CDMP Framework Workflow

Understanding the Framework

Step 1 **Review the Ontario Chronic Disease Prevention and Management Framework diagram.**

Step 2 **Review the Element Definitions in CDPM**

Step 3 **Review the Logic Models**

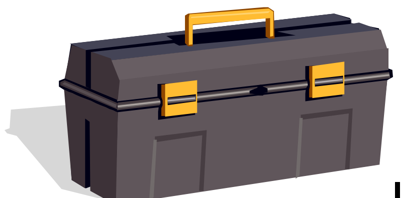
Applying the Framework

Step 4 **Complete Program Feasibility Checklist**

Step 5 **Complete the Logic Model for Program Planning**

Step 6 **Complete the "Initiating a Health Program Checklist"**

Step 7 **Revise Program (Logic Model) Plan as required**



Introduction:How to use the tool kit?

Many health care and health promotion organizations as well as communities and individuals play a role in chronic disease prevention and management (CDPM) therefore planning a CDPM initiative needs to be explicit and inclusive. In planning a CDPM initiative:

- How do you proceed?
- What is the purpose and scope of the initiative?
- Who are the recipients of the initiatives?
- Who are the partners and stakeholders?
- How does the initiative fit in the current, local system of CDPM?
- Are the objectives and deliverables identified?
- How will outcomes be measured?

The Grey Bruce Integrated Health Coalition CPDM Framework tool kit is a step by step approach to planning CDPM initiative, strategy or program.

To Begin:

Understanding the CDPM Framework

Step 1 Review the Ontario Chronic Disease Prevention and Management Framework diagram.

The Grey Bruce Integrated Health Coalition Chronic Disease Prevention and Management framework is based on the Ontario Chronic Disease Prevention and Management Framework (figure 1). The Ontario Chronic Disease Prevention and Management Framework is a picture of the components, relationships and interactions needed to improve clinical, functional and population health outcomes.

Step 2 Review the Element Definitions in CDPM

CDPM is a complex. Common language and definitions help to increase the understanding of CDPM. The following definitions are common to the Ontario and Grey Bruce Frameworks.

Individuals and families

Individual and families are at the centre of Chronic Disease Prevention Management (CDPM)). To achieve the best possible outcomes, they must be directly and actively involved in keeping themselves healthy and/or managing their chronic conditions(s). They work with providers to make decisions about their care. They understand the risk factors and disease process, and how in may affect them. They are supported and empowered to manage their day-to-day health, to direct their care, and to make informed choices. Care is person-centred, rather than provider or disease-centred.

Health Care Organization

Health care organizations include all those who deliver services as well as those who plan, fund and coordinate services (e.g.: public health units, family health teams, community health centres, hospitals, community agencies, other health practitioners, the Ministry of Health and Long Term Care, the Local Health Integrated Networks (LHINs), provincial associations, and provincial and regional service networks). Their role is to champion the changes required to shift from reactive episodic acute care to proactive chronic disease prevention and management. Health care organization work with individuals and families with other health care organization and with their community to develop the full range of high quality health services required to prevent and manage chronic disease. To make the kind of fundamental change in service delivery, health care organization:

- Provide strong leadership that visible support CDPM
- Align resources and incentives to support a system approach to chronic disease prevention and management
- Are accountable for services and outcomes; they set goals, evaluate the effectiveness of their services and strategies, and use performance results to continually improve quality of care and support organizations changes.

1. **Personal Skills and Self-Management Support**:

   When individuals and families have access to the right information, support and resources, they develop the knowledge and skills they need to play a more active role in managing their health and coping with disease. Certain types of self-management support are effective in helping people set goals, overcome barriers and challenges, and manage their health day by day.

   - Shared decision-making
   - Education and skills development
   - Behaviour modification programs
   - Counselling and supportive services
   - Links to community services
   - Links to community resources

- Follow-up

2. **Delivery System Design**:

Delivery systems for CDPM must be designed to focus on prevention (i.e.: primary prevention for people who are healthy, and secondary and tertiary prevention to keep people who have an illness from developing further complications), to improve access to and continuity of care, and to help people move easily between services and health care providers.

