Supporting Knowledge into Action: 
The Canadian Best Practices Initiative for Health Promotion and Chronic Disease Prevention

Nina Jetha, Kerry Robinson, Tricia Wilkerson, Nancy Dubois, Vincent Turgeon, Marie DesMeules

ABSTRACT

Public health practitioners and policy-makers working to address the burden of chronic disease are increasingly seeking to use best practices given the need to make thoughtful program and policy choices with limited resources. While the evidence base in chronic disease prevention is growing through a number of different information sources, there is often a disconnect between the desire to use best practices and their implementation. This is related not only to individual and organizational barriers in terms of time and resources, but also to lack of agreement on what constitutes best practice and what sources of evidence are valid guides for practice. This is compounded by lack of user-friendly and streamlined access to credible best practice evidence and decision making/practice supports. In response to these needs, six years ago Canadian researchers, policy-makers and practitioners came together to begin working on creating a best practice system in Canada for health promotion and chronic disease prevention. This article presents an overview of the development of the Canadian Best Practices Portal and in particular how an evolution in thinking about best practice methodology and evidence will contribute to an enriched knowledge base for health promotion and chronic disease prevention policy, practice and research.

Key words: Health promotion; chronic disease; program effectiveness; best practice analysis

Accountability and Effectiveness in Public Health

Quality assurance, evidence-informed decision making and best practices have become important guideposts for public health action during a time when public health system performance has come under increased scrutiny.1-3 Maibach et al.4 note “evidence-based disease prevention practice guidelines are the logical culmination of the health community’s investment in prevention research in that they can provide a rationale for public health program decision making at the local, state, and national levels.” It is a question of accountability: decision-makers need to be certain that the time, energy and money they allocate will translate into effective, concrete results.

The increased emphasis on ensuring effective public health practice requires a number of efforts designed to increase the capacity for evidence-informed decision-making. Recent research identified the need in Canada for “a standardized, widely disseminated and high-quality repository summarizing the current scientific evidence, from multiple disciplines, on the relative effectiveness and efficiency of key population and public health interventions.”5 Further, we know information alone will not result in change. Incorporation of best practices and evidence into routine decision making in public health organizations requires capacity building and organizational learning6 (focused on developing communication strategies, enhancing knowledge and skill bases, creating supportive infrastructures and allocating funding for implementation support).7,8

However, there are numerous challenges to supporting the use of best practice in health promotion and chronic disease prevention. Choosing a best practice is sometimes a matter of educated guesswork. Terms like “best” may or may not be synonymous with “recommended,” or “better,” and even when the same labels are used, they may or may not mean the same thing. The criteria for “best” often vary from one source to another, making it almost impossible to tell how programs differ from one another, or how they might complement one another. Sifting through multiple, sometimes inconsistent or contradictory sources of information is time-consuming, overwhelming and often confusing. The onus is often on the individual practitioner not only to find evidence on interventions, but also to decide whether that source was credible and how information might be adapted or used in their community setting. Few dissemination mechanisms for effective practice (i.e., websites) have knowledge exchange and/or uptake strategies to provide decision-making support and increase the likelihood that they will be used.

In response to these needs, in 2002 the Centre for Chronic Disease Prevention and Control within the Public Health Agency of Canada began collaborating with a broad range of health promotion and chronic disease practice, policy and research experts to

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Further Information: For further information, visit the Best Practices Portal at www.phac.gc.ca/cbpp. To nominate a resource, an intervention, or a systematic review for review for inclusion on the Portal, visit http://cbpp-pcpe.phac-aspc.gc.ca/nominate/index_e.cfm.

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develop the framework for the Canadian Best Practices Initiative (CBPI). This insert focuses on the first phase of the CBPI: the development of the Canadian Best Practices Portal and ongoing evolution in the understanding of evidence and related methodology behind the Canadian Best Practices Initiative – how it began, why it is changing, and how the Portal will be a richer venue for evidence-informed decision making and knowledge exchange for health promotion and chronic disease prevention.

Why a Canadian Best Practices Initiative? A Brief History

The CBPI’s roots began at a 2001 think-tank of like-minded public health professionals and researchers interested in influencing how health promotion intervention research information was collected, described, communicated and used in practice. An environmental scan, systematic review, gap analysis and needs assessment led to the recognition of a need for a consolidated approach to identifying and sharing best practices in Canada.

