7.1 Smoking Treatment for Ontario Patients (STOP) Program & Non-STOP Smoking Cessation

Criteria	**Description**
Program	Through a partnership with the Asthma Research Group Windsor-Essex Inc. (ARGI) individualized smoking cessation counseling is offered by a certified TEACH educator. In 2015, the STOP Program was implemented at WFHT with the goals of improving access to free nicotine replacement therapy (NRT) for patients who wish to quit smoking and to increase capacity of health care practitioners in FHTs to provide comprehensive smoking treatment to patients.[36] The Non-STOP program's smoking cessation counselling is provided through the use of a certified TEACH educator providing one-on-one counseling and support to smokers, without the use of NRT. **STOP program:** • Free NRT provided. • One on one counselling sessions provided in office and telephone visits. • Spirometry will be conducted. • Education provided at each visit. • Rates of cessation will be documented at each visit. **Non-STOP:** • Free medication provided (ex. Champix or Zyban). • One on one counselling sessions provided in office and telephone visits. • Spirometry will be conducted. • Education provided at each visit. • Rates of cessation will be documented at each visit.
Objective	To provide participants support to quit smoking or to decrease the amount of cigarettes they smoke per day.
CD Targeted	COP, asthma and emphysema
Risk Factors Addressed	Tobacco use
HEIA Results	To be completed
Partnership(s)	Asthma Research Group Windsor-Essex Inc. (ARGI)
Frequency	The RRT/CRE works one day a week at the WFHT for initial and follow-up appointments with referred patients. The WFHT health care providers refer patients who are interested with smoking cessation to the RRT/CRE for assessment and counselling.

Promotion	WFHT Facebook page, WFHT lobby TV displays, posters and computer displays in provider exam rooms and through word of mouth.
Location	WFHT
Evaluation	1) % of participants in the: a) STOP program- 83.3% b) Only counselled by TEACH educator- 16.7%. 2) % of participants who have decreased the # of cigarettes they smoke per day since onset of program- 27.8% 3) % of participants who have finished the program and self-identified they have quit smoking. - 0 4) % of participants who are tested with spirometry who are >40 years old.- 16.7% 5) # of participants identified to have COPD.- 0 6) # of participants identified to have asthma.- 0
Updates/Future Plans (2018-2019)	

7.0 Looking Forward

In summary, the vast majority of the programs and services will remain unchanged for the 2018-2019 year. Further understanding of the health equities and social determinants of health are required on thirteen programs and services. To achieve this, targeted deadlines for implementing the HEIA tool on the thirteen remaining programs and services are to be arranged with WFHT management and HP. Incorporating the outcomes from previous HEIAs is also recommended to optimize health equity within the five completed programs and services.

Overall, all programs and services could be improved through better mechanisms of promotion to increase participation and visibility of the programs and services at the WFHT. The Patient Engagement Café indicated that the WFHT patient population are looking for enhanced means of communication through email newsletters or an online events calendar.

Based on the information provided and the recommendations suggested by participants, the following changes have been made since the patient engagement session:

- A Nurse Health Promotor has been recruited to help disseminate information regarding clinic and community information to clients of the WFHT
- Computer screen savers and backs of doors in Provider's exam rooms are now being utilized to share important clinic/workshop information to clients
- TV screens in the lobby are being utilized to share clinic information
- The brochure/handout section of the lobby has been redone to include up to date clinic, workshop and community information.
- Cancer screening information in different languages has also been added to the brochure section
- WFHT website has been redesigned to provide clients with more clinic information
- WFHT Facebook page is now being utilized to notify clients of upcoming events
- Advertising for the WFHT website and Facebook pages have been added to TV and computer displays.

8.0 Appendices

8.1 WFHT Client Survey Results

WFHT has provided clients with an opportunity to voice their feedback regarding clinic access, opportunity for client involvement in care, hand hygiene practices, quality of care received as well as overall experience with the WFHT through an anonymous client survey that is available in office.

