TAKE heart

AHRQ's Initiative To Increase Use of Cardiac Rehabilitation

Implementing Effective Care Coordination

Module 8

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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

★ CRCP Resources Pages 10 -13
Table 3: Enrollment & Participation
Table 4: Adherence

Monthly Training Sessions: What to do and Why -- Eighth 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

American Hospital Association (AHA)/Health Research and Education Trust (HRET): TAKEheart AHRQ's Initiative to Increase Use of Cardiac Rehabilitation

TAKEheart Initiative Webinar Series: Implementing Effective Care Coordination: Module 8

November 18, 2021

The planners and faculty of TAKEheart Initiative Module 8 indicated no relevant financial relationships to disclose in regard to the content of their presentations with the exception of:

Hicham Skali,MD, MSc, faculty for this educational event, received a research grant from ABT Associates. This presentation has been reviewed and is found to contain no bias. There are no other relevant financial relationships to disclose regarding the content of this 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)/Health Research and Education Trust (HRET). ABQAURP is accredited by the ACCME to provide continuing medical education for physicians.

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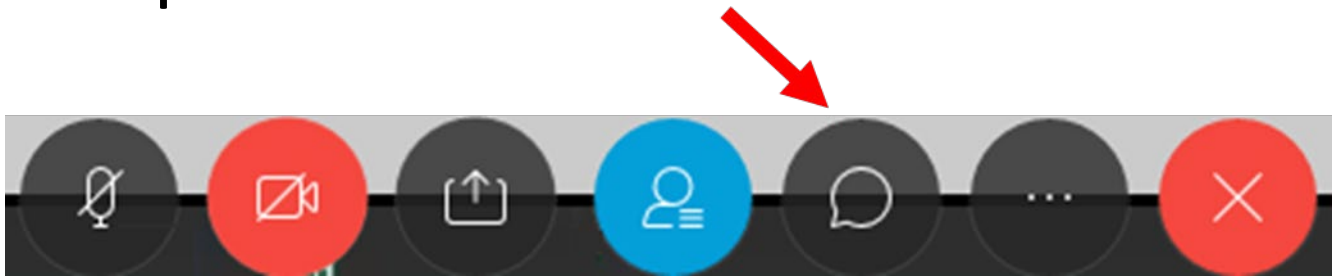
Chat Function