Best Practice Models from Other Jurisdictions

A review was undertaken of relevant Canadian and international literature on models and processes for identifying best practices in chronic disease prevention (i.e., US Preventive Services Task Force, WHO, Cochrane and Campbell Collaborations, Australian National Public Health Partnership, International Union of Health Promotion and Education) to compare definitions of best practices, labels, nomination, assessment and analysis process including criteria and types of evidence used. Only 2 of the 24 best practice models/processes reviewed were based on the same assessment methodology, illustrating the need for a coordinated and consistent approach to the assessment, labelling and dissemination of best practices in Canada.

Despite the diversity of methods to assess whether interventions qualified as “best practices” (or the equivalent term used by the author), one aspect was consistent: the intervention had to have been evaluated using the “gold standard” of a Randomized Control Trial (RCT) design. However, very few health promotion interventions were evaluated using an RCT design; therefore a second “level of evidence” was accepted as the “silver medallist.” Jackson et al. undertook a similar review and concluded that inclusion criteria for best practices need to be broadened to include both qualitative and quantitative studies as well as criteria beyond the quality of evaluation design. Finally, although some interventions are labelled as best, the real decision to implement a particular pro-

gram or not should rest with the program planner. Thus, judgement as to what is “best” cannot be made in a generalizable way.

Needs from the Field

In 2005, an informal online survey was conducted of health promotion and chronic disease prevention practitioners and policy-makers as potential users of a best practice initiative. Survey respondents (n=498) represented all provinces and were primarily affiliated with local/regional public health departments (or regional health authorities (35.2%), non-governmental organizations (12.5%), universities (11.3%), hospitals (11.3%), federal/provincial/territorial government (18.0%), federal/provincial/territorial resource agencies (3.1%), private sectors (3.1%) and others (5.5%) (see Table I)."

<table>
<thead>
<tr>
<th>TABLE I</th>
<th>Survey Respondent Characteristics (categories presented had highest frequency)</th>
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</thead>
<tbody>
<tr>
<td>Female</td>
<td>86%</td>
</tr>
<tr>
<td>Role: practitioner</td>
<td>64%</td>
</tr>
<tr>
<td>Work in large organization with over 500 employees</td>
<td>37%</td>
</tr>
<tr>
<td>Work in large urban area</td>
<td>42%</td>
</tr>
<tr>
<td>Involved in health promotion for over 10 years</td>
<td>49%</td>
</tr>
</tbody>
</table>

Survey respondents indicated they currently sought evidence on chronic disease prevention from printed literature most often (Table II), with websites highlighted most frequently as the most useful information source. Information was also gathered on potential features of a best practices website (Table III).

<table>
<thead>
<tr>
<th>TABLE II</th>
<th>Sources of Evidence about Chronic Disease Prevention and Control</th>
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</thead>
<tbody>
<tr>
<td>Printed academic literature</td>
<td>87%</td>
</tr>
<tr>
<td>Websites</td>
<td>85%</td>
</tr>
<tr>
<td>Provincial health and recreation organizations</td>
<td>66%</td>
</tr>
<tr>
<td>Non-government, voluntary organizations</td>
<td>64%</td>
</tr>
<tr>
<td>Listservs</td>
<td>51%</td>
</tr>
<tr>
<td>Other</td>
<td>16%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TABLE III</th>
<th>Features of a Best Practices Website Listed as Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listing of identified best practices</td>
<td>90%</td>
</tr>
<tr>
<td>Suggested ways to use best practices evidence</td>
<td>82%</td>
</tr>
<tr>
<td>Links to best practices sites</td>
<td>78%</td>
</tr>
<tr>
<td>Information about how to determine what is a best practice</td>
<td>58%</td>
</tr>
<tr>
<td>How best practices were determined (methodology)</td>
<td>48%</td>
</tr>
<tr>
<td>Interactive opportunities to exchange knowledge with researchers, practitioners and policy-makers (46% very important, 44% somewhat important)</td>
<td>46%</td>
</tr>
</tbody>
</table>

The result of this preliminary research demonstrated the need for reliable, trustworthy information, accessible to professionals working in health promotion and chronic disease prevention across the country. A Web portal was identified as an effective way to disseminate best practices information to the widest possible audience.

