TAKEheart Care Coordination Implementation Guide – Part 1 -- Module 6

Laying the Groundwork for Effective Care Coordination

Purpose and Overview

The overall goal of TAKEheart is to increase the enrollment and successful completion of cardiac rehabilitation (CR) by eligible patients. The evidence demonstrates that using a combined strategy of care coordination with automatic referral can increase CR participation to 86% (see Combined Training Modules 1 & 2 for more review of the literature). TAKEheart's Module 6 Training Session provides a working framework for care coordination and discusses the key steps for setting the course to establish or enhance the care coordination you provide to the patients in your CR program.

Patients enter the CR referral pipeline from multiple providers, experiencing multiple cardiac conditions, and coping with differing life experiences and backgrounds. The goal of care coordination is to support all eligible patients from the time they become eligible until they graduate from a CR program. The TAKEheart Care Coordination Implementation Guide (Guide) has three parts. Part 1, which is the current text, is designed to help you set improvement priorities. This is the focus of Training Module 6. Part 2 addresses how to implement a care coordination system and will be released in conjunction with Module 8. Finally, Part 3 will address the techniques and methods for engaging and empowering patients to take a more active role in their care and be released along with Training Module 9.

All existing hospitals and CR programs have at least some aspects of care coordination in place. You process referrals, enroll patients, schedule CR sessions, and respond to requests for assistance. To do this well you need to include staff coordinating care for hospitalized cardiac patients as well as outpatient CR program staff in your TAKEheart team. In smaller hospitals or programs, staff may coordinate both in- and out-patient cardiac rehabilitation. The following three questions are designed to help you assess whether and where to improve:

1) Do you have appropriate care coordination activities in place to support the full span of patient needs beginning in the inpatient setting and continuing into outpatient cardiac rehabilitation?
2) How well are your in- and out-patient care coordination activities working?
3) What priorities should you set for improving your care coordination system?

To help you answer these three questions, Part 1 of the Care Coordination Implementation Guide is divided into three sections:

- Ensuring you understand the framework for care coordination
- Assessing the gaps and levels of care coordination performance you currently have at your hospital
- Setting priorities and next steps for care coordination improvement

Step One: Understand the Care Coordination Framework

There are many misconceptions that can prevent an existing CR program from developing a fully functional and effective care coordination system. In discussions with your TAKEheart team and with staff that coordinate in- and out-patient CR, ask the following questions to surface possible misconceptions about care coordination and help create a shared understanding of what an effective care coordination system should be.

1) **Who should be the focus of the ideal care coordination system?**

   Misconception: The focus should be on coordinating the care of our current CR patients. While this seems plausible and while some care coordinators may work exclusively with current patients, the focus of your overall care coordination system needs to be broader than this.

   Better Answer: The care coordination system ought to support all patients eligible for CR in your catchment area.

   Why this Misconception Matters: If you focus your care coordination system on the patients you currently have, you won't be supporting the many patients eligible for CR that are never identified or referred to a CR program. Automatic referral is designed to ensure that all eligible patients are identified and referred to CR. But if your care coordination system fails to work with your automatic referral team to educate providers about how AR works and fails to follow up with providers who may be opting-out large numbers of their eligible patients, you will not achieve TAKEheart's full potential.

   Some programs are less concerned about this issue because their program already has a waiting list and is operating at full capacity. **Nonetheless, it is better to grow your program's onsite capacity or offer new options for virtual or hybrid CR than to ignore the needs of patients that need CR but do not currently receive it.**

2) **When should care coordination activities begin and end?**

   Misconception: Care coordination begins with a referral and ends when the patient is enrolled in our program.

   Explanation: While referral to enrollment phase is an important **PART** of any care coordination system, it cannot be the exclusive focus. Some staff roles may focus exclusively on this important phase in the patient's experience, but your overall care coordination system should probably be broader.

   Better Answer: Your care coordination system ought to begin when eligible patients are identified and then continue to support patients through their graduation from your program (and perhaps even beyond).

