



A manual to implement a healthy lifestyle empowerment service

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HEALTH EMPOWERMENT - Introduction

Hospital as a setting for people empowerment

The World Health Organization (WHO) defines patient empowerment as a “process in which patients understand their role, are given the knowledge and skills by their healthcare provider to perform a task in an environment that recognizes community and cultural differences and encourages patient participation” (WHO, 1998). Four components have been reported as being fundamental to the process of patient empowerment: 1) understanding by the patient of his/her role; 2) acquisition by patients of sufficient knowledge to be able to engage with their healthcare provider; 3) patient skills; and 4) the presence of a facilitating environment (Angelmar & Berman, 2007).

As practitioners consider patients compliance with their instructions as critical to good health, the concept of patient empowerment could be focused on a limited perspective. Marks et al. (2015), for example, highlighted the risk to attribute only to the individual the responsibility for his/her own health conditions without considering the responsibility of social structures, such as health services, and social inequity.

Another perspective states that the health of individuals improves not merely by complying with instructions but also when the patient becomes actively involved in decisions about his/her own health (Laverack 2015). Health professionals have traditionally controlled the management of disease, thus relieving patients of responsibility, but patient empowerment is increasingly recognized as being important, especially in illnesses that require both drug compliance and a life-style change, for example, in the case of diabetes, cardiovascular diseases and cancer. Patient empowerment could be promoted only if the health professional offers an equal relationship in which the expert knowledge is used to allow the patient to make informed decisions about their treatment, recovery and his/her lifestyle.

The role of education in the empowerment process is not to coerce people into following specific instructions, but to enable them to increase their self-reliance and to make autonomous choices. Education should therefore use decision making aids that assist people in choosing the health options that most closely align with their values and





preferences. This procedure may also help to increase patients' trust and facilitate the shared professional-patient decision making process.

In conclusion patient empowerment enables people to take control of their health, well-being and disease management and to participate in decision affecting their care. Patient empowerment involves respecting patients' rights, and giving people a voice so that they can collectively participate in making health system more user friendly and health information more accessible (The Lancet 2012).

Patient empowerment is an advanced strategy to promote healthy behavior, but it is not enough: it is necessary that also the family in which the patient lives creates an environment favorable to the life-style change. For a patient who smoke it would be more difficult to quit if relatives are smokers. Similarly, to change his/her personal diet, the patient needs that also the meals prepared and consumed by his/her family change as well. Coherently with the social learning theory, people learn from others, via observation, imitation, and modelling. For these reasons the patient' family have to be involved in the empowerment process.

If we study more in deep the factors that promote healthy behavior among patients, it is necessary to consider health professionals too. In fact, they play a central role in the promotion of health-related behaviors. Their personal life-style should therefore be coherent to the messages they promote among their patients, as they play as a model to the eyes of their assisted.

Finally, also the hospital and the healthcare facilities environments should send messages coherent with the habits the health professionals try to promote. In this perspective an Empowering Hospital should enforce several policies that facilitates healthy choices such as banning smoking in every place, offering healthy meals in its cafeteria and canteen, banning alcohol purchase and consume and promoting physical activity through an appropriate communication or with specific interventions like promoting the possibility to reach the hospital by bike, or let available cheap/out of cost gyms to patients, relatives and worker.





An Empowering Hospital should therefore embrace a comprehensive perspective in which people and environment interact to promote a healthy and supporting environment.

References

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CHAPTER 1 - Evidence based interventions

Summary of findings

Environmental interventions

Our search did not retrieve any good quality systematic review on environmental interventions. Interventions implemented as part of the EMP-H project randomised controlled trial were based on the WHO Europe Manual on health promotion in hospitals.

Interventions remotely delivered

Our overview of systematic reviews on the effectiveness of technology assisted and remotely delivered interventions (telephone, internet) did not provide sufficient evidence to recommend these e-health solutions to empower patients towards healthier lifestyles.

Telephone-based interventions are proven to be effective to improve dietary habits in colo-rectal and breast cancer patients only, but the evidence is limited by the fact that these interventions were a component of a multidisciplinary intervention targeting lifestyle behaviours.

1.1 Interventions to improve dietary habits

Educational multiple interventions targeting lifestyle changes seem to be effective in cardiovascular patients, but behavioural counselling interventions did not seem to be effective in modifying dietary behaviours in patients with diabetes type 2.

Colorectal cancer studies results were contradictory while all the studies on breast cancer survivors showed encouraging results in favour of counselling interventions.





In healthy people high-intensity diet and combined lifestyle counselling interventions decreased total energy intake from fatty food and increased fruit and vegetable consumption, but the evidence is limited by self-reported dietary habits.

Dietary intervention based on counselling are effective in increasing fruit, vegetables and fish intake and in reducing fat and energy intake, both among overweight and obese people but the TTM/SOC model is not effective to reduce body weight.

Summary of retrieved Systematic Reviews

No reviews on interventions delivered at the hospital were found.

In primary care, four reviews (Aguiar 2014, Ball 2013, Desroches 2013, Lin 2014) and one review of systematic review (Greaves 2011) were included.

Ball 2013 was on General Practitioners/Family physicians delivering nutrition care to patients whose lifestyles was potentially harmful. Desroches 2013 evaluated interventions enhancing adherence to dietary advice in chronic disease patients or patients with at least one risk factor for a chronic disease. Aguiar 2014 was on the effectiveness of lifestyle interventions in at risk or pre-diabetic population. Lin 2014 was on the effectiveness of counselling interventions on behavioural outcomes (change in eating habits); some interventions were target to diet and physical activity behaviours, some on diet only.

Greaves 2011 was a systematic review of reviews assessing the effectiveness of interventions for promoting dietary and/or physical activity change. This overview included 3 systematic reviews reporting outcomes on changes in dietary behaviours and it found positive changes in self-reported diet (calorie, fat, fibre, fruit and vegetable intake) at 6 to 19 months of follow up.

