

TAKEheart Care Coordination Implementation Guide – Part 2 -- Module 8

Implementing Effective Care Coordination	
Purpose and Overview	
<p>The overall goal of TAKEheart’s combined strategy of automatic referral with care coordination is to increase the enrollment and successful completion of cardiac rehabilitation (CR) by eligible patients.</p> <p>This is Part 2 of the three-part <i>TAKEheart Care Coordination Implementation Guide</i> (Guide) designed to help you think through the necessary steps to create an effective care coordination system. While there are a variety of definitions for care coordination used in the research literature describing its effectiveness (see box), we define care coordination as:</p> <ul style="list-style-type: none"> ➤ A group of workflow processes and activities designed and systematically executed to help ensure eligible patients get referred, enroll, and participate fully in CR. <p>This part of the three-part <i>Guide</i> is designed to supplement and expand on the information presented in TAKEheart’s Module 8 Training Session, which focused on how you can implement changes to establish or enhance the care coordination to address patient’ needs and concerns that may impact their enrollment and participation.</p> <ul style="list-style-type: none"> ➤ For more information on setting improvement priorities see Module 6 Laying the Groundwork for Effective Care Coordination and Part 1 of the <i>TAKEheart Care Coordination Implementation Guide</i>. ➤ Training Module 9 -- and Part 3 of the <i>Guide</i> -- will address the techniques and methods for engaging and empowering patients to take a more active role in their care. <p>Care coordination is multifaceted. Patients enter the CR referral pipeline from multiple providers, experiencing multiple cardiac conditions, and 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.</p>	<h3 style="text-align: center;">Definitions of Care Coordination</h3> <p style="text-align: center;">The literature uses “liaison” to describe care coordination</p> <p>Sherry Grace, PhD (2011) and her team defined liaison as one of several individuals, nurse, nurse practitioner, physical therapist and or patient graduate, acting to educate and guide eligible patients through the enrollment process to CR.</p> <p>Phil Ades, MD (2017) and his team defined liaison as a staff member(s) who act as a coach, meeting with eligible inpatients to educate them about the CR and guide them through the enrollment process.</p>

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

- Addressing the needs and concerns of patients
- Redesigning workflow processes
- Equipping staff to lead and support care coordination
- Monitoring and using data to support care coordination

We recommend reading through the entire guide before getting started implementing any changes.

Step One: Addressing the Needs and Concerns of Patients

Using Two Lenses

Effective care coordination requires the use of two lenses to better understand and support the needs of your patients.

One lens focuses on each individual patient in your program.

The BEST way to understand what any one of your patient's needs is by listening to them, asking them questions, and observing their behavior. Sections of this implementation guide provide suggestions for how to understand the needs of individuals. Module 9 will provide additional information for how to effectively listen and ask questions. Listening to the individual is the only way to avoid stereotypes and erroneous assumptions that can frustrate patients and undermine your efforts to coordinate their care. Some men have childcare responsibilities; some persons living in economically depressed areas may have no difficulties with transportation; some women may be completely comfortable exercising and sweating in mixed groups and some men may not be. Information you elicit during the intake process and conversations you have with each patient before, during, and after CR sessions are the best way to show you care about each of them as a person and want to help them address any challenges they encounter.

A second lens focuses on what you may infer about patients based on what you know about their environments.

These environmental factors are referred to a "social determinant of health" (SDOH). The CDC defines these as "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH will also be discussed more extensively in Module 9. Your knowledge of SDOH should be a mixture of what you know based on research experts have conducted and your own understanding of how geography, income, sex, and other factors in your community affect the care coordination needs of your patients. Information about SDOH can inform strategic choices you make in your CR program (e.g., the need to address transportation issues, to offer evening or early morning CR sessions, or to provide separate CR sessions for women). It can also inform what questions you ask patients based on their environments. And it can provide useful insights into the needs of patients you may not have directly communicated with (e.g., eligible patients that aren't being referred).

Understanding the needs of individual patients in your program and the patterns of needs associated with groups of your patients are both essential to making your care coordination as effective as possible. The sections that follow provide suggestions for how you can use each lens more effectively to improve your care coordination.

Understanding the Catchment Area

What is a catchment area?

Catchment area is a term used to describe the area a CR program draws from for patients. This is the general 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. Talk to the marketing and communication department for the hospital about available statistics for the region. The local commerce department might also be a good source of information. Try to identify some of the following characteristics:

- The average age
- The primary sex/gender
- The racial/ethnic distribution
- The average income
- The size of the area: small and densely populated or large and spread out
- The status of public services

What are the characteristics of the eligible patients missing from your CR program?

