TAKE heart

AHRQ's Initiative To Increase Use of Cardiac Rehabilitation

Systems Change: Laying the Foundation, Leadership and Action Plans

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Module 2

AHRQ Agency for Healthcare Research and Quality

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

TAKEheart Initiative Webinar Series: Systems Change: Laying the Foundation, Leadership and Action Plans: Module 2

February 27, 2020

The planners and faculty of TAKEheart Initiative Module 2 indicated no relevant financial relationships to disclose in regard to the content of their presentations with the exception of:

Kim Newlin, MSN, ANP, FPCNA reports that she received consulting fees from Boehringer-Ingelheim, Amgen, Kinetix Group, and PCNA. This presentation has been reviewed and is found to contain no bias. Ms. Newlin has no other relevant financial relationships to disclose regarding the content of this presentation.

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What do we know?

MODULE 1 RECAP

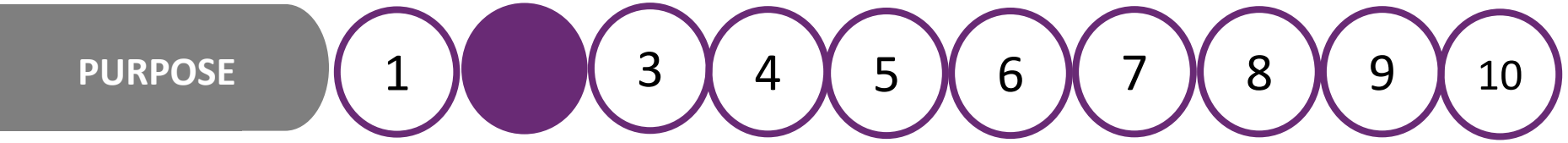
Scientific evidence shows Cardiac Rehabilitation (CR):

- Saves lives
- Improves health and wellbeing
- Reduces health care costs by reducing hospital readmissions

CR referrals, participation, and completion rates are low and should be increased

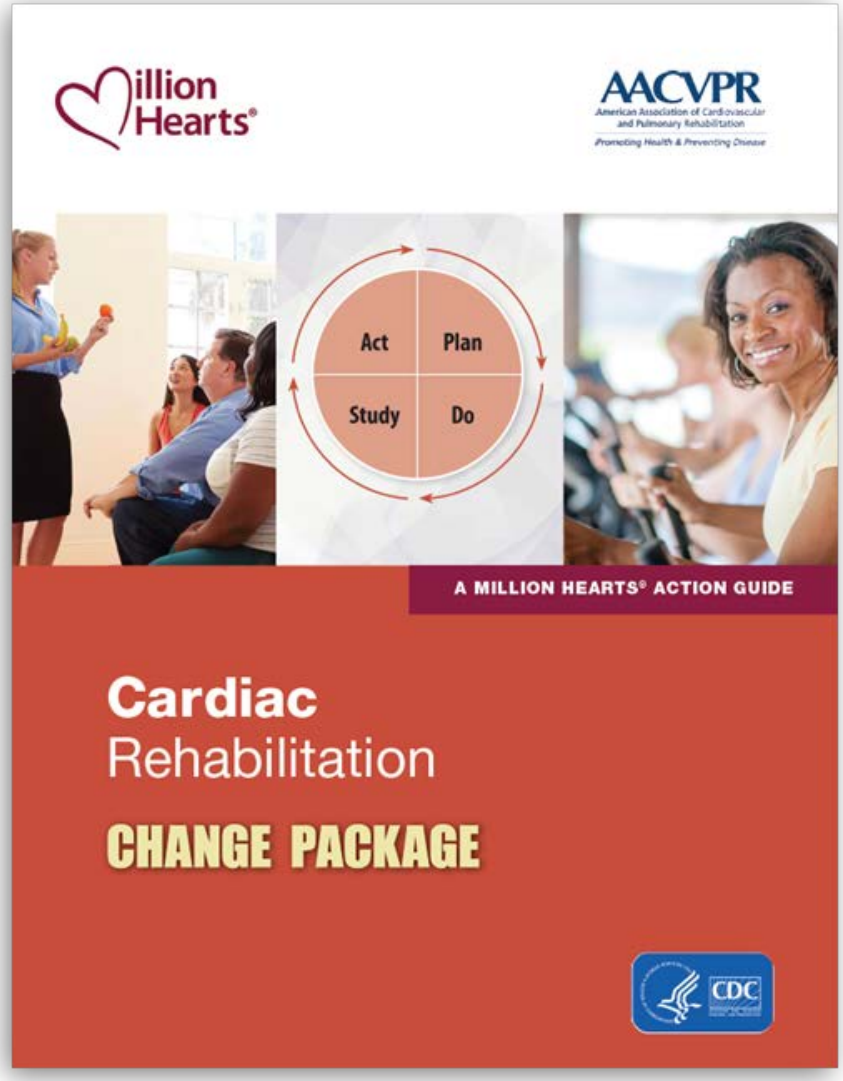
- Automatic referral (AR) with care coordination is an evidence based intervention to increase CR