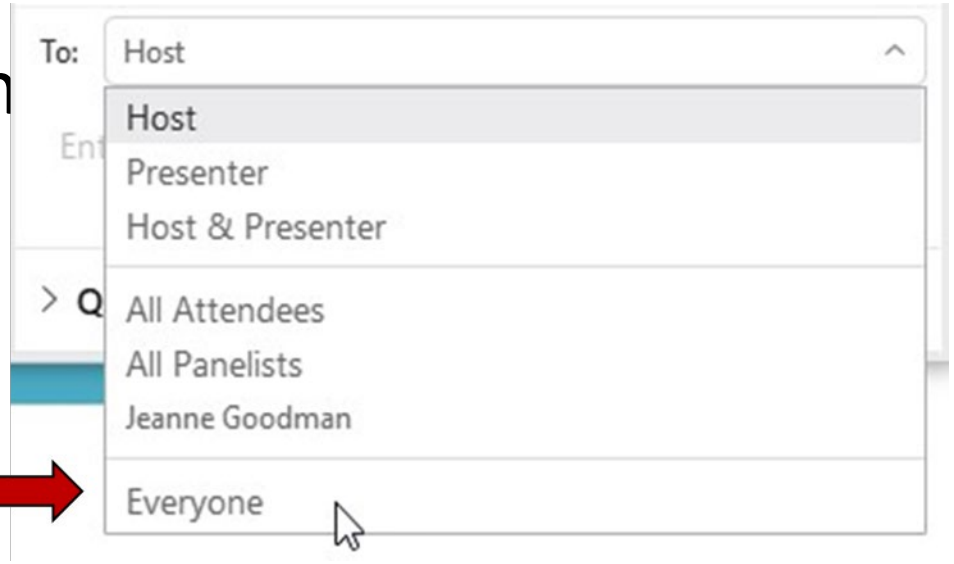
HOW TO ASK QUESTIONS

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



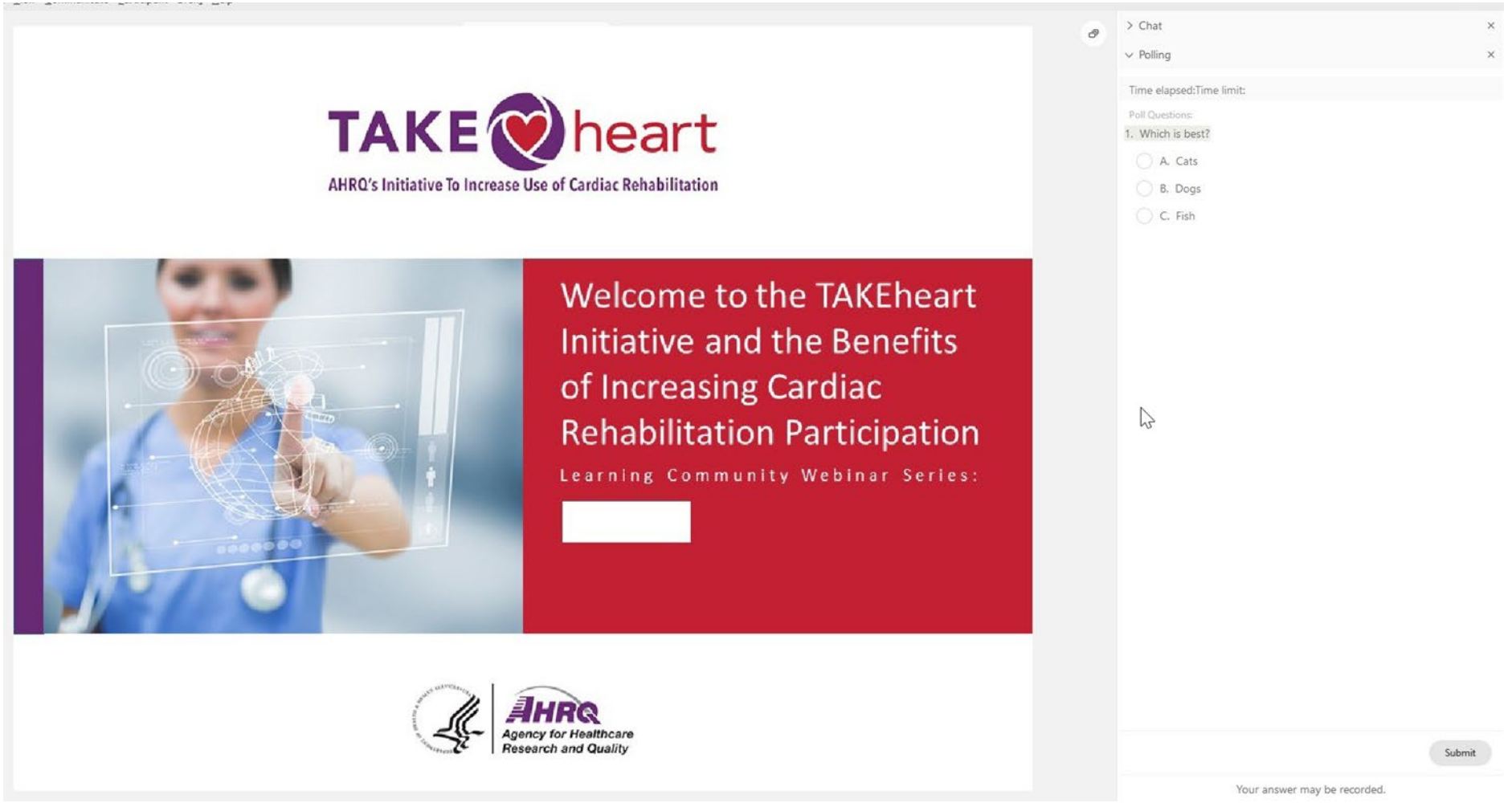
Set the TO: field to **Everyone** so that we can all see your question

Try the chat function now by sharing one thing you hope to learn today.