A limitation of the survey was that in the absence of any existing databases of relevant public health-related professionals, a snowball sample was used and survey invitations were distributed via a number of health promotion-related listservs and chronic disease networks and alliances that encouraged recipients to pass the invitation along to interested colleagues.
Building the Canadian Best Practices Portal

From its earliest stages, development of the CBPI has been based on advice and insights from some of Canada’s leading public health professionals. Front-line practitioners advised on the design and content of the Portal at key stages in the development process. The CBPI is also guided by a number of advisory and task groups that provide methodological, policy and practice-related advice on an ongoing basis (see Figure 1). The CBPI Group is the primary advisory group for the initiative made up of members representing a diverse balance of Canadian regions, jurisdictions at local, P/T and national levels, perspectives across policy, research and practice, and expertise in the areas pertinent to current project work.

The initial work of the CBPI focused on developing a systematic, evidence-based approach to evaluating intervention sources, sorting through intervention evidence that is currently available, and determining whether it meets a set of stringent criteria. Intervention information that met the established criteria would be considered best practices, and could be offered with confidence to practitioners, researchers and decision-makers. In 2006, this developmental work paved the way for the Public Health Agency of Canada to officially launch the Canadian Best Practices Initiative with the release of the Canadian Best Practices Portal for Health Promotion and Chronic Disease Prevention.

The content of the Portal reflects the underlying principles of an approach to population health that has been 15 years in the making. A population health approach focuses on improving health status through action directed toward the health of an entire population, or subpopulation, rather than individuals. To be included on the Portal, a resource (whether a best practice intervention, a systematic review site or a Population Health Template resource) must address at least one of the eight elements of the Population Health Template (see Figure 2) and involve evidence-informed decision making.

Using the Population Health Template

The Portal opens on the population health approach model, and then offers several access points for users. By linking each resource to the eight elements of the Population Health Template, the Portal makes it easy for users to learn about effective supports that enable them to address each element of the population health model. The updated version of the Portal revealed in November 2008 will link Portal users to resources for each element of the population health template that build capacity, increase understanding and illustrate application.

Search Elements of the Population Health Template (examples):
- A search for research focused on the health of populations might reveal a Canadian Community Health Survey website (www.hc-sc.gc.ca/fn-an/surveill/nutrition/commun/index_e.html) with information on identifying indicators for measuring health status (element 1).
- A review of methods for increasing upstream investments might direct the user to a report of the Canadian Population Health Initiative on promoting healthy weights (element 4).
The Portal aimed to address the need for a one-stop shop that pulls together international and domestic evidence, along with Canadian resources, exchange/learning opportunities and decision-making aids from a variety of sources; screens them for quality and credibility; and packages it in a user-friendly and interactive way to support evidence-informed practice and practice-based learning in the Canadian context.

It was the first resource of its kind in Canada or internationally, designed to meet the growing demand for solid, well-documented information on effective health promotion and chronic disease prevention interventions. The Portal is unique in serving as a gateway to a wide range of tools, resources and information sources. Each intervention listed in the Portal is annotated and summarized (e.g., by intervention origin, health issue addressed, priority/target population including setting, intervention objectives/purpose, implementation characteristics and resources, theoretical foundations, values, evaluation characteristics, intervention outcomes, adaptation considerations) so that users know what they can expect to find when they “jump off” the Portal to review the resource in more detail.

Endless Debates: What is Evidence, What is a Best Practice?

When the Canadian Best Practices Portal was launched in November 2006, it was described as a virtual front door to an array of online best practices in health promotion and chronic disease prevention. At that time, there was a strong feeling among the members of the Steering Committee that there was an obligation to provide users with interventions and systematic reviews that had been rigorously evaluated and proven to be effective. So the search began for sources of these types of interventions. The emphasis during the initial phase (2004 to 2006) of the Portal’s development was on increasing access to “best practice” interventions, labelled as such because they were supported by systematic review evidence and had a positive health outcome.

