TAKEheart Care Coordination Implementation Guide – Part 3 -- Module 9

Activating Patients to Engage and Complete Cardiac Rehabilitation

Purpose and Overview

This Implementation Guide represents Part 3 of a three-part TAKEheart *Care Coordination Implementation Guide* (Guide) designed to help you think through the necessary steps to create an effective care coordination system.

This part of the Guide is designed to supplement and expand on the information presented in the Module 9 training session entitled "*Activating Patients to Engage and Complete Cardiac Rehabilitation"*, which focused on case studies illustrating 1) how to assess a patient's activation level so as to select and apply appropriate engagement strategies and 2) how to use hospital/CR Program catchment area data to reduce barriers to patient engagement with CR.

- For more information on setting priorities for improving care coordination see Module 6 *Laying the Groundwork for Effective Care Coordination* and Part 1 of the TAKEheart *Care Coordination Implementation Guide.*

- For more information on designing care coordination see Module 8 *Implementing Care Coordination* and Part 2 of the TAKEheart *Care Coordination Implementation Guide.*

Care coordination is multifaceted. Patients enter the CR referral pipeline from multiple providers, experience multiple cardiac conditions, and are 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.

This part of the TAKEheart *Care Coordination Implementation Guide* is divided into two sections:

- Supporting patient activation and utilizing appropriate engagement strategies to increase attendance in and completion of CR, and

- Using hospital/CR Program catchment area data to understand the barriers to patient engagement with CR and developing strategies to address them.

We recommend reading through this entire guide first before seeking to implement any changes within it.

Supporting patient activation and utilizing appropriate engagement strategies to increase attendance in and completion of CR

What is Patient Activation Versus Patient Engagement?

Patient Activation

Patient activation is an individual's understanding, competence, and willingness to participate in their own care decisions and processes. There are low and high levels of patient activation and knowing the activation level of your patient is important in determining how ready the patient is to use various strategies and tools that will increase their responsibility for their own care. Studies show that a highly activated patient is more likely to self-manage their care. As a result, a highly activated patient will need less assistance to enroll in and complete CR.

Key Terms

Patient activation is the willingness and ability to take independent actions to manage one's own health and care.

Patient Engagement is the use of strategies or tools aimed at increasing a patient's participation in their care.

Many healthcare professionals use the Patient Activation Measure (PAM) to determine a patient's activation level. The PAM is a 13-item proprietary survey completed by the patient that can be used to quantify their activation level. It has been shown to have strong psychometric properties.

The PAM is copyrighted by Insignia Health and requires a license to use. There are other, similar questionnaires available free of charge that may be used in place of the PAM, such as:

- Self-Efficacy for Managing Chronic Diseases 6-item Scale - https://www.unmc.edu/centric/_documents/SEMCD6ISinfo.pdf
- Development and initial testing of a Health Confidence Score (HCS) - https://bmjopenquality.bmj.com/content/8/2/e000411

Patient Engagement

Once you've determined your patient's activation level, the next step is to decide which engagement strategies may best suit your patient as he or she proceeds through CR. Patient engagement is a broader concept that aligns intervention strategies with patient activation levels. Interventions are actions or tools designed to increase participation in care and promote positive patient behavior, such as being able to navigate discharge from a hospital to CR or maintain active participation in CR while managing challenges.[1] Patients who aren't ready to participate in their care (low activation) may not be ready for certain patient engagement strategies such as

[1] https://www.healthaffairs.org/do/10.1377/hpb20130214.898775/full/

reviewing a content-dense video or complex education materials without a detailed explanation or other support from their provider.
The use of patient engagement strategies is not one-size-fits-all. You may need to use different patient engagement strategies or tools as you work with individuals from different cultures. Be sensitive to the possibility that individuals may approach decisions about their care differently based on their culture; for example, your patient's culture may shape which individuals they wish to involve in the decision-making process.

Bringing together Patient Activation and Patient Engagement
It is important to work with each patient to determine what his or her goals are for CR and the most likely pathways or approaches for reaching them. Choose plain language documents that are easy to understand and that will help the CR staff gain the trust and buy-in of a less activated patient. Once trust is established and the patient becomes more activated, the patient can assume the responsibility of consuming more detailed and complex education materials on their own. In time, the most activated patients might even be able to serve as a CR patient ambassador or in an advisory role to the CR program.

Exhibit 1 shows some of the various types of patient, family, and caregiver engagement tools you can employ with your patients. **Exhibit 2**, that follows immediately below, shows appropriate engagement strategies and tools for patients at different levels of activation.

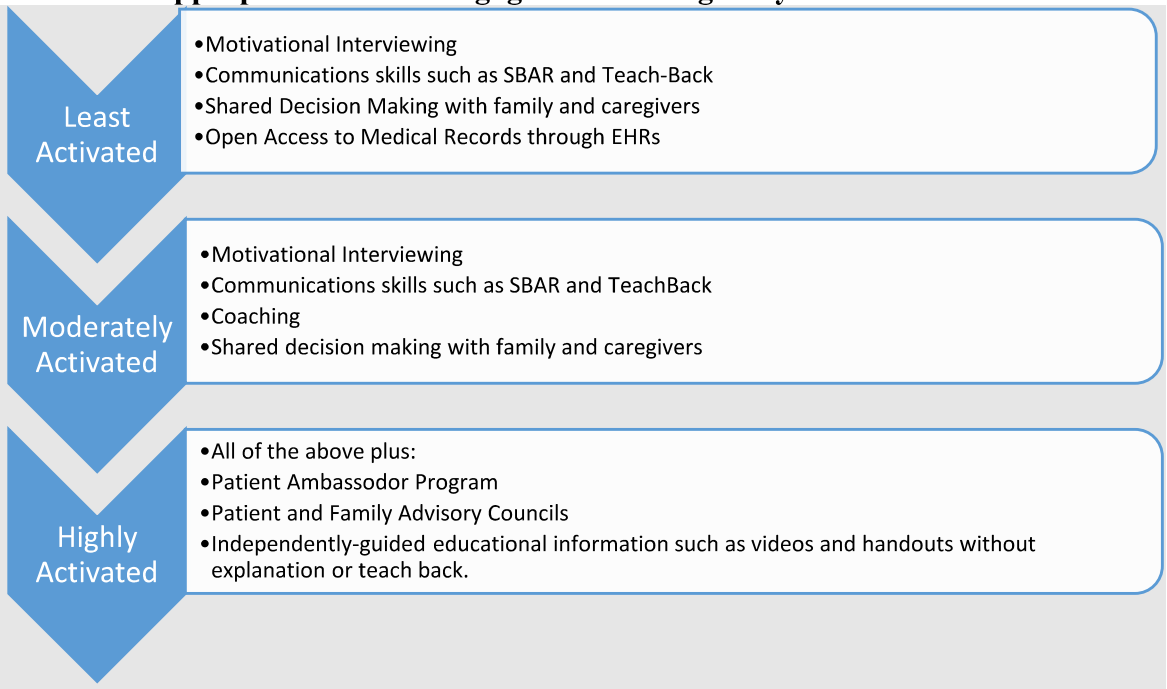
Exhibit 1: Engagement Strategies by Setting

Setting	Examples of Engagement Strategies

Direct Patient Care	▪ Motivational Interviewing (MI)
	▪ Communication skills such as:
	  ○ SBAR: SBAR is an acronym for Situation, Background, Assessment, Recommendation; a technique that can be used to facilitate prompt and appropriate communication.
	  ○ Teach-Back: The teach-back method is a way of checking understanding by asking patients to state in their own words what they need to know or do about their health.
	▪ Coaching
	▪ Health Literacy: Language and educational materials that enable individuals to find, understand, and use information and services to inform care decisions and actions for themselves and others.
	▪ Shared Decision Making: Family and caregiver involvement in health-related decisions.

	▪ Open Access to Medical Records: Providers share their notes with patients through electronic health records (EHR).
Hospital/CR Program	▪ Patient and Family Advisory Councils ▪ Patient/family members serving on safety and quality improvement committees ▪ Eliciting/acting on feedback from patients/families ▪ Collecting patient experience data/sharing with providers and staff ▪ Patient ambassador programs
Community	▪ Community Advisory Board ▪ Hospital/CR Program to improve/connect with neighborhoods served
Adapted from: https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/patient-family-engagement-protocol.pdf	

Exhibit 2. Appropriate Patient Engagement Strategies by of Patient Activation



Note: There is a detailed list of Patient Engagement Strategies in the Key Resources section at the end of this Guide.

Using hospital/CR Program catchment area data to understand the barriers to patient engagement with CR and developing strategies to address them.

Understanding Barriers to CR Participation to Increase Patient Volume

Please review the **Module 8** Implementation Guide Section entitled, *Step 1, Addressing the Needs and Concerns of Patients, Using Two Lenses*.

Now that you have determined the activation level of your patient and worked to engage them with self-management techniques, the next step is to determine what barriers exist in your hospital and/or CR Program catchment area that prevent these patient populations from accessing and successfully completing CR. Part of empowering patients to participate in their care is both addressing these barriers with high quality care coordination and, if possible, removing these barriers altogether. At the same time, removing these barriers is another way to both increase patient volume as well as determine, and serve, patient populations you may not be aware of that need CR in your community. Understandably, many of these barriers are longstanding and entrenched. The first step may be assessing these barriers to determine which can be easily removed versus those that can only be modified or not altered at all.

