TAKE heart
AHRQ's Initiative To Increase Use of Cardiac Rehabilitation

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
- Establish SMART (Specific, Measureable, Achievable, Relevant, and Time bound) goals.
- Complete the Action Plan Template, see attached Action Plan template

PH ACTION PLAN TEMPLATE.docx

- 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.
    3. Finalize an Action Plan & select milestones.
    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

SAMPLE_AGENDA.docx

Key Resources:

1. Institute for Healthcare Improvement (IHI). "Quality Improvement Essentials Toolkit." 2020. Available at: http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx

   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.

2. Institute for Healthcare Improvement (IHI). "Aim Statement Worksheet." 2020. Available at: http://www.ihi.org/resources/Pages/Tools/Aim-Statement-Worksheet.aspx

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

3. Institute for Healthcare Improvement (IHI). "Project Planning Form." 2020. Available at: http://www.ihi.org/resources/Pages/Tools/ProjectPlanningForm.aspx

   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.

4. McNeil, Patrick. "Clinical Champtions." *LiverPool Hospital*. Available at: https://www.health.nsw.gov.au/wohp/Documents/mc3-clinical-champions-mcneil.pdf

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

5. Centers for Disease Control and Prevention. "Million Hearts: Getting to 70% Cardiac Rehabilitation Participation: Action Steps for Hospitals." Available at: https://www.aacvpr.org/Portals/0/Million%20Hearts%20Change%20Package/4.24.2018%20Files/SC-3-CRCP-MH-Actions%20for%20Hospitals.pptx

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

6. Centers for Disease Control and Prevention. “Million Hearts: Tools and Protocols.” Available at: https://millionhearts.hhs.gov/tools-protocols/index.html

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

7. Centers for Disease Control and Prevention: Million Hearts. Cardiac Rehabilitation: Saving Lives, Restoring Health, Preventing Disease.” 2018. Available at: https://millionhearts.hhs.gov/files/Cardiac_Rehab_Infographic-508.pdf

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.

8. Health Information Technology, Evaluation, and Quality Center. “Guide to Improving Care Processes and Outcomes in Health Centers: An Approach to Quality Improvement.” 2016. Available at: https://hiteqcenter.org/Resources/HITEQ-Resources/guide-to-improving-care-processes-and-outcomes-in-health-centers

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.

9. TMIT Consulting, LLC. “Clinical Decision Support Quality Improvement Worksheet.” 2016. Available at: http://hiteqcenter.org/Portals/0/pdf/HITEQ%20HIT%20QI%20Guide%20CDS%20QI%20Worksheet_Essential.docx

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

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