Five reviews (Janssen 2013, Ghisi 2014, Aldcroft 2011, Allen 2010, Desroches 2013) were found on the effectiveness of multidisciplinary behavioral interventions aimed at modifying lifestyles in cardiovascular patients. Two reviews targeting type 2 diabetes patients were included (Ball 2013, Desroches 2013).





Three reviews on the effectiveness of dietary counselling among cancer patients were included: Avery 2013 was on dietary interventions to reduce cancer risk. Pekmezi 2011 was on lifestyle interventions (diet, physical activity and healthy body weight maintenance) effectiveness among cancer survivors and Spark 2013 reviewed the evidence on maintaining physical activity levels and dietary improvements following behaviour change interventions in breast cancer survivors.

Four reviews targeting adult overweight /obese patients were included (Dombrowski 2010, Lara 2014, Mastellos 2014, Taylor 2013).

Mastellos 2014 reviewed the effectiveness of interventions based on the trans-theoretical model (TTM) stages of change (SOC) to reduce body weight, to improve physical activity and to adopt dietary habits, such as reduced dietary fat intake and increased fruit and vegetable consumption.

Dombrowski 2010 reviewed the effects of behavioural interventions for obese adults with at least one additional risk factor for morbidity on behaviour (diet and PA), weight, and risk factors. Lara 2014 reviewed the effectiveness of dietary interventions that promote a health dietary pattern among adults in the retirement transition age range, with dietary behavior change as the primary outcome. Taylor 2013 included RCTs investigating nutrition interventions that target the adult male population.

In healthy people Sargent 2012 assessed the counselling intervention delivered in primary health care by nurses to change life risk factors of cardiovascular disease and Lin 2010 assessed the effectiveness of physical activity and dietary counselling interventions for changing potentially harmful behaviours.





1.2 Interventions to increase physical activity

No reviews on the effectiveness of behavioural interventions to increase physical activity delivered at the hospital were found.

Seven reviews (Ghisi 2014, Aldcroft 2011, Chase 2011, Allen 2010, Zhu 2013, Janssen 2013, Ferrier 2011) on patients with cardiovascular diseases provide strong evidence that behavioural interventions (as component of multidisciplinary interventions usually starting during hospital stay) improve physical activity at 12 months follow-up. In this population there is no evidence that remotely delivered interventions (telephone, internet) are effective to increase physical activity levels.

Five high quality reviews (Gagliardi 2015, Orrow 2012, Sargent 2012, Lin 2010, Tulloch 2006) on the effectiveness of counselling interventions delivered at primary care facilities to improve levels of physical activity provide evidence that 'metabolic syndrome' patients can benefit from these interventions.

Two reviews (Avery 2012, Sazlina 2013) on patients with diabetes type 2 were included. Behavioral interventions or counselling can produce a moderate to large increase in self reported physical activity at 6 and 12 months follow up when compared to usual care . These results are confirmed when measured by objective measures only for 12 months follow up.

Conclusions

There is evidence that multidisciplinary interventions, in particular those targeting healthier diet and higher levels of physical activity, are effective in selected clinical populations. Nevertheless, the evidence is limited by the fact that in most of the studies physical activity and dietary habits were self-reported and few studies reported the number of participants whose actual levels of physical activity matched WHO recommended amount/frequency.





Recommendations

Lifestyle multidisciplinary interventions to increase physical activity and to improve diet should be centred around counselling and provided to patients, relatives and hospital workers.

To improve physical activity levels and dietary behaviours counselling interventions have to:

- Target both diet and physical activity.
- Provide behavioural interventions based on well established models (e.g. trans-theoretical model).
- Use of established behaviour change techniques (e.g. motivational interviewing).
- Combine behavioural techniques with supervised exercise session.
- Prompt patients to identify barriers to change and to develop solutions.
- Assess patients' goals (assess, advise, agree, assist, arrange model).
- Involve physicians to briefly advice patients on the health benefits of regular physical activity and healthy diet.
- Involve nurses to assess risks factors.
- Involve psychologists, lifestyle change specialists to deliver counselling.
- Use group educational workshops involving multidisciplinary teams.
- Include advice on 'real world' opportunities such use of urban circuits.
- Encourage and plan home-based self-management activities.
- Activate social support.
- Encourage and facilitate participation to walking groups.
- Schedule high frequency contacts and at least six months follow-ups.
- Have a plan for supporting maintenance of behaviour change and prevent relapses.





1.3 Interventions to quit cigarette smoking

Four systematic reviews (Rice 2008, Rigotti 2008, Rigotti 2012, Grandi 2013) and one review of systematic reviews (Hartmann-Boyce 2014) were included.

Interventions delivered during hospital stay associated with intense follow-up after discharge are effective to lead to cigarette smoking cessation in chronic patients (the available evidence being mainly generated by studies among Cardiovascular and Chronic Obstructive Pulmonary Disease patients)

Recommendations

Interventions delivered to in-patients by a multidisciplinary team have to include:

- Physician' and Nurses intensive advice.
- Self-help educational materials about health risks associated with cigarette smoking, relaxing techniques, stress management, use of social support (and information on nicotine replacement therapy when applicable)
- Education and information group session.
- Behavioural and motivational interviewing techniques (goal setting, agreed smoking cessation plan, self-monitoring, advice/guidance on weight management and social support) delivered by psychologists, specifically trained nurses and patient educators and lasting up to 60 minutes (minimum 10 minutes).
- Face-to-face behavioural therapies have to be delivered according to a high intensity schedule and follow-ups have to be planned (telephone and other remote interventions can be used) so that a contact is established at least once a week for the first 8 weeks and once a month thereafter for at least three months to one year.
- When nicotine replacement therapy (NRT) is offered to the patients behavioural change is facilitated and healthcare staff (doctors, nurses, pharmacists) have to educate the patient towards NRT compliance and self-management.