   Why this Misconception Matters: If you ignore the needs of patients before they are referred, you will be failing to help some of your most at-risk and underrepresented

patients. Care coordination on behalf of patients **before** they are referred **includes working with physicians and practices to ensure that the care providers understand the benefits of CR for all eligible patients and are willing and able to communicate the benefits in conversations with their patients.** Failure to actively support patients throughout the duration of their CR increases the risks of their dropping out before completing the program. This is especially true of the most vulnerable patients. **Operating at full capacity is not a valid reason to neglect patients with the greatest initial or ongoing care coordination needs.**

3) **Which key stakeholders should be directly involved in your care coordination system?**

Misconception: Staff designated as "care coordinators" are solely responsible for all care coordination activities.

Explanation: Different CR programs define the care coordinator role in different ways. Sometimes care coordinators work with hospitalized cardiac patients; sometimes they manage scheduling and follow up in outpatient CR. However, your program may define the care coordinator role, it's important to understand that **you can have multiple care coordinators and still have an incomplete or inefficient care coordination system** that does not meet the needs of your patients or CR program. Conversely, **you may have no dedicated care coordinators and still effectively coordinate the care of your patients**

Better Answer: An effective care coordination system includes multiple team members and external partners committed to supporting the needs of eligible CR patients in your catchment area. This includes clinical and nonclinical staff that work directly with patients, cardiologists caring for them, and persons from your IT department that support your AR system and manage your CR program's data. It may also include volunteers, CR program ambassadors, or community resources that you partner with to support the needs of at-risk patient groups.

Why this Misconception Matters: **Assuming that you must hire a dedicated care coordinator may prevent you from ever getting started with improving your care coordination.** Alternatively, if you assume that care coordination is the sole responsibility of your care coordinator(s) then you'll be setting them up for failure. **Care coordination requires an effective system and team—not just hiring a capable person.**

4) **Why is an effective care coordination system needed?**

Misconception: The most important reason for care coordination is to ensure that your program has enough patients regularly attending CR sessions to keep it solvent.

Explanation: While financial stability is important, making this your sole concern creates a program-centered view of care coordination—not a patient-centered view.

Better Answer: A balanced answer to this question addresses the needs of both your patients and your program: Care coordination is important because patients eligible for CR need to receive it to improve their health outcomes and because the most at-risk patients need the most care coordination support. It is also important because the financial stability of your program is harmed when patients fail to attend, drop out before completion, and experience hospital readmissions for their underlying cardiac condition.

Why this Misconception Matters: If maintaining sufficient patient volume is the focus of your care coordination efforts, then you will be tempted to limit your activities to those patients that cardiologists already refer and to patients that seem most likely to attend CR sessions regularly and with limited support. **This focus will continue the low rates of CR participation for women, persons of color and persons with limited resources or inadequate health insurance coverage.**

Step Two: Identify and Articulate the Specific Aim(s) for Your Care Coordination System

Articulating the specific aims for your care coordination system will provide a foundation and roadmap for your improvement efforts. Key activities that you should undertake as part of this step include:

1. Creating an Aim Statement

We encourage you to create an aim statement for your CR program's care coordination system. This is different from the aim you may have created for your TAKEheart team. Instead, **it should provide a guide for your team as you assess your care coordination system and set priorities for improving it.** It should be broad enough to encompass care coordination activities in both the hospital and outpatient settings. An example aim statement is provided below:

Our Care Coordination system exists to maximize the number of eligible patients from both in- and out-patient settings who are identified, referred, enrolled, and successfully complete CR. This group of patients includes patients treated in our hospital as well, as others in our CR program's catchment area. This aim also means we need to help guide patients to the CR program best suited to their needs, even if that is not ours.