As described in Module 8, social determinants of health (SDOH) can affect a wide range of an individual's health outcomes and quality of life throughout the life course. Common SDOH include limited access to public transportation, housing, education, social support, employment, health care and healthy nutrition options and can influence an individual's choices and health-related behaviors. SDOH can have a direct impact on patient participation and retention in CR. Here are key points to keep in mind:

- Social determinants of health such as poverty, lack of education, lack of local transportation, and extended family obligations could all affect the ease with which an individual can access CR. Therefore, taking the time to better understand a patient's circumstances can serve as a proxy for knowing about access issues and impact successful completion of a CR program.

- When CR staff encounter barriers to CR participation that patients face related to SDOH, they may have opportunities to help mitigate these conditions. For example, staff may be able to help patients locate social services that would help with food insecurity.

- SDOH should be taken into account when developing an individualized, clinically appropriate CR plan, such as making sure to include realistic recommendations for diet or exercise based on the patient's circumstances.

Identifying and Overcoming Barriers to CR Participation

Understanding the demographic profile of your catchment area gives you important information about SDOH that may impact potential patients you might hope to serve and retain. Understanding the area's SDOH can help you understand the specific needs that your care coordination programs or activities should be designed to address. Research has shown that there are specific populations may need special help if they are to enroll and stay engaged in CR.

Studies have shown the following populations are less likely to participate in CR**:**

- Young adults,
- Older adults,
- Female,
- Black,
- Hispanic,
- Less educated, and
- Less insured.

Common barriers to CR participation include:

- Inadequate transportation,
- Lack of understanding of benefits and value of CR,
- Behavioral health issues
- Difficulty paying for care or missing work
- Lack of care for children/others at home

Evaluating Catchment Area Characteristics to Increase CR Participation

Here we describe how you can use available data to identify the barriers most likely faced by patients in your service or catchment area. Use these data in combination with conversations with your patients to focus your care coordination efforts.

What is a catchment area?

Catchment area describes the geographical area a hospital/CR program draws from for patients. This is the general health services area serviced by the CR program.

What are the demographic features of the area being served by the program?

To address patient needs and concerns it is important to have a general understanding of the overall population being served by your program. The hospital that your CR program is a part of will likely have the following data. The administrative data of the patient medical record can be pulled to get basic characteristics such as:

- ICD-10 diagnoses/procedure codes,
- Zip code,
- Age,
- Sex,
- Race,
- Languages spoken, and

- Health insurance/free care per claim.

How to Use Demographic Characteristics Data
Take this disaggregated data and aggregate it with other useful demographic data you may be able to access, as described below. Talk to the hospital marketing and communication department for the hospital about available data for the region. The local commerce department might also be a good source of information.

Most importantly, keep it as simple as possible and only pick a few characteristics that you think your CR program needs to focus on and can readily manage. Try to identify some of the following characteristics:

- Racial/ethnic distribution,
- Languages spoken,
- Levels of education,
- Average income,
- Size of the area: small and densely populated or large and spread out
- Most common healthcare insurances used/or lack of health insurance,
- Available transportation,
- Common industries e.g., large employers such as Amazon facility or meat processing plant,
- Access to food sources, and
- Status of public services.

Using these data, you can determine who are the patients that currently utilize your CR program as well as who are those who could benefit from CR but cannot access your program due to barriers in the community.

Addressing Identified Barriers

Interventions for addressing barriers include:

- Offering flexible hours as capacity allows,
- Offering group classes in most common languages spoken in your area,
- Using common cultural touchstones, such as languages and foods consumed for the nutrition by your most prevalent populations
- Facilitating transportation in zip codes that require it.

Examples of barriers and mitigation strategies:

Employer Intervention Example: There is a sizable population of cardiac patients from multiple zip codes that all work at a local, large company. Can you determine a way to have parts of the CR program occur onsite at a lunch time, early morning, or after work hours? Perhaps, you can work with the employer to offer flexible work hours and/or transportation during the week for employees to attend your CR program. Use hospital data to show the employer and the employer's healthcare insurer the potential cost savings through these interventions. This cost savings data might spur the will to get creative.

Food Desert Intervention Example: You have identified three populations of patients who live in food deserts -- zip code areas where there are no grocery stores. You work with your hospital community services department to host a food bank two days a week at times when patients from these food deserts attend your CR program.

Understanding your catchment area characteristics and accessing this data may provide valuable information and inform the direction of next steps to accommodate your populations served.

Key Resources used to develop this Implementation Guide:

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.