1.4 Interventions to reduce alcohol consumption

None of the retrieved Systematic Reviews investigated the effectiveness of interventions targeting chronic diseases patients.

Only 3 Systematic Reviews matched inclusion criteria and quality (AMSTAR score > 8) threshold. One was on interventions delivered at the hospital to patients hospitalised because of any reason except alcohol problems and assessed as at risk for harmful drinking, i.e. regularly consuming alcohol in excess of recommended safe daily/weekly amounts (McQueen 2011), one on interventions delivered in primary care settings to patients routinely visiting the clinic already diagnosed with alcohol consumption related problems (Kaner 2007).

Recommendations

Brief interventions (one to 3 face-to-face sessions and follow-up for 6 months) delivered at the hospital /clinic premises can reduce weekly alcohol consumption and this change persists up to six months.

Interventions shown to be effective to reduced alcohol intake and alcohol-related problems are based on psycho-social approaches designed to empower people and include:

- Educational materials (booklet reporting drinking national guidelines in a understandable language, use of pictures, and sessions focused on excessive alcohol consumption health and social risks).
- Patient activation through strategies such as goal setting, drinking diary (with emphasis on social context to address binge drinking), written feedback on discrepancies between measured and expected alcohol consumption, formal commitment to self-manage drinking behaviours.
- A variety of behavioural change strategies (with emphasis on social support available outside the hospital).
- Motivational approach based on empathy and support towards self-efficacy to move between stages of change.
- Plan for follow-up counselling (both face-to-face and telephone calls)





Brief interventions are face-to-face interventions delivered up to 3 times and lasting 15 to 30 minutes. This variety of intervention is particularly suitable to the hospital and primary care settings as many healthcare professionals and volunteers (Nurses, Psychologists, Occupational Therapists, Alcohol Counsellors) can be trained to deliver interventions.

Interestingly, our overview shows that screening alone might reduce alcohol consumption (as reported from control groups), confirming screening as a viable strategy to prompt people reducing alcohol intake as recommended by the WHO in 2012*.

* WHO (2012) Alcohol in the European Union: Consumption, harm and policy approaches. Geneva, World Health Organisation.





CHAPTER 2

Healthy Lifestyle Empowerment Service (HLES) organisation

Health Promotion centres in hospitals are now part of the overall healthcare process and in order to activate chronic patients to better manage their conditions the clinical treatments have to be supported by educational opportunities, behavioural empowerment and a supportive environment.

This chapter provides organisational guidance on how to set up and to run HLE within a hospital and its jurisdiction and gives 'real world' examples taken from the Empowering Hospital project

'Domains of action' were identified in order to evaluate the quality of activities empowering citizens towards healthier lifestyles leading to risk reduction and better quality of life.

For each domain, hospital performance as provider of empowering opportunities can be assessed against criteria and standards as proposed by Groene et al. (2005).

Standards (and sub-standards) have been adapted from the 'WHO Europe manual on implementing health promotion in hospitals' with the aim of facilitating managers and healthcare staff in the process of embedding Healthy Lifestyles Empowerment into the current hospital Health Promotion Center offer.

Reference

Groene O, Garcia-Barbero M. eds. Health promotion in hospitals. Evidence and quality management. Copenhagen, WHO Regional Office for Europe, 2005

2.1 Management policy

The organization includes healthy lifestyles promotion as part of its Quality Promotion plan. This policy is aimed at all hospital workers, volunteers, patients and visitors.



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- The hospital's stated aims and mission include healthy lifestyle promotion.

It is important to emphasise health promotion as relevant part of the overall process of healthcare and to highlight that patients empowerment plays a central role in improving clinical outcomes, chronic diseases patients quality of life and reduce the financial costs of treatment.

- The hospital Quality plan include healthy lifestyles promotion for staff, patients and relatives.

This plan highlights personal development towards well-being and healthier habits as strategic component. Emphasis should be given to targeting all hospital workers, including not only healthcare professionals, but also staff providing services such as cleaning, cooking, estate maintenance. Patients organisation volunteers should also be included in this plan as they can play a major role in facilitating the integration of services between the hospital and its catchment area.

The organization identifies roles and responsibilities for healthy lifestyles promotion.

- The hospital identifies personnel and functions to coordinate Healthy Lifestyles Empowerment Services (HLES).

A healthy lifestyles empowerment working group includes:

- HLES manager
- Head of health promotion
- Head of allied healthcare staff / volunteers
- Head of hospital Human Resources department
- Head of nurses
- Representatives of territory stakeholders, activities providers, local administrations, and patients organisations

The organization assesses its readiness to implement healthy lifestyles promotion:

- The HLES assesses the organisation readiness to implement and to sustain this new service. To this purpose HLES manager prepares a checklist that include potentially critical areas such as: Infrastructure (not only within the hospital but also in the territory), Leaders (recruited among clinicians as well as among stakeholders), Staff training





(preferably as part of their Continuing Professional Development / Continuing Medical Education), Evidence-based interventions (applicability to organisation context), Monitoring and Improvement (relevant indicators identified).

- Specific needs and facilities required for healthy lifestyles promotion (including additional staff, space, equipment, financial resources) are identified.

The organization allocates resources to implement healthy lifestyles promotion:

- There is an identifiable budget for HLE services and materials (Continuing Professional Development / Continuing Medical Education events organisation).
- There is a plan to access external sources of funding and to optimise collaboration with territory stakeholders.
- Healthy Lifestyles Empowerment operational procedures are available to inpatients and outpatients departments (to facilitate patients referral to internal and external empowering initiatives).

The organization has a plan to establish hospital-based healthy lifestyles empowering activities and to monitor their quality.

