Q1: Facility Name: Lakeview Medical Center
Q2: Program/ Project Name: Carry on with Cardio Programs
Q3: Address
   Address: 1700 W. Stout Street
   City: Rice Lake
   State: WI
   Zip Code: 54868
Q4: Contact Person's Name: Char Mlejnek
Q5: Phone Number: 715-236-6207
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PAGE 3: AACVPR Certified Program (10 points)

Q8: Does your Institution operate an AACVPR Certified Program (Cardiac or Pulmonary)? Yes

PAGE 4: Introduction (10 points)

Q9: (10 points) In 100 words or less please complete the following statement; "We believe our program is unique and innovative because..."

We believe our program is unique and innovative because of our success in care continuum with Carry on with Cardio Programs. Carry on with Cardio programs strive to enhance the delivery of care of wellness opportunities for our cardiopulmonary patients beyond rehab. This is about understanding our patients and how to best meet their needs. Our program is aimed at improving the quality of life for our patients along with the health of our community. Our goal is to create innovative ways to aide in reducing hospital readmissions, lowering healthcare costs, and improving the health of each individual we encounter.

PAGE 5: Population Served by The Program (up to 5 points)
The Carry On with Cardio programs are designed to first serve our clinical populations currently being cared for in our Phase II Cardiopulmonary Rehab sessions. Our Cardiac Rehab (CR) team identified the need for innovating changes to our discharge planning to assist our cardiac and pulmonary patients from Phase II to a more comprehensive way; a care continuum, by implementing the Patient-Centered Team-Based Care approach. As a leader, I have worked with my team to provide them the education and tools to be sure all patients receive care on a continuum (inpatient, clinic, outpatient, community) to protect and promote health and safety based on their specific needs.

Subgroups have been identified within our CR/PR, such as CAD or uncontrolled hypertension. They are introduced to a disease specific program based out of our Health and Wellness Center for these diagnoses. Other Clinical conditions or populations identified are BMI’s greater than 25 and/or at risk for diabetes. This population is determined by taking the CDC Risk screening test. If the patient is identified at risk, the patient is introduced to our Diabetes Prevention Program (DPP). If the patient agrees, we place them on the interest list to be contacted for next DPP class.

By addressing Primary prevention, our goal is to address disease risk factors in hopes to reduce the incidence of disease. Some approaches taken, have been to introduce our smoking cessation facilitator and another active approach is to provide influenza vaccine clinics during rehab classes to ensure 100% of cardiopulmonary patients we deliver care to, are vaccinated.

Prior to the Intake, the work has now already begun by identifying all of our clinical patients with Silver Sneakers or Silver and Fit benefits thru their insurance policies. The registration team has partnered to assist in this step. With one of these benefits, we are able to offer Health and Wellness Center memberships or strength classes once they graduate from Phase II. For a visual aide and process improvement, we apply a gold star on the patients’ charts that have this benefit. This in turn gives the staff an ongoing reminder as they deliver care throughout Phase II.

Populations have been identified with documenting biometrics and the use of our EMR data. One group identified is patients at risk for diabetes. We have worked with our IS team to query our patients with elevated blood sugar and BMI greater than 25. From here a letter was generated to be given to this population to introduce them to our Diabetes Prevention Program. The CDC screening form is another way we were able to educate and identify patients at risk.

Special considerations are now determined as we individualized our patient’s continuum of care. Patient populations which are at a disadvantage because of ability to pay, ability to access care, or ability to access comprehensive health care or other disparities for reason of race, religion, language or social status are documented on the patient’s ITP and is brought into consideration as we work to fit them into the Carry on with Cardio programs. Our team considers the socioeconomic factors of our patients' lives. Barron County and its surrounding areas are located in rural northwestern Wisconsin, with a population of 45,870. Several socioeconomic factors influence our health outcomes. Low incomes and lack of transportation leave many residents without the means to pursue a healthy lifestyle. The median household income is just $42,805, compared to the state average of $48,974. Public transportation options in the area are very limited and usually reserved for senior citizens. These present barriers that can impede an individual’s success in pursuing a healthy lifestyle. So as we form a continuum of care, more options in the community are now identified and offered thru the ADRC, which offers free or low cost programming, modes of transportation, and also our team applies and receives local grants to keep our programs affordable and also gas cards to diminish barriers of access of care and/or transportations.

PAGE 6: Research basis for program (up to 5 points)

Q14: Does your program have a research basis: Yes
Q15: If "yes", please indicate the specific guideline(s), scientific evidence, or research articles used in planning this program. Also include, research that supports that this type of innovative program can be/is effective.

Research articles used in planning our program are the following:
- Health Coaching for Patients with Chronic Diseases: Fam Pract Manag. 2010 Sep-Oct;17(5):24-29

Research that supports this type of innovative program to be effective has been based from the Stanford Coronary Risk Intervention Project. This multifactorial risk-reduction model has shown individualized changes in lifestyle and medical treatment has reduced the risks of disease progression and coronary events in patients with coronary heart disease.

