TAKE heart

AHRQ's Initiative To Increase Use of Cardiac Rehabilitation

# Laying the Groundwork for Effective Care Coordination

## Module 6

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AHRQ Agency for Healthcare Research and Quality

# TAKEheart Training and Technical Assistance Components

Training sessions guided by the Million Hearts®/AACVPR Cardiac Rehabilitation Change Package (CRCP), located in the Resource Center TAKEheart Website

**Monthly Training Sessions: What to do and Why** -- Sixth of 10 modules

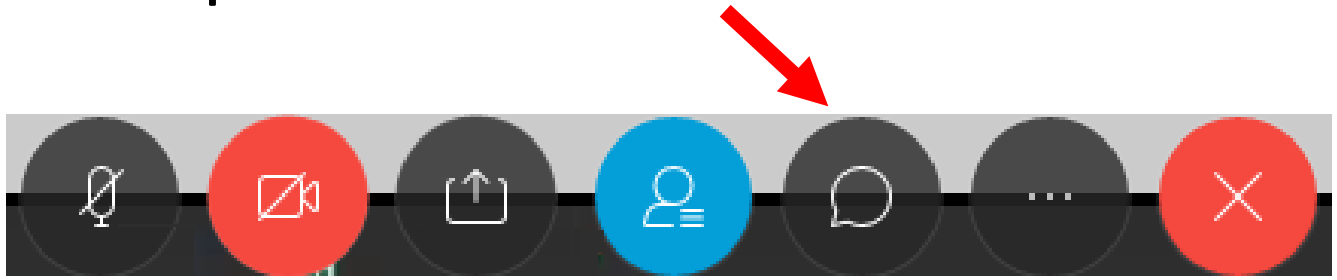
**Implementation Guide (IG): Focus on the How**
Supplemental documents which outline the content, and provide specific actions, steps and resources designed to assist with integrating the training material

**Partner Hospital Peer Action Groups (PH PAGs): Discussion of the HOW**
Meet with coaches to discuss module content, share ideas and offer support to other hospitals in the group

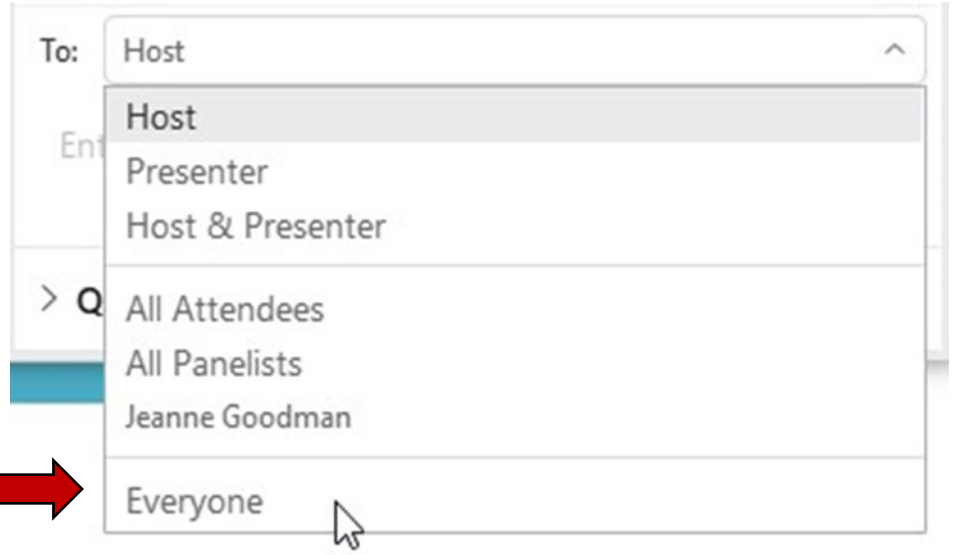
# Chat Function

**HOW TO ASK QUESTIONS**

To ask a question or make a comment open the chat box



Set the TO: field to **Everyone** so that we can all see your question




Try the chat function now by sending a short greeting to the rest of the group

# American Hospital Association (AHA)/Health Research and Education Trust (HRET): TAKEheart AHRQ's Initiative to Increase Use of Cardiac Rehabilitation
## Module 6: Laying the Groundwork for Effective Care Coordination
## September 30, 2021

The planners and faculty of TAKEheart Initiative Module 4 indicated no relevant financial relationships to disclose in regard to the content of their presentation.

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education through the joint providership of the American Board of Quality Assurance and Utilization Review Physicians, Inc. (ABQAURP) and American Hospital Association (AHA) / Agency for Healthcare Research and Quality (AHRQ). ABQAURP is accredited by the ACCME to provide continuing medical education for physicians.