- A plan for making empowering activities accessible to hospital staff, patients and relatives is established.
- A plan for quality assessment of the empowering activities is established.

Patients opinion/evaluation is gathered and analysed by HLES in order to improve users' compliance and interventions' efficacy.

- A literature search for the evidence available is planned at least once a year. Potential changes are discussed at the working group meetings, approved and documents, including procedures, updated accordingly.
- Best practices of 'environmental initiatives' as suggested by International Organisations (e.g. WHO, Local Governing Authorities) are listed and assessed against feasibility and sustainability criteria, approved by the working group and implemented in collaboration with stakeholders.





2.2 HLES users profiling

The organisation has a plan to offer hospital workers, patients and their relatives an assessment of their risk factors and lifestyles and operational procedures are distributed to all hospital departments.

- A profiling tool to identify smoking status, alcohol consumption, physical inactivity and unhealthy diet is made available across the hospital.

A questionnaire to detect risks related to behaviours and to evaluate level of empowerment is available in Annex 1.

A profile is defined for each user to allow for tailoring the most suitable behaviour change activities depending on individual needs

- Users receive clear instructions on how to fill out the questionnaire
- Guidelines are available to staff to refer users to the HLES and to tailored empowering interventions

After being assessed patients are given clear, understandable instructions to access empowering initiatives based on their profile

The process of profiling patients according to their risks starts at first contact with the hospital

- Risk profile is documented in the patient's record at admission or at first contact when the patient visits the primary care clinic.
- The most convenient times to profile individuals are identified.
in order to screen the highest number of citizens living in the hospital catchment area, it is paramount to make the questionnaire available not only during hospital admission: outpatients waiting rooms can be an ideal place for volunteers to approach patients and relatives.
- Primary care clinics profile patients at first contact and on a regular basis (at least once a year for those rarely visiting their General Practitioner)
- Information collected from patients include social and cultural background potentially relevant to behaviour change.





- There are procedures to ensure re-assessment and re-tailoring of the empowerment strategy on a regular basis (primary care services are involved and patient's record updated accordingly).

2.3 Staff, Patients and Relatives Empowerment

The organization provides staff, patients and their relatives with information on relevant lifestyle factors and on 'empowerment towards healthy habits' activities.

- Information given to the patient is recorded in the user/patient's record

Staff can receive this information from Occupational medicine service within the hospital

Charities and patients organisations contribute to inform citizens about the benefits of healthy lifestyles and opportunities available in the catchment area

Primary care clinics promote healthy lifestyles and related activities to staff, patients and relatives

- Healthy lifestyle promotion activities and expected results are documented and evaluated

Activities are regularly assessed (offer comprehensiveness, attendance, etc) and updated by HLES manager in collaboration with all those involved in delivering such activities

Expected results are reported as individual level changes (user's record) as well as at organisational level (Quality Promotion annual report)

- Users satisfaction assessment of the information given is performed and the results are integrated into the quality management system HLES collect and analyse feedback from staff, patients and relatives

Patients (and their relatives) are given understandable follow-up instructions at out-patient consultation, referral or discharge

A healthy lifestyles adoption plan / 'contract' has to be prepared and agreed by both HLES staff and the patient

Follow-ups are to be scheduled according to the plan





The plan includes instructions on how the patients will receive communication from the HLES about empowering initiatives organised/managed/endorsed by HLES

Social support available in the patient's living area has to be given emphasis in the plan

The organization provides staff, patients and their relatives with educational events and activities within the hospital and in the territory.

- Educational events (seminars, workshops, classes) are organised and regularly delivered to users

Events are repeated on a regular basis and scheduled on different days and at different times to facilitate users attendance

Workshops involve clinicians and experts (e.g. clinical psychologists) to explain the risks and the benefits of changing habits and the current models of effective interventions.

Users' assessment is planned and feedback to HLES manager is provided by hospital staff and by stakeholders.

Each event attendance is assessed and recorded.

- Educational materials are made available as distant learning.

Users are given access to a repository where self-learning materials are conveniently accessible.

Educational materials include: Health literacy, Behaviours change models, Self-Management strategies (e.g. goal setting, habits diary), Motivational techniques (e.g. motivational interviewing),

- Empowerment initiatives are designed taking into account seasonality, environmental factors, and timely promoted (e.g. walking groups and cooking classes).
- Users empowerment level is assessed on a regular basis (at least annually)





ASL Bi : Embedding Empowerment into Healthcare staff Continuing Professional Development

ASL Bi developed a blended learning course and self-learning materials are available on-line to all healthcare staff. Subjects included in this course were: Health determinants; Non-communicable chronic diseases (NCD) risk factors; Lifestyles and their role in prevention and self-management among NCD patients; Behavioural changes theories and models; Behavioural changes techniques (motivational interview); Distant learning was associated to class lectures and workshops on the major NCD risk factors and the benefits of healthier lifestyles. Initiatives involving patients, staff and citizens were organised to empower people towards better risk awareness, knowledge and 'healthy lifestyle induction' opportunities were offered at the hospital premises and in the hospital catchment area. This course was approved, in Italy, as CPD/CME event for healthcare professionals so making it more sustainable over the next few years. Teaching and learning materials were developed by risk factors specialists. Citizens from charities were involved with the aim of sharing their experiences, promoting their initiatives and offering patients, relatives and hospital staff their support to start changing habits.

Materials are available on the Empowering Hospital project website (<http://www.emp-h-project.eu/>)





2.4 Roles and responsibilities of HLES, collaborating hospital departments and external services providers

- HLES prepares a map of services and patients' flow within the hospital and outside the hospital to guide services providers.

The HLES Manager prepares a map where hospital-based empowering initiatives are briefly explained to users. Similarly, a map of initiatives available in the territory is available to users after leaving the hospital. Charities and patients organisations should be involved at this stage in order to facilitate users access to healthy lifestyles activities available in the hospital jurisdiction.