A delivery system designed to prevent and manage chronic diseases has the following features:

- An interdisciplinary team
- Focus on health promotion and wellness
- Planned interaction, active follow-up and easier navigation thought the system
- The capacity to tailor services to meet individual needs
- Capacity to provide culturally competent care
- Innovative practices
- Surveillance system

3. **Provider Decision Support**:

To provide consistent, proactive care, the team uses tools and resources that will help them develop evidence-based care plans and make informed decision. Decision support includes:

- Educational and training
- Clinical management tools
- Access to expertise
- Performance measurement systems

4. **Information Systems**

Information systems support all aspects of chronic disease prevention and management by connecting members of the team, providing effective ways to monitor individuals' needs and care, and maintaining timely accurate information to help guide care. They give team members easy access to the decision support tools and other information they need to plan care, make clinical decisions, and coordinate services across the health system. Information systems also help individuals and families with their own self-management and care.

They include:

- Information technology systems that connect team members, sites and data
- Electronic health records
- Registries
- Interactive tools and software
- Health information for individuals and families
- Health care organizations

Community

The community collaborates with health care organization to: identify priority health issues for the community; link and coordinate services for individuals and families; and minimize threats to health. The community plays a key role in addressing the social determinants of health. Examples of community: schools, churches, municipalities, recreation centres, chambers of commerce, service clubs, YMCA, Parks Canada, First Nations, agricultural organizations, safety associations.

1. **Healthy Public Policy**:
   Improving the overall health of the population – including preventing and managing chronic disease – is a shared responsibility. To influence the many determinants of health, a variety of sectors – health, education, justice, labour, social services, housing, transportation, technology, recreation – must work together to improve individual and population health and reduce inequality. All must be actively engaged in developing and supporting healthy public policies that will ultimately lead to the prevention and reduction of chronic disease.

   Healthy public policies help people who are well stay healthy and people with chronic disease take care of their health. In a systems approach to CDPM, healthy public policy involves health care organization working with community partners to advocate for changes such as:
   - Legislation and regulations
   - Fiscal policies
   - Guidelines
   - Organizational policies

2. **Supportive Environments**:
   People are more likely to be empowered to prevent and manage their chronic diseases if they live in supportive environments where it is "easier" to make healthy choices. Supportive environments remove barriers to healthy living, and promote living and working conditions that are safe, stable, secure and enjoyable. They give people more opportunities to be healthy and they enhance self-reliance.
   - Supportive physical environments
   - Supportive social environments

3. **Community Action**:
   Effective chronic disease prevention and management depends on communities being able to take action on issues that affect their overall health. Community action engages people and organizations, and uses the wisdom of the community to find solutions to often complex problems.

As part of CDPM, the health care sector collaborates with other sectors and parts of the community to share their knowledge, expertise, strengths, and resources to create a healthier community. They identify key issues, build trust and relationships, and work together to find shared solutions. Community action is an important element of CDPM because many of the major determinants of chronic disease are outside the health care sector.

- Community engagement/mobilization
- Community partnerships/coalitions

Adapted from Ontario Ministry of Health and Long Term Care (2005) *A Systems Approach to Chronic Disease Prevention and Management in Ontario: A framework.*

Productive interactions and relationships – Interactions (e.g. education, coaching, treatment) and relationships (e.g. hospitals, public health, family health teams) resulting in a coordinated, integrated approach that focuses on the person and not the disease. The goal is to reduce and control symptoms and to help the individual lead a healthier life (Adapted Hindmarsh, 2006).

Activated communities and prepared, proactive community partners - Information, programs, services and policies in communities that support individuals in healthy living and to manage their condition. Partners are knowledgeable in chronic disease prevention and management, prepared to support healthy living as routine and anticipate the support needed to maintain a healthy life style. Communities are collaborating across sectors and with health care organizations to identify and meet the needs of their population. Individuals and families are linked to community resources (Keast, 2006)

Informed, activated individuals and families – Directly and actively involved in keeping themselves healthy and managing their chronic condition. Work with providers to make decisions about their management. They understand the disease process, are part of the care team and realize his/her role as the daily self manager. Family and caregivers are engaged in the individual's self- management. (McColl Inst. For Health care Innovation, Group Health Cooperative of Puget Sound)

"The provider is viewed as a guide on the side, not the sage on the stage"
Keast, 2006

Prepared, proactive practice teams – Practice teams bring together individuals and families, different health care practitioners, community providers and volunteers. The team members have a common goal, understand each member's skills, roles and expertise. The team has consumer information, decision support, people, equipment and time required to deliver evidence-based clinical management, health promotion/prevention and self-management support (Keast, 2006, adapted from McColl Inst. For Health care Innovation, Group Health Cooperative of Puget Sound)

Step 3 Review the Logic Models.