While your aim statement should be specifically tailored to your program and its patients, try to retain key elements from the example above. Any good aim statement should be:

- **Balanced.** You need to both meet the needs of your patients and maintain the financial viability of your program. **If you focus exclusively on finances, you won't fully support the needs of your patients.** And if you steer patients to the CR program in which they will have the highest opportunity of success, you will reduce the need to coordinate the care of patients that really would be better supported elsewhere.
- **Focused on the ultimate goal of helping patients graduate from CR**. While not all patients will graduate, **if maximizing completion is not your focus then you will never reach this goal.**

- **Inclusive of all CR-eligible patients in your catchment area**—not just patients currently being referred or those from your hospital. **You cannot meet the needs of all patients that would benefit from CR if you do not even know who they are.**

1. **Reviewing the Elements of an Effective Care Coordination System. A**n effective care coordination system will include:

   - Workflow processes and activities designed and systematically executed to help ensure eligible patients get referred, enroll, and participate fully in CR.
   - A set of sequential activities performed throughout the continuum of care from eligibility determination to CR program graduation.
   - Execution by a team vs. a single person
   - specific Processes and activities aimed at facilitating patient conversations, developing and disseminating education materials, screening for patient needs and concerns, addressing provider concerns that may or may not impact referrals and linking patients to community resources.

2. **Be sure to pay attention to three major factors as you assess the needs of your care coordination system:**

   - **The status of implementation of your automatic referral (AR) system and clinicians' understanding and acceptance of it**

The first essential step in care coordination is the physician conversation with the patient and family recommending participation in CR. It's critical to ensure that that this important conversation happens and that there are sufficient opportunities to involve families in discussions of CR. For this reason, it is essential to begin by assessing the level of physician understanding and acceptance of AR. It is not uncommon for providers to be frustrated by new processes and workflows like automatic referral. This frustration may lead to resistance to using the automatic referral system or opting out eligible patients who should in fact be referred. Establishing mechanisms to address provider concerns can help promote adoption. Understanding reasons for opt-outs can help inform refinements of the automatic referral system.

- **The needs of your patients**

Patients are often overwhelmed and scared following a cardiac episode, procedure, or surgery. They often feel lost in the maze of the healthcare system. Many do not understand what has happened to them and can't comprehend the role of CR. Others think of CR as just an exercise they can do on their own. An effective care coordination system meets the patient where he or she is and has processes and activities to address patient-patients' specific issues, questions, needs or concerns.

- **Common barriers encountered by your patients**

Common patient barriers to CR include transportation constraints, cultural and linguistic barriers (e.g. expected family obligations, discomfort exercising with men and women,

challenges understanding spoken English), and limited finances resources An effective care coordination system establishes relationships with hospital-based (social workers, interpreters, etc.) and community resources and develops processes to connect patients with resources that can facilitate their participation in CR.

Step Three: Understand and Evaluate Current Care Coordination Processes

TAKEheart emphasizes the need to work with your team and key stakeholders as you set goals, assess processes, and review progress. This doesn't mean scheduling lots of meetings that busy team members may choose not to attend. **It does mean you need to be both eliciting input from, and sharing insights with, members of your team.** This will probably require meetings, email updates, and individual and small group conversations with team members. **You must engage with your team and key stakeholders. HOW you do this will depend on the needs and preferences of your individual team, hospital, and program.**

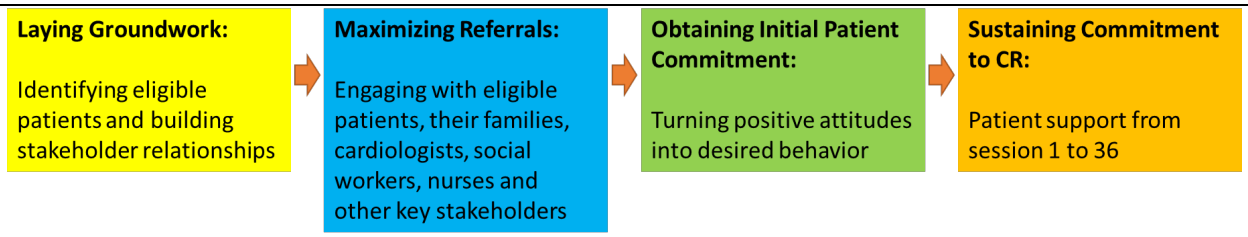
To improve your care coordination system, you need three types of information:

- **How** your care coordination processes currently work. In Module 3 you learned about process mapping and were encouraged to map your care coordination processes. While process mapping is invaluable, it risks ignoring aspects of care coordination you may not be doing at all (e.g., working to elicit more referrals of eligible patients).