Results indicate respondents are: satisfied with their ability to book an urgent appointment, feel they are given opportunities to ask questions and be involved in their care/care decisions and are satisfied with the overall quality of care they receive from the WFHT. Results also indicate that there is room for improvement regarding hand hygiene practices of both WFHT care providers as well as WFHT clients.

Table 5: Most recent WFHT client survey results

Questions	Responses
The last time you were sick or were concerned you had a health problem, how many days did it take from when you first tried to see your doctor or nurse practitioner to when you actually SAW him/her or someone else in their office?	70.3% reported "same day/ next day"
When you need an urgent appointment, are you able to see a doctor or nurse practitioner or another provider at your Family Health Team on same day or next day? *Urgent appointment is defined not as an emergency, but still requires care within 24 hours.	91.4% reported "same day/ next day"
I can usually book an appointment within a reasonable time.	97.7% reported "Yes"
When you see your doctor or nurse practitioner, how often do they or someone else in the office give you an opportunity to ask questions about recommended treatment?	93.9% reported "Always"
When you see your doctor or nurse practitioner, how often do they or someone else in the office involve you as much as you want to be in decisions about your care treatment?	92.8% reported "Always"
When you see your doctor or nurse practitioner, how often do they or someone else in the office spend enough time with you?	94.2% reported "Always"
Did you witness your health care provider wash/sanitize their hands today before caring for you?	78.0% reported "Yes"
Did you wash/sanitize your hands today while at the WFHT or did someone at the WFHT ask you to wash/sanitize your hands today?	78.0% reported "Yes"

Did your MAIN health care provider address your concerns during your visit?	97.4% reported "Yes"
Thinking about your most recent visit, how would you rate your overall experience with our office staff?	93.3% reported "Excellent"

*Each question was maxed to 100 responses.

8.2 WFHT Health Conditions by ICD-9 Codes

Table 6: Number of unique patients by high level classifications of diseases and health problems

Rank	Diagnosis Code Range	Classification Description	F	M	Total	%
1	240 - 279	Endocrine, Nutritional And Metabolic Diseases, And Immunity Disorders	1249	1095	2344	34.4%
2	320 - 389	Diseases Of The Nervous System And Sense Organs	885	806	1691	24.8%
3	290 - 319	Mental Disorders	905	755	1660	24.4%
4	390 - 459	Diseases Of The Circulatory System	692	745	1437	21.1%
5	710 - 739	Diseases Of The Musculoskeletal System And Connective Tissue	753	528	1281	18.8%
6	520 - 579	Diseases Of The Digestive System	648	604	1252	18.4%
7	460 - 519	Diseases Of The Respiratory System	471	453	924	13.6%
8	780 - 799	Symptoms, Signs, And Ill-Defined Conditions	396	362	758	11.1%
9	280 - 289	Diseases Of The Blood And Blood-Forming Organs	513	206	719	10.6%
10	680 - 709	Diseases Of The Skin And Subcutaneous Tissue	358	223	581	8.5%
11	580 - 629	Diseases Of The Genitourinary System	329	238	567	8.3%
12	V01 - V91	Supplementary Classification Of Factors Influencing Health Status And Contact With Health Services	115	118	233	3.4%
13	140 - 239	Neoplasms	139	91	230	3.4%
14	001 - 139	Infectious And Parasitic Diseases	104	112	216	3.2%
15	800 - 999	Injury And Poisoning	95	99	194	2.8%
16	740 - 759	Congenital Anomalies	62	53	115	1.7%
17	630 - 679	Complications Of Pregnancy, Childbirth, And The Puerperium	37	1	38	0.6%
18	E000 - E999	Supplementary Classification Of External Causes Of Injury And Poisoning	2	2	4	0.1%
19	760 - 779	Certain Conditions Originating In The Perinatal Period	2	2	4	0.1%

* Classification descriptions based on 2015 ICD-9-CM Diagnosis Codes database (http://www.icd9data.com/2015/Volume1/default.htm)
* A patient is only counted once if the patient has multiple diagnoses within the same classification, but patients may have diagnoses from multiple classifications.