You might have a lot of information about the patients you are currently seeing in your program, but what do you know about the eligible patients you are missing? The research literature has identified some vulnerable populations (see box). Keep these features in mind as you spend some time looking at your data to gather the answers to some of the following questions:

- What is the average age?
- What is the primary sex/gender?
- What are the top two or three races and ethnicities represented?
- Where do the patients live?

The answers can provide valuable information and inform direction of next steps.

Understanding Barriers to CR Participation

More about SDOH

SDOH can affect a wide range of an individual's health and quality of life, and their health risks and outcomes. SDOH influence physical and mental well-being outcomes throughout the life course. Conditions to which we are exposed can influence behaviors and limit access. Limited access to public transportation, health care, poor nutrition, housing, education, social support, and employment can influence health, health behaviors and health outcomes. Thus, they can have a direct impact on patient participation in CR. Knowing the SDOH profile of your catchment area gives you important information about potential patients, who may not be currently enrolled or retained in CR at the same rates as your "regular" patients, for example patients with limited incomes or those in distant, rural communities. These under-represented subgroups may need special help if they are to enroll and stay in CR.

Eligible Patients Less Likely to Participate in CR

- A young or older adult
- Female
- Black
- Hispanic
- Less well educated
- Lacking/limited insurance

What are the common barriers to CR?

Understanding the makeup of your service area and collecting data about missing eligible patients is only a portion of the information you need to assist patients throughout the continuum of care. You should also have an appreciation for the barriers patients face. The common barriers to CR participation include individual concerns, transportation, lack of education about the benefits and value of CR, behavioral health issues and financial issues. Talk to your patients and actively listen to discover the common barriers for your program. Combining this information with the data about your service is key to enhancing care coordination.

Patient-Centered Care

At the core of care coordination is the patient. Failure to actively support patients from referral to completion of CR increases the risk of non-enrollment and/or dropping out before completing the program. This is especially true of the most vulnerable patients. As a reminder, even for those CR programs operating at full capacity, overlooking patients with the greatest needs is not acceptable.

What is a patient centered approach to care?

Addressing patient needs and concerns to promote increased enrollment and participation in CR begins with adopting a patient-centered approach to care. Patient-centered care is designed to meet the individual needs of each patient. Patient needs, resources, abilities, and concerns vary. For example, two low-income patients might have different transportation experiences to CR. One patient might be able to take one bus to reach CR while another might have to take three. Take time to talk to patients **and actively listen to what they are telling you**. More detail on patient conversations is provided in **Module 9**. Find out the answers to some of these questions:

- How has the patient's role in the family/community been affected by this recent event?
- What is the impact on the patient's cultural values and beliefs?
- What kind of support system exists for the patient?
- What are the patient's goals and preferences?

Use the information to tailor a patient-specific care plan.

How should you begin?

A patient-centered approach to care requires rethinking how CR is organized, managed, and delivered. Workflow processes need to be created so that information can be shared among all the participants concerned with a patient's care. Processes are necessary to ensure patient needs and preferences are identified at the start of care, communicated at the right time to the right people and used to provide safe, appropriate, and effective care.

What can we do to identify patient needs and concerns?

In addition to standard clinical assessment tools, for example the PHQ-9 for depression, there are tools available for assessing CR barriers and identifying patients at risk for non-adherence. A description and link to each instrument is provided below.

- [Cardiac Rehabilitation Barriers Scale](#) -- this is an online patient self-assessment instrument for barriers to CR. At the end of the assessment the patient is given tips for mitigating identified potential barriers.
- [Risk Stratification Tool for Non-Adherence in CR](#) -- this tool assesses a patient's relative risk for non-adherence

Step Two: Redesigning Workflow Processes

As you set out to redesign workflow processes keep in mind a patient-centered style of practice requires health care workers from various professional backgrounds to work together with patients, families, caregivers, and communities. An effective care coordination system includes:

- Workflow processes and activities designed and systematically executed to help ensure eligible patients get referred, enroll, and participate fully in CR.
- A set of sequential activities performed throughout the continuum of care from eligibility determination to CR program graduation.
- Execution by a team vs. a single person

As you work together to revise workflow processes, use the following resource to help guide discussions and revisions:

- [Tools To Promote Cardiac Rehabilitation Utilization](#)

What are the important considerations along the continuum of care?