Q16: Describe in detail your model of collaboration; how have you worked to include a variety of caregivers into your program?

A. Our multi-facet team has embraced the concept of collaboration. The concept is based on the expertise of several care providers. Our team understands this requires time, energy, and patience to implement, and demands understanding of its elements and structure.

One collaborative model used by our CR/PR and HWC staff is the Health Coach Model adapted from Glasgow, et al. which is described in their roles below. Another model utilized is the Interprofessional (IP) Collaborative Care Model. This model has given our team the innovative edge to deliver more effective processes and improved results. IP Collaborative Care Model is step-by-step processes, including patient admission, begin the discharge assessment during Intake, monthly updates, discharge day assessment, post discharge collaborative team meeting, post discharge collaborative Handoff of Care delivery to HWC.

The following are the caregivers involved in this collaborative process and their roles:
- CR/PR staff: They deliver daily care to Cardiac and pulmonary patients. Their roles are crucial to be the Health coaches. They have incorporated the Health Coach Model into their practice.
  - Assess: Health behaviors and self efficacy is determined with ITP
  - Advise: Health risks, benefits of change, and appropriate amount, individualized for each session
  - Agree: Collaborative goals based on patient’s interest and confidence to perform, and staff expertise to assist in goal setting
  - Assist: Barriers and problem-solving techniques, opportunities for care continuum, and social support addressed
  - Arrange: Referral and follow-up referred to Health and Wellness Center staff
- Physician and other Health Care professionals: Monthly meetings occur to discuss program outcomes, and individual caseloads with our Medical Director, CR/PR staff, Health and Wellness staff, and Health Promotions Manager. Also utilized in the Care Continuum if agreed upon, the social worker to assist in Advance Directive planning and if applicable, the respiratory therapist for smoking cessation.
- Other Ancillary departments: In addition to routine checking of insurance coverage, registration and finance departments assist Silver Sneakers or Silver and Fit benefits if applicable.
- Community-based organizations: We partner with our county’s ADRC to stay current with local programs. Some examples are the Stepping On or Living with Chronic Diseases classes. The Health Promotion manager is active in the ADRC coalition which meets monthly. Current community classes are then shared with staff to provide to patients.

Q17: Who are the caregivers involved in this collaborative process? (identify members of the team):

CR/PR staff, Physician,
Community-based Organizations, Family,
Health Plan Providers,
Other Health Care Professionals,
Other Ancillary Departments
Q18: Describe (or show evidence of) how participant results are shared among all team members and provide examples of this communication process:

Patient data, progress, and results are shared during monthly meetings. Data is collected on an Excel spreadsheet, consisting of the following:

- Patient name, admission to CR/PR date, potential Discharge date, survey numbers, risk numbers, out of range results, recommended interventions for care continuum: presented by CR/PR staff
- Post discharge plan and updates, and at 3 month, 6 month, and 1 year checks reported out by HWC staff.

Meetings are held monthly with the multidisciplinary team consisting of the following: CR/PR staff, Medical Director, and HWC staff. We follow the format of topic, discussion, and conclusion with Action items, person responsible, and the deadline. Minutes are recorded and sent out electronically to the Core Group and Connectors.

PAGE 8: Patient Self-Management Education (up to 10 points)

Q19: Are patient self-management strategies included? (including primary prevention, behavior modification, compliance and surveillance)  
Yes

Q20: If yes: Provide details of the education process used and explain how it encourages patient self-management. State the process for identifying barriers to learning, determining state of readiness for learning, and identifying patient’s preferred learning style. Identify by what means education information is provided to the patient/participant:

Cardiac and pulmonary staff work with patients within a group or individual setting. Staff facilitates and empowers the client to develop and achieve self-determined goals and behavioral changes related to health and wellness. A discharge plan is initiated at Intake.  
During the Initial Intake in Rehab, the stage of Readiness is determined with the Trans theoretical model (pre-comp, comp, preparation, action, maintenance). This is then documented and re-evaluated every 30 days. Upon Discharge this is entered in the continuum of Care tracking.  
Learning barriers, such as hearing, vision, speech, literacy level, and Knowledge test score are all determined at Intake and reiterated at monthly meetings. This assessment in turn gives staff feedback on identifying the best means to deliver education to each patient.

Specific patient surveys given aide us in identification of barriers and learning styles, these consist of the Quality of Life Index, DASI, PHQ-9.

