CLIP-ON: Comprehensive e Lifestyle Interventions for for Prevention and Treatment

Introducing the Complete Lifestyle Medicine Intervention Program (CLIP) to address chronic disease prevention, treatment, and reversal in underserved communities.

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Land Acknowledgement

- The CLIP gathers on the lands of the Anishinaabeg/Anishinaabek Ojibway, Odawa and Potawatomi peoples, and the territory of the Wasauksing, Shawanaga, Magnetawan, Dokis and Henvey Inlet First Nations and is under the Robinson-Huron Treaty.
- We are committed to work continually on building a practice that reflects this wisdom, and to never forget what a disconnected heart and unconscious mind can lead us to do.

Affiliations:

- NOAMA Grants
 - 50K 2023 for Parry Sound Complete Lifestyle Medicine Intervention Program – Ontario (CLIP-ON) Research
 - 60K 2024 for Moose Deer Point First Nation CLIP-ON Research
- Co-Founder of Blue Life Rx Teaching lifestyle medicine and coaching families struggling with symptoms of ADHD and Autism using principles of lifestyle medicine and nutritional therapy.

Financial Support:

 This session/program has not received financial or in-kind support.

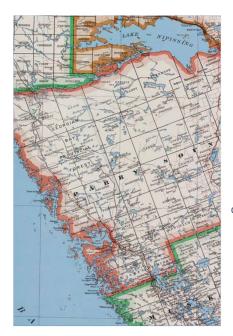
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Learning Objectives

- 1- Describe the foundational principles of Lifestyle Medicine and its six evidence-based pillars used in the CLIP-ON program to address chronic disease prevention, treatment, and reversal.
- 2- Recognize the unique challenges and opportunities in delivering comprehensive interdisciplinary care in underserved communities and identify how programs like CLIP can improve health equity, reduce provider burnout, and strengthen patient engagement.
- 3- Reflect on your own clinical practice patterns and assess opportunities for integrating lifestyle counseling and motivational interviewing within standard chronic disease management.







Chronic Disease Burden

The Parry Sound District in Ontario faces unique challenges and health disparities when it comes to chronic disease burden. This region, located 247 km north of Toronto, has a population of just 6,879 (2021), yet experiences significantly higher rates of chronic conditions like diabetes, hypertension, and cardiovascular disease compared to the rest of the province. For example, the district has double the average rate of patient admissions to the hospital for diabetes, and 27% of deaths are diabetes-related, compared to 18% for the rest of Ontario. The age-standardized hospitalization rate for hypertension is more than double the Ontario rate, with the rate among adults aged 75 and older being more than triple the provincial rate.

https://www.myhealthunit.ca/en/community-data-and-reports/chronic-disea.aspx

Main findings

Our analysis finds that there will be an estimated 3.1 million people (239 per 1,000) with major illness in 2040, up from 1.8 million (192 per 1,000) in 2020. Approximately 1 in 4 adults over the age of 30 will be living with a major illness in 2040, requiring significant hospital care, up from approximately 1 in 8 individuals in 2002. In addition to more people living with major illnesses, the number of illnesses any individual will be living with will also increase significantly with the average number of conditions each person lives with. There is also a considerable burden of individuals living with at least one chronic condition, expected to increase by 2 million more individuals with at least one chronic condition compared to currently. The conditions expected to increase the most in number consist of conditions that increase with age, including osteoarthritis, diabetes, and cancer. The aging population contributes significantly to the estimated increases; however, underlying structural and social determinants of health and an increase in chronic disease risk factors also contribute.

Implications for the health system

Our results highlight the significant burden of illness in the Ontario population and reveal that strain on the system will increase considerably in the next two decades. As more Ontarians will live with more illnesses, significant efforts in chronic disease prevention and management are needed. Many chronic diseases can be managed outside the hospital with appropriate support, and investments in disease prevention, early detection and early and continuous treatment can reduce the subsequent strain on the hospital system. More ambitious chronic disease prevention strategies must be invested in to improve population health, including population-level approaches to prevention alongside tailored individual support. Given longstanding health inequities, chronic disease trends will not be equally felt in the population, necessitating an increased focus on community care and addressing health's social and structural determinants. No single policy approach will address the expected burden of illness; several short- and long-term scenarios are suggested to ensure the health system can continue to care for its citizens.