Below are tables describing the key activities for each phase of supporting patients from eligibility determination to graduation. Use the tables as templates and checklists for your own programs.

Inpatient CR (PHASE I)

The inpatient length of stay tends to be short. Using a patient centered approach, the goal is to determine who the patient is and what is important to them. Remember, the patient is separate from the diagnosis/condition. Information about social and cultural background can be used to help tailor the plan of care. Develop an understanding of how the patient's health status/condition impacts their life. Find out beliefs and preferences. This information should be shared with all involved in the patient's care. Whenever possible include the patient and family in discussions about CR.

Key activities	Who should do it?	When will it be done?	What skills/training are necessary?
Make sure eligible patients are identified and referred	RN, PT, RT, MD Discharge planner. Care manager	Prior to discharge, ideally in-person	CR eligibility, relationship management with providers, automatic referral
Screen the patient	Collaborative effort of the interdisciplinary care team	Upon admission	Screening tools, cultural sensitivity, SDOH
Clinician/Patient conversation about CR	Treating clinician	Just prior to discharge	Patient engagement, effective communication, cultural sensitivity

Provide CR education	Any member of the interdisciplinary care team including discharge planner and/or care manager	Throughout the hospital stay; Develop a letter introducing CR to be given in person at discharge	Learning styles, health literacy, patient engagement, outpatient CR enrollment & workflow processes
Clinician/clinician conversation for complex patients discharged to post-acute care facilities	Treating clinician	Prior to discharge	Services provided at local post-acute care facilities

Transition (Discharge to Enrollment)

The goal here is to provide the patient with a smooth, timely transition and ensure the patient enrolls in CR. Reducing the time from inpatient to outpatient care is a known driver of CR participation.

Key activities	Who should do it?	When will it be done?	What skills/training are necessary?
Confirm the referral and the destination of the referral	Any member of the interdisciplinary care team including discharge planner and/or care manager	Prior to discharge	Automatic referral system, CR eligibility, relationships with external programs
Schedule first outpatient CR visit	Any member of the interdisciplinary care team including discharge planner and/or care manager	Best practice dictates before the patient leaves the hospital	Communication, collaboration, outpatient CR program and workflow processes
Connect patient with needed community resources	SW, Discharge planner, Care manager,	During the time from discharge to attending the first visit	Awareness and relationships with community resources
Provide patient support	Community health worker, former CR graduates acting as ambassadors	During the time from discharge to attending the first visit	Listening, effective communication; knowledge of outpatient CR
Track complex medical patients	Any member of the interdisciplinary care	For the duration of the post-acute care	Organization, relationships with

discharged to post-acute care facilities	team including discharge planner and/or care manager	stay until the patient starts outpatient CR	post-acute care facilities, effective communication, knowledge of outpatient CR
Warm handoff from inpatient CR staff to outpatient CR staff	Any member of the interdisciplinary care team including discharge planner and/or care manager	Prior to discharge, ideally involving the patient and family in the discussion	Listening, effective communication, SDOH

Outpatient CR (Phase II)

Once the patient arrives at outpatient CR, use the same multidisciplinary approach, leveraging the skills and professional backgrounds of the entire team to support the patient through the completion of CR. The entire team should take time to develop an understanding of each patient. Treatment plans should be developed in collaboration with the patient with the knowledge the plan of care might require modification to effectively address patient needs and concerns. Be flexible and think “outside the box” to create efficient and effective solutions to accommodate patients so they can complete their program.

Key activities	Who should do it?	When will it be done?	What skills/training are necessary?
Acknowledge referral	Intake personnel	Best practice dictates within 48 hours	Computer, organization, scheduling, listening
Enroll patients	Intake personnel	Best practice dictates within three weeks-sooner the better	SDOH, listening, scheduling
CR sessions	Members of the interdisciplinary care team	The duration of the plan of care	SDOH, listening, effective communication, cultural sensitivity
Patient education and self-management	Members of the interdisciplinary care team	The duration of the plan of care	SDOH, listening, effective communication, learning styles

How do you ensure consistent workflow processes and activities?

Throughout the process of redesigning workflow processes it is important to engage staff. Provide them frequent opportunities to review and give input. Taking these steps is likely to promote buy-in among staff which should in turn help promote adoption.

