



Editorial

Access to Evidence-Based Clinical Health Promotion for All Patients in Need Future – and Follow-up for Effect

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The critical problem/question

It is a challenge for patients to get access to relevant clinical health promotion (Clin-HP) during their healthcare journey. Lack of adding evidence-based Clin-HP to the clinical treatment is followed by reduced outcomes on short term, the development of new or aggravation of existing non-communicable diseases and the general health on longer term.

In the best of all worlds, all people should have open access to high-effective HP during their life course outside the healthcare (1). Today, however, this is not the case. Even in nations, regions and local communities with access to universal healthcare, Clin-HP is seldom offered to patients as part of their treatment; neither in short nor in complex healthcare journeys. The lost opportunity of integrating Clin-HP as part of a clinical treatment leads to a longer and a more troublesome patient journey with a heavier burden for the individual patient and the family as well as extra costs and lost investment for the healthcare and the society at large.

The facts

About 50-80% of the patients entering the healthcare have one or more risky lifestyle that directly influences their conditions and the effect of recommended treatment. Important risky lifestyles include (but are not limited to) smoking, nutrition problems, alcohol intake above the limit of risk or physical inactivity (SNAP). Classic example are people with diabetes type-II, chronic obstructive lung disease and ischemic heart disease, but risky lifestyles also counteracts the prognosis and outcomes in case of e.g. pregnancy, neurology and surgery.

The good message is that Clin-HP is cheap and the evidence for effect of intensive lifestyle intervention on disease development, aggravation and treatment outcome is solid.

Therefore, requirements of tailored patient information and identification of risky lifestyles are well integrated in most clinical guidelines and standard operation procedures developed by the scientific societies of the different clinical specialties, internationally, nationally or locally, e.g. the ASA score for preoperative evaluation of the surgical risk (2). Shining examples exist on long-term successful integration of effective Clin-HP to reduce the increased clinical risk originating from SNAP, such as the regional smoke-free psychiatry in Catalonia, Spain and the smoke-free surgery in the Västerbottens län in Sweden amongst many others. So far – so good!

However, most patients in need don't have access to the evidence-based Clin-HP, though it seems beyond common sense and good clinical practice.

Why don't we just offer evidence-based Clin-HP as part of the healthcare journey?

Numerous barriers have been reported – and systematic removal of those recommended to increase the delivery of more relevant Clin-HP to more patients (3). However, removal of barriers and meeting specific requirements does not guarantee an implementation effect, as shown previously even if including extra salary, establishment of easy referral for intervention, common development of smart information and follow-up with feed-back on success and failure rate, ownership and involvement by all involved parties amongst others (4).

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Editorial

Other important hindrances may be hidden in the shadows and therefore harder to put on the agenda, such as the very low priority of scheduled SNAP education and inclusion in the grading tests at medical schools, as reported in a Swedish study (5), and the general culture among health professionals considering e.g. cardiac surgery more esteemed than dealing with smoking cessation intervention, though cardiac diseases are often initiated and aggravated by smoking, and the surgical procedures are followed by a double complication rate among smokers. In addition to knowledge, own SNAP factors among management and health professional have shown to severely influence the implementation of e.g. smoking ban and smoking cessation intervention (6;7).

When adding the weak medical tradition for identifying (= diagnosing) the SNAP status as well as documenting the SNAP intervention (= treatment) and follow-up for effect (= result), the implementation may seem impossible. This in spite that validated and easy-to use tools have been developed long ago by the International Network of Hospitals & Health Services (8;9) as well as by the World Health Organization and many others. For this patient reported experiences and outcomes are needed, but validation of those are often lacking though needed, as shown in a recent study of the substantial difference between self-reported and objectively reported physical activity (10).

All over the healthcare, implementation is a challenge especially when involving patients as in SNAP intervention and processes of up to 17 years have been described. Altogether, implementation of Clin-HP involves innumerable visible and invisible barriers and hindrances to be removed before getting started. The main question is if this is the way forward?

The solution

An easier implementation process would be focus on the evidence-based implementation models that work in real life, and then translate and adapt this into own context – with a close follow-up for effect to make sure that you get the results you expect.