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ABQAURP is an approved provider of continuing education for nurses. This activity is designated for 1.0 contact hours through the Florida Board of Nursing, Provider # 50-94.

# Implementing an Effective Care Coordination System

## Module 6

Preliminary work

- Understanding care coordination
- Identifying gaps, opportunities & underserved populations
- Brainstorming & setting priorities

## Module 8

Implementing changes

- Managing capacity
- Preparing staff
- Rolling out changes to the care coordination system

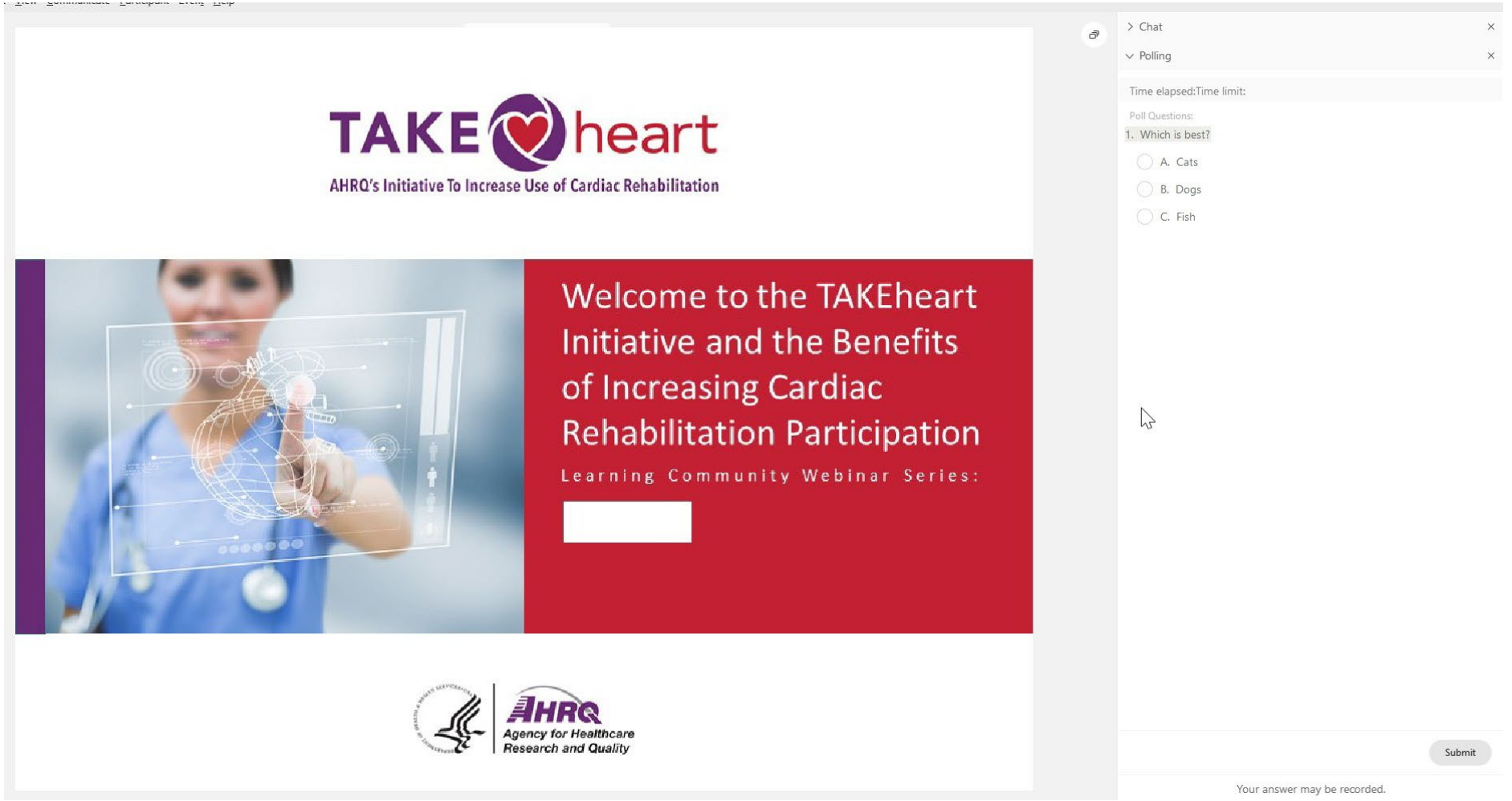
## Module 9

Empowering patients

- Pulling automatic referral and care coordination together

# Polling Function

**HOW TO POLL**



# Audience Question 1

Of the topics we've addressed in the modules so far, we still need to make the most progress with:

Please select your answers here

Remember to click **SUBMIT** when complete

# Learning Goals

*Upon completion of this module, attendees will be able to:*

1. **Explain WHY** implementing effective care coordination benefits CR patients

2. **Assess the effectiveness** of current care coordination workflow processes for inpatient CR to outpatient CR , especially the transition between the two settings.

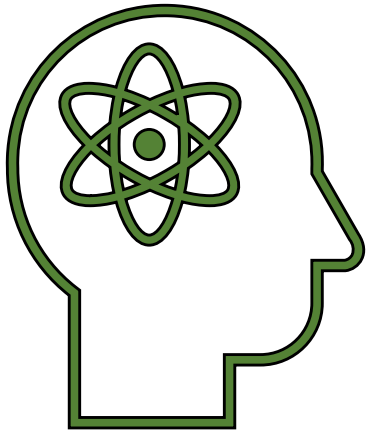
3. **Understand HOW** to establish priorities for enhancing care coordination to better meet patient needs to improve enrollment and participation in CR

# Today's Presenters

**Rachel Jarvis, MA, ACSM-RCEP, CEP**

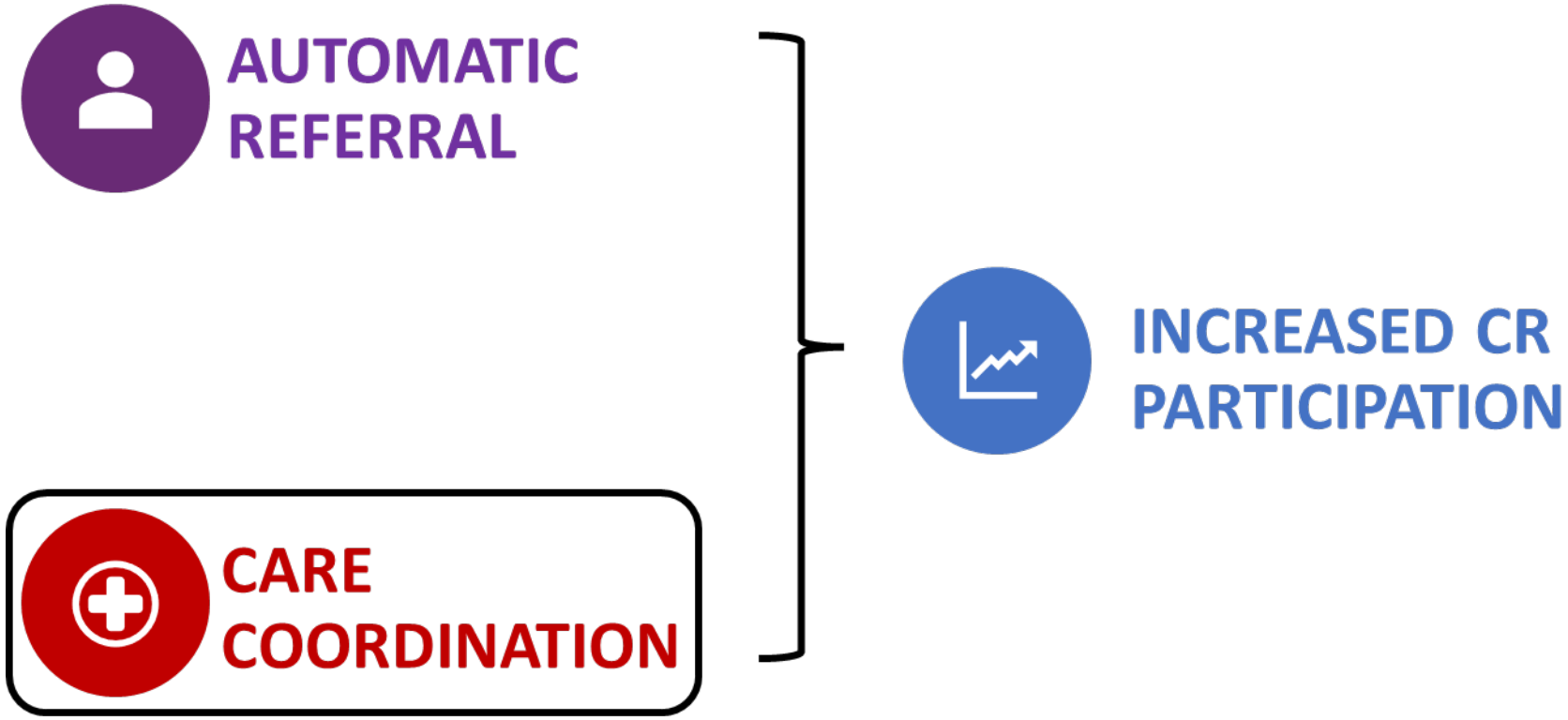
**Tammy Garwick, MA, MBA, ACSM RCEP, ACSM CEP, FAACVPR**

# Insights from the Speakers



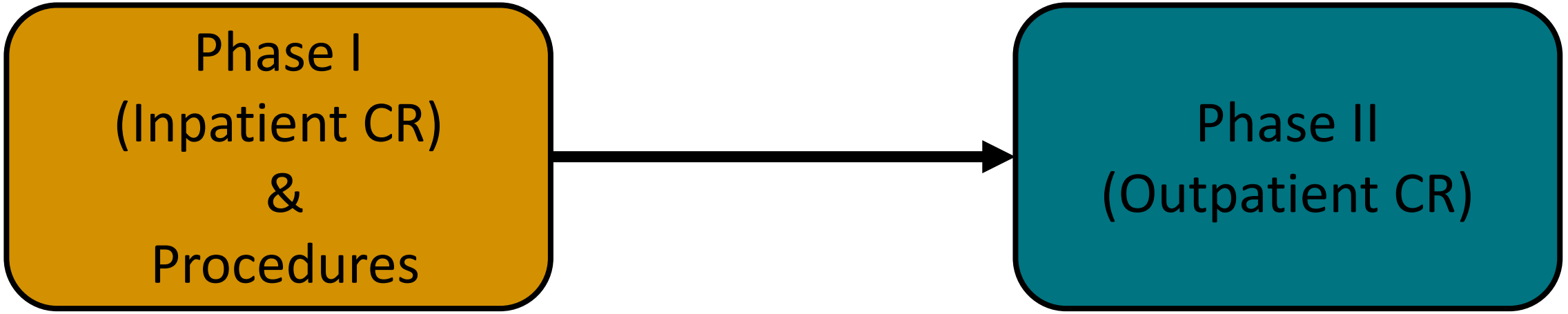
Organizational background
Why care coordination is important
Experience implementing care coordination
Key tips and advice for peers

# TAKEheart: A QI Project For CR




The purpose of TAKEheart is to close the gap between Cardiac Rehabilitation (CR) evidence and practice.

# Where Should You Focus: Inpatient CR & Procedures



# What Constitutes a Completed Referral?

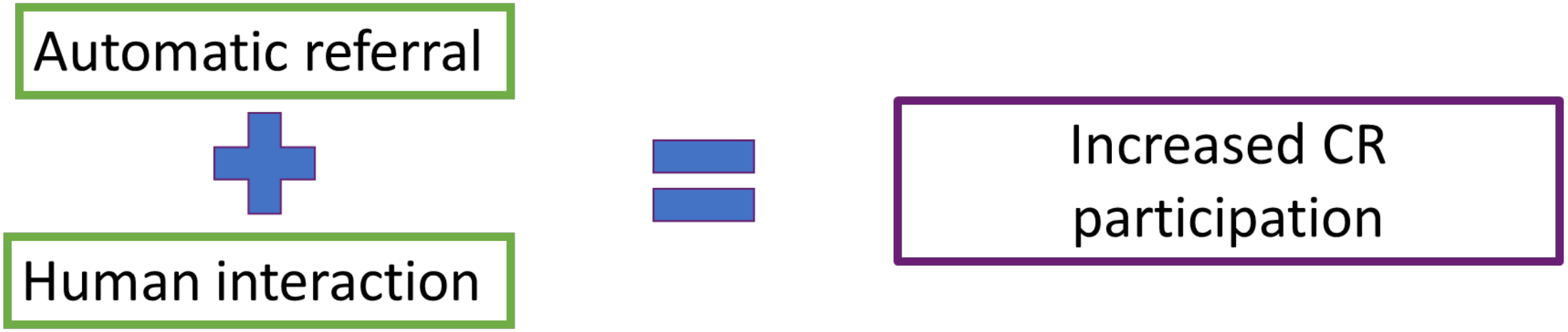

- Automatic referral (AR) of eligible patient to CR
- AR + ordering clinician conversation with referred patient about CR
- AR + patient conversation + scheduling the patient for the first CR visit prior to discharge

# How is Enrollment Defined for CR?

Enrollment

Participation in 1 CR Session

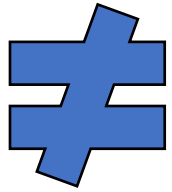
# Why is Care Coordination Important?