Table 7: Number of unique patients in the top 20 sub-classifications of diseases and health problems

Rank	Diagnosis Code Range	Classification Description	F	M	Total	%
1	270 - 279	Other Metabolic Disorders And Immunity Disorders	1059	981	2040	30.0%
2	300 - 316	Neurotic Disorders, Personality Disorders, And Other Nonpsychotic Mental Disorders	707	620	1327	19.5%
3	401 - 405	Hypertensive Disease	518	579	1097	16.1%
4	295 - 299	Other Psychoses	491	331	822	12.1%
5	710 - 719	Arthropathies And Related Disorders	490	324	814	12.0%
6	360 - 379	Disorders Of The Eye And Adnexa	348	373	721	10.6%
7	490 - 496	Chronic Obstructive Pulmonary Disease And Allied Conditions	321	289	610	9.0%
8	280	Iron deficiency anemias	468	140	608	8.9%
9	530 - 539	Diseases Of Esophagus, Stomach, And Duodenum	316	291	607	8.9%
10	249 - 259	Diseases Of Other Endocrine Glands	265	318	583	8.6%
11	338	Pain	279	239	518	7.6%
12	780 - 789	Symptoms	276	212	488	7.2%
13	340 - 349	Other Disorders Of The Central Nervous System	313	136	449	6.6%
14	560 - 569	Other Diseases Of Intestines And Peritoneum	272	151	423	6.2%
15	470 - 478	Other Diseases Of Upper Respiratory Tract	209	202	411	6.0%
16	720 - 724	Dorsopathies	198	201	399	5.9%
17	730 - 739	Osteopathies, Chondropathies, And Acquired Musculoskeletal Deformities	263	97	360	5.3%
18	240 - 246	Disorders Of Thyroid Gland	281	73	354	5.2%
19	690 - 698	Other Inflammatory Conditions Of Skin And Subcutaneous Tissue	191	142	333	4.9%
20	790 - 796	Nonspecific Abnormal Findings	153	172	325	4.8%

* Sub-classification descriptions based on 2015 ICD-9-CM Diagnosis Codes database (http://www.icd9data.com/2015/Volume1/default.htm)
* A patient is only counted once if the patient has multiple diagnoses within the same sub-classification, but patients may have diagnoses from multiple sub-classifications.

Table 8: Number of unique patients with the top 20 health problems by grouped diagnoses codes

Rank	Diagnosis Code	Diagnosis Description	F	M	Total	%
1	272	Disorders of lipoid metabolism	745	811	1556	22.9 %
2	278	Overweight, obesity and other hyperalimentation	620	472	1092	16.0 %
3	401	Essential hypertension	482	536	1018	15.0 %
4	296	Episodic mood disorders	486	306	792	11.6 %
5	300	Anxiety, dissociative and somatoform disorders	440	273	713	10.5 %
6	715	Osteoarthrosis and allied disorders	409	291	700	10.3 %
7	280	Iron deficiency anemias	468	140	608	8.9%
8	367	Disorders of refraction and accommodation	270	320	590	8.7%
9	530	Diseases of esophagus	285	258	543	8.0%
10	338	Pain	279	239	518	7.6%
11	305	Nondependent abuse of drugs	243	269	512	7.5%
12	250	Diabetes mellitus	230	281	511	7.5%
13	493	Asthma	252	193	445	6.5%
14	346	Migraine	289	102	391	5.7%
15	244	Acquired hypothyroidism	261	70	331	4.9%
16	722	Intervertebral disc disorders	165	160	325	4.8%
17	733	Other disorders of bone and cartilage	228	75	303	4.4%
18	564	Functional digestive disorders not elsewhere classified	192	80	272	4.0%
19	477	Allergic rhinitis	131	122	253	3.7%
20	525	Other diseases and conditions of the teeth and supporting structures	90	157	247	3.6%

* Diagnosis descriptions based on 2015 ICD-9-CM Diagnosis Codes database (http://www.icd9data.com/2015/Volume1/default.htm)
* A patient is only counted once if the patient has multiple diagnoses within the same set of grouped diagnoses, but patients may have diagnoses from multiple groups.

