CARDIOPREVENT® PROGRAM

- PARTNER SITE OVERVIEW -

AN EVIDENCE-BASED, THEORY DRIVEN GLOBAL CARDIOVASCULAR RISK REDUCTION PROGRAM SUPPORTED BY HEALTH BEHAVIOUR COACHING

UNIVERSITY OF OTTAWA HEART INSTITUTE
INSTITUT DE CARDIOLOGIE DE L'UNIVERSITÉ D'OTTAWA

CardioPrevent®
Heart Health Program

AT A GLANCE

The CardioPrevent® program provides an evidence-based, tailored primary prevention cardiovascular health program for patients at a moderate to high risk of developing cardiovascular disease (CVD). During the year long program, CardioPrevent® health coaches will guide and support patients through a customized program plan based on their personal risk factor profile using cognitive-behavioural and behaviour change strategies.

GOAL

To lower the risk of developing CVD in individuals who may be at a moderate to high risk.

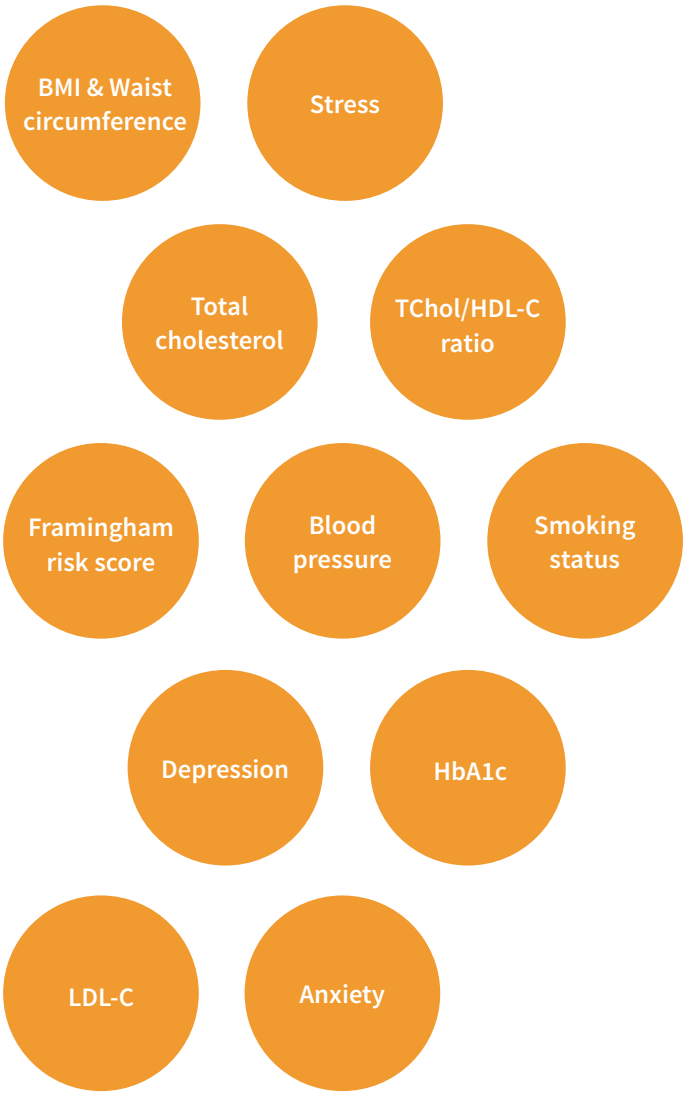
OBJECTIVES

1. To support health care providers through the deployment of CVD preventive care models to support lifestyle screening, behavioural counseling, and community linkages.

2. To improve accessibility to CVD risk screening and risk management through community outreach.

IMPACTS

REDUCTIONS IN:



INCREASES IN:

BACKGROUND

The development and progression of subclinical atherosclerosis begins from as early as the second decade of life. Since the burden of atherosclerosis increases over time, this long pre-clinical phase provides a window of opportunity for risk prediction and cardiovascular disease prevention.