- Automatic referral combined with the strength of the physician recommendation and family support drives improved participation in cardiac rehabilitation
- More referrals should result in more conversations with patients and families about beginning and completing cardiac rehabilitation

# Why does Care Coordination Matter?

**GAP 1 :** Underutilization of CR

Automatic referral alone  enrollment & participation

Care coordination is needed to get referred patients to enroll and complete CR

# Why does Care Coordination Matter? cont.

**GAP 2:** Disparities exist in CR participation

If you are

- A young or older adult
- Female
- Black
- Hispanic
- Less well educated
- Lacking insurance

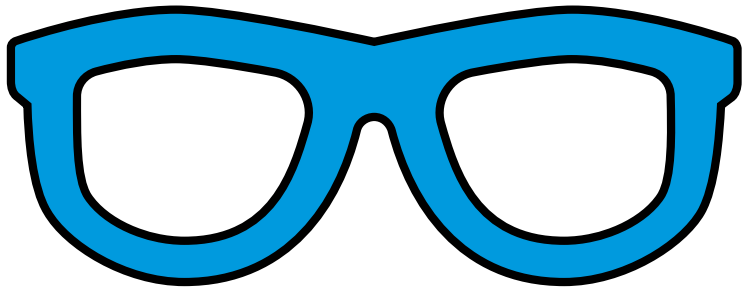
→ Less likely to participate in CR

Care Coordination is needed to understand and address patient needs and concerns to promote CR enrollment & participation

# Factors Impacting CR Enrollment & Participation

- Work/Family Obligations
- Finances
- Lack of Understanding / Overconfidence
- Transportation
- Fear and Anxiety

# Different Views of Care Coordination



**The view from the literature:**

Workflow processes and activities performed by the inpatient staff to introduce CR and transfer the patient's care to the staff of the outpatient CR program.

# Broad View of Care Coordination

**Care coordination involves**:

- deliberately organizing patient care activities
- sharing information among all the participants concerned with a patient's care

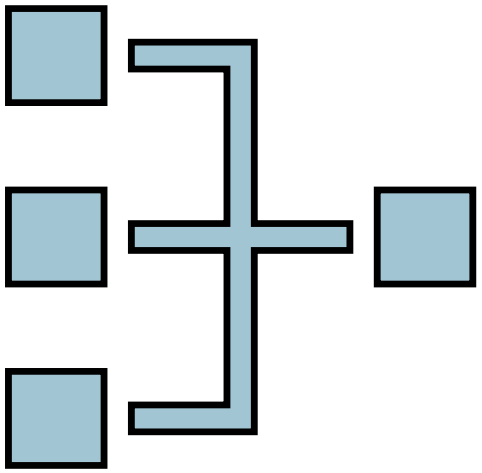
**This means**:

- patient's needs and preferences are known ahead of time
- communicated at the right time to the right people
- information is used to provide safe, appropriate, and effective care to the patient.[1]

**Learn more about AHRQ's Framework for Care Coordination at**

https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html.