The Grey Bruce framework (figure 2, 3) consists of a high level logic model defining the mission, inputs, components, outputs, outcomes and vision. A mid-level logic model defines roles and responsibilities.

Why a logic model?

If you don't know where you're going, how are you gonna' know when you get there?

–Yogi Berra

A logic model is defined as "a picture of how your organization does its work – the theory and assumptions underlying the program. A program logic model links outcomes (both short- and long-term) with program activities/processes and the theoretical assumptions/principles of the program… a systematic and visual way to present and share your understanding of the relationships among the resources you have to operate your program, the activities you plan, and the changes or results you hope to achieve." (Kellogg, 2004).

Logic Model Terms

Inputs: Describes those resources that will be allocated to an initiative including knowledge, skills and expertise, financial and human resources (Videre).

Components: Describe the major activities of the program in one or two words (Letts, 1999)

Outputs: Establish the linkages between the current situation and the impact (outcomes) of the initiative (Videre).

Outcomes: Answer the question "What happened as a result of the initiative?" and are useful to communicate the impact of the investments in the initiative (Videre).

The Grey Bruce Integrated Health Coalition CDPM Framework Logic Model

The Grey Bruce Health Coalition CDPM Framework Logic Model consists of a number of elements. The high level logic model divides into three distinct but interrelated components:

- Community Capacity and Integration
- Individual and Family Capacity and Integration
- Health Care Organization (HCO) and Provider Capacity and Integration.

The logic model begins with a description of the mission. To achieve the vision outcomes are established but the timelines differ with outcomes set for shot-term, intermediate and long-term achievement.

The mid-level logic model maps out the roles and responsibilities for each of the three components' stakeholders but further refines the definitions according to levels of health promotion and prevention:

- health promotion
- primary prevention
- secondary prevention
- tertiary prevention

Definitions: Levels of Health Promotion and Prevention

The Grey Bruce Integrated Health Coalition CDPM Framework logic model identifies levels of population management for health promotion and prevention:

Health Promotion
Health promotion is the process of enabling people to increase control over, and to improve their health (Ottawa Charter for Health Promotion. WHO, Geneva,1986).Health promotion represents a comprehensive social and political process, it not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. Health promotion is the process of enabling people their impact on public and individual health. Health promotion is the process of enabling people. (WHO, 1998)