Polling Function

HOW TO POLL



Audience Question

How would you describe the current status of your efforts to improve care coordination for your CR patients?

Please select your answers here

Remember to click **SUBMIT** when complete

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

Activating Patients to Engage in CR

- Pulling automatic referral and care coordination together

Learning Goals

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

1. **Understand HOW** to redesign care coordination to better meet patient needs to improve enrollment and participation in CR
2. **Develop** training and policy materials to facilitate care coordination enhancements
3. **Monitor and use data** to determine effectiveness of the care coordination redesign and inform future refinements

Today's Presenters

Diann Gaalema, Ph.D.

Vermont Center on Behavior and Health
Associate Professor, Departments of Psychiatry and Psychology
University of Vermont

Hicham Skali, MD, MSc

TAKEheart Principal Investigator,
Associate Director of the Cardiac Rehabilitation Program at Brigham and Women's Hospital, Division of Cardiovascular Medicine

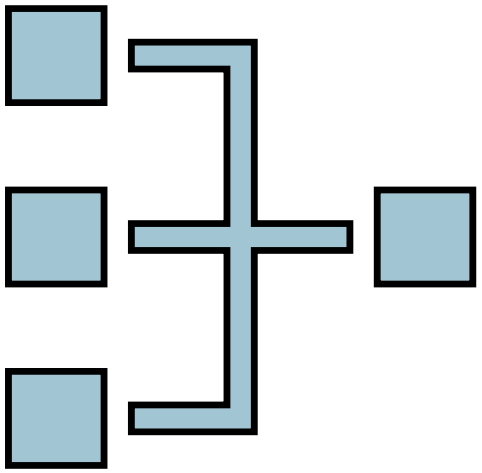
Part 1

Introduction/Review

Elements of Care Coordination for CR

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

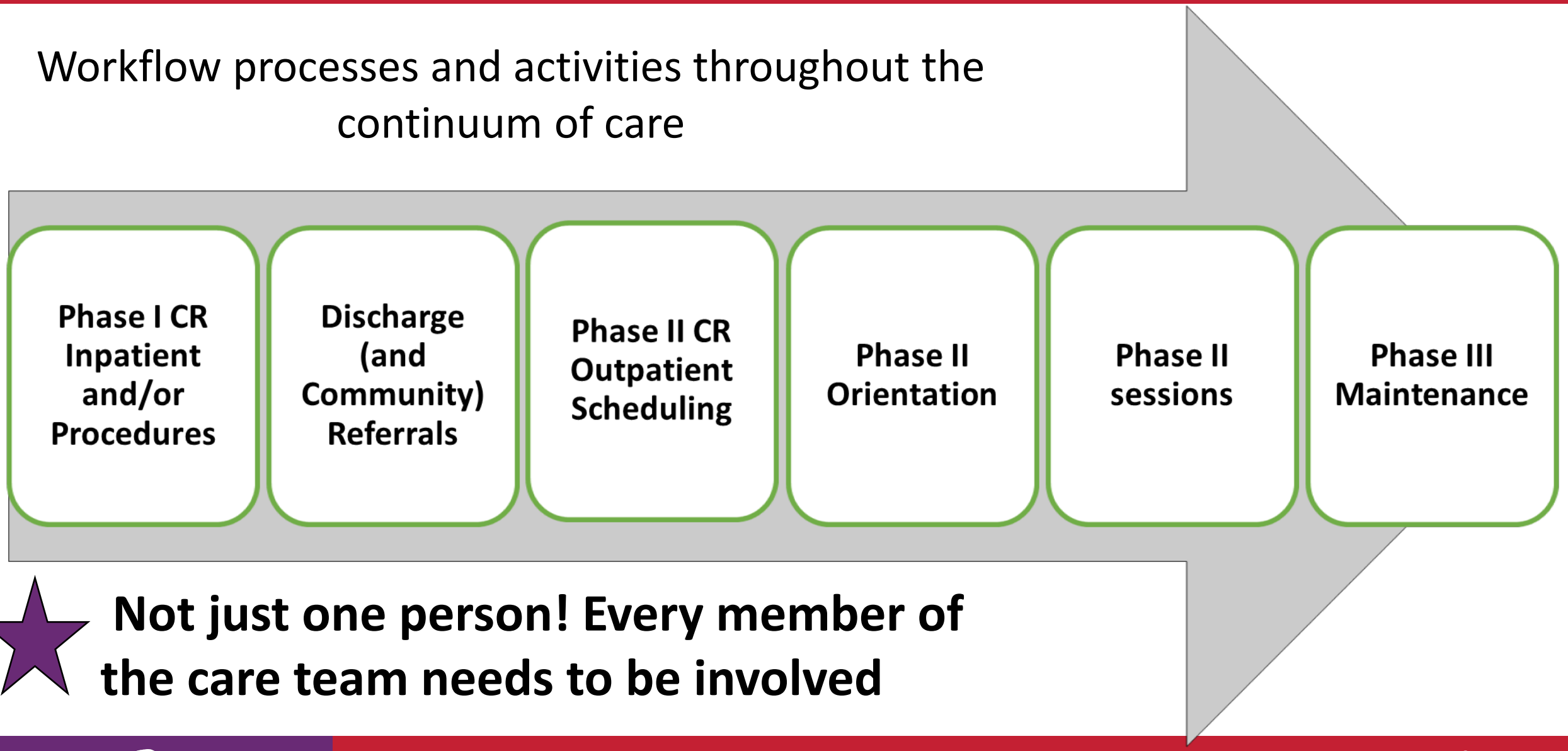
What Does Effective Care Coordination Mean for CR?



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

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

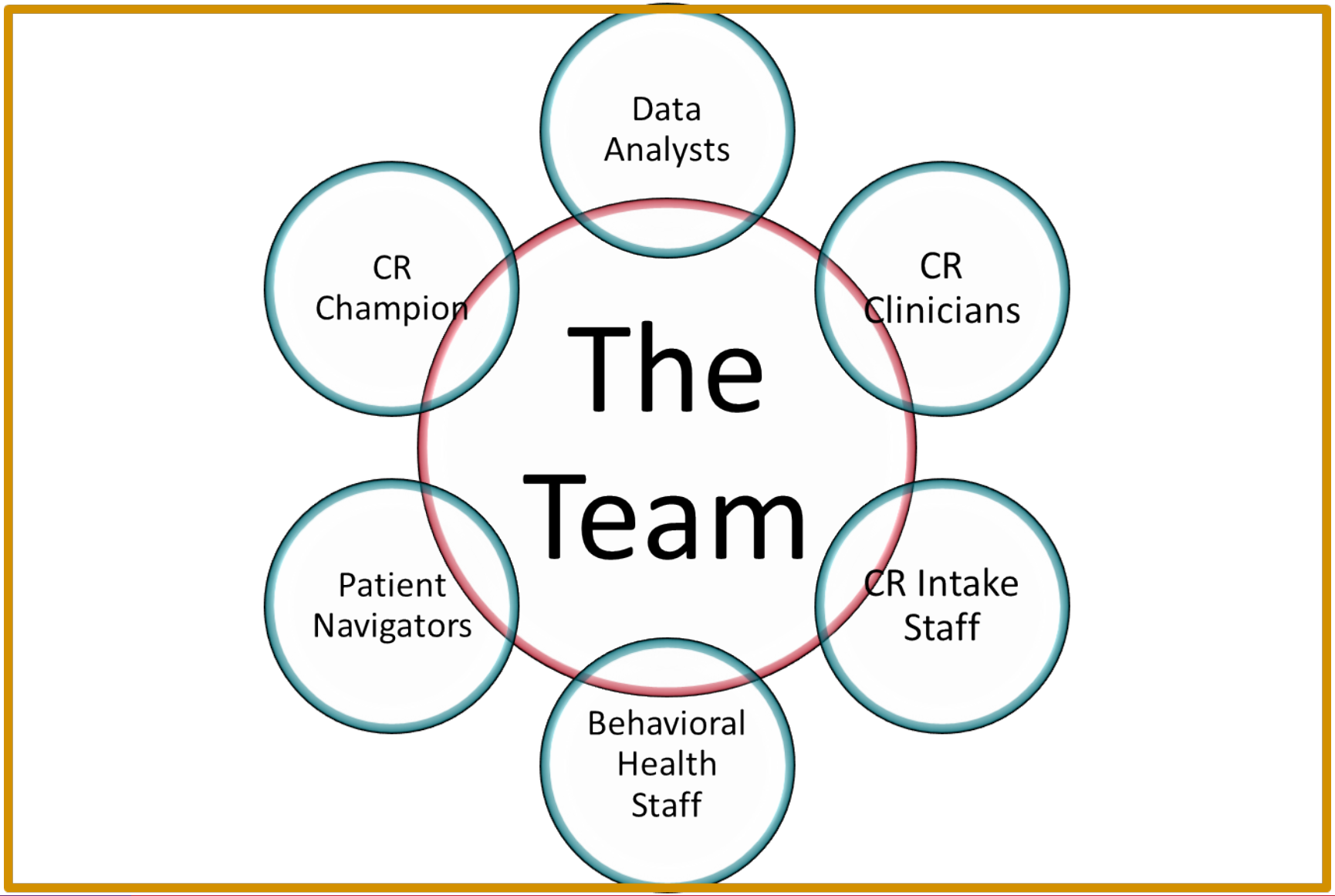
Let's Hear from a Patient

Patricia McNair

Part 2

Addressing Patient Needs and Concerns

Who Needs to Be Involved?



What are the Social Determinants of Health (SDOH)?

Which Eligible Patients Are Missing from CR?

If you are

- A young or older adult
- Female
- Black
- Hispanic
- Less 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

Create a Patient-Centered Approach to Care

Include	Include the patient and family in discussions to identify needs and concerns. Understand who the patient is and the impact of their condition.
Tailor	Tailor care to be culturally sensitive with a focus on effective communication.
Educate	Educate the patient and family in plain language about the patient's condition, the discharge process, and the value and next steps to CR at every opportunity throughout hospital stay.
Listen	Listen to and honor the patient and family's goals, preferences, observations, and concerns.

Some Common Barriers to CR

Individual Concerns

- Cultural values/beliefs
- Need to work
- Child or eldercare responsibilities

Financial

- Food/Rent vs. medical care
- Limited insurance coverage

Education

- Poor health literacy
- A belief they can do it on their own
- Don't identify with brochure pictures

Behavioral Health

- Pre-existing or new onset anxiety/ depression
- Social isolation

Transportation

- Costs
- Access

Possible solutions: Individual Concerns

- Adjust treatment plans
- Leverage the influence of family & caregivers to reinforce the value of CR
- Connect with community resources & services
- Offer flexible hours: after/before work and weekends
- Hybrid versions of CR

Possible solutions: Finances

- Confirm insurance coverage and be explicit about cost from the start
- Set up payment plans
- Provide support to help patients with insurance issues: approvals, documentation
- Set up philanthropic fund to partly underwrite CR costs for those without insurance or those with high copays
- Create financial incentives
- Adjust treatment plans

Possible Solutions: Education

- Ensure educational brochures and materials appeal to a wide audience, ethnicities, gender and ages
- Leverage the influence of family & caregivers to reinforce the value of CR
- Connect patients with CR ambassadors: former CR graduates who can provide peer-to-peer support and encouragement
- Train staff in patient engagement techniques
- Use plain language in conversations about the value and benefits of CR.