However, the selection criteria used during the initial phase were too narrow and did not reflect the range of methods used to evaluate most health promotion practices. According to Kiefer et al.,3 “ecological, observational, quasi-experimental, and time-series designs to evaluate intervention effectiveness are often the only sort of evidence available and appropriate to inform the population and public health field”. The reality is that for many health promotion interventions, this type of scientific, “medical model” evidence is not available, is inconclusive, has been conducted using less than ideal methodologies, or is of questionable relevance for population

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**Searching the Portal**

To illustrate the functioning of the Best Practices Portal in practice, here’s what a potential public health practitioner might do to search for a successful intervention on physical activity in the workplace:

2. On the left menu bar, click Search Best Practice Interventions.
3. As a keyword string, type <“physical activity”> work> and review each of the interventions on the page.
4. To refine your search, click Advanced Search and select the following criteria:
   - Under Language, click English and French.
   - Under Population Characteristics, click adults.
   - Under Gender, click male and female.
   - Under Population Focus, click population-health level.
   - Under Topic, click obesity prevention and physical activity promotion.
   - Under Purpose, click environmental support (social and physical).
   - Under Disease, click general chronic disease prevention & control.
   - Under Determinants of health, click employment and working conditions, personal health practices and coping skills, physical environment, and social environments.
   - Under Setting, click workplace.
5. Read the summary of PHAC's Stairway to Health initiative. Click the link at the bottom of box for the full summary. Click the heading for a link to the program website to learn more about how to adapt this program for use in your community.

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**Figure 2. Population Health Template**

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health approaches. Programming decisions must often be made in the face of uncertainty.

Building on the above considerations, the CBPI broadened its view of evidence:

The best available research and evaluation information based on a systematic analysis of the effectiveness of an intervention, strategy or service and its use, in order to produce the best outcome, result or effect. Evidence may be generated from a range of rigorously implemented and appropriate quantitative and/or qualitative research and evaluation methodologies (adapted from UK National Health Services).12

Evidence, from the perspective of the Canadian Best Practices Initiative, is not based on hearsay or an assumption of what works. Research or evaluation findings are critical to expanding beyond opinion and demonstrating evidence, but a broader range of evidence must be brought to bear on decision making. In response to this reality, the Canadian Best Practices Initiative has expanded its inclusion criteria to include interventions which have demonstrated their desired changes through the most rigorous or stringent research or evaluation appropriate for their circumstance. The most appropriate research or evaluation for their circumstance may be quantitative (e.g., experimental, quasi-experimental, observational) and/or qualitative (e.g., phenomenological, grounded theory, case study, ethnography, narrative) study designs.

Exploring Promising Practices

Given the limited number of interventions in public health that are able to meet the best practice standard based on systematic review or RCT evidence and the continued need for evidence to inform practice decisions, in 2007 the CBPI began to explore identifying and adding “promising practices” to the Portal. Upon initial investigation of this concept, there appeared to be even more variation in the labels, assessment criteria and interpretations of this level of evidence than at the “best” level. To help sort out this quagmire, the CBPI commissioned an environmental scan of promising practices work in Canada and internationally,13 held a consultation workshop with 40 Canadian and international experts in health promotion and chronic disease prevention, reviewed existing classification frameworks, and conducted key informant interviews with experts in intervention assessment to explore the similarities and differences between several more prevalent promising practices assessment processes and labels.

The result was a new proposed classification system for interventions on the Portal which would categorize interventions on a continuum on the basis of both the research methodology used to evaluate the intervention and the resulting intervention effects. Thus interventions with a positive outcome were to be labelled as ‘best’, ‘promising’ or ‘to watch–appear promising’ and those with negative outcomes labelled as ‘harmful’, ‘discouraging’ or ‘to watch–appear discouraging’. The hierarchy of labels followed the traditional hierarchy of evidence such that systematic reviews and RCTs with positive outcomes were labelled ‘best’ and the more common observational and qualitative study designs in health promotion with positive effects would always be labelled ‘to watch–appear promising’.

Beginning with a few, and growing to many, expert advisors to the CBPI began to voice discomfort with this “Best/Promising” labelling system. The rationale was twofold:

- A “promising” practice was often limited from being “best” not because it was in fact an inferior program, but because the evaluation methodology was not as rigorous; and,
- No practice can be guaranteed to be “best” when transplanted from the original (often artificial) environment in which it was created, to a different context.

The importance of “context” to health promotion and chronic disease prevention focused on population- and community-level efforts has been a strong driver away from the “best/promising” labelling system which did not take context into account. Lo and behold, we were not alone in this line of thinking:

“The definition of best evidence and best practice should be made on the basis of their fitness for purpose and their connectedness to research questions, not on the basis of a priori notions about the superiority of particular types of evidence or method or placement in an evidence hierarchy.”

