# Implementation Guide - Module 2

## System Change: Laying the Foundation and Leadership

### Module Purpose

Following the call to action in Module 1, the purpose of this module is to lay the foundation for systems change. Topics include how to: 1) identify a CR champion, 2) form a multidisciplinary CR Quality Improvement (QI) team (composition of the team, and why), and 3) develop an Action Plan. The module provides a brief introduction to the Institute for Healthcare Improvement’s (IHI) Model for Improvement.

### Target Audience

**Primary audience:** CR QI Team implementing automatic referral with care coordination  

**Secondary audience:** Non-team cardiac clinicians, discharge planners, care coordinators, hospital leadership

### Learning Objectives

Upon completion of this module attendees will be able to:

- Select a CR champion to lead the CR QI Team and advocate for automatic referral with care coordination.
- Identify key members of a multidisciplinary CR QI team with representatives from key departments and patient advisors.
- Create an Action Plan for implementing automatic referral with care coordination.

### Key Takeaways from the Module

- Ensure the champion has the skills to engage and collaborate with hospital leadership to set the course for automatic referral with care coordination.
- Start with a few key members for the multidisciplinary team, then as you build momentum you can add team members.
- Break each change that you want to make (to implement automatic referral with care coordination) into specific tasks with discrete responsibilities and timeframes.
  - Keep the process flexible, don’t be afraid to make adjustments
  - Start small and build upon the successes
**Steps and Guidance for Getting Started**

**STEP 1: Choose a Champion**

Identify a CR champion to work with key members of the hospital leadership and other stakeholders who will need to buy-in to the effort and help marshal resources.

- The champion needs to be a credible and trusted member of the cardiac care group at the hospital.
- He or she will work to persuade key stakeholders of the value of increasing CR specifically through automatic referral with care coordination.
- The CR champion may be the team leader although in some hospitals the implementation team may be led by someone else.
- The Champion will help to manage challenges such as conflicting interests and scarce resources to move the project forward.
- In many cases the Champion will be a clinician, although there may be other hospital staff who can assume the role.

**STEP 2: Create a Multidisciplinary Cardiac Rehabilitation Implementation Team**

Form a multidisciplinary team to serve as the foundation for system change.

- Select action oriented individuals who have credibility with peers and possess good communication skills.
- Include individuals who “touch” all parts of the process. Crucial members are likely to include:
  - IT representatives with the expertise needed to set up an automatic or “opt-out” electronic referral of all eligible patients to CR.
  - Physicians and nurses who can advocate for automatic referral with peers and other clinicians.
  - Hospital QI staff and managers who can bring expertise in leading organizational change.
  - Patients (including CR graduates) who, as end users, can bring valuable insights about the process. If the hospital has patient family advisory committee, consider asking them to participate.
  - CR staff (if applicable)
- Set up designated meeting time for the team.
- Develop meeting agendas and materials.
- Set up daily/weekly/monthly huddles and check-ins with different members of the team for status updates on the Action Plan tasks, sharing information and data about the project, celebrating successes and generating of new ideas.
- Determine what is needed in terms of infrastructure, cost, and technical expertise to implement automatic referral with care coordination.

**STEP 3: Create an Action Plan:**

- Develop a summary of what the team hopes to achieve: create an aim statement.
  [http://www.ihi.org/resources/Pages/Tools/Aim-Statement-Worksheet.aspx](http://www.ihi.org/resources/Pages/Tools/Aim-Statement-Worksheet.aspx)
- Establish SMART (Specific, Measureable, Achievable, Relevant, and Time bound) goals.
- Complete the Action Plan Template, see attached Action Plan template.
Determine the tasks required to accomplish automatic referral with care coordination.

The Action Plan template includes project milestones under the tasks column.

- Milestones are high level tasks that are critical for achieving a goal. TAKEheart recommends that hospitals include the following milestones in their Action Plans. These milestones were culled from the Million Hearts/AACVPR Cardiac Rehabilitation Change Package (CRCP) and recommended by national CR experts who have successfully implemented automatic referral with care coordination in their own hospitals.

- The five milestones in **bold and underlined** below have been deemed especially important by the experts. The TAKEheart Project Team will track each hospital's progress towards achieving these five milestones as part of the evaluation of the TAKEheart initiative.

1. Plan to advertise benefits of CR to relevant hospital staff.
2. Plan to engage cardiologists in TAKEheart.
4. Map out the hospitals current CR process from time of referral/discharge to appointment and identify patient, program, and system barriers.
5. Create new workflow incorporating automatic referral.
6. Develop a protocol for clinician to clinician hand-off to inpatient/rehabilitation CR programs to clarify CR plan of care, improve transitions, and reduce readmissions.
7. Develop a protocol for outpatient CR programs to follow when a patient attends their first CR session.
8. Plan to engage staff (e.g., cardiologists, staff currently involved in CR) in developing the specifications for an automatic prompt.