Table 9: Number of unique patients with the top 50 health problems by distinct diagnosis code (decimal)

Rank	Diagnosis Code	Diagnosis Description	F	M	Total	%
1	401	Essential Hypertension	447	502	949	13.9%
2	278.0	Overweight and Obesity	437	347	784	11.5%
3	272.4	Other and unspecified hyperlipidemia	385	369	754	11.1%
4	272.0	Pure hypercholesterolemia	275	337	612	9.0%
5	300.0	Anxiety states	370	224	594	8.7%
6	715.9	Osteoarthrosis unspecified whether generalized or localized	341	234	575	8.4%
7	280	Iron deficiency anemias	428	134	562	8.3%
8	530.81	Esophageal reflux	272	253	525	7.7%
9	250	Diabetes mellitus	226	275	501	7.4%
10	338.2	Chronic Pain	259	230	489	7.2%
11	296.2	Major depressive disorder single episode	290	183	473	6.9%
12	493	Asthma	247	189	436	6.4%
13	305.1	Tobacco user disorder	229	207	436	6.4%
14	346	Migraine	283	102	385	5.7%
15	367.1	Myopia	172	184	356	5.2%
16	477	Allergic rhinitis	128	118	246	3.6%
17	278.02	Overweight	140	104	244	3.6%
18	564.1	Irritable bowel syndrome	152	63	215	3.2%
19	277.7	Dysmetabolic syndrome X	85	129	214	3.1%
20	272.2	Mixed hyperlipidemia	100	110	210	3.1%
21	327.23	Obstructive sleep apnea (adult)(pediatric)	55	143	198	2.9%
22	244	Acquired hypothyroidism	151	46	197	2.9%
23	268	Vitamin D deficiency	107	90	197	2.9%
24	722.6	Degeneration of intervertebral disc, site unspecified	94	87	181	2.7%
25	414.0	Other forms of chronic ischemic heart disease	54	117	171	2.5%
26	367.0	Hypermetropia	65	93	158	2.3%
27	733.0	Osteoporosis	111	40	151	2.2%
28	296.3	Major depressive disorder recurrent episode	86	56	142	2.1%
29	525.9	Unspecified disorder of the teeth and supporting structures	50	90	140	2.1%
30	706.1	Other acne	103	35	138	2.0%
31	733.90	Disorder of bone and cartilage, unspecified	105	32	137	2.0%
32	389	Hearing loss	50	85	135	2.0%
33	562.10	Diverticulosis of colon (without mention of hemorrhage)	79	52	131	1.9%
34	790.21	Impaired fasting glucose	47	81	128	1.9%

35	571.8	Other chronic nonalcoholic liver disease	65	62	127	1.9%
36	296.8	Other and unspecified bipolar disorders	74	53	127	1.9%
37	314.0	Attention deficit disorder of childhood	46	75	121	1.8%
38	692	Contact dermatitis and other eczema	69	50	119	1.7%
39	473	Chronic sinusitis	57	48	105	1.5%
40	496	Chronic airway obstruction, not elsewhere classified	47	53	100	1.5%
41	455	Hemorrhoids	54	44	98	1.4%
42	354.0	Carpal tunnel syndrome	61	35	96	1.4%
43	600	Hyperplasia of prostate		94	94	1.4%
44	281.1	Other vitamin B12 deficiency anemia	44	50	94	1.4%
45	427.31	Atrial fibrillation	40	53	93	1.4%
46	367.4	Presbyopia	37	56	93	1.4%
47	266.2	Other B-complex deficiencies	65	27	92	1.4%
48	244.9	Unspecified acquired hypothyroidism	71	18	89	1.3%
49	780.57	Unspecified sleep apnea	36	52	88	1.3%
50	492	Emphysema	33	55	88	1.3%

* Diagnosis descriptions based on 2015 ICD-9-CM Diagnosis Codes database (http://www.icd9data.com/2015/Volume1/default.htm)