- HLES provide a detailed list of hospital staff with roles and responsibilities in delivering empowerment activities within the hospital (this list includes all categories of hospital workers).

A key factor to make Healthy lifestyles promotion sustainable is to involve staff with different roles so that overlaps are avoided and staff time is minimised. As well, this list includes nutritionists and hospital kitchen staff will facilitate the organisation of nutrition classes and cooking workshops.

- Each department responsibilities are clearly defined to timely offer patient's profiling and counselling to change harmful habits for each of the four risk factors identified.

Doctors specialists should make themselves available to briefly talk to users / attendees at the beginning of topic specific seminars in order to put emphasis on risks of a specific behaviour and benefits determined by changes.

- Individuals' responsibilities to approach, assess, advise the patients are clearly defined in each collaborating department (including outpatients clinics services)
- HLES coordinates and promotes empowering activities available in the hospital territory.
- Staff working for external services providers are fully qualified to deliver interventions and a documentation is on record at the HLES





2.5 HLES sustainability plan

The organisation has a plan to ensure sustainability to the empowering activities coordinated by HLES

- The HLES manager prepares a 5 years sustainability plan to secure services continuity and improvement.

This plan include the organisation readiness to implement such a new service (leadership, staff, infrastructure) and has to be designed to be flexible to adapt to changes likely to occur during the implementation timeframe (e.g. staff replacement).

- An assessment of sustainability factors is undertaken by HLES manager

This assessment address each step of the evidence-based intervention implementation: the strength of the scientific evidence is included, the evidence is regularly reviewed and the interventions updated.

- The sustainability plan is discussed and approved by HLES working group

Sustainability is included as agenda item to be discussed at HLES Working Group meetings in order to be able to smoothly introduce changes without disrupting the service.

- Resources (financial, personnel, logistics) are secured and clearly reported in Health Promotion Unit and Hospital budgets

This report should include all contributions from stakeholders.

- The HLES sustainability plan includes clear strategies to ensure promotion and communication of external empowerment activities to staff, patients and relatives

Depending on the local context, strategies are developed so that the responsibility for healthy lifestyles promotion is shared between local healthcare administration and territory stakeholders. Activities that can benefit from establishing long-term collaboration are fund-raising initiatives, co-marketing, new stakeholders involvement.

- Local governing authorities formally commit to support a 'health in all' approach to their policies and to promote initiatives locally.





- Local media are involved and contribute to promoting healthy lifestyles empowerment initiatives, educational events, citizens' awareness and locally available opportunities to maintain behavioural changes.





CHAPTER 3 – Hospital and territory as environments facilitating healthier lifestyles.

The organisation has a plan to ensure continuity of healthy lifestyles empowerment between the hospital and the territory.

3.1 Safe and healthy workplace

- Working conditions comply with national/regional directives and indicators (EU regulations)
- Staff comply with health and safety requirements and all workplace health and lifestyles risks are identified

Staff are aware of National laws, local rules and hospital regulations as well as services offered to quit smoking cigarettes by local health authorities.

3.2 The hospital as healthy lifestyles promoting environment

- A policy to encourage and to facilitate healthy choices is prepared by HLES manager

A short policy document is prepared by the HLES manager. This document includes all areas of intervention and departments involved in the process of changing the hospital environment (estates management, food services, human resources education unit, etc)

- All staff in all departments are aware of the healthy lifestyle promotion policy and of their roles in the promotion process.
- Staff are involved in ‘hospital as healthy lifestyles promoting environment’ annual review

Involving staff in the review process is useful to ‘activate’ themselves to adopt healthier habits and to facilitate their role in developing new empowering initiatives and activities within the hospital.

- Human Resources, Occupational Medicine Department, hospital services and departments engage in promoting healthy lifestyles initiatives among staff and patients.





Education is an important component of the empowerment process. Human resources should collaborate with Occupational Medicine department to embed healthy lifestyles empowerment into hospital staff educational offer and risks profiling as part of hospital workers' health assessment routines.

Hospital services and departments are encourage to contribute to and organise events aiming at empowering citizens towards healthy lifestyles. Educational events take place at the hospital and are replicated in the territory (with stakeholders support).

Initiatives, when feasible, are open to the public and advertised via local media, patients' organisations and stakeholders and internet social networks.

Case study: Hospital La Fe Television Channel

Hospital La Fe offers his patients and visitors an internal TV circuit watchable in rooms and public areas. In order to promote healthy lifestyles among hospitalised patients and among those attending the hospital premises as accompanying persons and outpatients a short animation videoclip has been produced. This video shows the risks associated with harmful habits and the benefits of healthy lifestyles to prevent diseases and better manage clinical conditions. It also promotes healthy initiatives available at the hospital and gives instructions on who to contact anyhow to start changing habits. An educational tool as such has many advantages: patients are repeatedly exposed health promotion messages, its content can be updated with reduced costs, it has a minimal environmental impact, it can be delivered as promotional material using new mass media technologies and it is sustainable over time.





3.3 External (territory) empowering activities and providers

- The HLEM compiles a list of external empowerment activities preferably arranged by geographical location within the catchment area.

This list includes all activities useful to 'activate' citizens to self-manage their health and improve their behaviours. It is made available to all stakeholders to be promoted. This list should also include initiatives targeting the society at large (e.g. healthy food classes in primary and secondary school children, introduction to sport classes, etc)

- The HLEM compiles a list of the requisites for an external empowering services provider to be included in the HLES list.

Requisites should include all relevant logistics and quality aspects such as: staff qualification, flexible timetable, access criteria, locations, etc. This is to support the HLES manager in optimising the territory offer and to better integrate the hospital and its jurisdiction.

- The HLEM compiles a list of external empowerment activities providers working in partnership with the hospital and the list is annually updated.