All new processes and revisions need to be documented in writing. Creating written resources has many benefits:

- Drives consistent behavior and actions
- Fosters continued actions when staff leave or move to different positions

- Specifies the referral process, for both internal and external referrals
- Dictate care coordination activities
 - One action that tends to be forgotten is the clinician-to-clinician conversation for medically complex patients being discharged to post-acute care facilities
 - It is important for the physician in the facility to understand the plan of care and the patient's eligibility status for CR when he or she is ready.
- Directs the screening of eligible patients for needs and concerns
- Provides structure and accountability for the referral and care coordination activities

Step Three: Equipping Staff to Lead and Support Care Coordination

As your program works to implement new workflows and practices, it will affect both **what** staff need to know and do and as well as how much work and time may be required to do it. It might also affect **which** staff are responsible for specific tasks and when some tasks need to be performed. Job descriptions may need to be written for new positions or revised to include new roles and responsibilities. Job expectations and performance criteria may need to be adjusted. Therefore, it is important to devote time to onboarding and training to support staff through the changes. Both onboarding and training processes should be documented, for reference and future use, in the event of inevitable staff turnover.

Onboarding

Spending time orienting and mentoring can help ensure staff can operate successfully with in the care coordination system. If team members are shifting roles, try to allow time for overlap which provides an opportunity for the transfer of knowledge. The departing individual can provide mentorship to the incoming team member which can ease anxiety about assuming new roles and responsibilities.

Who needs to be involved?

All staff involved with new workflow processes should be oriented. Some workflow processes -- such as the automatic referral system -- will require orientation for the entire CR team, including all Phase I and Phase II staff. Everyone also needs to understand where and how to access information and reports to support their position. If you listen while you explain and review new workflow processes and changes, it can be an opportunity to generate fresh ideas to inform future care coordination refinements and enhancements. Orientation materials should be accessible for staff reference.

Training

All staff who interact with CR patients need to develop knowledge and competency for addressing SDOH. They need to understand the variability of SDOH and how they impact an individual's life and ability to manage. For example, physical activity is crucial to cardiac rehabilitation, but some patients live in areas without green space or sidewalks and can have perceptions of decreased safety. Staff need to tailor a program to fit the patient's home environment and help the patient identify accessible space. They need to learn to listen and honor patient and family goals, preferences and observations and care concerns.

Members of the interdisciplinary care team need to:

- Discuss SDOH and determine how this knowledge can be used to transform the delivery of care, for example, implementing interprofessional care teams that maximize patient access to varied perspectives and skill sets
- Discuss integrating assessment tools and data collection

Health Literacy

Health literacy is the ability to obtain, read, process, understand and use health care information to make appropriate health decisions and follow instructions for treatment. Health literacy is considered a modifiable risk factor for health disparities; therefore, it deserves training time. Staff need to learn how to communicate effectively by using plain language to educate patients and families about the process of CR at every opportunity throughout the patient stay. Health literacy can be improved through screening and tailored patient education to improve understanding of CR and self-management strategies. Patients have different learning preferences, literacy levels and learning styles. All members of the care team should ensure that accurate information is presented clearly in plain language tailored to a diverse population. Use a combination of interventions, visuals along with written material. Use demonstration and ask patients to teach-back what they heard and understood. Provide a list of reputable websites for education.

Additional training

Don't overlook supplemental training for staff to improve their ability to address patient needs and concerns. Training in motivational interviewing and patient self-management techniques can improve conversations with patients and equip staff to help steer patients to take a more active role in their care. Allow staff the opportunity to practice the skills they are learning. This topic will be discussed in more detail in **Module 9**.

Biases can exacerbate and perpetuate disparities in care. Antibias and cultural sensitivity training can help give staff a new perspective on the patients they are helping.

Step 4: Monitoring and Using Data to Support Care Coordination

Improving care coordination for individual patients requires that your staff receive patient-level reports containing:

- Information needed to confirm eligibility and to follow up with physicians about the appropriateness of referring the patient to CR.
- Information that will help your staff develop a CR plan suitable for the patient and to anticipate and address challenges or obstacles to their successful participation.
- Information needed to reach the patient or to place them in the CR program that they may be the most successful in.
- Information about patient participation that you need for follow-up so you can reinforce success or rapidly respond to emerging participation barriers.

CR programs in TAKEheart should have the ability to either generate patient-level reports or to query their systems to obtain information to support the care coordination of individual patients. Because many programs have experienced staffing changes over the past year, it is essential that all new staff receive the training and support they need to access reports or make patient queries.

If staff don't know how to access data in your system, then they can't give patients all the help they need. Relevant data that all staff should be able to access include:

Where can I find more information about data?