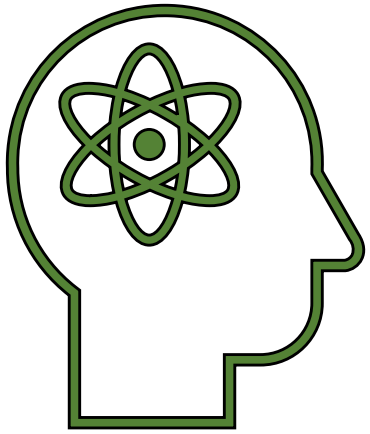
Possible Solutions: Behavioral Health Issues

- Screen for anxiety, depression and social isolation
- Enlist the assistance of hospital behavioral health staff
- Establish a patient ambassador program
- Connect with community resources & services: community health workers

Possible Solutions: Transportation

- Hospital sponsored bus passes
- Leverage the assistance of family & caregivers
- Uber, Lyft, carpooling
- Hybrid versions of CR
- Flexible hours: before/after work, weekends
- Connect with community resources and services
- Parking passes/waivers

Insights from the Speakers



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

Part 3

Redesigning Care Coordination Workflow Processes

Planning Workflow Process Changes

Start	with easy fixes, progress to harder
Iterate	the new workflow until it meets needs of patients and program
Create	a new flow chart with new workflow process to follow
Educate	staff in the use of new workflow; support & reward consistent, productive use

Workflow Processes to Support Referrals to Phase II

