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Clinical Prevention Services - Primary, Secondary and Tertiary

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Introduction

Situation Analysis

The BC Association of Kinesiologists (BCAK) participated in the Committee consultations and provided input related to improving health services delivery and outcomes.

Years of research demonstrate that healthcare prevention services (such as clinical exercise prescription, nutrition education/counselling, ergonomic interventions, optimization of human biomechanics and implementation of physiologically sound practices and advice) deliver economic, social, and health benefits far beyond their initial investment costs.

People who are insufficiently or inappropriately active present a 20 to 30 percent increased risk of early death compared to people who are sufficiently and appropriately active. The World Health Organization found those who adhere to a healthy lifestyle (for example, by eating well and maintaining appropriate and adequate physical activity) can reduce the prevalence of developing, and the severity of, preventable lifestyle-based diseases, such as hypertension, type 2 diabetes, dyslipidemia, COPD, chronic liver disease, various forms of cancer and other conditions. In 2018, the World Health Assembly agreed on a global target to reduce physical inactivity by 15% by 2030 and align with the Sustainable Development Goals.

BC's provincial government has emphasized enhancing clinical-based prevention and created a Clinical Prevention Policy Review Committee (CPPRC). In recognizing that increasing physical activity requires a systems-based approach, the Committee is tasked with devising a lifetime

prevention plan – a series of services paid for by the public healthcare system and provided to British Columbians over their lifetime to promote long term good health, detect disease early, and when possible, minimize disease progression and disability.

The key to the success of the lifetime prevention plan is collaboration among allied and healthcare professionals. Only through constructive collaboration between patients, policymakers, physicians, and healthcare providers can the goals of this policy be effectively maximized. As members of the healthcare team, kinesiologists can contribute to providing healthcare prevention services.

This Policy will be formed in four parts

1. **Part I** Defining clinical prevention.
2. **Part II** How best to deliver clinical prevention services.
3. **Part III** The vital role of patients as partners in prevention.
4. **Part IV** Proposal of additional steps to realize the vision of a successful lifetime prevention plan.

Part I - Defining and Prioritizing Clinical Prevention Services[1]

Definition of Prevention
Actions aimed at eradicating, eliminating, or minimizing the impact of disease and disability, or if none of these is feasible, retarding the progress of disease and disability.

Levels of Prevention

1. *Primordial prevention*
   Measures taken in preventing and avoiding the development of risk factors that can lead to causation of disease.

   Example: following Canada's Food Guide and Healthy Living Exercise Guidelines

2. *Primary prevention*
   Measures that prevent the onset of illness or injury before the disease process begins.

   Example: Regular physical activity and enhancing nutritional status, enhancing current physical activity status, eliminating environmental/ergonomic risks, and avoiding noxious/extreme environmental physiological exposures.

[1] *Sources: Starfield, B., et al., The concept of prevention: a good idea gone astray? J Epidemiol Community Health, 2008. 62(7): p. 580-3; Robinson, S. and T. Hancock, Draft Interim Report, Clinical Prevention Policy Review Committee, Editor. 2009, Ministry of Health Services. p. 70; Gervas, J., B. Starfield, and I. Heath, Is clinical prevention better than cure? Lancet, 2008. 372(9654): p. 1997-9.*
https://courses.lumenlearning.com/diseaseprevention/chapter/three-levels-of-health-promotiondisease-prevention/
https://www.doctorsofbc.ca/sites/default/files/prevention_jun2010.pdf

Health Education - educate people to practice preventive behaviors, such as having a balanced diet so that they can protect themselves from developing disease in the future.

3. *Secondary prevention*

Preventive measures that lead to early diagnosis and prompt treatment of a disease, illness, or injury to prevent more severe problems developing. These measures available to individuals and communities for the early detection and prompt intervention to control disease and minimize disability.

Example: Screening for, and flagging, populations to medical practitioners/general practitioners for high blood pressure, elevated blood sugars, elevated lipid profiles and breast self-examination.

Health Education - educate people to visit their local health center when they experience symptoms indicative of potential health risk factors so they can get early treatment for their health problems.