# What Does Effective Care Coordination Mean for CR?



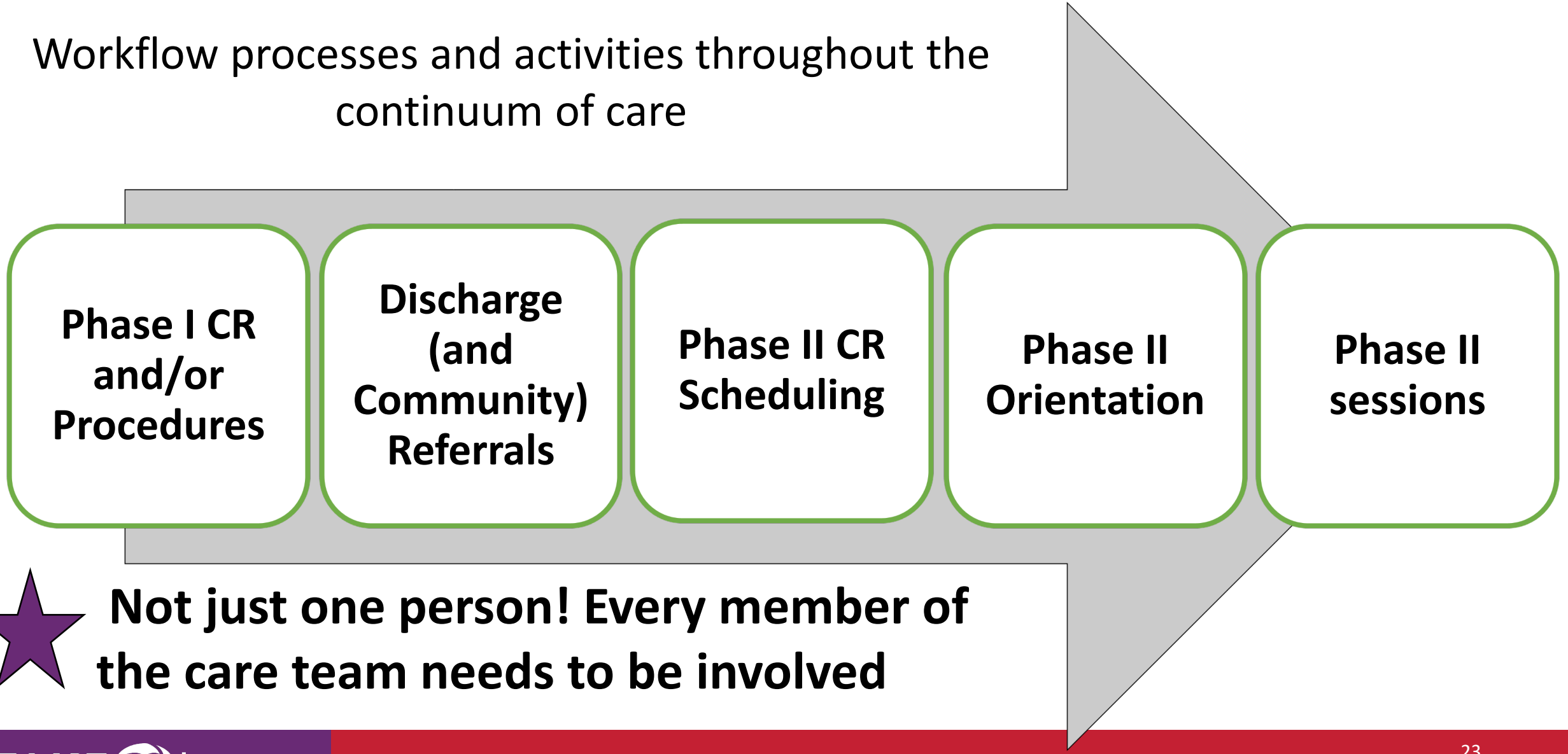
A group of workflow processes and activities designed and systematically executed to help ensure eligible patients get referred, enroll and participate fully in CR.

# Elements of Care Coordination for CR


- Patient education
- Patient engagement
- Assistance with care transitions
- Collaboration
- Relationship management
- Assessing patient needs & concerns
- Linking to community resources

# When does Care Coordination Take Place?

Workflow processes and activities throughout the continuum of care




**Not just one person! Every member of the care team needs to be involved**

# Key Care Coordination Processes & Activities in CR

Patient & Provider conversations

Coordinating referrals

Identifying and addressing patient needs and concerns

Developing education materials

Understand available community resources & connect patients

# Phase 1

| Description | Example Care Coordination Activities |
|---|---|
| Delivered immediately following surgery/procedure | Works w/ providers to refer eligible patients |
| Short length of stay: hours -> a few days | Helps ensure clinician conversations about CR w/ referred patients |
| Focus on improving daily function for self-care and mobility | Provides early CR education |
| | “Sells” outpatient CR |
| | Ensures warm handoff to outpatient CR |

# Transition from Phase I to Phase II

| Description | Example Care Coordination Activities |
|---|---|
| The time from inpatient discharge to the start of the first session | Requires collaboration between inpatient and outpatient staff |
| Shorter wait times promote greater CR participation | Requires communication about patient needs and concerns which may impact participation |
| Patients discharged to short-term rehab facilities or home health agencies often get lost | Requires knowledge of available programs and other community resources |

# Phase II

| Description | Example Care Coordination Activities |
|---|---|
| Supervised and monitored exercise in an outpatient setting tailored to each individual patient | Requires collaboration between inpatient and outpatient staff |
| Should start as soon as possible following inpatient discharge | Requires acknowledging the referral by communicating with the patient about scheduling |
| Usually consists of 36 sessions | Involves screening for patient needs and concerns |
| | Involves connecting patients with available community resources to facilitate CR participation and completion |

# Audience Question 2

In our CR program, care coordination is:

Please select your answers here

Remember to click **SUBMIT** when complete

# Getting Started with Care Coordination Redesign

- Requires an inpatient & outpatient champion to make the case for effective care coordination: **Module 1**
- Use the aim statement as the beacon, update the action plan and remember to assign targets & responsibilities: **Module 2**
- Revisit workflow processes: **Module 3**
- Review internal data and compare to external benchmarks: **Module 4**

# Make the Case with Data

Examining and analyzing aggregated data on referral, enrollment, participation, and completion rates for different types of patients should tell you whether and how gender, race/ethnicity or other factors are affecting CR referral, participation and completion.