TAKEheart Training



- Second of 10 training webinars to help Partner Hospitals implement automatic referral with care coordination
- Bookmark the TAKEheart website (https:\\takeheart.ahrq.gov)
  - Central hub for all program materials and resources, including webinar recordings

Roadmap for Training



The training, educational resources and technical assistance offered by TAKEheart are designed to support the implementation of interventions contained in the Million Hearts®/AACVPR Cardiac Rehabilitation Change Package (CRCP).

Access the Change Package at: TAKEheart Website Resource Center

CDC & AACVPR Collaboration

- American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) board members, headquarters staff
- 100+ tools and resources:
  - AACVPR strategies
  - Case studies
  - Program specific tools
  - Organization specific tools: CDC, AHA, ACC
- Expertise, tools, and resources from:
  - 18 states
  - 22 institutions
  - 36 CR professionals and researchers

Today's Webinar Presenters

INTRODUCTIONS

Kim Newlin,
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Sutter Roseville Medical Center

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RN, MS FAACVPR
Director
Cardiovascular Disease Prevention Center
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Learning Goals

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

1. **Select a CR champion** to advocate for automatic referral with care coordination and lead the team
2. **Identify key members** of a multidisciplinary CR QI team, e.g. representatives from key departments and patient advisors
3. **Create an action plan** for implementation of automatic referral with care coordination

Select a CR Champion

ROLE

- Team Leader
- Engages and collaborates with hospital leadership to obtain support for automatic referral with care coordination
- Understands staff and patient needs, as well as management
- Manages conflicting interests and scarce resources to get things done
- Helps to build a culture to support the change
- Assists the team in developing its Aim Statement and Action Plan

Select a CR Champion (Cont.)

QUALITIES TO CONSIDER

- Credibility with peers
- Passion and interest in improving CR
- Understanding of CR programs, structure and regulations
- Action oriented
- Experience with change management and improvement projects
- Communication skills

Forming Your Multidisciplinary CR Implementation Team

CHOOSING TEAM MEMBERS

- Who will be involved in implementing automatic referral with care coordination?
- Bring together individuals who represent all parts of the CR referral, enrollment and participation process; clinicians and managers
- Plan for coordination across inpatient and outpatient settings by involving staff members from both
- Include billing and insurance personnel
- Include staff or patients (advisors) who can address the needs of patients

Potential Multidisciplinary CR Team Members

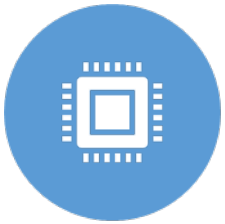
CR Champion: leads the team and advocates for the initiative

Cardiac care clinicians: cardiologists, cardiac surgeons, physician assistants, or nurse practitioners provide input on treatment and referral

Cardiac Rehabilitation clinicians: nurses, physical therapists, exercise physiologists, physicians provide valuable perspectives on enrollment and participation

Cardiac care manager: provides important information about current workflows and potential areas for improvement

Potential Multidisciplinary CR Team Members(Cont.)