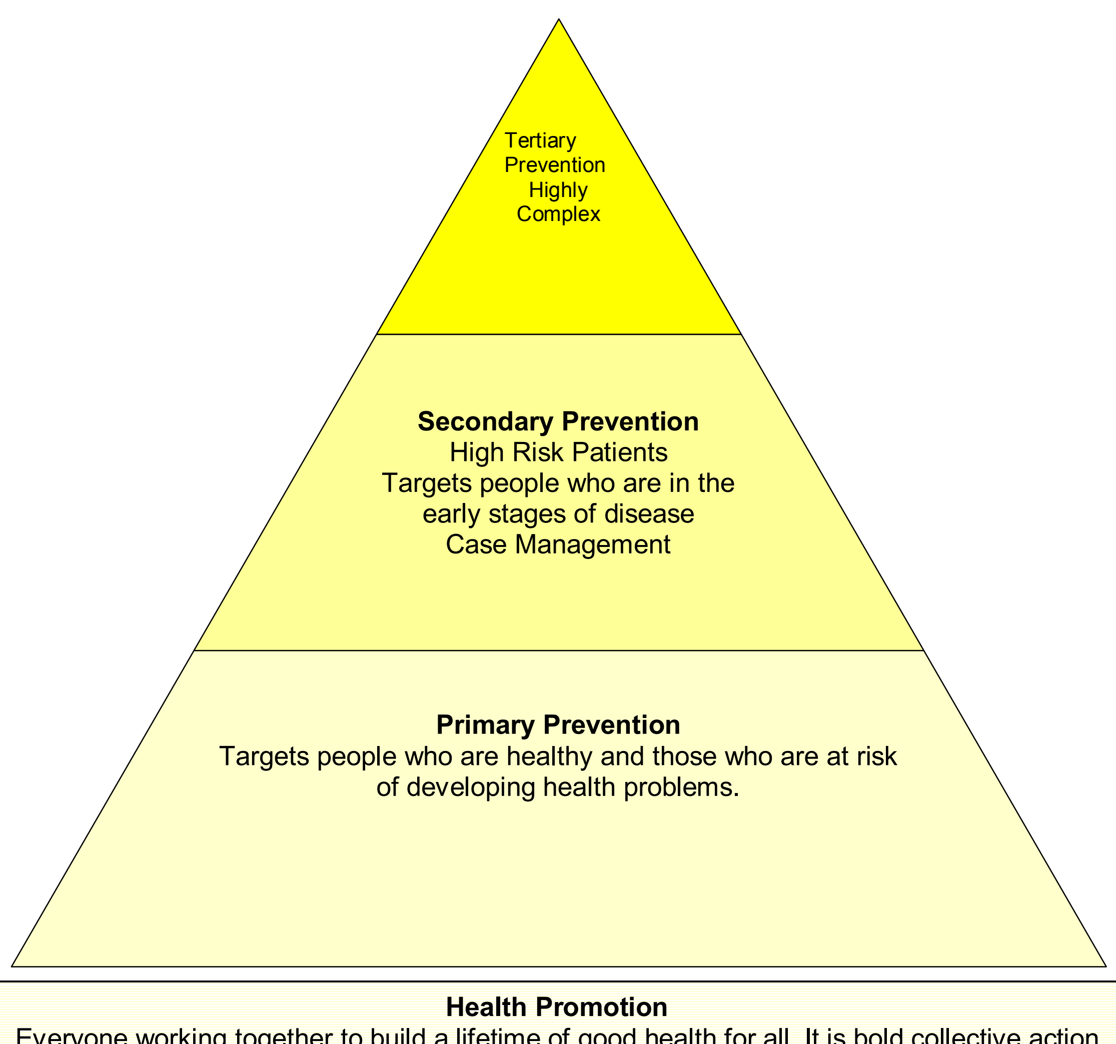
Primary Prevention (Level 1)
With the right support many people can learn to be active participants in their own care, living with and managing their conditions. This can help them to prevent complications, slow down deterioration, and avoid getting further conditions. The majority of people with chronic conditions fall into this category – so even small improvements can have a huge impact. (Department of Health, 2004)

Secondary Prevention (Level 2)
Disease/care management, in which multidisciplinary teams provide high quality evidence based care to patients, is appropriate for the majority of people at this level. This means proactive management of care, following agreed protocols and pathways for managing specific diseases. It

is underpinned by good information systems – patient registries, care planning, and shared electronic health records (Department of Health, 2004).

Tertiary Prevention (Level 3)
As people develop more than one chronic condition (co-morbidities), their care becomes disproportionately more complex and difficult for them, or the health and social care system, to manage. This calls for case management – with a key worker (often a nurse) actively managing and joining up care for these people (Department of Health, 2004).

Levels of Health Promotion and Prevention



(Adapted from Department of Health, 2004)

Glossary of Terms used in Grey Bruce Health Coalition CDPM Logic Model (See Appendix A)

Steps 4-7: Building Your Program

You are now ready to build your program. The following questions can be used as an exercise to think through the elements, linkages, business implications, appropriateness, and feasibility of the program or service plan.
Tools to assist with program development include:

- **Service/Program Feasibility Review**: explores the scope and appropriateness of the potential program. Chart the client journey especially services accessed by the client to ensure that your client has consistent messaging and intervention from all services (See example).
- **Logic Model for Program Planning**: provides a template, with supporting information, to develop a program plan and evaluation, using the logic model design.
- **Initiating a Healthcare Program (Checklist)**: reviews the key plan elements necessary for a comprehensively designed program that is congruent with the CDPM Framework. Completion of this tool identifies any gaps in the draft program plan, and supports the final plan content.

Questions to help the planning process –
Answering the questions may help in conceptualizing your program and producing data and information for your planning**.** We have included an example which may be helpful.

Example: The ACME health service has identified a need to increase prevention and risk modification to individuals with CD or those individuals at risk of CD. CD is a grouping of symptoms resulting from eating high fat foods, being inactive, smoking and drinking large quantities of alcohol. It is usually managed through lifestyle interventions and therapeutic interventions such as medications. Where do ACME team start?

✓Chart the individual with CD typical journey.
✓Star areas of contact or influence.
✓For each contact remember to list all providers – some contacts such as CCAC may have multiple providers.
✓Remember the key messages: The client always encounters a client-focused approach and consistent messaging about CD.