- **How well** your care coordination processes are working. While process mapping should expose you to what key stakeholders think is (and isn't) working well, it will not tell you how well specific processes are working compared to internal goals or external benchmarks. For that, you need to capture and review data. How to do use data was the focus of Module 4. The Data Implementation Guide provided multiple examples of measures and ideas for how to collect the data needed to evaluate your care coordination processes.

- **What** your care coordination system should do. As noted above, creating a clear aim statement for what your care coordination system should do will help you determine whether you have missing or inefficient processes and whether your processes are achieving your defined goals.

While you may not have all of this information yet, you should have enough to get started while you work to complete process mapping or to obtain and review relevant data. Appendix 1 includes a checklist that you can use to assess care coordination processes that frequently contribute to effective patient support. These activities fit into one of the four sequential phases shown below.



We encourage you to carefully consider what care coordination activities you currently perform in each of these four phases as well as what activities you may want to add or enhance in order to best support your patients' and program's needs.

Phase I: Laying Groundwork

Timing: Before patients even become eligible

Primary Foci: Ensuring all eligible patients can be identified and establishing positive working relationships with the units and staff you will need to collaborate with to support eligible patients

Major Considerations:

- **Defining what your program's catchment area is**. This could be as small as a part of your city or could encompass multiple counties. You need to determine your catchment area in order to know your patient population and their unique needs and which hospitals or cardiology practices you may need to reach out to in order to best support the needs of eligible CR patients in your catchment area. **Because patterns change, you may want to reassess your program's catchment area every several years as part of your care coordination activities.**
- **Developing and maintaining positive relationships with your referring practices and cardiologists**. This should be guided by the information you have regarding which hospitals, practices and physicians currently make referrals to you. It should also be informed by your knowledge of which hospitals do not refer to you. **Developing positive relationships should be a bigger short-term priority than immediately getting more referrals.** Take time to listen and understand the reasons that are provided for referring or not referring patients, and lay groundwork for continued dialogue with the potential sources of referrals into your program. Ultimately dashboards and data reports may also help convince some cardiologists to refer more of their suitable patients. You may also want to assess your relationships with CR programs in adjacent areas. While you may compete with these programs, this should not keep you from coordinating with them to steer patients towards whichever program they will be most capable of succeeding in.
- **Monitoring changes in referring units of your hospital and developing or maintaining positive relationships with key staff from these units**. Some CR

programs know the staff and operations of key hospital units exceptionally well, but others do not. It may be important for your care coordination system to have a process for monitoring any relevant changes in key unit operations or personnel and for updating CR program staff of any relevant changes.

- **The status of automated referrals**. While automated referral is a distinct process from care coordination, people coordinating patient care need to understand enough about how the process works to discuss it with potential referrers. This includes being able to explain why it has been implemented, what general logic is being used to identify patients eligible for CR, and how well the system is working (or what phase of implementation it's in). Staff that interact with referring units, hospitals, practices or cardiologists are your eyes and ears for trouble shooting and improving how AR system.

As you perform these foundation-laying activities you can use the table below to discuss with your team how important improvements in each area are and to consider what types of improvements may be needed. These could include resources to assist with the task (e.g., tip sheets, one-page handouts, FAQ document), specific processes or activities that need to be implemented, defining the persons responsible, determining whether training is needed to ensure these persons' success, or data to inform your approach to the task and assess progress over time.