For every provider the following information has to be available to HLES:

- a contact telephone number, email, webpage
- lifestyle empowerment activity delivered and delivery modalities
- detailed instructions for the patient to start
- logistics information (venue, schedule, cost, how to book)
- additional materials/equipment needed to take part
- a detailed, agreed procedure for the external providers to communicate changes to HLES
- a detailed, agreed procedure for the external providers to communicate patients attendance information (anonymously) to HLES





Case study: La Fe Hospital and CONSUM

An agreement has been signed with Consum (supermarket cooperative) to collaborate on prevention of obesity by empowering citizens towards food awareness and healthier diet. This agreement is an excellent example of outsourcing services otherwise difficult to be offered and managed by the health authority / hospital staff. Healthy food promotion activities are developed and offered by Consum: healthy food offers, cooking lessons, nutritional information, nutritionist supervised grocery shopping. These empowering opportunities are available to Consum customers and promoted by healthcare staff among people visiting the hospital and interested in improving their healthy lifestyles behaviours. Some of these activities will be available on CONSUM website as video tutorials and interactive games (healthy recipes, nutritional facts and guidance, self-learning materials).





3.4 Local administrations, policy-makers and stakeholders

There is a plan, prepared by the HLES manager, to coordinate and facilitate the 'Health in all' strategy territory implementation.

- The WHO Health in all strategy (Shanghai 2016) is presented to stakeholders, including local policy-makers, administrators, patients' organisations and volunteers (social workers providing healthcare support)
- During both face-to-face meeting and public events activities are selected and roles assigned among stakeholders.
- Each stakeholder role, services and activities are analysed against criteria of accessibility and sustainability and solutions discussed to integrate services and to avoid unequal services distribution in the hospital jurisdiction.
- This plan include sharing experiences and 'best practices' at least at regional level to ensure sustainability.
- This plan include an annual meeting/event to present the impact of the interventions, to facilitate networking between stakeholders and to launch new initiatives.





Case study - A wide variety of stakeholders to implement 'health in all policies'

Hospital La Fe Valencia (Spain)

“**Las Naves**” is a public entity managed by Valencia Local Government, aiming at developing innovative initiatives centered around citizens. ‘Las Naves’ has 5 main areas of intervention: mobility, water and energy, health and healthy cities, food industries, cultural and creative industry.

“**Pacient Actiu**” is a program launched by a group of healthcare workers from Valencia La Fe Health Department aimed to improve chronic patients disease knowledge and self-management through workshops involving patients to share experiences and advices. NCD patients act as testimonial that changes are feasible and at the same time they motivate other patients and facilitate them to adopt different habits.

Lithuanian Association Multiple Sclerosis (Lithuania)

The Lithuanian Ministry of health, the Lithuanian Ministry of Social security and the Lithuanian drug, tobacco and alcohol control Department, Klaipeda University and Pharmaceutical companies are involved in a collaboration with LISS to raise awareness about risk factors and to change citizens’ harmful habits. A strategy plan for the next 5 years has been agreed with the aim of redefining a sociocultural model of healthy living in Lithuania. This model combines Lithuanian traditions and new approaches to healthy living: one of the current actions is to empower Lithuanian people living in rural areas towards healthier diet by using their own resources, because preserving local traditions is paramount to sustain this change over time.

Biella Local Healthcare Authority (Italy)

After the first event organised to promote HLES coordination of hospital and territory services, twenty-five (out of 77) villages governing administrations have agreed to contribute to a local network of ‘healthy lifestyles empowering opportunities’ supporting activities such as ‘walking groups’, ‘walking school’ and urban planning projects to make available to citizens safe, convenient and didactic walking paths. It is important to mention here that the General Practitioners association has been involved to promote healthy lifestyles and practitioners were offered training to improve their skills in behavioural change techniques and brief counselling (delivered by hospital-based psychologists).

Two local charities (cancer) have given access to non-communicable chronic diseases patients to their current activities (e.g. self-help smoking and drinking groups, fitness classes and educational materials about healthy food and diet).





EMPOWERING HOSPITAL IMPLEMENTATION STAGES

1. Get Started

- Activate a small group of catalysts, preferably including clinicians.
- Assess how ready is the hospital to begin the process.
- Identify key hospital leaders to champion the process.
- Invite diverse stakeholders to get involved.
- Secure a formal commitment to health promotion activities (involving hospital executives).

2. Get organized

- Convene a health promotion committee and give roles to heads of hospital departments (doctors, nurses, volunteers).
- Plan educational activities to learn about prevention.
- Write a vision statement.
- Organize a workgroup.

3. Assess

- Review data on health - related behaviour among patients, relatives and hospital staff.
- Identify priority risk and protective factors that predict targeted health and behaviour problems.
- Assess hospital policies already in force.
- Assess hospital and community services and opportunities to sustain healthy behaviours.
- Identify gaps to be filled in using existing resources.

4. Create an action plan

- Select and expand tested and effective policies and programs contained in this handbook.
- Identify departments in charge of profiling individuals.





- Identify how to deliver the counselling or informative sessions.
- Set up procedures and make them available to hospital departments and community services.
- Organize health professionals training workshops.

5. Implement and evaluate impact

- Implement selected programs and policies.
- Monitor and evaluate the 'empowerment offer' as a whole (hospital + territory).
- Measure results and track progress to ensure improvements are achieved.





