Heart Healthy Communities

We live in an exciting, encouraging era of frequent advances in medicine. The results of studies asserting the latest advances for preventing and treating a host of ailments are proclaimed in daily papers, evening newscasts, and medical journals. Most people don't realize, however, that there's a gap in translating this material into practical programs that are ready for implementation in our communities. Even when there are real programs in place, there may not be methods for tracking their effectiveness and helping them evolve.

SPRC's Stanford Heart Network (SHN) is a good example of how research can be translated into action. SHN is the mechanism by which Stanford disseminates its HEAR^{2}T model to organizations around the world to help them improve the cardiovascular health of their patients or members.

Stanford's Approach

In 1994, SPRC researchers published the landmark SCRIP study, which revealed that an intensive intervention program could reduce the incidence of cardiac events (heart attack, bypass, etc.) by 40-50% among men and women known to be at high risk.

It quickly became clear to everyone—health care providers, insurance companies, employers—that there were tremendous benefits to identifying high risk individuals and teaching them heart-healthy behaviors. The challenge was to take this realization out of the medical center and into the community. Could doctors and nurses be taught to be more aggressive? SPRC researchers knew that the answer could shift the paradigm for treating and managing all chronic diseases.

HEAR^{2}T and the Stanford Heart Network

Physicians and nurses, it turned out, were eager to conduct interventions with patients who were at high risk for cardiovascular disease. So, based on their earlier work, SPRC developed the HEAR^{2}T model: the Health Education and Risk Reduction Training Program. SPRC then formed the Stanford Heart Network to provide health professionals with training and information to augment their existing programs. SHN members now include hospitals, clinics, physician offices, rehab programs, worksite health programs, government agencies, and community programs.

"The Stanford Heart Program has enabled us to help San Mateo County employees learn about their cardiovascular health and take action to reduce their risk for a heart attack or stroke. The Stanford HEART model makes it easy to guide people toward the best resources to meet their needs—such as advice from a dietitian, help in quitting smoking and ways to improve physical activity. We are happy we can help people help themselves."

Susan Vana
Nurse Practitioner and Co-ordinator
San Mateo County HEART Program

The HEAR^{2}T Program

individualized **widely applicable** **cost-effective**

- *A low-fat, low-cholesterol diet emphasizing vegetables, grains, fruit, and fish*
- *An endurance-oriented exercise program*
- *Medication to control cholesterol and blood pressure*
- *A program to stop smoking*
- *A weight loss program*
- *Clinical visits and phone calls from staff*
- *A website and mailings with educational material and program updates*

(continued on back)

StanfordHeart.net

The SHN website (www.StanfordHeart.net) is a crucial and dynamic part of the HEAR^{2}T program. Member professionals access a wealth of information from the site—but that's not all. The site is home to an ever-growing clinical database that collects information about patients in member programs around the world. A physician at a cardiac rehab center, for example, can send his patients to StanfordHeart.net to submit a questionnaire about their cardiovascular health. The benefits are then twofold. First, patients feel like they're taking an active role in maintaining their health. Second, Stanford is collecting research data that can be studied to take the pulse of a particular group (e.g., poor immigrants of Santa Clara County, California) or detect patterns across communities (from Manchester, England, to Vancouver, British Columbia). The conclusions derived from this data can be recycled back into training and from there into programs around the world.

The SPRC model satisfies the demands of the current trend toward evidence-based medicine and completes the missing link in the feedback loop. SPRC plans to extend its pioneering practices to other disease intervention applications.

Interview with Bill Haskell & Randy Stafford

William L. Haskell, Ph.D., is a founder and Deputy Director of the Stanford Center for Research in Disease Prevention. A member of the Stanford community for the last 27 years, he is a Professor of Medicine in the Division of Cardiovascular Medicine and SPRC. Much of his research has focused on the combined role of lifestyle factors and pharmacological therapy in the prevention and management of cardiovascular and other chronic diseases.

Randall S. Stafford, M.D., Ph.D., is an Assistant Professor of Medicine at Stanford. He brings new expertise in health care quality improvement and evidence-based medicine to SPRC. He has conducted key studies on how to improve the effectiveness of the health care system.

Why is there such a big gap between public health research and program implementation?
A highly integrated approach is necessary to prevent or treat complex diseases. Successful implementation involves an individual *and* his or her family, employer, health care providers and the insurance industry. It also involves dealing with major countervailing influences in the community that contribute to risky behaviors such as cigarette smoking, poor nutrition, inactivity and obesity.

How is SPRC's model for closing this gap unique?
The SPRC model provides an individualized care management approach for each high-risk person, integrating comprehensive lifestyle changes with medical treatment. It takes into account the person's clinical and risk factor status, their interests and readiness to make changes, and resources available in the family, at work and in the community. Furthermore, it's integrated with the care of their personal physician. Our results are unparalleled; our model has been shown in a randomized controlled trial to reduce hospitalization rates by 45% over 4 years.

Tell us about the interest that insurance companies and other large organizations, like United Airlines and Merck, have had in your model.
We are working with a number of different organizations, especially employers, hospitals and health plans, on ways to more effectively implement risk reduction for target populations at high risk for multifactor cardiovascular disease. Our major goal is to develop cost-effective strategies for reducing high-cost hospitalization, disability and death. So far very few systems that meet these goals have been developed, implemented and evaluated.

What does the future hold for this program you've developed?
Our focus will continue to be on preventing heart attack and strokes. However, many of the lifestyle changes we promote also reduce major risk factors for diabetes and some specific cancers. They also contribute to an improvement in overall health, successful aging and quality of life.