GOAL: Eligible patients are referred and leave knowing Phase II is part of care

- Develop, document and communicate standardized processes for:
  - Screening patients for needs & concerns & connecting patients to resources
  - Discharge: clinician/patient conversations; CR intro letter
  - Referring eligible patients to CR (automatic referral)
  - Informing external CR programs about referred patients
  - Referring eligible patients on other units in the hospital: med-surg
  - Clinician-to-clinician hand-off to inpatient/rehab CR Programs
  - Phase II collaboration

Phase I transition to Phase II

Phase I — **Phase II**

GOAL: Strive for a smooth, timely transition

❖Develop, document and communicate standardized processes for:

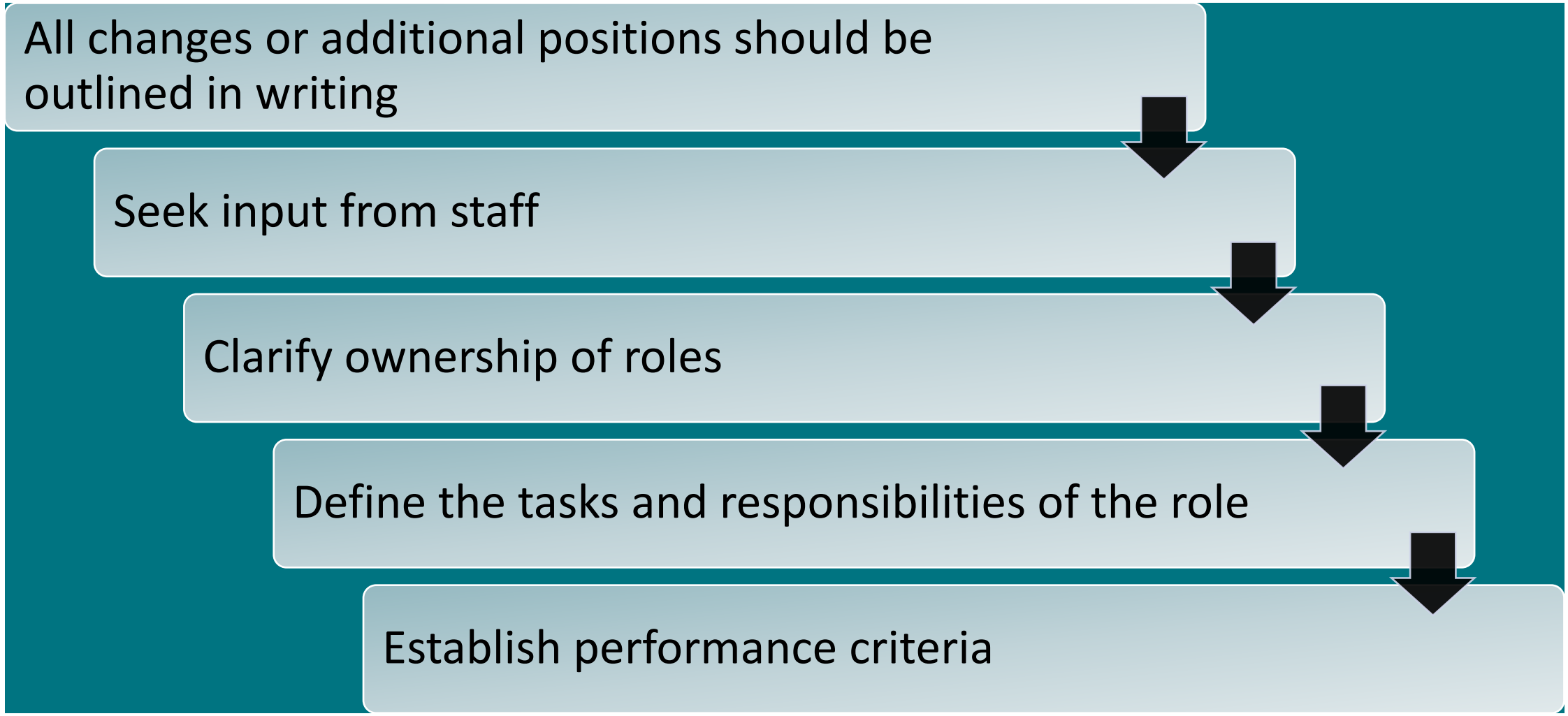
- Confirming the discharge referral
- Tracking medically complex patients discharged to post-acute care settings
- Cultivating relationships with intake personnel for internal and external CR programs
- Verifying insurance
- Supporting patient: patient navigator/CR ambassador
- Connecting patient to community resources & services

Phase II Workflow Processes

GOAL: Patients experience minimal wait time and complete their plan of care

- Develop, document and communicate standardized processes for:
  - Screening patients for needs and concerns
  - Connecting patients to resources & services
  - Acknowledging referrals promptly, i.e., call within 48 hours
  - Scheduling CR Orientation/Evaluation/Sessions
  - Patient education/orientation
  - Supporting patients through to graduation

Creating or Adjusting Job Descriptions and Expectations



Onboard Staff to New Roles & Responsibilities

- Orient all staff to new roles and responsibilities
  - Make expectations and performance criteria clear
- Create written orientation guidelines
  - Materials can be used when staff changes occur
  - Make sure the team knows where materials are stored
- Provide mentorship
  - For individuals transitioning from one role to another allow an overlap time for the transfer of knowledge

Staff Training

- Ensure staff have the time and resources necessary

- Make sure the entire CR team (Phase I and Phase II staff) has a thorough understanding of how:
  - The automatic referral system works
  - To access information and reports needed for their position

- Provide Supplemental training:
  - Conversation techniques: motivational interviewing, patient self management (**Module 9**)
  - Cultural sensitivity training

Part 4

Monitoring & Using Data to Support Care Coordination

Evaluate Changes to Care Coordination

Listen to staff & patients

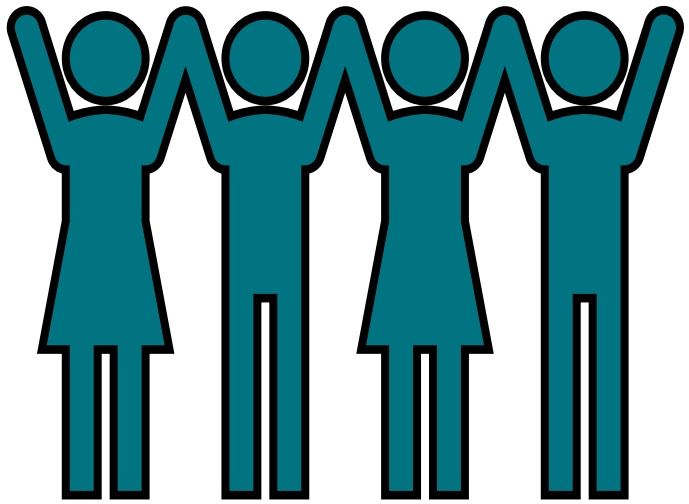
- Essential source of improvement ideas
- Solicit feedback on what and how well things are working
- Discuss struggles and failures with a focus on learning and improving

Monitor Care Coordination Performance

As you make changes to enhance and integrate care coordination

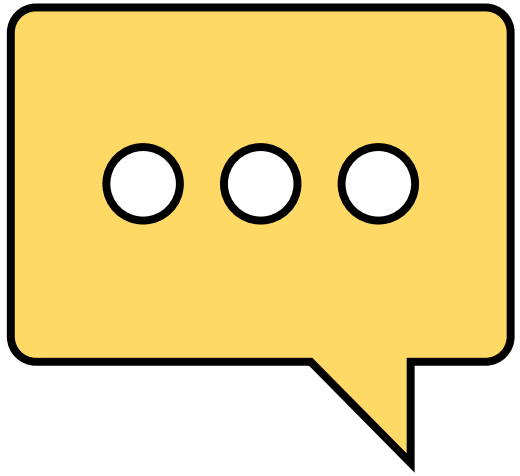
- Develop performance measures
- Define success criteria
- Analyze data and adjust as necessary
- Celebrate successes

What Does Success Look Like?



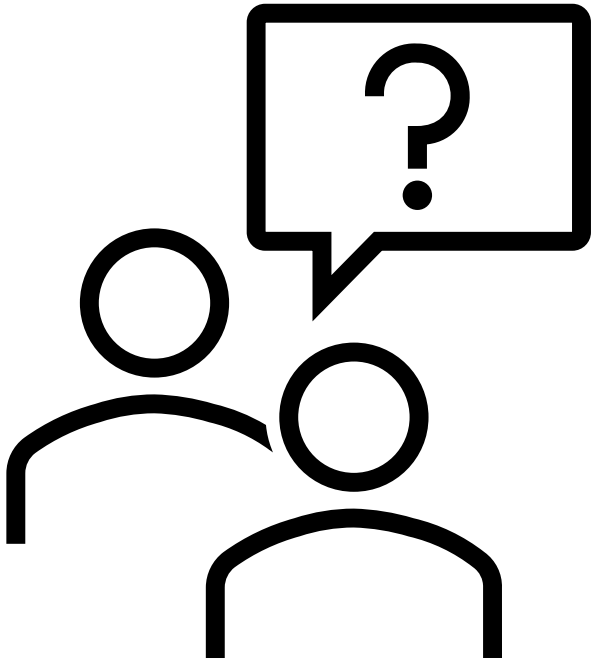
- Percent of participation & completion by underrepresented patient groups – **CR program overall**
- Percent of eligible patients referred – **Inpatient CR**
- Percent of inpatients receiving a CR education visit – **Inpatient CR**
- Time from Referral to Enrollment and/or attendance at first session --**Transition**
- Percentage of referrals who enroll -- **Transition**
- Percent of patients attending CR orientation –**Outpatient CR**
- Percent of enrolled patients who complete CR – **Outpatient CR**

Audience Sharing



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

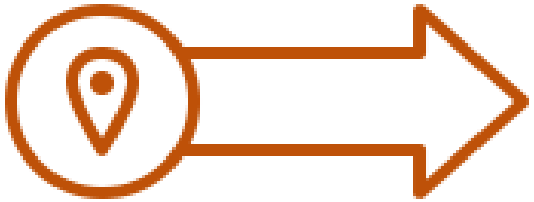
Q&A



Action Steps

Feel free to contact coaches with questions

Continue	Working with your team: define & assign roles and responsibilities, create onboarding & training processes, and establish written policies and training materials
Explore	Steps, actions and resources available in the Module 8 Implementation Guide
Discuss	Progress, challenges and solutions in your PH-PAG



Activating Patients to Engage and Complete CR

January 27, 2021, 3- 4pm ET

Registration Link

Today's presentation focused on the steps you can take to redesign your patient care model to better address patient needs and concerns. In January, we will resume training with a discussion of patient activation and provide some case scenarios to stimulate your thinking.

Help us help you!

Please answer the survey questions as you leave the event today