Healthy lifestyles empowerment process indicators:

Objective 1	To profile patients according to their risk factor and deliver individual counselling
Process Indicator	
Materials and training delivered to health professionals	
Output Indicators	
Proportion of patients profiled out of at-risk patients	
Proportion of patients participating to counselling out of profiled patients	
Outcome/Impact Indicators	
Proportion of patients aware of their risk factor, out of those receiving counselling (knowledge)	
Proportion of patients willing to change their risk factor, out of those receiving counselling (intentions)	
Proportion of patients modifying their risk factor by adopting behavioural change, out of those receiving counselling (behaviours)	
Objective 2	To engage patients in interactive workshops aiming at monitoring and changing their risk factors
Process Indicators	
Organisation of the interactive workshops	
Materials and training delivered to health professionals involved in the project	
Output Indicators	
Proportion of patients participating to first workshops out of those who received counselling	
Proportion of patients participating to workshops on average, out of those who received counselling	
Proportion of patients participating to last workshop able to measure and keep record of their risk behaviours (e.g. eating habits, physical activity)	



Outcome/Impact Indicators	
Proportion of patients aware of their risk factor, out of those participating to workshops (knowledge)	
Proportion of patients willing to change their risk factor, out of those participating to workshops (intentions)	
Proportion of patients modifying their risk factor by adopting behavioural change, out of those participating to workshops (behaviours)	
Objective 3	To redesign the hospital environment to be fully conducive in a health promotion perspective
Process Indicator	
Re-organisation of the hospital environment	
Output Indicator	
Proportion of patients benefiting from at least one hospital-based facility for health promotion (e.g., fitness centre, healthy food at the hospital canteen and cafeteria) out of profiled patients	
Outcome/Impact Indicators	
Proportion of patients aware of their risk factor, out of those benefiting from hospital-based health promotion facilities (knowledge)	
Proportion of patients willing to change their risk factor, out of those benefiting from hospital-based health promotion facilities (intentions)	
Proportion of patients modifying their risk factor by adopting behavioural change, out of those benefiting from hospital-based health promotion facilities (behaviours)	
Objective 4	To create <i>liaisons</i> with the hospital catchment area, useful to maintain and strengthen permanent healthy behavioural changes among patients
Process Indicator	
Survey on resources in the community and contact with relevant organisations	
Output Indicators	



Proportion of patients benefiting from at least one proposal of community organisations who adhere to the network (e.g., discounts for fitness centres, leisure-time activities) out of profiled patients

Outcome/Impact Indicators

Proportion of patients aware of their risk factor, out of those benefiting from *liaisons* with the community (knowledge)

Proportion of patients willing to change their risk factor, out of those benefiting from *liaisons* with the community (intentions)

Proportion of patients modifying their risk factor by adopting behavioural change, out of those benefiting from *liaisons* with the community (behaviours)





ANNEX 1 – Lifestyles and empowerment profile questionnaire

EMP-H Questionnaire

Male

Female

Your age (or date of birth):

Do you know your body weight and your height?

weight in kg _____ don't know height in cm _____ don't know

SECTION 1

1.1 In your opinion, is your current body weight detrimental to your health status?

YES NO

Which of the following is true:

I don't intend to reduce my body weight in the next six months

I am thinking to reduce my body weight in the next six months

I intend to reduce my body weight in the next month

I have reduced my body weight over the last six months

1.2 In the last year, how many times did you eat the following foods?



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1.2.1 fresh fruits and/or fresh or cooked vegetables

5 or more times each day	2-3 times a day	1 time a day	5-6 times a week	2-4 times a week	1 time a week	Less than 1 time a week	Never	Don't know
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1.2.2 soft drinks (with added sugar)

(cola, fruit juices from concentrated, carbonated energy drinks, etc)

4 or more times each day	2-3 times a day	1 time a day	5-6 times a week	2-4 times a week	1 time a week	Less than 1 time a week	Never	Don't know
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1.3 Thinking about your diet, do you believe quantity (calories) and quality (choice of foods) are correct to avoid chronic illnesses?

YES

NO

If your answer is NO, which of the following is true:

I don't intend to improve my diet in the next six months

I am thinking to improve my diet in the next six months

I intend to improve my diet in the next month





I have improved my diet over the last six months

SECTION 2

2.1. Do you smoke cigarettes?

NO YES

2.2 If you smoke, how many cigarettes do you smoke every day? _____

2.3 If you don't smoke now, did you smoke in the past?

NO YES

2.4 If you have been a smoker in the past and now you don't smoke, when did you quit ?

less than six months ago	between 7 months and three years ago	more than three years ago
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2.5 How soon after you wake up do you usually smoke your first cigarette of the day?

within half an hour	after half an hour
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2.6 If you are a smoker, which of the following is true:





I don't intend to quit smoking in the next six months

I am thinking to quit smoking in the next six months

I intend to quit smoking in the next month

I have already quit smoking over the last six months

SECTION 3

(please circle one answer only)

3.1 During the past 12 months, how often did you drink a glass of wine or a pint/can of beer or a shot of spirit?

Never	Once a month or less	2 to 4 times a month	2-3 times a week	4 or more times a week
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3.2 How many glasses of wine or pints of beer or shots of spirit do you have on a typical day when you are drinking?

MEN

1-2	3-4	5-6	7 to 9	more than 10
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WOMEN

1	2-4	5-6	7 to 9	more than 10
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3.3 How often do you have the following amount of alcohol on one occasion?

MEN

more than 5 glasses of wine or pints of beer or shots of spirits ?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
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WOMEN

more than 4 glasses of wine or pints of beer or shots of spirits ?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
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3.4 Thinking about your drinking habits, which of the following is true:

- I don't intend to reduce my alcohol consumption in the next six months
- I am thinking to reduce my alcohol consumption in the next six months
- I intend to reduce my alcohol consumption in the next month
- I have already reduced my alcohol consumption over the last six months

3.5 When you are drinking, do you drink alcohol:





With meals	Without meals	With and without meals
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SECTION 4

(Please select one answer only)

4.1 During the last year, did you participate in any vigorous physical activities

(noticeable increase in breathing, heartbeat and sweating, not able to talk during the effort) such as running, cycling or competitive sports ?