Information Technology (IT) staff: have the ability to enact the required changes for automatic referral and data collection. May include IT vendor representatives.

Quality improvement leaders (QI): provide insight into best practices for implementing and measuring quality improvement.

Patients: provide the end user perspective.

Clinical Champion Story

Secrets to Success

- Peer to Peer Strategy- MD Advocate
- It Takes a Village
- Communicate, Communicate, Communicate
- Remain Vigilant

Resources for Selecting a CR Champion

TABLE 1 CRCP

Table 1. Cardiac Rehabilitation Change Package—Systems Change

Change Concept	Change Ideas	Tools and Resources
Make CR a Health System Priority	Establish a hospital champion, such as a quality of care leader or a CR administrator	• **Lake Regional Health System**—Cardiopulmonary Rehabilitation: Presentation for Board of Trustees • Liverpool Hospital—Clinical Champions PowerPoint • AACVPR—Crucial Conversations with Medical Providers & Hospital Administrators About Cardiac Rehabilitation Services Delivering Value Based Care • Million Hearts®—Getting to 70% Cardiac Rehabilitation Participation: Action Steps for Hospitals
	Engage the care team in CR and ensure their buy-in in CR	• AACVPR—Crucial Conversations with Medical Providers & Hospital Administrators About Cardiac Rehabilitation Services Delivering Value Based Care • **Lake Regional Health System**—Cardiopulmonary Rehabilitation: Update to Department Managers • Million Hearts®—Cardiac Rehabilitation Infographic
	Use CR referral, enrollment, and participation as quality of care indicators	• 2018 ACC/AHA Clinical Performance and Quality Measure for Cardiac Rehabilitation. Thomas RJ, et al. 2018.[19] • AACVPR Cardiac Rehabilitation Systems Change Strategy—*Using Cardiac Rehabilitation Referral Performance Measures in a Quality Improvement System* • AACVPR—Sample Performance Measures Letter for Physicians and Providers

Set the Stage for Change: Model for Improvement

MODEL FOR IMPROVEMENT

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

TAKEheart change/improvement

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Automatic referral with care coordination

Develop an Action Plan

STEPS IN DEVELOPING AN ACTION PLAN

Step 1: Develop an Aim Statement

Step 2: Determine how to assess or measure your progress

Step 3: Identify the tasks required to achieve the aim, who is responsible for each task and the timeframe for completing each task

Develop an Aim Statement

WHAT IS IT?

- **Why create an Aim statement?**
  Acts as your beacon to guide and focus your team's efforts

- **An Aim state answers:**
  What are we trying to accomplish?

- It is an **explicit statement**, crafted by the team, of the desired outcome of your improvement project

Develop an Aim Statement in TAKEheart

AIM STATEMENT

Q: What do you hope to accomplish?
A: Increase cardiac rehabilitation referrals, enrollment, and participation
Q: For whom?
A: Patients with eligible diagnoses, e.g. MI, CABG, PCI
Q: Why is it important?
A: Improves health, saves lives and reduces hospital readmissions
Q: What change will you implement?
A: Automatic referral with care coordination

A TAKEheart Aim Statement Example

EXAMPLE

We aim to increase the number of patients with MI, PCI and CABG who are referred, enrolled and participate in cardiac rehabilitation by 30%. This is important because we want to improve patient care and outcomes and reduce hospital readmissions. We will accomplish this aim by implementing automatic referral with care coordination by December 31, 2020. We intend to see a 30% increase in current participation rates by December 31, 2021.

Determine How to Assess Your Progress

MEASUREMENT

- Include both short term and long term assessments.
- Develop specific outcome and process measures.
- Set specific goals that are numeric and measurable.

SMART Goals

Specific	Description of a specific outcome or process
Measureable	How is it going to be measured, e.g. rate, frequency?
Achievable	Plan to stretch but make sure it is achievable
Relevant	Need to link directly to the Aim statement
Time bound	Need clear start and finish dates

Examples

SMART GOALS

- The percentage of eligible patients referred to cardiac rehabilitation will increase by 10% from Q1 to Q3.
- The percentage of referred patients who enroll in a CR program will increase by 5% from Q1 to Q2.
- The percentage of enrolled patients who complete a CR program will increase by 15% from Q2 to Q4.

Complete an Action Plan

IDENTIFY ACTION PLAN COMPONENTS

- What tasks does your hospital need to undertake to implement automatic referral?
- What tasks does your hospital need to undertake to implement care coordination?
- Who will lead each task?
- When will each task be completed?
- Consider resource needs and priorities

Utilize an Action Plan Template

TEMPLATE

ACTION PLAN						
TASK/ MILESTONE	**TASK LEAD**	**TARGET DATE**	**COMPLETION DATE**	**STATUS**	**SMART GOAL**	**COMMENTS (include challenges or facilitators)**
Choose a milestone or enter your own.	Enter name.	Click to enter a date.	Click to enter a date.	Choose or add one.	Click here to enter a goal.	Click to enter comments.
Choose a milestone or enter your own.	Enter name.	Click to enter a date.	Click to enter a date.	Choose or add one.	Click here to enter a goal.	Click to enter comments.

Tasks Need SMART Goals Too

TASK: DEFINE AUTOMATIC REFERRAL

Beginning 2/4/2020, the CR QI team will meet with IT representatives each Tuesday and Thursday at noon for a half hour to define the changes necessary for automatic referral and will complete the task by 2/28/2020 .

Example of Action Plan

ACTION PLAN						
TASK/ MILESTONE	**TASK LEAD**	**TARGET DATE**	**COMPLETION DATE**	**STATUS**	**SMART GOAL**	**COMMENTS (include challenges or facilitators)**
Schedule meetings with IT representatives and leaders to discuss automatic referral	Luna Patel	2/28/2020	Click to enter a date.	In progress	Beginning 2/4/2020, the CR QI team will meet with IT representatives each Tuesday and Thursday at noon for a half hour to define the changes necessary for automatic referral and will complete the task by 2/28/2020.	Lots of conflicting IT projects within the hospital

What's Next?

PARTNER HOSPITAL PEER ACTION GROUP MEETINGS

- Continue working with your CR Team on your Action Plan
- Discuss how you are progressing
- Exchange your Action Plan with another hospital and provide feedback

Next Up: Module 3

WORKFLOW, DATA & IMPLEMENTATION

We will continue our discussion of systems change by looking at the cardiac rehabilitation process with a discussion of workflow mapping, data collection and using data for implementation.

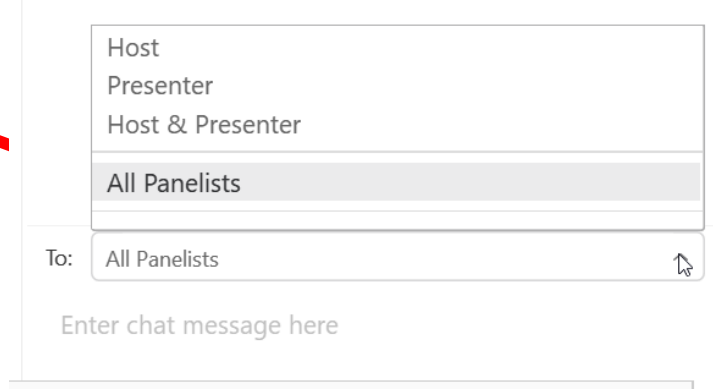
"Automating bad processes does not improve anything…our experience is that it is best to fix the process, then automate the fixed process."
Dr. John Halamka, CIO BIDMC, Boston, MA

Q&A

HOW TO ASK QUESTIONS

To ask a question open the chat box

Set the TO: field to All Panelists so that we can all see your question

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TRAINING
AWARENESS
KNOWLEDGE
ENGAGEMENT