Q21: If yes: Describe behavior modification techniques or interventions used. Explain how patient / participant compliance to treatment plans is tracked and how issues of non-compliance are addressed:

As staff continuously work and build relationships with their patients and their families over the course of their Phase II, they will continue to assess the patient’s learning needs, by following the Health Coach Model. To find what the patient’s learning style is, will assist us to match teaching strategies as closely as possible to the patient’s preferred learning style. Some questions staff have implemented in their time with patients are the following:

- What time of day do you learn best?
- Do you like to read/what types of books or magazines do you enjoy reading?
- Do you learn something better if you read it, hear it, or do it hands on yourself?

Also to gather information about the patient’s readiness to learn. Questions we have asked include:

- How do you feel about making the changes we’ve discussed?
- What changes would you like to work on now?
- Are there any problems that would prevent you from learning right now?

Staff assist patients to use their insight, personal strengths, and resources, goal setting, action steps and accountability towards healthy lifestyle changes. Documentation is held within the patients daily session reports and reported out in the monthly team meetings.

PAGE 9: Process/ program outcomes evaluation - How is success measured? (up to 30 points)
Q22: What is evaluated in your patient outcomes tracking system:
Outcomes tracked:
• Number/percentage of discharged patients in programs
• Percentage of participation completion (if applicable)
• Pre and post survey results
• Participation rates, drop-outs
• Participation feedback and satisfaction
• Changes in attitudes, behaviors, morale
• Senior management feedback
Per patient: Admission date, projected discharge date, survey results obtained at Input which do not met thresholds, Biometrics, Readiness to change score, barriers, Recommended Intervention, program attendance, follow up measures at 3, 6, 12 month.

Q23: How is your patient outcomes tracking system measured?
By utilizing our 3Pe scorecard, where target goals have been identified with our Watch Indicators

Q24: Describe your outcomes to date (provide "n," pre- & post-values, %change, & supporting narrative):
Tracking and Outcomes Measures:
In the last year, 80% reported home exercise as their Discharge Plan, with no care continuum or follow up in place.
Conclusion: To date 30 patients are on the Care Continuum tracking system. Reports on our 3PE have shown a 30% increase of discharged patients has joined our Health and Wellness Center or a Silver Sneakers benefit versus home exercise. Visits to Health and Wellness Center have increased 25% from our Cardiopulmonary rehab in last 3 months. A 3 month follow up email 12 patients whom chose home exercise plan with 3% now members of Health and

Q25: Describe your program/ process-related outcomes - how do you know your program is successful (how did your patients do)? Describe outcomes to date (provide pre- & post-values, %change, & supporting narrative):
Process Measures we have implemented:
• Are we meeting the goals of the program?
• What is going well? And not so well?
• What types of resources and inputs are missing in the program?
• What are the anticipated outcomes of the program?
• What contextual factors may affect the program?
• What are the barriers or challenges to the program?
• Is there a return on investment for the program?
Patient satisfaction surveys are done with each program with testimonials.

Q26: Describe the evidence of Operational Benefit gained from this program (e.g., growth documented by increased visits or patients; enhanced efficiency and process as evident by improved productivity; improved customer and/or physician satisfaction):
The unique characteristic identified in this new approach of delivery of care is the accelerated awareness and adoption of a more patient-centered, team-based care we are now providing. We have always had a vast array of programs and opportunities for our graduating patients, and thought our delivery was being met. With studying our discharge planning outcomes, and readmissions to hospital and rehab, our long term outcomes were not being met. With our new approach, growth has been documented with increased visits to our Health and Wellness programs, and also biometrics thresholds met in our Diabetes Prevention Program within our Cardiac patients.
Our collaboration of team players within our healthcare system and community has built durable linkages between communities and health care. We found the sustained infrastructure supports are also necessary to sustain and grow team-based care.
Q27: Describe the evidence of Financial Benefit gained from this program (e.g., return on investment (how it is measured); description of revenue or reimbursement sources; indication of cost savings, in-direct revenue enhancement elsewhere in organization; any evidence of payer cooperation or support):

Financial benefits have shown with increased revenue growth in our Health and Wellness Center programs by 33% in last 3 months. Our long term goal is to reduce hospital readmissions. Also a more team-based care supports the management of chronic disease in a comprehensive way. The current one-provider to one-patient model of care is inefficient, so our care continuum approach can provide patient teaching, self-management, referral management, care-coordination, and support by connections with Carry on with Cardio programs.

Q28: Describe the evidence of Health Benefit gained from this program (e.g., increased health awareness and/or decreased health risk; improved health of community (or population targeted) as evidence by improved health knowledge and/or behavior; decreased hospital, physician or ER visits):

A team-based approach in our rehab program has shown improvement in our patients’ experiences and patient safety with use of patient surveys. Our county health rankings have shown improvement over the last 5 years, with our goals to continue to focus on population health. Our health system’s goal is to be a key resource for our communities. This innovative way of thinking and delivery of care can connect patients back to the community and build a healthier community. Once again, our goal is to create innovative ways to reduce hospital readmissions, lower healthcare costs, and improve the health of each individual we encounter.