“No single approach to the generation of evidence or data is to be favoured over others. Evidence should not be appraised and evaluated on the basis of adherence to a single evidence hierarchy in which a particular method is to be given priority. Appraisal of evidence should be on the basis of whether the research method used is appropriate for the research question being asked and the knowledge being collected, and the extent to which in terms of its own methodological canon it is considered to be well executed. Some evidence will be more useful than others, but all sources of evidence may make a contribution to understanding how social factors influence health outcomes.”

(Measurement and Evidence Knowledge Network, 2007; 20)14

Shifting the Locus of Decision-making Control to Users

The CBPI team went back to the literature to explore ways to combine the search for evidence of effectiveness on a range of health-related outcomes with the importance of contextual factors in public health practice. What has emerged is an intervention classification system on the Portal that provides the decision-maker with as much information as possible to enable informed and context-sensitive decisions as to whether there is potential for intervention adoption, or more likely, adaptation of a given practice in their setting. This is in contrast to the “best/promising” system that judges the value of an intervention before the user even considers it. The descriptive fields in the new classification system represent a hybrid of three well-respected approaches:

1. The RE-AIM Framework – a systematic way for researchers, practitioners, and policy-makers to evaluate health behaviour interventions. It can be used to estimate the potential impact of interventions on public health. (www.re-aim.org)

2. McNeil and Flynn’s15 update on the ‘Promise Table’ which highlights three elements to consider to assess potential for population impact: “Program logic, where the theoretical basis of the program is considered, including whether it is logical and consistent with current knowledge of physiology, behaviour, etc.; Reach, which takes into account range and breadth of participation, including characteristics of the study population; Uptake, which includes utility (such as evidence and extent of stakeholder involvement) and feasibility (such as practicality and costs etc. including rates of participation).”

3. Three components of program assessment developed by Dr. Roy Cameron and colleagues at the University of Waterloo, Ontario: effectiveness, plausibility and practicality.
The following chart plots the descriptive fields based on the Cameron approach as the organizing framework.

<table>
<thead>
<tr>
<th>Effectiveness</th>
<th>Plausibility</th>
<th>Practicality</th>
</tr>
</thead>
<tbody>
<tr>
<td>“What has worked”</td>
<td>“What should work”</td>
<td>“What might work in your context”</td>
</tr>
<tr>
<td>Study design</td>
<td>Theoretical basis/Program logic</td>
<td>Population focus</td>
</tr>
<tr>
<td>Outcomes/Efficacy/effectiveness</td>
<td></td>
<td>Risk factor/Risk condition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Determinant of health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Population characteristic</td>
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<td></td>
<td></td>
<td>Setting</td>
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<tr>
<td></td>
<td></td>
<td>Purpose</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reach</td>
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<tr>
<td></td>
<td></td>
<td>Adoption/Uptake</td>
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<tr>
<td></td>
<td></td>
<td>Implementation</td>
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<tr>
<td></td>
<td></td>
<td>Maintenance</td>
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<td></td>
<td></td>
<td>Context</td>
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The new classification system for the Portal will provide information on key fields relating to intervention effectiveness, plausibility and practicality to allow users to search, review and compare interventions to make evidence-informed decisions that best fit the needs and context of their practice setting.

This whole process has thus led to a revised interpretation of the term “best” in the title of the Portal and the CBPI:

Best Practices are interventions, programs/services, strategies, or policies which have demonstrated desired changes through the use of appropriate well documented research or evaluation methodologies. They have the ability to be replicated, and the potential to be adapted and transferred. A best practice is one that is most suitable given the available evidence and particular situation or context.

In the context of population health/health promotion, such practices are used to demonstrate what works for enhancing the health status and health-related outcomes of individuals and communities, and to accumulate and apply knowledge about how and why they work in different situations and contexts.*

For inclusion in the Canadian Best Practices Portal, an individual intervention or collection of assessed interventions must successfully meet each of the following criteria:

- Addresses chronic disease or health promotion topics
- Designed for primary or secondary prevention, or reducing risk factors
- Addresses one or more of the social determinants of health
- Documented evaluation using quantitative (experimental, quasi-experimental, observational, descriptive observational study) and/or qualitative (phenomenological, grounded theory, case study, ethnography, narrative) study design
- Meets quality and rigour criteria appropriate to the study design
- Shows evidence of effectiveness in eliciting the desired changes
- Evidence of effective strategies that are replicable and adaptable (practical).