Table 10: Number of Diagnoses of Health Conditions by Diagnosis Group

Diagnosis Codes	Diagnosis Groups	F	M	Total	%
	Lung				
493	Asthma	247	189	436	6.4%
327.23	Obstructive sleep apnea (adult and child)	55	143	198	2.9%
496	COPD	47	53	100	1.5%
492	Emphysema	33	55	88	1.3%
491	Chronic bronchitis	5	2	7	0.1%
	Lung Group Total	387	442	829	12.2%
	Gastric				
530.81	GERD	272	253	525	7.7%
564.1	Irritiable bowel syndrome	152	63	215	3.2%
571.8	Fatty Liver	65	62	127	1.9%
556	Ulcerative colitis	11	17	28	0.4%
555	Regional enteritis	16	10	26	0.4%
	Gastric Group Total	516	405	921	13.5%
	Mental Health				
296	Affective psychosis (e.g. Major Depression, Bipolar Disorder, etc.)	526	325	851	12.5%
300	Anxiety states	455	291	746	11.0%
302.85	Gender Identity Disorder	26	29	55	0.8%
295	Schizophrenia	2	16	18	0.3%
301	Personality disorder	9	5	14	0.2%
	Mental Health Group Total	1018	666	1684	24.7%
	Endocrine				
278	Overweight, obesity and other hyperalimentation	634	485	1119	16.4%
250	Diabetes Mellitus	233	289	522	7.7%
790.21	Impaired Fasting Glucose	47	81	128	1.9%
585	Chronic renal failure	51	48	99	1.5%
362	Diabetic Retinopathy	23	14	37	0.5%
357.2	Neuropathy in Diabetes	8	8	16	0.2%
	Endocrine Group Total	996	925	1921	28.2%
	Heart				
401	Essential hypertension	483	536	1019	15.0%
272.4	Hyperlipidemia	385	369	754	11.1%
414	Coronary Atherosclerosis	55	125	180	2.6%
427.31	Atrial Fibrillation	40	53	93	1.4%

405	Secondary hypertension	37	42	79	1.2%
443.9	Peripheral vascular disease	32	32	64	0.9%
428	Congestive Heart Failure	15	17	32	0.5%
435	Transient Ischemic Attack	7	6	13	0.2%
436	Cerebrovascular Accident	3	5	8	0.1%
	Heart Group Total	1057	1185	2242	32.9%
	Cancer				
185	Malignant Neoplasm of Prostate		20	20	0.3%
174.9	Malignant Neoplasm of Breast Not Otherwise Specified	17		17	0.2%
153	Malignant Neoplasm of Colon	4	4	8	0.1%
162	Malignant Neoplasm of Trachea, Bronchus and Lung	1	1	2	0.0%
	Cancer Group Total	22	25	47	0.7%
	Musculoskeletal				
715.9	Osteoarthrosis	360	246	606	8.9%
733	Osteoporosis	231	75	306	4.5%
722.6	Disc degeneration	94	87	181	2.7%
733.9	Osteopenia	109	34	143	2.1%
729	Fibromyalgia	93	7	100	1.5%
714	Rheumatoid Arthritis	33	9	42	0.6%
	Musculoskeletal Group Total	920	458	1378	20.2%
	Addictions				
305.1	Tobacco Use Disorder	229	207	436	6.4%
305.0	Alcohol Abuse	15	66	81	1.2%
304	Opioid Dependence	5	5	10	0.1%
312.31	Pathological gambling		2	2	0.0%
	Addictions Group Total	249	280	529	7.8%
	Pain				
338.2	Chronic Pain	259	230	489	7.2%
338.1	Acute Pain	10	5	15	0.2%
	Pain Group Total	269	235	504	7.4%
	Other				
280	Iron deficiency anemia	428	134	562	8.3%
389	Hearing loss	50	85	135	2.0%
266.2	Vit B12 deficiency	65	27	92	1.4%
	Other Group Total	543	246	789	11.6%

* The percentages from the above table are calculated based on a denominator of 6392 – the number of WFHT rostered patients as of February 2nd, 2017.
* The totals show the number of diagnoses present in patient charts for the above health conditions. The patients may have multiple diagnosis codes per condition and/or diagnosis group.
* In cases where the diagnosis extension (decimal point) is not specified, it includes all specific diagnoses that begin with the same first three digits.
* These group totals only account for the diagnoses and conditions listed in the table.

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