YES

NO

Don't know / Not sure

4.1.1 If yes, how many days a week?

Weekly

____ days weekly

Daily

Don't know / Not sure

4.1.2 If yes, how many minutes did you spend in those activities in a typical day when you were active?

less than 10 minutes

10 minutes

30 minutes

more than 30 minutes

more than one hour





Don't know / Not sure

4.2 During the last year, did you participate in any moderate physical activities

(slight increase in breathing, heartbeat and sweating, able to talk during the activity) such as walking, slowly cycling, dancing, gardening or housekeeping activities?

YES

NO

Don't know / Not sure

4.2.1 If yes, how many days a week?

Weekly

____ days weekly

Daily

Don't know / Not sure

4.2.2 If yes, how many minutes did you spend in those activities in a typical day when you were active?

10 minutes

30 minutes

more than 30 minutes

more than one hour

Don't know / Not sure

4.3 During the last year, the amount of physical activity you have undertaken was, in your opinion:

More than what is needed to improve my health

Just right to improve my health





- Not enough to improve my health
- Far from being useful to improve my health
- Don't know / Not sure

4.4 Thinking about your level of physical activity, which of the following is true:

- I don't intend to increase my physical activity in the next six months
- I am thinking to increase my physical activity in the next six months
- I intend to increase my physical activity in the next month
- I have increased my physical activity over the last six month

SECTION 5

(Please select one answer only)

5.1 Do you believe you can improve your health by changing your habits?

1 (not at all)	2	3	4	5	6	7	8	9	10 (entirely)	Unable to respond
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5.2 How **well-informed** do you think you are about the opportunities available at the hospital and in the area where you live to make your lifestyle healthier ?

1 (not at all)	2	3	4	5	6	7	8	9	10 (entirely)	Unable to respond
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5.3 How much of the **lifestyle-related advice** you receive from healthcare professionals do you follow ?

1 (not at all)	2	3	4	5	6	7	8	9	10 (entirely)	Unable to respond
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5.4 Do you look for **additional information** regarding how to adopt healthier lifestyles ?

1 (not at all)	2	3	4	5	6	7	8	9	10 (entirely)	Unable to respond
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5.5 Do you believe the environment where you live facilitates a healthy lifestyle?

1 (not at all)	2	3	4	5	6	7	8	9	10 (entirely)	Unable to respond
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5.6 To what extent do you feel able to draw your healthcare professionals' attention to the difficulties in changing your habits?

1 (not at all)	2	3	4	5	6	7	8	9	10 (entirely)	Unable to respond
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ANNEX 2 - Selected High Quality Systematic Reviews

Diet and Physical activity

Aguiar E.J.; Morgan P.J.; Collins C.E.; Plotnikoff R.C., and Callister R. Efficacy of interventions that include diet, aerobic and resistance training components for type 2 diabetes prevention: A systematic review with meta-analysis. *Int. J. Behav. Nutr. Phys. Act.* 2014; 11: 2

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Belanger-Gravel, A.; Godin, G.; Vezina-Im, L. A.; Amireault, S., and Poirier, P. The effect of theory-based interventions on physical activity participation among overweight/obese individuals: a systematic review. *Obesity Reviews.* 2011; 12(6):430-439

Bluethmann S.M.; Vernon S.W.; Gabriel K.P.; Murphy C.C., and Bartholomew L.K. Taking the next step: a systematic review and meta-analysis of physical activity and behavior change interventions in recent post-treatment breast cancer survivors. *Breast Cancer Res. Treat.* 2015; 149(2):331-342;

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Gagliardi, Anna R.; Faulkner, Guy; Ciliska, Donna, and Hicks, Audrey. Factors contributing to the effectiveness of physical activity counselling in primary care: A realist systematic review. 2015; 98(4):412-419;

Ghisi, Gabriela Lima de Melo; Abdallah, Flavia; Grace, Sherry L.; Thomas, Scott, and Oh, Paul. A systematic review of patient education in cardiac patients: Do they increase knowledge and promote health behavior change 2014; 95(2):160-174

Gourlan M.J.; Trouilloud D.O., and Sarrazin P.G. Interventions promoting physical activity among obese populations: A meta-analysis considering global effect, long-term maintenance, physical activity indicators and dose characteristics. *Obes. Rev.* 2011; 12(7):e633-e645

Hudon C.; Fortin M., and Soubhi H. Single risk factor interventions to promote physical activity among patients with chronic diseases: Systematic review. *Can. Fam. Phys.* 2008; 54(8):1130-1137

Knols R.H.; de Bruin E.D.; Shirato K.; Uebelhart D., and Aaronson N.K. Physical activity interventions to improve daily walking activity in cancer survivors. *BMC Cancer.* 2010; 10:406

Janssen V.; De Gucht V.; Dusseldorp E., and Maes S. Lifestyle modification programmes for patients with coronary heart disease: A systematic review and meta-analysis of randomized controlled trials. *Eur. J. Prev. Cardiol.* 2013; 20(4):620-640





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Larson, Janet L.; Vos, Carol M., and Fernandez, Dena. Interventions to increase physical activity in people with COPD: Systematic review. *Annu Rev Nurs Res.* 2013;31:297-326

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Sazlina, S. G.; Browning, C., and Yasin, S. Interventions to promote physical activity in older people with type 2 diabetes mellitus: a systematic review. *Front Public Health.* 2013; 1:71

Short C.E.; James E.L.; Stacey F., and Plotnikoff R.C. A qualitative synthesis of trials promoting physical activity behaviour change among post-treatment breast cancer survivors. *J. Cancer Survivorship.* 2013; 7(4):570

Spark L.C.; Reeves M.M.; Fjeldsoe B.S., and Eakin E.G. Physical activity and/or dietary interventions in breast cancer survivors: A systematic review of the maintenance of outcomes. *J. Cancer Survivorship.* 2013; 7(1):74-82;

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