Rosella LC, Buajitti E, Daniel I, Alexander M, Brown A. Projected patterns of illness in Ontario. Toronto, ON: Dalla Lana School of Public Health; 2024.





Lifestyle Medicine



Evidence-Based Approach

Lifestyle medicine is an evidence-based field that that utilizes therapeutic lifestyle interventions to to prevent, treat, and often reverse chronic diseases. diseases.



Six Pillars

The six pillars of lifestyle medicine are: nutrition, nutrition, physical activity, sleep, stress management, management, substance use, and positive social social connections.



Whole-Person Care

Lifestyle medicine takes a holistic, whole-person person approach to care, addressing the root causes of causes of chronic conditions and empowering individuals to make sustainable lifestyle changes. changes.



Chronic Disease Prevention

By addressing the lifestyle-related risk factors, lifestyle medicine interventions can prevent, treat, and even reverse many chronic diseases, such as cardiovascular disease, type 2 diabetes, and certain cancers.

https://lifestylemedicine.org/positions/ https://www.plantbaseddata.org/

The CLIP-ON program is grounded in the evidence-based principles of lifestyle medicine, using the six pillars to help participants make sustainable lifestyle changes that can significantly improve their health and well-being.

https://lifestylemedicine.org/wpcontent/uploads/2023/06/Pillar-Booklet.pdf

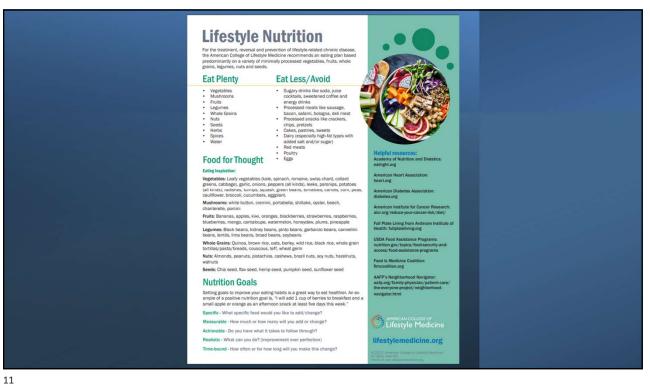


















Healthy eating is more than the foods you eat. It is also about where, when, why and how you eat.

Be mindful of your eating habits

- Take time to eat
- Notice when you are hungry and when you are full

Cook more often

- Plan what you eat
- · Involve others in planning and preparing meals

Enjoy your food

· Culture and food traditions can be a part of healthy eating

Eat meals with others

Make it a habit to eat a variety of healthy foods each day.

Eat plenty of vegetables and fruits, whole grain foods and protein foods. Choose protein foods that come from plants more often.

Choose foods with healthy fats instead of saturated fat
 Limit highly processed foods. If you choose these foods, eat them less often and in small amounts.

- Prepare meals and snacks using ingredients that have little to no added sodium, sugars or saturated fat
- Choose healthier menu options when eating out