Charting the journey

Not feeling well →Seeks information on the internet and at the library*. → Unable to get comprehensive answer so visits the doctor*. Doctor prescribes medication to reduce symptoms and improve some impact of CD.→ Referred the ACME for risk modification counselling* and goes to the pharmacist for medication*. →Acme suggests enrolling in a healthy weights program at the clinical nutrition clinic*, arranges for a personal trainer at the Y*, and a smoking cessation course with public health*. →Client asks that the family be involved.* →Client delays initiating the program until after the summer holidays and falls following a party and is admitted through the local ER* and has a 2 day stay in hospital*.→Due to injuries suffered, he is referred to CCAC*. →Returns to ACME to resume self-management plan but wants to add an evaluation of drinking through the local addictions centre*. Client works well with follow up on the established goals for 6 months. Suddenly following a death in the family he feels he is regressing and is depressed. →Returns to the family doctor and is referred to the mental health program*. Depression begins to improve and the client returns to working on his goals.

List the contact points.

Questions?

1. What type of initiative is planned? (Strategy, project, program, research, guideline, policy, education, communication, marketing, collaboration- networking)
Notes:

Acme is looking a starting a collaborative network of health and community providers to ensure consistent messaging and approaches to CD.

2. What is the scope of the initiative? What does the initiative hope to achieve? (management of disease, health promotion, prevention, capacity building)
Notes:

Acme hopes to build capacity within the health and community system to effectively and efficiently manage and prevent CD.

3. Do similar initiatives exist? Locally? Distance?
Notes:

Yes. There are initiative for obesity in children and an alliance for health promotion and prevention.

4. If yes, how would Grey Bruce benefit from this initiative?
Notes:

It would be concentrated on a large risk population in Grey Bruce who are not managed well. It would ensure a move to consistent messaging and best practice. Could be the start of a large coalition to address similar conditions.

5. Referring to the Health Promotion and Prevention Pyramid, what is the level of involvement for this initiative?
Notes:

Primary and secondary prevention primarily.

6. Should my organization be involved in the levels this initiative is designed to address? (Examine the mandate of your organization.)
Notes:

Yes. Our mandate is to assist in the modification of risk factors on an individual level.

7. Is my organization ready for the change in practice which would result from this initiative?

ACME is frustrated with the status quo and has committed to changing the current, fragmented approach to CD.

8. Who is the target audience/client/consumer? (Example: public, risk populations, individuals, providers, families)
Notes:

Though the improved practice would assist individuals with CD the collaboration is targeting health and community service providers.

9. What partners need to be involved to achieve the goals of this initiative? (Example: community agencies, public health, hospitals, LHIN, advocates)
   Notes:

The list of contacts as indicated on the journey plus initiatives which would also benefit due to similar risk factors and shared populations – Cardiac rehab, Regional diabetes, district stroke centre, First Nations Health, Active 2010

10. What are the roles and responsibilities of my organization in this initiative?
    Notes:

Initiate the gathering of the stakeholders, get buy in, facilitate a planning process, lead the planning process until a coalition/network is formed.

11. What outcomes fit my organization's mandate?
    Notes:

Having consistent messaging and approaches from each provider influencing an individual with CD should result in better health outcomes and a reduction in risk behaviours.

12. At what levels– health promotion, prevention, secondary prevention or tertiary prevention - are outcomes defined?
    Notes:

Most of the outcomes will be defined at the prevention and secondary prevention level but for consistency the tertiary level needs to be part of the coalition.

13. Are the outcomes measurable? (SMART)
Notes:

The outcomes are defined and measurable. Timelines may be optimistic.

14. Can areas of misunderstanding or “Fuzziness” in your initiative be identified? Can these areas be made more explicit?
Notes:

Need to ensure a clear understanding of the initiative and the advantages of consistency. Do not want participants to think we are on their territory.

15. Do you know who to ask to help you with this process?
Notes:

We know to contact the Grey Bruce Health Network CDPM task team for help.