	Priority Level (high, medium, low)	**What's Available**	**What's Needed**
Defining your catchment area			
Resources			
Processes or activities			
People			
Training			
Data			
Developing and maintaining positive relationships			
Resources			
Processes or activities			
People			
Training			
Data			
Monitoring and building relationships in key hospital units			
Resources			
Processes or activities			
People			

Training			
Data			
Integrating care coordination and automatic referral			
Resources			
Processes or activities			
People			
Training			
Data			

Phase II: Maximizing Referrals

Timing: From eligibility determination to formal referral

Primary Foci: Creating positive attitudes towards CR referral by referring physicians, patients and their families and ensuring formal referrals actually occur

Major Considerations:

- **Knowing which hospitals, units, practices and providers are and are not referring patients.** Knowing your high referral sources will enable you to reach out to them to advocate for more referrals. Understanding which referral sources are not referring patients and are opting-out patients from your AR system can enable you to focus your efforts on non-referrers who care for the most eligible patients. Influencing non-referring cardiologists may require the use of multiple strategies, including:
  - Talking with them directly to understand and respond to their objections or misunderstandings about CR.
  - Providing evidence such as publications or materials from Million Hearts that document the positive impact of CR.
  - Identifying cardiologists and working with them to advocate for CR with their peers. Peer influence is a demonstrated method for influencing physician behavior.
  - Working through the Chief Medical Officer or other physician leadership within the hospital to promote more appropriate referrals.
  - Working with hospital or health system administration to create comparative data reports related to referral rates and to align financial incentives for referring eligible patients.
- **Knowing which subpopulations of eligible patients are not being referred.** Few providers may be consciously or deliberately failing to refer patients based on race, gender, or ethnicity. Nonetheless, the evidence is very clear that women, persons of color, older persons, and persons lacking insurance are less likely to be referred. While citing published literature may be a useful tool, actual data on the

referral rates for at-risk and not at-risk populations may be your most effective strategy for promoting referrals for persons in underrepresented groups.

- **Understanding the reasons for non-referrals.** There are legitimate reasons why some patients may not be well suited to CR and for why some cardiologists or practices have lower referral rates. Part of your care coordination system should include understanding reasons for non-referrals so that you can focus your interventions on practices or cardiologists whose reasons for not referring patients are less well grounded.
- **Interventions to promote more referrals.** Staff supporting care coordination should be equipped to foster positive attitudes towards CR referrals. Staff training and coaching, resources and publications that promote CR referrals, and enlisting cardiologist champions to talk with their peers are all proven methods for promoting more referrals. Sometimes patient engagement is also key to this process. You can also promote referral by helping patients and their families understand the need for CR and believe that they can succeed in CR. Sometimes cardiologists are reluctant to refer patients they assume will not succeed in CR. Communication with the patient and family may equip them to advocate for a referral into your CR program.

As you assess what your care coordination system is doing to promote more referrals of eligible patients, you can use the table below to discuss with your team how important improvements in each area are and to consider what types of improvements may be needed. You may choose to complete the table. Or you can just select one or several of the listed areas where you know improvements are needed and begin to work on them. Priority areas could include resources to assist with the task (e.g., tip sheets, one-page handouts, FAQ document), specific processes or activities that need to be implemented, defining the persons responsible, determining whether training is needed to ensure these persons' success, or data to inform your approach to the task and assess progress over time.

	Priority Level (high, medium, low)	**What's Available**	**What's Needed**
Knowing which hospitals, units, practices, and providers are and are not referring patients			
Resources			
Processes or activities			
People			
Training			
Data			

Knowing which subpopulations of eligible patients are not being referred			
Resources			
Processes or activities			
People			
Training			
Data			
Understanding the reasons for non-referrals			
Resources			
Processes or activities			
People			
Training			
Data			
Interventions to promote more referrals.			
Resources			
Processes or activities			
People			
Training			
Data			

Phase III: Obtaining an Initial Commitment to CR

Timing: From formal referral to attendance at initial CR session

Primary Foci: Translating a general favorable attitude towards CR participation into the preliminary activities that lead up to attending an initial CR session

Major Considerations:

Many CR programs have processes in place to follow up and support patients after they have been referred and before they attend their first session. Whether they are performed by inpatient staff or the outpatient CR program, optimal processes include:

- Patient follow up within 48 hours of referral
- Sharing educational materials about the value of CR and how it works
- Verifying insurance and discussing options (if any) for obtaining financial support for sessions or copays
- Assistance working out logistics associated with scheduling and transportation
- Updates to providers regarding the patient's referral and enrollment status
- Group intake and orientation processes

- Tracking patients discharged from acute care as they transition to a post-acute care facility
- Managing the CR program wait list and providing updates to patients on the list
- Tracking key metrics for this phase including:
  - Percent of referred patients enrolled
  - Percent of enrolled patients attending first session
  - Time on CR program wait list
  - Patient satisfaction

Some programs also have defined processes for using CR ambassadors or others to engage with referred patients and their families to address concerns and offer additional information. As you review your process mapping and the list of potential activities in this phase noted above, you may want to focus on a limited number of known problems and work with your team to develop and begin implementing potential solutions.