Make water your drink of choice

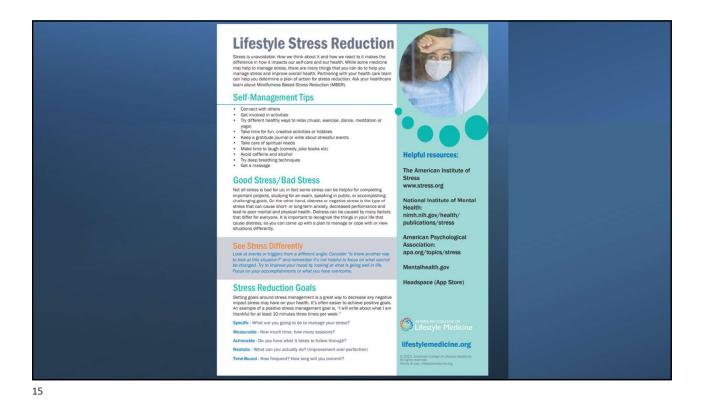
Replace sugary drinks with water

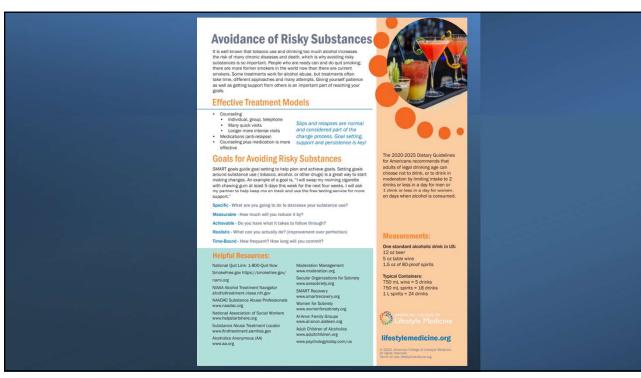
Use food labels

Be aware that food marketing can influence your choices

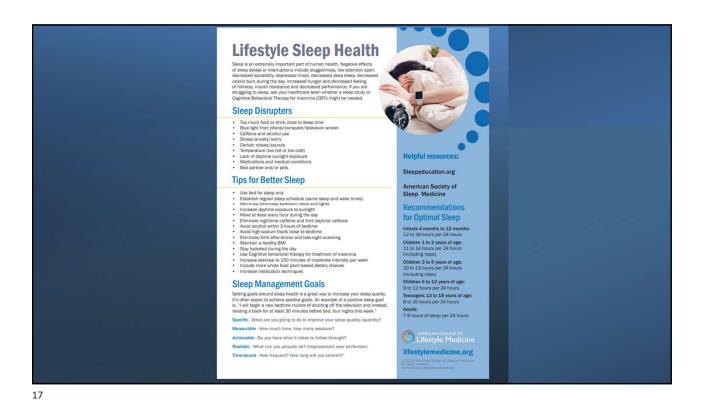
























Implementation project

Funded by NOAMA for 50K 2x 6 months cohorts for 10 participants each





Maximizing peer support and practical tips Working alongside their primary care team.



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The low hanging fruit

- There is a subset of the population already interested in making lifestyle changes.
- We maximize our efforts to provide them with the support they need to be successful in creating consistent changes that are sustainable over the long-term.
 - Fostering stronger connections along the way with cohort specific as well as open group meetings and gatherings for CLIP members and their families adds the social piece necessary to build a healthier community.
 - We aim for a positive snowball effect whereby our alumni are empowered to have a positive influence in their own circle.



Our program includes the support of



Coaches



Registered Dieticians



Registered Kinesiologists



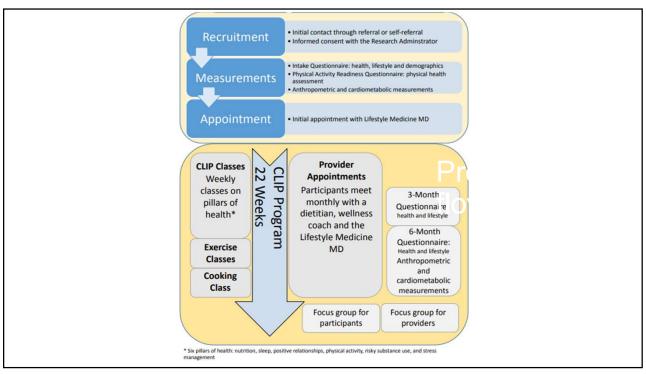
Social workers scheduled group activities



Other experts that address specific needs as needed

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Participant Journey Initial Physical Assessment **Final Assessment** PARQ+ & medical clearance, anthropometric measurements, and kinesiology measures and requisition for blood work Questionnaire with research team member, anthropometric data, kinesiology assessment, blood work Lifestyle Classes Attend weekly sessions on the pillars of lifestyle medicine and structured exercise program with a kinesiologist Intensive Completed Consent & Intake Typically, two phone meetings are booked to complete the consent form and fill the intake questionnaire with the research team Recruitment **Focused Groups** Outreach to eligible participants in the community. Pamphlets, posters, social media, and word of mouth, Participants can self-refer or get Referred by their healthcare providers a. For participants and Providers to give their anonymous feedback in the presence of an external Researcher Extras Exercise & cooking Begin ... 1:1 Appointments Meeting monthly with the interdisciplinary care team 24



CLIP Updated Program Overview

Intensive Phase

Individual Appointments

Maintenance Phase

The intensive phase of the CLIP program consists of 25 weekly virtual or in-person group sessions. Each **90 minutes session** focuses on one of the six pillars of lifestyle medicine (nutrition, physical activity, sleep, stress, addictions and risky substances, and relationships), and also includes 30 minutes of movement, and group discussions.

Participants in the CLIP program also receive monthly follow-up appointments with the interdisciplinary care team, which includes a includes group activities (e.g.: ongoing dietitian, health coach, and lifestyle medicine weekly exercise classes and monthly cookprimary care provider (family physician or scheduled to provide at least one follow-up by a team member every two weeks during the ~6-month duration of the intensive phase.

After the intensive phase, the CLIP program transitions into a maintenance phase, which along sessions) and as-needed follow-up with nurse practitioner). These appointments are their interdisciplinary care team. Participants also complete questionnaires to collect data on the maintenance of their healthy habits and behaviors.

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GROUP ACTIVITIES



FOLLOW-UP PRN



DATA COLLECTION Q6-12 MONTHS

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Parry Sound District and its Nurse Practitioner Led Clinics

- Port Loring (Argyle NPLC)
- Pointe au Baril
- Britt
- Whitestone
- Rosseau
- Moose Deer Point
- Wasauksing
- West Parry Sound Health Centre
- Parry Sound Family Health Team





Collaboration and Health Equity

Improving Health Equity

Meeting communities closer to home

Self-referrals lower the barrier

Running the program free of charge for participants.

Culturally inclusive and adaptable

Reducing Provider Burnout

The interdisciplinary care team

Shared responsibility for patient outcomes

Sharing hope

Positive patient wins/ Being the cheerleader

Strengthening Patient Engagement

Peer support

Community building

Patient-centered care

Role models for their own social group & the next generations

Collaborative Approach

Co-design and implement the program, leveraging diverse expertise and resources.

Interdisciplinary team of healthcare providers,

Community organizations, Local stakeholders

Participants

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"Lifestyle is the medicine, culture is the spoon"

DR. DAVID KATZ, MD, MPH, FACPM, FACP, FACLM

Preliminary Results

Cohort 1

>80% satisfied or very satisfied with CLIP-ON 80% progressed towards health goal 100% accomplished more & increased physical activity 100% found providers to be knowledgeable, helpful, and supportive

| Participant | Providers |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| "I'd recommend it to everybody." | "I do think that this can be sustained in that community." |
| "Well, they said how important balance is. And when I started, I couldn't stand on one foot. I was wobbly, and now I can kick and all kinds of things. I can stand on one foot, no problem." | "I certainly hope that the program can be duplicated or replicated again in other parts of the Northern Ontario." |
| "I have enjoyed all the information. I would have more team building amongst the group to get to know them — just to debrief with other people, what things are working, what aren't, tips and tricks, that would have been good." | "I had my participants; they actually became friends from meeting in person and they were able to work together and motivate each other going forward. So, I think that social connectedness from the program really helped people." |
| "I would like to say it felt quite pampering to have your own dietitian, to have your own life coach, to have one-on-one with a doctor. I can't emphasize this enough That was the most valuable thing Nothing like it." | "Once throughout the session, we set goals. And then next time we go back to the goals and see whether they were able to achieve them or any adjustments might be required. So, that help keep them that part works very well." |

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Preliminary Results

Positive outcome measures thus far

- Strong patient demand, engagement, acceptance, and program completion
- Strong provider support
- Both groups believe model is sustainable & expandable to other rural communities

CLIP-ON Parry Sound, ON

- 2 Cohorts now in maintenance phase
- Cohort 3 started in January

Gaining attention -> \$1Million support over next 5 years

Program Expansion!

• Beginning Recruitment in Moose Deer Point





Integrating Lifestyle Medicine In Your Practice

Leverage Existing Visits

Incorporate lifestyle-focused discussions into routine chronic disease management visits, such as such as annual check-ups or medication follow-ups. follow-ups.

Adopt Motivational Interviewing Interviewing

Train clinical staff on motivational interviewing interviewing techniques to better understand patient goals and collaboratively support lifestyle lifestyle behavior changes.

Patient Resources

Create or curate evidence-based patient education education materials on the six pillars of lifestyle lifestyle medicine to share during appointments, or

Facilitate Referrals

Establish referral pathways to connect patients with with interdisciplinary providers. Get acquainted with with existing programs and providers (setbacks Reset Reset pediatrics, Lifestyle Rx, Aroga, ReCAPS, EXCEL, EXCEL, CLIP – if in our area)

Follow Up and Cheer Them On...

Ask how its going! Celebrate small wins! Help them get them get back on the saddle – its part of the journey. journey. Success isn't defined by failures or setbacks, setbacks, but by your ability and willingness to try try again.

Trying Group Visits

Leveraging peer-support, using billing codes for group group visits and shared medical appointments allows

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Ask for their WHY

- Why do you want to recover better/faster after your gall bladder surgery?
- What do you hope to be able to do once you get your new knee?
- Why does it matter for you to lose the weight, what would you be able to do...?
- Why would you like to go off some of your medications
- What makes you want to get up in the morning...

Share your WHY

- Most patients want to know what you do and want for your health and your family
- They want to know some of your hopes and visions.

Share Hope

- Preventing diseases they fearReversing diseases they have
- Regaining mobility
- Less pain
- Peeing without a catether
- Traveling again
 Playing with their grand children on the ground (and getting back up again)

Share what you LEARN

• I've been to a talk about something called lifestyle medicine last week! Mind if I share something that I learned?













CLIP-ON Providers, Research Administration Team

- Dr. Mylène Juneau
- Dr. Caroline Rhéaume
- Lisa Allen
- Magdalena Partyka-Sitnik
- Jenna Smith-Turchyn
- Sangeeta Kumar Lifestyle Coach
- Clarissa Kennedy Guest Speaker
- Deanna Lavigne- Kinesiologist
- Olivia Ball Kinesiologist Student
- Nicholas Hoey Kinesiologist
- Nicole Rietze Dietitian
- Michelle Fedele Dietitian
- Karine Boucher Dietitian
- Debbie Fong Dietitian

- Heather Fisher Dietitian
- Erin Marinoff Dietitian











Department Teams

Canadian Association for Lifestyle Medicine

New York Lifestyle Medicine Team

West Parry Sound Health Centre

Ambulatory Care & Emergency

Parry Sound Local Education Group











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Contact us

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| | | Year 1 | | | | | | | | | | | | Year 2 | | | | | | | | | | | | | Year 3 | | | | | | | | | | |
|-------------------------|----|--------|----|----|----|----|----|----|----|-----|-----|-----|----|--------|-------|----|----|----|----|----|------|-----|-------|-----|----|----|--------|----|----|----|----|----|------|-------|-------|--|--|
| Task | М1 | M2 | М3 | M4 | M5 | M6 | М7 | М8 | М9 | M10 | M11 | M12 | М1 | M2 | МЗ | M4 | M5 | М6 | М7 | М8 | M9 I | M10 | M11 | M12 | М1 | M2 | МЗ | M4 | M5 | M6 | М7 | М8 | M9 N | 110 N | 111M1 | | |
| Grant preparation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| General preparation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Recruitment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Pre-assessment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Intake Questionnaire | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Group sessions | | | | | | | | | | | | | | Coh | ort : | 1 | | | | | C | Coh | ort 2 | 2 | | | | | | | | | | | | | |
| Individual appointments | | | | | | | | | | | | | | Coh | ort : | 1 | | | | | C | Coh | ort 2 | 2 | | | | | | | | | | | | | |
| End Questionnaire | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Post-assessment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Data analysis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Knowledge dissemination | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Legend: Cohort 1 and 2 refer to the intensive phase of the program which consists of 22 weekly virtual or in-person group sessions (14 fundamentals on the pillar of lifestyle medicine followed by 8 weekly exercise sessions), as well as monthly follow-ups, either virtually or in person, with the interdisciplinary team, which includes a dietitian, health coach, and lifestyle medicine primary care provider (family physician or nurse practitioner) for 6 months.