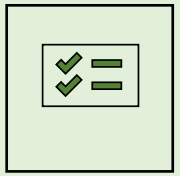
# Understand the Catchment Area

Use data to increase understanding about the population of eligible patients

- Which patient populations are missing?
- What are the characteristics of the typical CR patient?

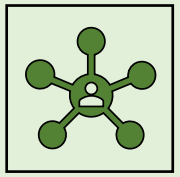
# What Other Data is Needed?

Information needed to confirm eligibility and to follow up with physicians.



Information that will help your staff develop a CR plan suitable for the patient and to anticipate and address their needs or concerns.

Information needed to contact the patient or to place them in the CR program that they may be the most successful in.



Information about patient participation to reinforce success or rapidly respond to emerging participation barriers.

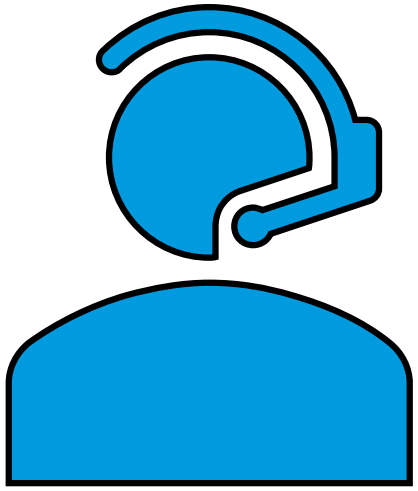
# Workflow Processes

## Identify what is working and what is not

- Where do patients fall through the cracks?
- Are conversations occurring between patients and the referring clinician?
- Are patients screened for needs and concerns?
- Who is communicating with the patient?
- How is health insurance factored in?
- Who follows up to make sure the patient enrolls?
- What is the wait time?

## Identify opportunities for improvement

# Talk to Patients



- Survey current and past patients, including those who did not enroll or did not complete
  - Identify factors that made the referral & enrollment process easy and/or difficult
  - Identify reasons for drop-out
  - Identify reasons for failure to enroll
- Information can be used to inform changes to workflow processes

# Audience Question 3

**Please check all that apply**

The biggest factor(s) preventing us from doing care coordination better:

Please select your answers here

Remember to click **SUBMIT** when complete

# Evaluate Results

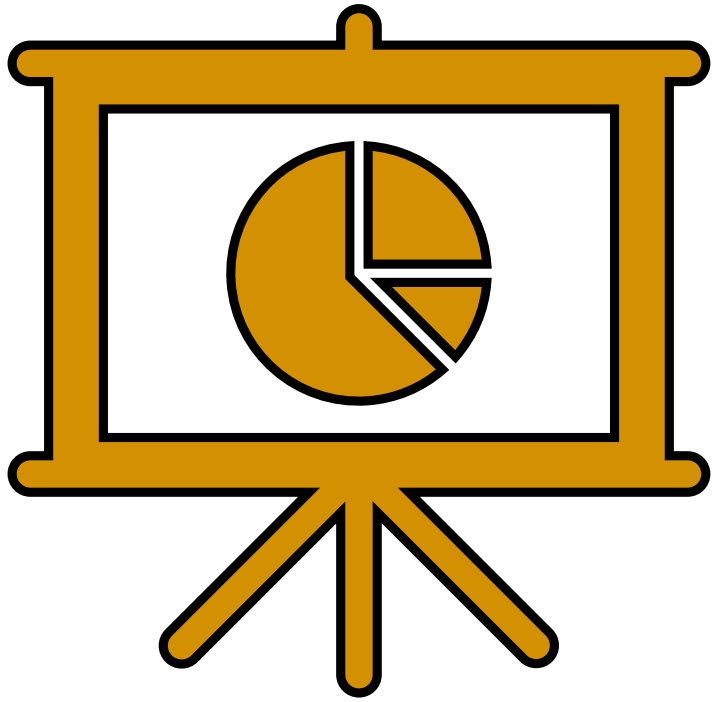
**As a team discuss what have you learned:**

**Process workflows**

- Make a list of process gaps
- Make a list of opportunities, especially for conversations with patients & families
- Make a list of patient needs & concerns

**Data**

- What are the characteristics of the catchment area?
- Time from discharge to enrollment
- Are eligible patients missing, which ones and why?