Application of the CDPM Logic - Lessons Learned (To go in the section with the examples)

Here are some comments from organizations who have applied the CDPM Framework Logic Model their initiative:

District Stroke Centre

- A good exercise. Explicitly explains our relations, roles and responsibilities.
- Health Care organization and the individual component of the model are easy to complete
- Identifying outputs succinctly is challenging
- Community component is challenging due to the need to be inclusive
- Identify time frames of outcomes – used 1 – 5 years with stroke
- Outcomes will depend on disease process or the goal of the initiative
- For stroke dividing Health Care Organizations into Education, Evidence Base Practice etc was helpful
- Need to identify partners and relationships
- Need a glossary of terms e.g. International Classification of Function – can add this to the Definitions in the Model
- Outcomes section forces you to indicate how you would measure the outcome.
- Model helps to identify where we needed to strengthen relationships
- Self Management – messages or skills sets are the same with different groups

Priisme Project (Diabetes)

Appendix A: Glossary of terms used in Grey Bruce Integrated Health Coalition CDPM Logic Model

Capacity: "the actual knowledge, skill sets, participation, leadership and resources" required by community groups to effectively address local issues and concerns (Ontario Health Promotion Resource System (OHPRS)
.
Integration: "The process involving the establishment of greater interdependence between the parts of a living being or between members in society, It strengthens the connections among stakeholders involved in a organized system who work together on a collective project" (Le Robert, 1998; Contandriopoulous et al, 2003)

Interdisciplinary: Interdisciplinary is defined as the ability to analyze, synthesize and harmonize links between disciplines into a coordinated and coherent whole (Canadian Institutes of Health Research, 2005).

Primary health care: Primary health care is essential health care made accessible at a cost a country and community can afford, with methods that are practical, scientifically sound and socially acceptable (Alma Ata Declaration, WHO, Geneva, 1978).

Disease prevention: Disease prevention covers measures not only to prevent the occurrence of disease, such as *risk factor* reduction, but also to arrest its progress and reduce its consequences once established (adapted from Glossary of Terms used in Health for All series. WHO, Geneva, 1984)

Health education
Health education comprises consciously constructed opportunities for learning involving some form of communication designed to improve *health literacy*, including improving knowledge, and developing *life skills* which are conducive to individual and *community health* (WHO, 1998).

Community: A specific group of people, often living in a defined geographical area, who share a common culture, values and norms, are arranged in a social structure according to relationships which the community has developed over a period of time. Members of a community gain their personal and social identity by sharing common beliefs, values and norms which have been developed by the community in the past and may be modified in the future. They exhibit some awareness of their identity as a group, and share common needs and a commitment to meeting them (WHO, 1998).

Community action for health: *Community action for health* refers to collective efforts by communities which are directed towards increasing community control over the *determinants of health,* and thereby improving *health* (WHO, 1998).

Determinants of health: The range of personal, social, economic and environmental factors which determine the *health status* of individuals or populations (WHO, 1998).

Empowerment for health: In health promotion, empowerment is a process through which people gain greater control over decisions and actions affecting their health (WHO, 1998).

Enabling: In health promotion, enabling means taking action in *partnership* with individuals or groups to empower them, through the mobilization of human and material resources, to promote and protect their *health* (WHO, 1998).

Health behaviour: Any activity undertaken by an individual, regardless of actual or perceived *health status*, for the purpose of promoting, protecting or maintaining *health*, whether or not such behaviour is objectively effective towards that end.
(Health Promotion Glossary, 1986).

Health communication: Health communication is a key strategy to inform the public about health concerns and to maintain important health issues on the public agenda. The use of the mass and multi media and other technological innovations to disseminate useful health information to the public, increases awareness of specific aspects of individual and collective health as well as importance of health in development(adapted from Communication, Education and Participation: A Framework and Guide to Action. WHO (AMRO/PAHO), Washington, 1996)

Health policy: A formal statement or procedure within institutions (notably government) which defines priorities and the parameters for action in response to health needs, available resources and other political pressures (WHO, 1998).

Lifestyle (lifestyles conducive to health):
Lifestyle is a way of living based on identifiable patterns of behaviour which are determined by the interplay between an individual's personal characteristics, social interactions, and socioeconomic and environmental *living condition* (WHO, 1998)*s*.

Network: A grouping of individuals, organizations and agencies organized on a non hierarchical basis around common issues or concerns, which are pursued proactively and systematically, based on commitment and trust (WHO, 1998).

Risk behaviour: Specific forms of behaviour which are proven to be associated with increased susceptibility to a specific disease or ill-health(WHO, 1998).

Risk factor: Social, economic or biological status, behaviours or environments which are associated with or cause increased susceptibility to a specific disease, ill health, or injury.