4. *Tertiary prevention*

Preventive measures aimed at rehabilitation following significant illness. At this level health services workers can work to retrain, re-educate, and rehabilitate people who have already developed an impairment or disability. Measures are aimed at softening the impact of long-term disease and disability by eliminating or reducing impairment, disability, and handicap; by minimizing suffering; and by maximizing potential years of useful life.

Health Education - educate people to take their medication appropriately, to develop effective pain management strategies, and to find ways of working towards rehabilitation from significant illness or disability.

Part II - How best to deliver clinical prevention services

The medical care setting. This encompasses secondary and tertiary care and allied care providers, such as pharmacists, laboratory staff, and dentists.

The mixed healthcare setting. This includes any platform involving systematic or centralized screening and interventions of a specialized nature (e.g., invitation to mammography screening).

The non-medical care setting. Any CP services delivered by public health staff in community contexts.

1. *Primary prevention*

The non-medical care setting. Any clinical prevention services delivered by public health staff in community contexts, recreation centers, or in-home outpatient services.

2. *Secondary prevention*

The mixed healthcare setting. This includes any platform involving systematic or centralized screening and interventions by a medical practitioner in conjunction with outpatient resources and recreational facilities.

3. *Tertiary prevention*

   The medical/clinical care setting. This encompasses secondary and tertiary care and allied care providers such as pharmacists, laboratory staff, and nurses, and physicians, and other allied health professionals.

Part III - The vital role of patients as partners in prevention

In British Columbia, the most obvious example of this trend is the Primary Health Care Charter, which not only recognizes patient partnerships as the central prerequisite of clinical transformation, but also states that such partnerships are part of the basic philosophy for infrastructure initiatives (Ministry of Health Services, 2007).

At a practical level, this philosophy is being realized by the creation of the position of Director, Patients as Partners, in the Ministry of Health Services, and by Impact BC, a Ministry of Health Services funded organization that provides support to both the collaborative Practice Support Program and to Integrated Health Networks.

Impact BC's patient- and family- centered principles include (Impact BC, 2007)

- People are treated with respect and dignity,
- Healthcare providers communicate and share complete and unbiased information with patients and families in ways that are affirmative and useful,
- Individuals and families build on their strengths through participation in experiences that enhance control and independence, and
- Collaboration among patients, families and providers occurs in policy and program development and professional education, as well as in the delivery of care.

Part IV - Additional steps proposed to realize the vision of a successful lifetime prevention plan (LPP)

As with any large-scale, province-wide initiative, developing and implementing an LPP requires that all stakeholders work together to overcome barriers and seize opportunities. This section addresses specific areas where kinesiologists can contribute to the success of the LPP and to the development of an implementation strategy to maximize physician participation.

Relationships. A trusting relationship built upon shared goals, a long-term commitment to success, and a culture of learning is essential to the success of collaborative programs between the healthcare authorities and BCAK. This may be achieved through mutual agreement, and a long-term commitment to the collaborative process, that the primary objective of the program is to improve the quality of care for patients. By funding the LPP primarily through the health authorities, both parties can leverage structures that have engendered trusting relationships with physicians to improve the likelihood of success.

Incentives. Both parties have learned that behavioural change is impossible without clearly defined incentives. Success of the LPP depends on the implementation of appropriate incentive structures for kinesiologists to provide clinical prevention services. Part of the initial implementation of clinical prevention could be a Ministry of Health Services collaborative

program that adds clinical prevention to current health prevention and community health and wellness promotion guidelines.

Supports. Without assisting the Ministry of Health/ Provincial Health Authorities to overcome the systemic barriers to adopting and managing new incentive structures, uptake will be limited. Moreover, those that do adopt new incentives may do so for only a short period of time if they are unable to adapt their practice patterns to new ways of doing business due to continued increases in future healthcare costs that are predicted to continue to rise.

Quality Measures. By agreeing upon, adopting, and regularly reviewing, quality measures under current BC healthcare guidelines, members of the BCAK can foster a culture of learning, achieve their common goal of a patient-centered healthcare system, and realize improvements in health services delivery and outcomes. Recognition of these improved outcomes will lead to a stronger voice within the healthcare team.