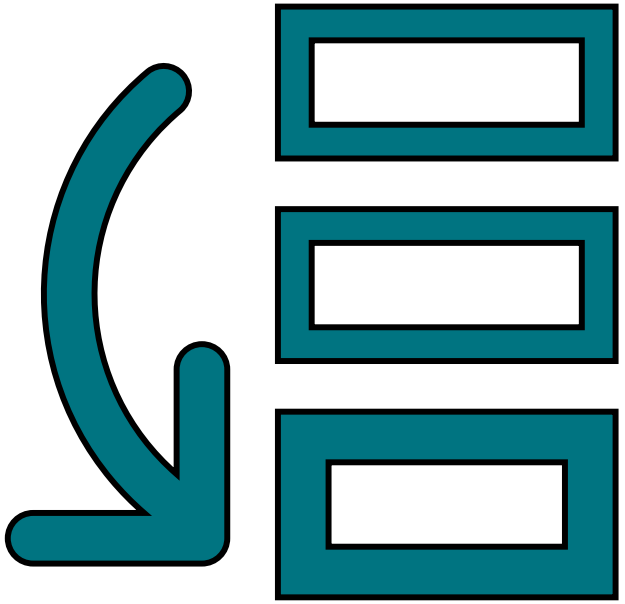


# Brainstorm Improvements

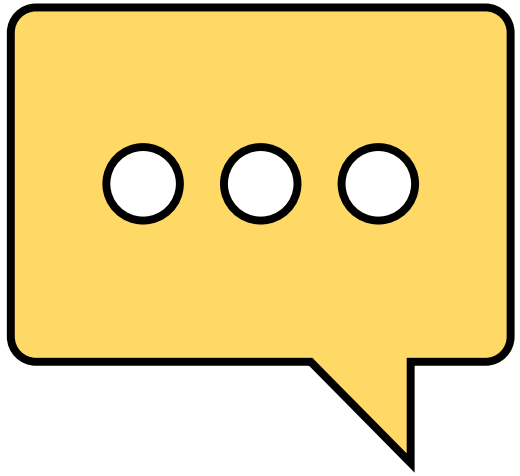
- Explaining CR
- Coordinating referrals
- Decreasing wait times
- Accommodating patient needs & concerns

# Set Priorities

- Reflect on aim statement
- Determine tasks to enhance care coordination that need to be added to action plan
- Set a course for revising or developing care coordination processes based on priorities

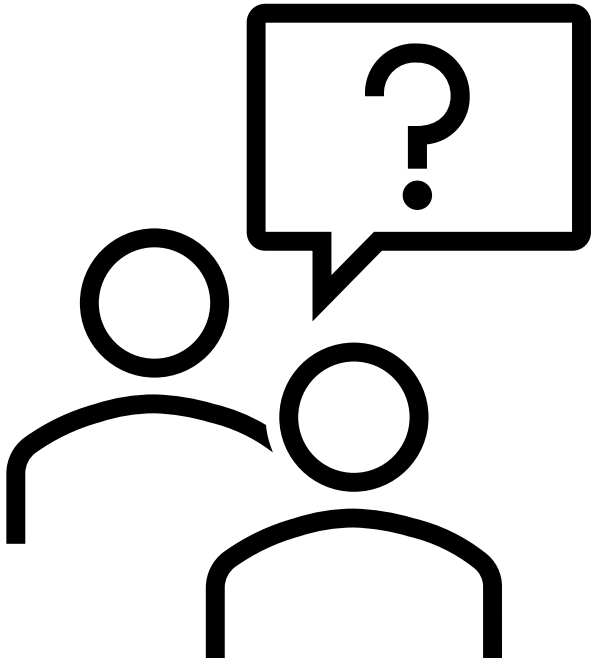


# Audience Question



**Question:** **In the chat box, tell us one useful insight you will take away from today's training session.**

# Q&A



# Action Steps


Feel free to contact coaches with questions

| | |
|---|---|
| Continue | Work with your team to develop a list of care coordination enhancements |
| Explore | Steps, actions and resources available in the Module 6 Implementation Guide |
| Discuss | Progress, challenges and solutions in your PH-PAG |

# Upcoming Events

**October 28, 2021, 3pm-4pm ET**

**This is Harder than I thought: Troubleshooting the Automatic Referral**

**Registration Link:**

https://abtassociates.webex.com/abtassociates/onstage/g.php?MTID=e103104ecb4c6eec9fd29b037c55e3f76

**November 2nd 1:00-2:00 pm ET.**

TAKEheart Affinity Group: ***Enhancing Care for Heart Failure Patients in Your Cardiac Rehabilitation Program***

**Registration Link**:

https://abtassociates.webex.com/abtassociates/onstage/g.php?MTID=e478a5af61d58353efe2705fd98a03f80