One of the newest and easy-to-use tools is the Fast-Track Implementation Model (Fast-IM), which significantly improves the implementation of the WHO Standards & Indicators for Health Promotion in Hospitals as well as the service delivery and follow-up of SNAP intervention over just 12 months. Furthermore, it is welcomed by the patients, the staff and the management (11). Fast-IM has been developed and successfully tested in a randomized controlled trial with clinical

departments from 38 member hospitals of the International Network of Health Promoting Hospitals & Health Services together with the World Health Organization. It is free to use (12). The Fast-IM is data-driven, requires few resources and includes capacity building, clear milestones to reach as well as effect evaluation. It works well with the reporting tool RE-AIM (13), which is used by many organizations to visualize the level of implementation in a certain period.

There are no really good reasons for further delay of implementing evidence-based Clin-HP to patients in need across their healthcare journey.

References

- (1) <https://www.un.org/development/desa/disabilities/envision2030.html> (accessed 31-12-2019)
- (2) <https://www.asahq.org/standards-and-guidelines/asa-physical-status-classification-system> (accessed 31-12-2019)
- (3) Nolan MB, Warner DO. Perioperative tobacco use treatments: putting them into practice. *BMJ*. 2017 Sep 6;358: j3340. doi: 10.1136/bmj.j3340.
- (4) Ralov H, Holm RH, Faurschou P, Tønnesen H. [Preoperative smoking cessation and alcohol quitting]. *Monthly J General Practice (DK)* 2005; 4: 505-10.
- (5) Krachler B, Jerdén L, Lindén C. Written Examinations in Swedish Medical Schools: Minds Molded to Medicate? *Am J Lifestyle Med*. 2017 Aug 18;13(6):611-614. doi: 10.1177/1559827617724338. eCollection 2019 Nov-Dec.
- (6) Willaing I, Jørgensen T, Iversen L. How does individual smoking behaviour among hospital staff influence their knowledge of the health consequences of smoking? *Scand J Public Health*. 2003;31(2):149-55. doi: 10.1080/14034940210164876.
- (7) Zabeen S, Tsourtos G, Campion J, Lawn S. Type of unit and population served matters when implementing a smoke-free policy in mental health settings: Perceptions of unit managers across England. *Int J Soc Psychiatry*. 2015 Nov;61(7):700-10. doi: 10.1177/0020764015575799.
- (8) Tønnesen H, Svane JK, Lenzi L, Kopecky J, Suurorg L, Rashida Khan Bukholm I, Hsu S-T, Hübner M, Krogerus S, Kellner-Rechberger S, Masiello MG, & the HPH Network in Tuscany, Italy; Spain; Ontario, Canada and Germany. Handling Clinical Health Promotion in the HPH DATA Model: Basic Documentation of Health Determinants in Medical Records of tobacco, malnutrition, overweight, physical inactivity & alcohol. *Clin Health Promot*. 2012;2(1):5-11.
- (9) Tønnesen H, Christensen ME, Groene O, O’Riordan A, Simonelli F, Suurorg L, Morris D, Vibe P, Himel S, Hansen PE. An evaluation of a model for the systematic documentation of the hospitals-based health promotion activities: results from a multicentre study. *BMC Health Serv Res*. 2007;7:145.
- (10) Dohrn IM, Gardiner PA, Winkler E, Welmer AK. Device-measured sedentary behavior and physical activity in older adults differ by demographic and health-related factors. *Eur Rev Aging Phys Act*. 2020 Jun 11;17:8. doi: 10.1186/s11556-020-00241-x. eCollection 2020.
- (11) Svane JK, Egerod I, Tønnesen H. Staff experiences with strategic implementation of clinical health promotion: A nested qualitative study in the WHO-HPH Recognition Process RCT. *SAGE Open Med*. 2018 Aug 13;6:2050312118792394
- (12) Svane JK, Chiou ST, Groene O, Kalvachova M, Brkić MZ, Fukuba I, Härm T, Farkas J, Ang Y, Andersen MØ, Tønnesen H. A WHO-HPH operational program versus usual routines for implementing clinical health promotion: an RCT in health promoting hospitals (HPH). *Implement Sci*. 2018 Dec 22;13(1):153. doi: 10.1186/s13012-018-0848-0.
- (13) Gaglio B, Shoup JA, Glasgow RE. The RE-AIM Framework: A Systematic Review of Use Over Time. *Am J Public Health*. 2013;103(6):e38-e46.