Self Management: "involves (the person with the chronic disease) engaging in activities that protect and promote health, monitoring and managing the symptoms and signs of illness, managing the impact of illness on functioning, emotions and interpersonal relationships and adhering to treatment regimes"(Centre for the Advancement of Health as cited in The Flinders Model of Chronic Self-Condition Management, 2006, p.2).

Supportive environments for health: Supportive environments for health offer people protection from threats to *health*, and enable people to expand their capabilities and develop self reliance in health. They encompass where people live, their local *community*, their home, where they work and play, including people's access to resources for health, and opportunities for *empowerment*. (adapted from Sundsvall Statement on Supportive Environments for Health. WHO, Geneva, 1991)

Appendix B

How to find the most trustworthy health information on the Internet

Being able to have more control over and improve our health is what health promotion is all about. At the CHN, we believe that having access to trustworthy health information is key to our ability to take control over and improve our health. The Internet offers a richness of health information, but wading through hit after hit to find *trustworthy, high quality and health promoting* information can be difficult. How do you know what's good information and what's less reliable? In consultation with a panel of experts on health information, we have put together a checklist to help you in your search for health information on the Internet.

Checklist for a great health promotion Web site

Is the resource credible?

- Is the author's name (or the name of the organization responsible for the document) clearly stated?
- If the author is identified, is he or she a professional or accredited authority on the subject?
- If not, does the author state his/her perspective on the subject? For example, by saying "I'm a cancer survivor," or "I've used chiropractors for 10 years"?
- If an organization is responsible for the information, is it a reputable organization recognized as an authority on the subject?
- If medical information is given by a non-professional, is this clearly said?
- What kinds of evidence are provided to endorse a specific treatment or service? Keep in mind that scientific studies and research have a different credibility than first-hand experience.
- Does the site provide contact information about the author (for example, full name, address, phone number, e-mail address)?

Is the content relevant to you?

- Does the content discuss the issue(s) you're interested in?
- Does it match what you are looking for?
- Is there enough detail or does the information seem superficial?
- Does the site have original content or does it only link to other sites?
- Is the information presented within a Canadian context?

✓ Does the site reflect a broad view of health?

For example, does the content seem to recognize that health:

- has many elements
- is dynamic and changing
- can be different for different groups of people, and
- is determined by many factors, including basic things like income?

✓ Is the resource timely?

- Is the information reviewed and/or updated often enough given the content? For example, if it deals with the latest in safety features on child car seats, has it been changed lately?
- Is the date of the last update clearly marked on each item or screen?
- If information is only valid for a short time, is this fact clearly labeled?

✓ Is there clear and adequate disclosure?

- Is the author's interest and/or mandate in developing and sharing this information clear? For example, is a non-profit organization trying to promote exercise and active living or is a fitness product company trying to sell you exercises equipment?
- Is there potential for bias or conflict of interest? For example, is a company telling you that only their product or service is valuable?
- Are both (or all) sides of the issue presented?
- If not, does the resource state that it presents only one side of an issue? For example, a site that promotes a vegetarian diet should indicate that there are other dietary options, or clearly state that they are only presenting one side of a multifaceted issue.
- Are commercial links and/or sponsorships clearly stated?
- Are these sponsorships separate from the health information content?
- If the site collects or requests information about you, do they tell you exactly why they want this information?
- Are their privacy guidelines stated?
- If you have to register to use the site, is the reason clear and your privacy ensured?

✓ Are there clear caution statements?

- Does the site offer a clear statement that health information should not be taken as health advice or a substitute for visiting a health professional?
- If there are fees associated with use of the resources on the site, are they clearly explained?

✓ Is the site user-friendly?

- Is the information presented in a clear manner?
- Can you contact the author/administrator by e-mail if you have difficulties using the site

✓ Is the site accessible to groups with all types of income, education, culture and other similar factors?

- For example, if users can download information from the site, is there a toll-free number so people without the proper software can get the information they need in another format?

✓ Does the site treat you with respect?

- For example, is the "voice" the site uses to talk to readers friendly? An example of an unfriendly voice is one that seems to place all of the responsibility for health on the individual; a friendly, health promoting site would recognize the many other factors that affect people's health.

Does the site support a variety of activities?

- For example, is there mention of ways to address your concerns through, for example, community-building or advocacy?

Does the site give you opportunities to participate?

- For example, is there an e-mail address where you can write to offer feedback, make

suggestions, or get involved in actions in your area of concern?

(Canadian Health Network, 2007)