In addition, the source of interventions must be:

- Detailed enough in the information about interventions to enable front-line adoption or adaptation of recommended interventions
- Credible
- Current

* Adapted from: United Nations Population Fund, Glossary of Monitoring and Evaluation Terms and Advance Africa (USAID), Best Practices Compendium

- Free of commercial influence
- Detailed enough to permit adequate annotation on the Portal site.

To date, the following 13 Systematic Review Databases have satisfied all of the abovementioned criteria:

1. Campbell Collaboration Reviews of Interventions and Policy Evaluations
2. Canadian Task Force on Preventive Health Care
3. Cochrane Database of Systematic Reviews
4. Database of Abstracts of Reviews of Effects (DARE)
5. Effective Public Health Practice Project (EPHPP)
6. EPPI-Centre Database of Promoting Health Effectiveness Reviews (DoPHER)
7. EPPI-Centre Health Promotion Review Documents
8. Evidence-Based Practice Centres Evidence Reports
9. Guide to Community Preventive Services
10. health-evidence.ca
11. National Institute for Health and Clinical Excellence (NICE) public health evidence base
12. National Institute for Health and Clinical Excellence (NICE) public health intervention guidance
13. U.S. Preventive Services Task Force (USPSTF)

The Road Ahead

Recognizing that enhancing effective public health practice requires more than just access to available evidence, there are six strategic priorities for the CBPI that will be unrolled in three phases (Figure 3):

1. Effective internal and external communication, which includes marketing efforts.
2. Evaluation – formative, process and outcome.
3. Strategic partnerships.
4. Relevant Portal content and infrastructure.
5. Relevant knowledge exchange mechanisms (Phase II).
6. Monitoring and learning from the uptake and use of these practices in the Canadian context so as to track impact and learn more about how these practices evolve (Phase III).

The Portal will function as the virtual front door for all three phases of the Canadian Best Practices Initiative and will links users to evidence, decision-making and practice resources, learning and knowledge exchange opportunities between practice, policy and research.

Phase II: Fall 2006 to Fall 2008

The CBPI will see an expansion of evidence available on the Portal on:

- Current topics such as physical activity, healthy eating, substance abuse programs;
- New priority topic areas, such as obesity prevention, mental health and social determinants of health;
- A broader range of practices, programs and policies with different levels of evidence.

Supporting the uptake of evidence-based practice does not only involve providing possible interventions. One feature of the Portal that facilitates multi-directional exchange and identification of innovative and effective interventions missing from the published literature is the invitation for researchers, practitioners and policy-
Figure 3. Phases of CBPI

Long-term Vision
It is also hoped that the CBPI will foster closer links with areas and disciplines that have an impact on health, such as transportation, recreation and education, thereby bringing together a mix of methods and perspectives from different fields of knowledge and practice. Like any legitimate user-driven initiative, the development plan for the CBPI will evolve over time to meet stakeholders’ emerging needs. A high degree of flexibility will sustain the relevance and currency of an initiative that must keep up with a rapidly-shifting field of practice, while keeping abreast of emerging technologies that could help make the Portal more effective and interactive. These services will help meet the demand from Canadian health promotion practitioners, policy-makers and researchers for a means of identifying and implementing evidence-informed practices in chronic disease prevention and health promotion.

A Call for Feedback
This is the first of a few inserts on the Canadian Best Practices Initiative that you will find in the Canadian Journal of Public Health. In line with the interactive nature of the Portal itself, PHAC is looking for your feedback for the next insert. Our priority over the next year is to find and showcase more Canadian content on the Portal that demonstrates success through well-conducted evaluation, shows innovation and has potential for application across Canada:

- What one or two chronic disease prevention/health promotion interventions is your organization using that you consider innovative or most promising?
- In what context or setting are you using them?
- What type of evaluation results for these interventions would you be prepared to share with colleagues through the Portal?

This focus on evaluation underscores a continuing challenge for chronic disease prevention and health promotion communities. There is only limited information available on the measurable results of specific interventions, and the Portal reflects that gap. Future development of the Portal will emphasize collection of practice-based evidence and learnings through evaluation, as one part of the process of strengthening health promotion and chronic disease prevention capacity across Canada.

References