Phase IV: Sustaining the Commitment to CR

Timing: From attendance at session 1 through graduation

Primary Foci: Reinforcing a positive attitude towards CR completion and helping patients overcome obstacles to CR program graduation.

Major Considerations:

CR programs should have defined processes for scheduling follow up visits, contacting no-shows, and responding to patient requests for assistance. Other key processes you should consider in this phase of coordinating patient care include:

- Process for providing regular updates to providers on the status of their participating patients. Such updates can benefit the patient and strengthen relationships with referring cardiologists, leading to more referrals in the future. They also will assist the cardiologist in reviewing the patient's individualized treatment plan—something often required every 30 days.
- Offering patient support that is **proactive**, rather than **reactive**. Unfortunately, many patients that begin CR drop out long before they graduate. You and other CR program staff know the common reasons for dropping out. Continuously assessing problems the patient may encounter and working proactively to address them is more likely to succeed then reacting once the patient begins to miss sessions. This process can begin when enrolling the patient or once they begin attending sessions and interacting with CR program staff.
- Leveraging external forms of social and emotional support for patients and families. This may include processes for identifying and partnering with other family members to address patient needs, developing social support networks, or connecting with former CR graduates as a "buddy" to provide additional assistance and encouragement to patients.

- Regularly capturing and monitoring relevant data to identify care gaps and trends that suggest the need for improved care coordination.
- Traditional onsite CR programs may be very challenging for patients with transportation, work, or family obligations that are difficult to work around. If your program is offering a virtual CR option to some patients, care coordination should include assessing whether some patients might benefit from this option and supporting their transition to it.

As you assess what your care coordination system is doing to maximize the success of participating patients, discuss with your team which potential improvements will have the largest positive impact, what types of improvements may be needed and how important they are or valuable they are likely to be. These could include identification or development of resources to assist with the task (e.g., tip sheets, one-page handouts, FAQ document), specific processes or activities that need to be implemented, defining the persons responsible, determining whether training is needed to ensure these persons' success, or improving access to data that can improve your ability to monitor patient progress and your improvement efforts.

Step 4: Setting Priorities and Next Steps for Care Coordination Improvement

If you've done the process mapping recommended in Module 3, obtained relevant data suggested in Module 4, and assessed your current care coordination activities across the four phases described above, then you should have a very long list of ways to improve your care coordination system. Module 8 will guide you as you design and implement your overall care coordination system.

There are multiple proven methods to help you get off to a successful start to this process. These include:

- Be patient centered as you set care coordination improvement priorities. **If you actively involve patients in setting priorities, you'll be less likely to focus elsewhere and more likely to focus on patient needs.**
- Narrow your focus to a doable number of improvements. **It's better to successfully fix a few things than to fail to improve a large number of known challenges.**
- Engage with your team to set priorities and who is responsible for implementing them.
- Align your improvement efforts with available resources and institutional priorities.
- Choose some easy and quick wins to get started. Creating a letter to give to patients at discharge introducing CR is an example of an easy fix that has been shown to have significant impacts on enrollment and participation. Establishing relationships with home health agencies and short-term rehabilitation facilities to track eligible medically complex patients after discharge will most likely take time and more resources.
- Choose priorities across all four phases. **Your efforts will have the greatest positive impact if you improve CR outcomes for both the patients you currently have and the patients in your catchment area that need CR but never receive it.** Making improvements across the four phases will ensure you are addressing the needs of all patients eligible for CR, including those that currently do not enroll.

- Use data to identify priorities that have the greatest potential impact.