The cornerstone of CVD prevention is the favourable modification of risk factors. Nine modifiable risk factors have been shown to have a consistent association with CVD risk, including:

- lipid/lipoprotein levels
- smoking
- hypertension
- diabetes
- abdominal obesity
- psychosocial factors
- dietary factors
- physical inactivity
- alcohol consumption

Patients and the medical community often focus on medications as a first-line strategy to stabilize or favorably modify risk factors such as hypertension, dyslipidemia, and/or diabetes. However, the most proximal risk factors for CVD are health behaviours, including poor dietary habits, physical inactivity, and cigarette smoking. Notably, these unhealthy lifestyle practices strongly influence blood pressure, lipid/lipoprotein levels, and glucose-insulin homeostasis. Accordingly, modifying unhealthy behaviours is critical to addressing the foundational causes of CVD.

THE NEED

Primary care settings are important to CVD prevention efforts because more than 90% of patient interactions with the health care system occur here. This is where screening for risk factors can occur and where lifestyle and medical interventions to control risk factors can be initiated.

HOWEVER:

- Prevention needs are usually perceived as non-urgent so they are often not addressed and therefore go un-assessed and un-treated.
- Clinicians often lack the knowledge, skills, and support systems to quickly and easily provide a range of different behavioural counseling interventions.
- Physicians report spending an average of only 8 minutes counseling their patients on lifestyle change annually.
- When lifestyle changes are required, primary care providers typically rely on health information and their professional status to convince patients to change.
- Physicians do not rate themselves as very effective in their ability to help patients prevent and manage risk factors.
- In clinical settings, many prevention management activities (e.g., lifestyle screening, behavioural counseling, linkages with community resources) fall outside the scope and culture of clinical medicine.
- Health-behaviour models suggest more effective methods for helping patients accomplish behaviour change goals and compliance with risk reducing treatments.

ALIGNMENT WITH ONTARIO PATIENT'S FIRST: ACTION PLAN FOR HEALTH CARE

The CardioPrevent® program supports primary care providers, the hub of Ontario's health care system, and a key priority in Ontario's Action Plan for Health Care. The intervention promotes healthy behaviours and supports lifestyle changes that will reduce chronic disease risk and improve patient quality of life.

Health Quality Ontario indicates that to strengthen Quality Improvement Plans in Patient Experience that more organizations need to implement evidence-based strategies such as promotion of self-management in health behaviors.

THE PROGRAM

The CardioPrevent® program is a global risk reduction program that is based on seven years of research conducted through the University of Ottawa Heart Institute by a multidisciplinary team of clinicians and behavioural scientists. (Reid RD, McDonnell LA, Riley DL, Mark AE, Mosca L, Beaton L, Papadakis S, Blanchard CM, Mochari-Greenberger H, O'Farrell P, Wells G, Slovinec D'Angelo M, Pipe A. Effect of an intervention to improve the cardiovascular health of family members of patients with coronary artery disease: a randomized trial, Canadian Medical Association Journal. 2014;186(1):23-30).

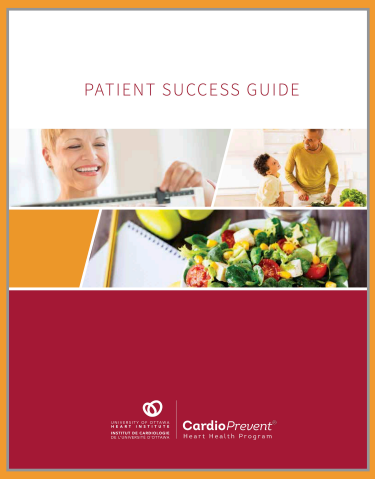
Outreach Facilitators support and work with primary care practices to introduce systematic processes to screen at-risk individuals who can then be linked into the CardioPrevent® Program.

To be eligible patients must be:

- 18 years of age or older
- Referred by physician or nurse practitioner
- Be at moderate to high risk of developing CVD (or on lipid lowering therapy)
- Have no known CVD or cerebrovascular disease

WHAT IS INCLUDED FOR PATIENTS?