PATIENT ACTIVATION

1. Health Affairs - When Patient Activation Levels Change, Health Outcomes and Costs Change, too
   This article provides an overview on patient activation, its importance, and the patient activation survey and measure.
2. Health Services Research - Development of the Patient Activation Measure (PAM): Conceptualizing and Measuring Activation in Patients and Consumers
   This article provides an overview on the patient activation survey and measure.
3. NHS - The Patient Activation Measure: supporting people to manage their own wellbeing
   This video reinforces that knowledge, skills and confidence are key to people's active involvement in their own well-being. Practitioners in primary care and social prescribing talk about the value of using the Patient Activation Measure to assess patients' levels of knowledge, skills, and confidence, enabling them to provide the support that is right for the patient and see the impact of their work is having with their patients.
4. *Journal Cardiovascular Nursing - Patient Activation in Acute Decompensated Heart Failure*
   This article describes patient activation with heart failure patients.
5. *Promoting Patient Participation in Cardiac Rehabilitation*
   This video is an overview on patient participating in CR.
   US Department of Defense zip file of patient activation modules and resources

PATIENT ENGAGEMENT

6. AHRQ Evidence-based Practice Center Technical Brief Protocol
   This brief provides an overview of strategies for patient, family, and caregiver engagement.
7. Motivational Interviewing - Good Example - Alan Lyme
   This video provides an overview of how to conduct motivational interviewing.
8. Motivational Interviewing: A Bad Example - Alan Lyme
   This video provides an overview of how not to conduct motivational interviewing.
9. Enhancing Motivation for Change in Substance Use Disorder Treatment
   This SAMHSA TIP 35 is a detailed overview of how to conduct motivational interviewing with a different population.
10. 16 ways to improve your communication skills with patients
    Tips for improving patient clinician communication.

11. Tips for Improving Communication with Older Patients
    Tips for talking with your older patients.
12. Family Caregiver Alliance - Communicating with Your Doctor
    Tips for patients talking with their doctors.
13. IHI - SBAR Tool: Situation-Background-Assessment-Recommendation
    The SBAR (Situation-Background-Assessment-Recommendation) technique provides a framework for communication between members of the health care team about a patient's condition.
14. AHA - Health literacy and patient safety: Help patients understand
    This video is part of a health literacy educational toolkit developed by the American Medical Association Foundation.
15. AHRQ - Health Literacy Universal Precautions Toolkit, 2nd Edition
    This toolkit contains health literacy tools such as videos, posters, templates, etc., clustered into the following areas:
    Tool 1: Form a Team
    Tool 2: Create a Health Literacy Improvement Plan
    Tool 3: Raise Awareness
    Tool 4: Communicate Clearly
    Tool 5: Use the Teach-Back Method
    Tool 7: Telephone Considerations
    Tool 8: Conduct Brown Bag Medicine Reviews
    Tool 9: Address Language Differences
    Tool 10: Consider Culture, Customs, and Beliefs
    Tool 11: Assess, Select, and Create Easy-to-Understand Materials
    Tool 12: Use Health Education Material Effectively
    Tool 13: Welcome Patients: Helpful Attitudes, Signs, and More
    Tool 14: Encourage Questions
    Tool 15: Make Action Plans
    Tool 17: Get Patient Feedback
    Tool 18: Link Patients to Non-Medical Support
    Tool 19: Direct Patients to Medicine Resources
    Tool 20: Connect Patients with Literacy and Math Resources
    Tool 21: Make Referrals Easy
16. AHRQ - Working with Patient and Families as Advisors Implementation Handbook
    This handbook is a step-by-step guide for starting a patient and family advisory council at your system.
17. Institute for Patient- and Family-Centered Care - How to Identify Strong Patient and Family Partners to Help Drive Practice Transformation
    This slide deck discusses techniques for incorporating patients and families into the quality improvement process.
18. AHRQ - Strategy 1 - Working with Patients and Families as Advisors
    This guide details multiple strategies in the form of handouts, orientation manuals, and guides for engaging patients and families as advisors.
19. Advancing Health Equity - Tips for Developing a Community Advisory Board
    This guide gives an overview of how to form a community advisory board.

CATCHMENT (GEOGRAPHY/DEMOGRAPHICS) BARRIERS and SDOH

20. Health IT Analytics - How Geographic Data Can Help Address Social Determinants of Health
    This article provides tips on what and how to use geographic data to understand the populations you serve.
21. Feeding America - Hospital – Food Bank Partnerships: A Recipe for Community Health
    This article offers examples of hospitals and communities developing innovative approaches to solve food insecurity in the community.
22. Circulation - Addressing Social Determinants of Health in the Care of Patients with Heart Failure: A Scientific Statement from the American Heart Association
    This article addresses SDOH in heart failure patients.
23. Kaiser Family Foundation - Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity
    This report is an extensive overview of SDOH and health equity in healthcare.
24. AACVPR 36th Annual Meeting - Building Equity in Rehabilitation Panel 10.7.21
    This video is a panel from the conference on equity and cardiac care.