Appendix 1: Workflow worksheet

	In place & working	Adjustments needed	If adjustments needed, what steps are you planning to take to improve?
Phase I CR -Regular CR education visits -Education materials -Physician follow up: opt-outs -Screen for patient needs or concerns			
Phase I to Phase II transition			
Phase II CR -Education materials -Orientation -Screen for patient needs/concerns			
Coordination with outside CR centers			
Maintain a list of other CR programs			
Insurance verification			
Plan for tracking eligible patients discharged to a post-acute care setting following an inpatient stay			
Patients called w/in 48 hours of referral			
Phase II weekly group intake			
Scheduling plan following group intake			
Transportation plan for patients w/ need			
Financial plan to assist w/ copays			
Regular communication w/ referring providers			
Process for no shows and cancellations			

Key Resources:

All key resources begin with a hyperlink that can be pasted into a browser to access. You can also probably access hyperlinks directly by holding the control key down while clicking the hyperlink in the document.

- AACVPR—Commercial Insurance Pre-Authorization Template for Cardiac Rehabilitation
  This AACVPR template suggestion is intended to expand reimbursement and payment information that is specific to CR services. In addition to demographic and insurance information that is collected prior to enrollment in CR, the following information is important in individualizing patient care.
- Case Study: Christiana Care Health System—Reducing Cost-Sharing Barriers for CR Services with Creative Options
  A brief Q&A with Christiana Care System about their successful reduction of financial barriers to CR, with links to a longer program summary.
- AACVPR Cardiac Rehabilitation Enrollment Strategy—Cardiac Rehabilitation Pre-Enrollment Group Screening
  This case study recognizes the importance of (and provides strategies for) timely referral to CR.
- Case Study: Genesis HealthCare System—Group Orientation
  Q&A with Genesis HealthCare System, which implemented peer support programs for CR patients, as well as additional links to a program summary.
- Genesis HealthCare System—Welcome to Heart & Vascular and Pulmonary Rehabilitation PowerPoint for Patients
  An example of a slide deck presented at a CR orientation.
- AACVPR Cardiac Rehabilitation Enrollment Strategy—Accelerated Usage of CR
  A short implementation guide for accelerated CR enrollment.
- AACVPR Cardiac Rehabilitation Enrollment Strategy—Matching Capacity to Demand: Open Gym
  A short implementation guide for open gym sessions.
- Case Study: Southwest Florida Heart Group—Open Gym Model
  Q&A with Southwest Florida Heart Group, which implemented an Open Gym model.
- Case Study: Mount Carmel Health System—Cardiac Rehab Open Gym
  Q&A with Mt. Carmel Health System, which implemented an Open Gym model.
- Case Study: Christiana Care Health System—Use Clinician Follow-up to Bolster Enrollment
  Q&A with Christiana Care Health System, which uses "non-enrollment letters" to notify referring cardiologists about patients' progress (or lack thereof) with CR, thus promoting patient accountability and engagement.
- AACVPR Cardiac Rehabilitation Enrollment Strategy—Cardiac Rehabilitation Patient Progress Report
  A short implementation guide for patient progress report, with a link to a sample report.
- AACVPR Cardiac Rehabilitation Enrollment Strategy— AACVPR Cardiac Rehabilitation Adherence Strategy—Incorporating Motivational and Financial Incentives
  An implementation guide for motivational and financial incentives for CR, including a sample tracking sheet and monetary breakdown.
- Case Study: University of Vermont Medical Center—Financial Incentives to Improve Cardiac Rehabilitation Attendance Among Medicaid Enrollees
  Q&A with Dr. Diann Gaalema about the implementation of financial incentives for CR patients enrolled in Medicaid.
- AACVPR Cardiac Rehabilitation Adherence Strategy—Use of Text Messaging and Mobile Applications
  An implementation guide for mobile monitoring of CR.
- Case Study: Miriam Hospital Center for Cardiac Fitness—Patient Ambassador Program
  Q&A with Miriam Hospital, which implemented a patient ambassador program to reduce the rate of patient drop-out, emphasizing the importance of personalized support for retaining patients.