9. **Develop specifications for EMR**
10. **Launch of tested EMR with functionality desired by the hospital**
11. Assess the hospitals CR baseline referral rate.
12. Implement a system to monitor CR after participation in TAKEheart cohort is completed, if monitoring is not embedded into EMR.
13. **Create a care coordinator position with written role/job description**
14. **Develop training materials for the care coordinator**
15. **Care coordinator identified/hired and starts work**
16. Develop a list of CR programs available to hospital's patients.
17. Plan to advertise the benefits of CR to patients & their families.

- As noted above, each hospital will have its own, individual Action Plan with many tasks and subtasks, in addition to these recommended milestones. Some hospitals may have achieved certain milestones before starting the intervention, and some milestones may not be relevant to a particular hospital.

- Identify the individual responsible for each task
- Determine a target date for completing each task.
- Establish SMART goals for each task
- Consider resource needs and priorities
  - Additional features might need to be added to the EHR system.
  - Data labor hours for data management and analysis
  - Additional headcount
Hold a Meeting to create an Aim statement for the project; see attached Sample Meeting Agenda

Key Resources:


   IHI’s QI Essentials Toolkit includes the tools and templates to launch a successful quality improvement project and manage performance improvement. These tools include a short description, instructions, an example, and a blank template.


   IHI’s Aim Statement Worksheet provides guidance around writing an effective aim statement, which delineates clear and specific plans for upcoming improvement work.


   The Project Planning Form is a useful tool to help teams think systematically about their improvement project, including a listing of the changes that the team is testing, the person responsible for each test of change, and the timeframe for each test. The form allows a team to see at a glance the overall of the project.


   This PowerPoint, created by Liverpool Hospital, suggests the roles, responsibilities, and recruitment of clinical champions.


   This PowerPoint, created by CDC’s Million Hearts, outlines both clinical and community-based steps for hospitals to optimize their cardiac rehabilitation programs.


   This webpage, developed by the CDC’s Million Hearts, provides tools, protocols, and action guides to improve patients’ cardiovascular health.


   The CDC’s Million Hearts “Saving Lives, Restoring Health, Preventing Disease” infographic provides an overview of the individual and systemic benefits of cardiac rehabilitation, the common barriers to referral and enrollment, and some potential interventions for reducing this gap.

   This quality improvement approach can be used to augment current QI approaches used in your health center, or can serve as a placeholder QI methodology when there isn’t already a robust QI process in place.


   This tool can help users document and analyze current approaches to specific quality improvement targets and plan enhancements.

*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 the American Hospital Association (AHA). ABQAURP is accredited by the ACCME to provide continuing medical education for physicians.

The American Board of Quality Assurance and Utilization Review Physicians, Inc. designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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.
Instructions: The template below is designed to assist you with the creation of your action plan. The Task/Milestone column allows you to click on a prepopulated milestone or type a task your organization needs to undertake to implement automatic referral (AR) and care coordination (CC). The milestones are high level tasks identified in the Cardiac Rehabilitation Change Package (CRCP) as important for successful implementation of AR and CC. Each one is covered in a specific training curriculum module. Although the milestones are important, the expectation is each organization will identify many additional tasks as part of their action plan. In the Task Lead column, type in the name of the person responsible for the task. A calendar drop down will appear when you click on the Date columns. The Status column allows you to click on a prepopulated option or type in your own. The Smart Goal and Comment columns allow for free text typing.

The template provides an initial table with four rows. Additional rows can be added by hovering over and clicking the single row below the table. A blue (+) sign will appear and an additional row will be added. You can add as many rows as you need.

<table>
<thead>
<tr>
<th>ACTION PLAN</th>
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<tbody>
<tr>
<td><strong>TASK/ MILESTONE</strong></td>
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<tr>
<td>Choose a milestone or enter your own.</td>
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<tr>
<td>Choose a milestone or enter your own.</td>
</tr>
<tr>
<td>Choose a milestone or enter your own.</td>
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</tbody>
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AGENDA

Automatic Referral with Care Coordination

Kick-off

Date January 2020
1:00PM – 2:00PM
Meeting called by Cardiac Rehabilitation Champion

Attendees: Members of the Multidisciplinary CR QI Team

Please read:

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Meeting Rm. A</th>
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<tbody>
<tr>
<td>1:00 – 1:15</td>
<td>Introduction</td>
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<td></td>
<td>Call to action</td>
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<tr>
<td>1:15 – 1:45</td>
<td>Item #1</td>
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<td></td>
<td>Develop Aim statement</td>
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<tr>
<td>1:45 – 2:00</td>
<td>Item #2</td>
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<td>Assignments for next meeting</td>
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Notes: