TAKEheart
AHRQ's Initiative To Increase Use of Cardiac Rehabilitation

EVENT SUMMARY

AFFINITY GROUP DETAILS AT-A-GLANCE

Title	**Innovations that can Improve your Cardiac Rehabilitation Program** **May 20, 2021**
Purpose	• To share innovations that cardiac rehabilitation programs implemented during the pandemic and then made permanent because of their operational efficiencies and benefits for their patients and program.
Format	• A moderated panel discussion with four panelists, with additional input from the 131 event participants
Special Thanks to our Moderator and Panelists	**Moderator:** • **Hicham Skali, MD, MSc**, TAKEheart's Principal Investigator and Director of the Cardiac Rehabilitation program at Brigham and Women's Hospital **Panelists:** • **Heidi Haglin**, MS, CCRP, Essentia Health in Duluth, MN • **Jessi Hyduk**, RN, RCEP, Cardiopulmonary Rehab Supervisor, Saint Joseph Regional Medical Center (SJRMC), South Bend, IN • **Sara Schaub,** MSEP, CCRP, Cardiac Coordinator, Aultman Deuble Heart and Vascular Hospital, Canton, OH • **Matt Thomas**, MS, MBA, ACSM-CEP, Cardiopulmonary Rehab and Employee Fitness, CHI – Memorial Hospital, Chattanooga, TN
TAKEheart Update	TAKEheart resumed training activities in May 2021. Partner hospitals have received information about re-start activities; other programs interested in participating can contact us at: https://takeheart.ahrq.gov/join-takeheart
Resource Link	**Slides** and a **recording** of the event along with **links** to resources for addressing COVID-19 are available online at: https://takeheart.ahrq.gov.

OVERALL EVENT THEMES

CR programs evolved during the pandemic and will continue to change in response to a permanently altered environment.

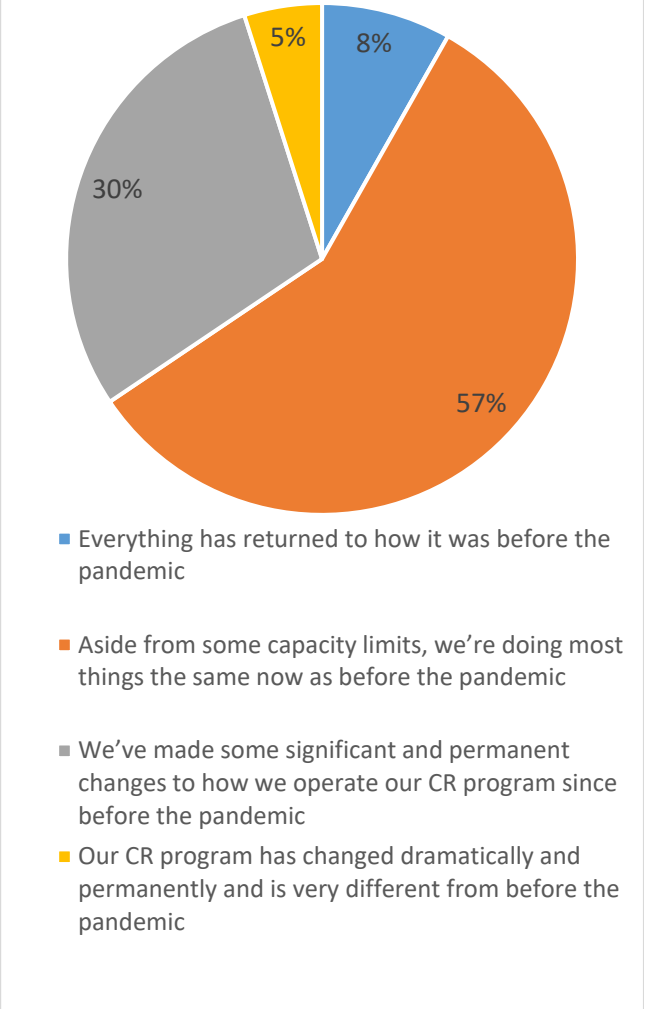
- Patients have changed. Comfort with virtual technologies, interacting in group settings, work patterns, and viable transportation options are all different; CR program support for them must evolve in response.
- CR programs have changed. Capacity limits, staffing availability, and the uses of virtual technologies and reimbursements for them create challenges and opportunities CR programs must continue to adapt to.
- CR programs need to "evolve to better" versus "return to normal" because patients, operations, and billing requirements have all changed substantially and probably permanently.

Many changes are worth making permanent because they benefit CR patients and enhance operational efficiencies.

- Changes to intake and orientation processes can save staff time, reduce wait times, and help patients successfully enter CR.
- Changing onsite program operations can improve efficiency, enhance patient safety and comfort, and provide more support and advice patients need to successfully complete CR.
- Expanded uses of virtual CR and online patient supports can increase program capacity, broaden patient participation, and better meet patient needs.

CR Program Trajectories

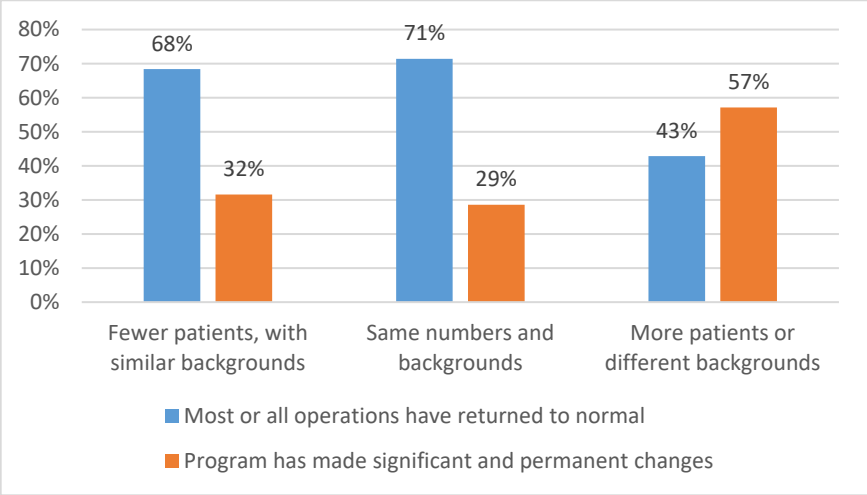
CR Programs are split between those reporting complete or partial return to pre-pandemic conditions and those reporting substantial transformations. Evolving patient and program needs make further changes inevitable for most CR programs.



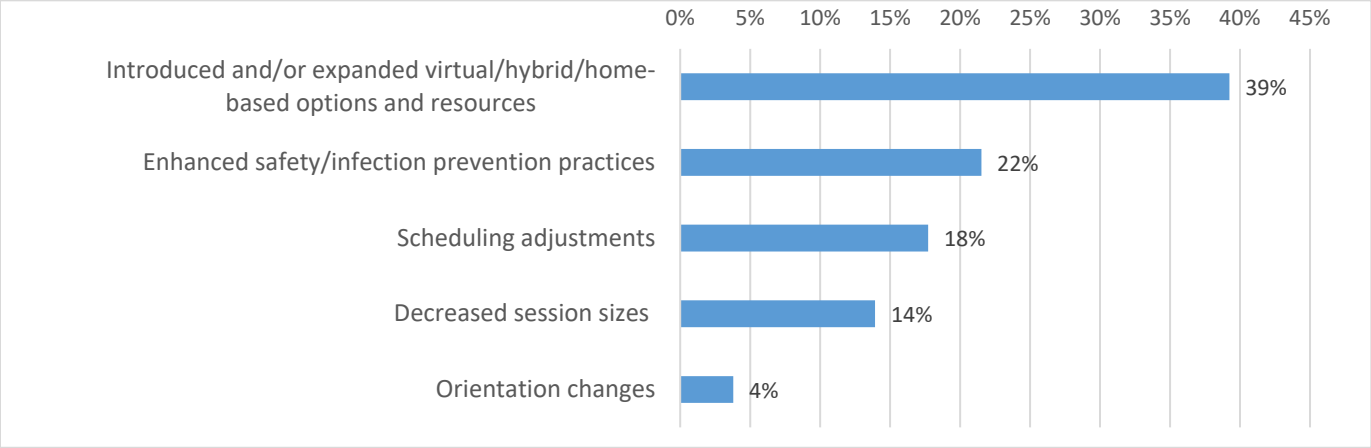
DISCUSSION HIGHLIGHTS

Many CR Program Changes are Likely to Continue

- Factors panelists identified as likely to continue included greater reliance and comfort with online resources and virtual communication, increased sensitivity to infection prevention and avoidance, reduced capacity limits, and greater ability to bill for virtual CR activities.
- Factors panelists felt strongly about sustaining included the need to foster social support for CR participants, the need for all persons eligible for CR to be able to access it, the need for onsite CR that allows for careful monitoring of higher risk CR patients, and the need for patients to be able to connect with their care providers.
- Fifty-two of the 131 event participants who responded to the poll (40% response rate) reported that their program was supporting fewer patients with similar backgrounds, while 35% reported serving the same number of patients with the same backgrounds as before the pandemic. 16% indicated their program was not supporting more patients and/or patients of different backgrounds (e.g. more persons of color, women, economically disadvantaged, etc.). About 2/3s of the programs in the first group reported that most or all of their operations had returned to normal while almost 60% of programs serving more or different patients now indicated they had made significant and permanent changes. In the future, success as a CR program may require change in order to serve enough CR patients to sustain financial viability and remain competitive.



- Audience members reported changes made in their programs they expect to be permanent. The top five changes are captured below. While orientation session changes were relatively uncommon, this option generated substantial interest and positive comment during the session.



Innovations in Cardiac Rehab May Result in Program Efficiencies and Improvements

- Required changes in cardiac rehab provided an opportunity to re-envision operational and programmatic processes.
- More efficient use of staffing and space resources are allowing for budget and operational efficiencies as well as expanding access and services.
- Innovations are allowing for greater peer-to-peer interaction, additional 1:1 clinical attention, and interactive educational programming.

Innovations in Patient Intake and Orientation Processes

- According to Jessica Hyduk, **implementing group intake processes**, while previously discussed, became necessary for more efficient use of staffing resources during COVID 19 for her CR program in South Bend, Indiana. Group intakes of three patients to two staff members consists of reviewing consent forms, conditions of participation, and expectations for the program, separate meetings with a nurse to review medications, completing the six-minute walk test with an exercise physiologist, filling out screening tools (e.g. PHQ-9), and watching a short video explaining the diagnoses that qualify patients for CR, and finally regrouping to schedule upcoming classes; all activities taking less than 2 hrs. Patients appreciate the efficiency of completing all these activities at one time as well as in "developing comradery" with other patients as they begin their CR experience.

- Patients are now offered **virtual intakes** over Zoom or phone, which began to address the reluctance of some patients to return on-site. According to **Matt Thomas**, while some patients were reluctant to use virtual platforms, there has been better reception to this approach over time. In fact, Matt's CR program has seen increased participation rates for the virtual intake process, as it removes many logistical barriers to coming on-site. Patients complete their six-minute walk test and sign their informed consent at a later in-person orientation.
- To address "pent-up demand" for CR during COVID closures, **Sara Schaub** implemented a **group orientation** to "get patients in more efficiently". Each group intake process involves five patients and three staff members and in under two hours, patients undergo a nurse assessment, risk factor planning, six-minute walk test, and review of exercise goals and treatment plan. The group format has allowed patients to "get to know more people as they get started, and it's a more efficient process" for the program. This modification has eliminated the waitlist for patient intake and now appointments are "immediately available."

Audience Member Insights

- *We now ask that the patients before signing up are serious about the program and can commit to at least 12 sessions*
- *We have social work interns that provide patient support and help us make referrals to our community health team*
- *We have 8 patients enrolled in our two virtual classes at this time. 12 have completed. We have started offering it to patients that provide transportation and location as a limitation.*

Modifications to Onsite Program Operations

- Adjusting **session length from 60 to 90 minutes**, reduced the number of weekly CR visits from 3x/week to 2x/week. Panelist **Jessica Hyduk** indicated that by increasing the duration of each class, the program could get "a longer turnaround for [completing] paperwork". Adjusting the class length to at least 91 minutes allowed the program to bill for four visits per week. To accommodate these longer class times, the program now offers Friday classes and stays open later during two days per week.
- To address social distancing guidelines, panelist **Sara Schaub** provided patients with their **own supplies and materials at "home base" locations** spaced six feet apart. Even as the risk of contracting COVID diminishes, her patients are "more conscious of having their own space" and therefore this modification will remain. Additionally, the **educational component** of her program, while previously provided in a group setting, is being **delivered 1:1** while patients are exercising, allowing for more individualization to meet their specific educational needs.
- **Heidi Haglin** indicated that her CR program also created **personal spaces** for its patients, which the "patients have appreciated."
- Utilizing unused space allowed **Matt Thomas** to set up an **unmonitored program** for low-risk patients after seeing some bottlenecks when group classes were coming in, waiting in the lobby. Specifically, low-risk patients who have completed 3-6 sessions "graduate" to the unmonitored program, which allows for more "spreading out into the gym" and making use of space that had been underutilized during the pandemic. This approach has allowed Matt and his colleagues to see more patients.

- Utilizing **interactive educational methods,** including PowerPoint presentations, YouTube videos and Wii video games, has increased the patient engagement. Panelist **Jessi Hyduk** sees the value of this approach as it "hits on multiple ways of learning and educating." Education related to stretching or resistance training is done at the gym, so patients can practice in real time. Patients have given positive feedback on this modified educational approach.
- **Livestreaming educational classes** allows for both in-person and remote participation. Panelist **Matt Thomas** reported that while his program shifted the educational component to an online format to accommodate social distancing requirements, many patients have requested to continue this format even after the pandemic ends.
- **Reduction in blood pressure monitoring** has allowed staff more time to interact with patients on educational components. **Sara Schaub** and her colleagues minimized blood pressure checks during the pandemic to reduce physical contact with patients. Staff risk-stratify patients at the initial blood pressure check and only perform the remaining two blood pressure checks as needed.

Virtual Delivery of Cardiac Rehabilitation: Strategies and Benefits

As CR programs eliminated or reduced onsite operations in response to COVID-19, supporting CR patients virtually emerged as a priority. Added use of virtual supports enhanced an understanding of its potential benefits and challenges.

Virtual delivery allows patients in underserved areas to access previously unavailable services and eliminates transportation barriers to care.

- Virtual delivery of cardiac rehabilitation provides visual monitoring by clinicians and back up support, through signed consents indicating presence of onsite caretaker, if necessary.
- Virtual delivery eliminates transportation barriers and time intensive commitment for patients living a distance from the CR program.
- Patients appreciate the ability to rehab in the comfort of their homes.

Cardiac Rehabilitation Education Can be Engaging and Delivered Virtually

- Hands on education addresses multiple learning styles and actively engages patients.
- Developing a program that breaks up both the exercise and educational components keeps patients more actively involved in their CR.
- Once comfortable with the technology, patients may appreciate the convenience of virtual cardiac rehabilitation education.

Panelist insights about effective uses of virtual alternatives to support their patients included:

- Panelist **Matt Thomas** originally set up virtual cardiac rehabilitation for patients who were trying to avoid exposure to COVID. Requirements for in-person CR were limited to the six-minute walk and the exit. His program now conducts **virtual intakes** for all patients, then requires patients to come on-site for only two visits. The first visit includes the six-minute walk test, sign consent forms, learn how to use the virtual technology, and receive basic exercise equipment (e.g. resistance bands) and the second occurs at the very end for patients to repeat some assessments and return their equipment. All CR sessions in between are done virtually. One requirement enforced by Matt's program is that all patients who do CR virtually **must have a caregiver present** in case of an adverse

event during exercise. Currently, many of his patients prefer using the platform as it eliminates transportation barriers.

- Virtual CR has increased access for patients with limited options within their community. **Sara Schaub** was able to **extend virtual CR access to sister hospitals**, which had to shut down their own programs due to staffing issues. As her facility has some surrounding rural areas, Sara's program leveraged virtual CR to reach patients who would otherwise struggle to attend in-person appointments.
- Counseling sessions conducted virtually were able to **reach a broader patient population**. According to **Heidi Haglin**, prior to the pandemic, her program required that a dietician and health psychologist meet with patients face-to-face. During COVID, they started providing services virtually using Zoom through Epic and added an additional service of a mindfulness facilitator. Once these clinicians became accustomed to the virtual platform, they were able to reach out to six other CR sites and expand services significantly.

Successful Change Isn't Easy but It Is Possible

While many programs attempted changes, not all were successful and virtually none succeeded without adjustments and persistence. Panelists shared their challenges/perspectives on their lessons learned in modifying their programs.

- **Matt Thomas** indicated that **transparency** with patients is key, particularly with the "rapid amount of change" in the past few months. Matt and his colleagues frequently ask patients for feedback on their initiatives (including virtual CR).
- **Sara Schaub** believed that persistence and **shifts in thinking** were critical. When her program first transitioned to group orientations "it took a while and lots of feedback from staff in order to adapt the vision to the reality."
- **Heidi Haglin** also emphasized the need for **flexibility** and to incorporate lessons learned as they adapted their program structure**.** Her program originally split the intake session into two parts: one session over the phone, then a physical assessment and six-minute walk in person. However, they soon realized that if the patients don't show up for the second session, the intake couldn't be billed. In response, Heidi's program "scrapped the first half" and now do all activities on-site.
- **Jessica Hyduk** described her program's many iterations to the group intake process and urged providers to "**do what's simplest for the patients**."

Additional Details

Event slides and a recording of the event provide additional details that complement the insights shared in this document. The event slides and recording are available online at: TAKEheart.ahrq.gov