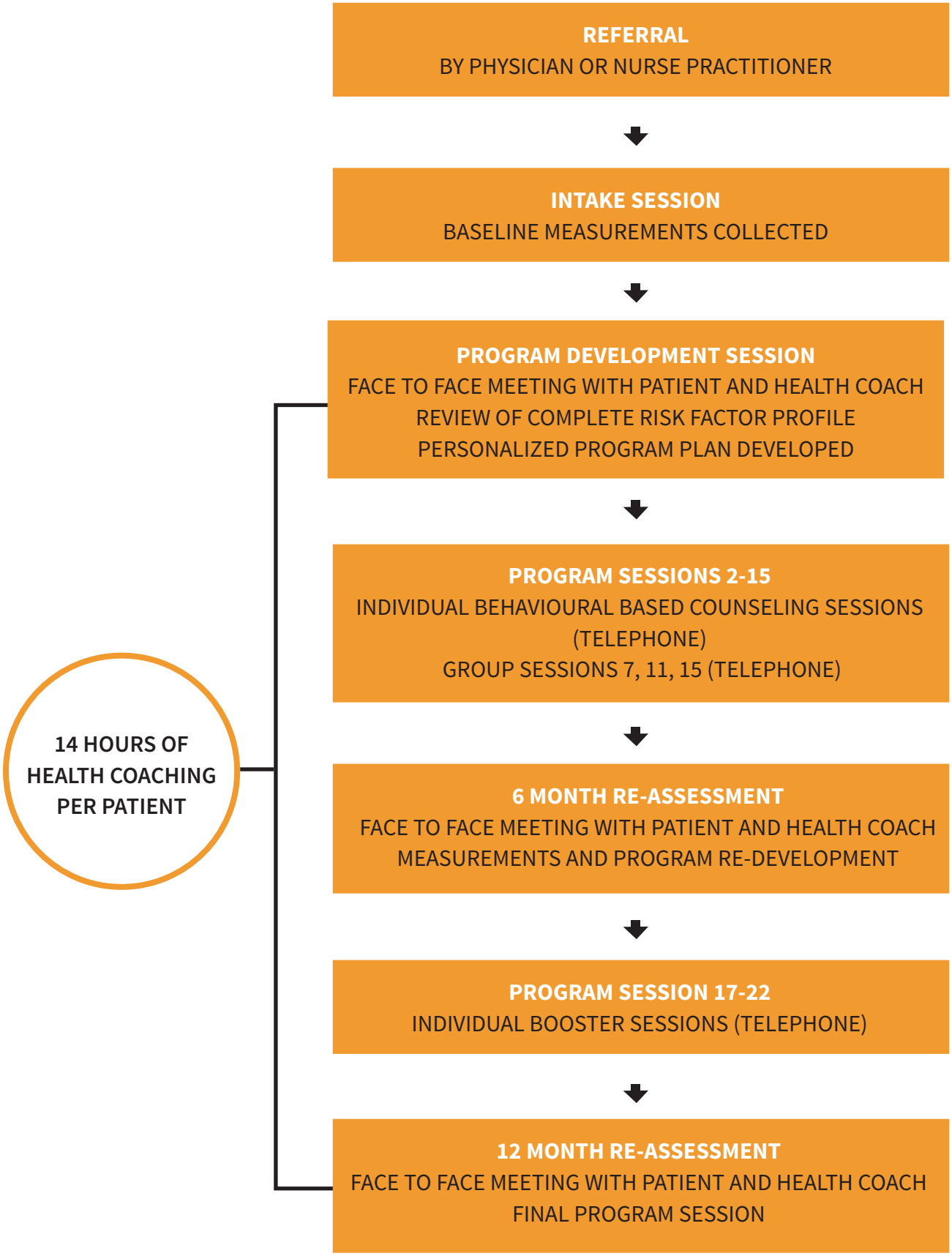
- Complete cardiovascular risk factors screening.
- Personalized programming and education tailored to individual risk factors supported by behavioural-based counseling.
- Patient success guide with worksheets to support counseling sessions.
- Risk factor education kits to support learning and risk factor management.
- Linkages to services to help the patient meet their personal goals.
- Regular follow-up support and guidance from a dedicated Health Coach.
- Weekly, bi-weekly and monthly phone contacts with a dedicated personal Health Coach over the course of the full 12 month program.
- Re-assessment of their cardiovascular risk profile at 6 and 12 months.



"I found this program invaluable. Getting reports on the numbers from my blood tests showed me just what the changes in my lifestyle were doing."

"I feel that this program has helped me to take a good look at my life and lifestyle to make the changes needed to prevent a heart attack or stroke. It has given me a healthy future and the knowledge that I needed to know so that I can improve my risk factors and lead a better life."

HOW IT WORKS


14 HOURS OF HEALTH COACHING PER PATIENT
REFERRAL
BY PHYSICIAN OR NURSE PRACTITIONER
INTAKE SESSION
BASELINE MEASUREMENTS COLLECTED
PROGRAM DEVELOPMENT SESSION
FACE TO FACE MEETING WITH PATIENT AND HEALTH COACH
REVIEW OF COMPLETE RISK FACTOR PROFILE
PERSONALIZED PROGRAM PLAN DEVELOPED
PROGRAM SESSIONS 2-15
INDIVIDUAL BEHAVIOURAL BASED COUNSELING SESSIONS (TELEPHONE)
GROUP SESSIONS 7, 11, 15 (TELEPHONE)
6 MONTH RE-ASSESSMENT
FACE TO FACE MEETING WITH PATIENT AND HEALTH COACH
MEASUREMENTS AND PROGRAM RE-DEVELOPMENT
PROGRAM SESSION 17-22
INDIVIDUAL BOOSTER SESSIONS (TELEPHONE)
12 MONTH RE-ASSESSMENT
FACE TO FACE MEETING WITH PATIENT AND HEALTH COACH
FINAL PROGRAM SESSION

BECOME A PARTNER SITE

With this “train the trainer” approach CardioPrevent® can be integrated into your practice.

Includes:

A) OUTREACH FACILITATION

Facilitation services include the assistance of an Outreach Facilitator specialized in risk factor management and program integration from the UOHI CardioPrevent® Program.

Your Outreach Facilitator will provide support services via. teleconference, email or site visits (depending on the needs).

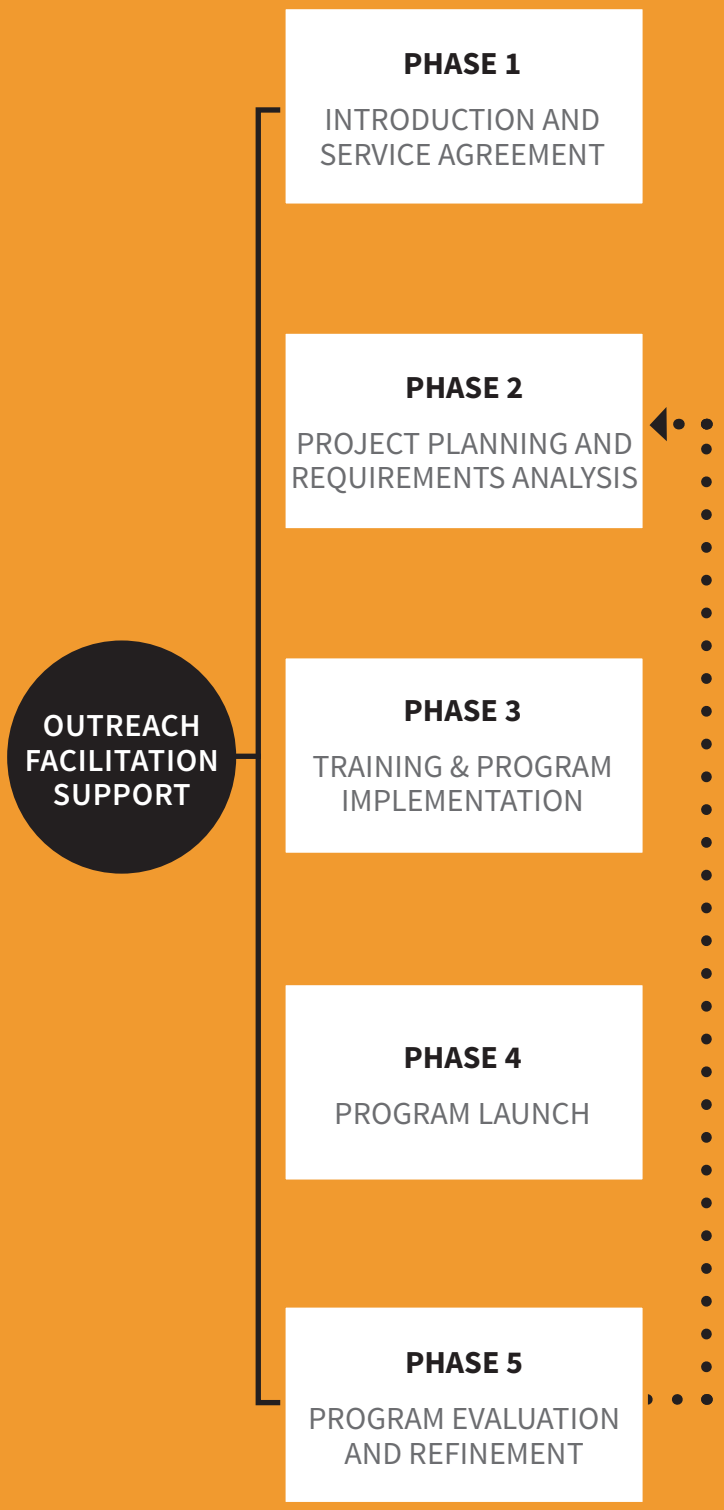
Services include:

- Preparation and signing of the agreement
- Gathering of needs assessment and background documents at site
- Support implementation of CardioPrevent® program into current workflow practices

B) PROGRAM MANUALS AND PATIENT MATERIALS

Licensed practices and organizations will receive complete details of the program protocol with step by step instructions in the form of an operating manual and health coach manual.

- **Operating Manual**: A guide outlining program processes related to screening, assessment and follow-up. Templates for all program forms are included.
- **Health Coach Manual**: Detailed scripts for each module and all 23 sessions. Each module provides background information and content with references based on current, best-practice evidence and behavioural change counseling strategies.
- **Patient Success Guide**: A resource guide for patients related to the program session that includes self-management skills and worksheets to align with the health coaching scripts.
- **Risk factor education kits**: Information on eight modifiable CVD risk factors and one general information document addressed in the program. Education kits are provided to patients upon beginning program, and assigned readings by the health coach are issued throughout the program as necessary.



C) CUSTOMIZATION

Licensed organizations will receive an electronic copy of the Patient Success Guide, Risk Factor Education Kits and Manuals co-branded with their logo and information and the University of Ottawa Heart Institute logo.

D) HEALTH COACHING & PATIENT MANAGEMENT SYSTEM TRAINING

New health coaches, will participate in a workshop concerning delivery of the CardioPrevent® program, counseling principles, mechanics of program delivery and the behaviour change techniques used in the coaching sessions with patients. Administrative staff and health coaches will also receive training concerning the use of the patient management system.

E) WEB-BASED PATIENT MANAGEMENT SYSTEM (OPTIONAL)

An automation system designed to support administrative outputs for health coaches. Patients also complete online surveys, at baseline and follow up assessments (6 and 12 months) through a secure web link, in which the data is automatically transferred to the patient management system

Outputs include:

Physician letter: A letter addressed to the referring physician indicating the patient's program status and risk factor profile. Any risk factor results exceeding threshold values are flagged with indications for best practice guideline targets to optimize management. These letters are generated at the baseline and follow up assessments (6 and 12 months).

Facilitator quick reference sheet (Health coaching patient summary): A personalized summary of patient results from their behavioural assessments from the baseline and follow up assessments. This serves to support the health coaching wellness plan.

Patient Risk Factor Profile: A risk factor profile that tabulates the patient's values on all collected non modifiable and modifiable risk factors (age, gender, family history, Framingham risk score, blood cholesterol, smoking, blood pressure, B.M.I., diabetes, psychosocial factors, physical activity and nutrition) values relative to best practice guidelines. This profile is shared with the patient and the referring physician.

F) ANNUAL REPORTS

Annual reports will be provided indicating site specific outcomes compared to total aggregated data of all sites offering a CardioPrevent® program. Reports will include average results for baseline, 6 and 12 months, and comparison values for baseline to 6 months and baseline to 12 months on all collected measures.

FOR MORE INFORMATION AND TO BECOME A PARTNER SITE OF THE CARDIOPREVENT® PROGRAM, PLEASE CONTACT:

UNIVERSITY OF OTTAWA HEART INSTITUTE

CARDIOPREVENT® PROGRAM
PREVENTION AND WELLNESS CENTRE
40 RUSKIN STREET, H-2353
OTTAWA ON K1Y 4W7
TELEPHONE: 1-866-399-4432
FAX: 613-761-4748
PWC@OTTAWAHEART.CA
PWC.OTTAWAHEART.CA/CARDIOPREVENT-PROGRAM/HEALTHCARE-PROVIDERS

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