TAKEheart's **Module 4** focused on data and provided many tools and resources to draw on to support enhancements to care coordination. Specifically, we suggest you review the following sections of the *Implementation Guide*:

- Data You'll Need for Enhanced Care Coordination
- Using Your Data Strategically
- Sample Dashboard Reports for Care Coordination

Evaluate Improvement Efforts

In the spirit of continuous improvement and refinement, seek input from staff and patients. They can be a great source for current and future improvement ideas. Engage in discussions about struggles and failures, promote them as opportunities for learning. Find out what changes are working well, and which need some adjustment.

Monitor Data

As you implement changes and integrate enhancements to care coordination use performance measures to evaluate your progress. Since many of your efforts will be directed to addressing the needs and concerns of underserved patient groups, you will want to watch the enrollment, participation and completion rates for those groups. Here is a small sample of other performance measures you might track:

- Percent of participation & completion by underrepresented patient groups – **CR program overall**
- Percent of eligible patients referred – **Inpatient CR**
- Percent of inpatients receiving a CR education visit – **Inpatient CR**
- Time from Referral to Enrollment and/or attendance at first session --**Transition**
- Percentage of referrals who enroll -- **Transition**
- Percent of patients attending CR orientation –**Outpatient CR**
- Percent of enrolled patients who complete CR – **Outpatient CR**

As a team decide on your performance measures, start with a few, and add more as you progress.

- Try to align your measures with your aim statement.
- Remember to define the success criteria for each.
- Take time to analyze your data and use the information to adjust.
- Celebrate and spread the word about success to drive further improvement efforts.

Key Resources:

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.

1. [International Council of Cardiovascular Prevention and Rehabilitation-CR Utilization](#)
This guide provides many useful tools and resources to address participation and adherence in cardiac rehabilitation.
2. [AACVPR—Commercial Insurance Pre-Authorization Template for Cardiac Rehabilitation](#)

This AACVPR template suggestion is intended to expand reimbursement and payment information that is specific to CR services. In addition to demographic and insurance information that is collected prior to enrollment in CR, the following information is important in individualizing patient care.

3. [Case Study: Christiana Care Health System—Reducing Cost-Sharing Barriers for CR Services with Creative Options](#)
A brief Q&A with Christiana Care System about their successful reduction of financial barriers to CR, with links to a longer program summary.
4. [AACVPR Cardiac Rehabilitation Enrollment Strategy—Cardiac Rehabilitation Pre-Enrollment Group Screening](#)
This case study recognizes the importance of (and provides strategies for) timely referral to CR.
5. [Case Study: Genesis HealthCare System—Group Orientation](#)
Q&A with Genesis HealthCare System, which implemented peer support programs for CR patients, as well as additional links to a program summary.
6. [Genesis HealthCare System—Welcome to Heart & Vascular and Pulmonary Rehabilitation PowerPoint for Patients](#)
An example of a slide deck presented at a CR orientation.
7. [AACVPR Cardiac Rehabilitation Enrollment Strategy—Accelerated Usage of CR](#)
A short implementation guide for accelerated CR enrollment.
8. [AACVPR Cardiac Rehabilitation Enrollment Strategy—Matching Capacity to Demand: Open Gym](#)
A short implementation guide for open gym sessions.
9. [Case Study: Southwest Florida Heart Group—Open Gym Model](#)
Q&A with Southwest Florida Heart Group, which implemented an Open Gym model.
10. [Case Study: Mount Carmel Health System—Cardiac Rehab Open Gym](#)
Q&A with Mt. Carmel Health System, which implemented an Open Gym model.
11. [Case Study: Christiana Care Health System—Use Clinician Follow-up to Bolster Enrollment](#)
Q&A with Christiana Care Health System, which uses "non-enrollment letters" to notify referring cardiologists about patients' progress (or lack thereof) with CR, thus promoting patient accountability and engagement.
12. [AACVPR Cardiac Rehabilitation Enrollment Strategy—Cardiac Rehabilitation Patient Progress Report](#)
A short implementation guide for patient progress report, with a link to a sample report.
13. [AACVPR Cardiac Rehabilitation Enrollment Strategy— AACVPR Cardiac Rehabilitation Adherence Strategy—Incorporating Motivational and Financial Incentives](#)
An implementation guide for motivational and financial incentives for CR, including a sample tracking sheet and monetary breakdown.
14. [Case Study: University of Vermont Medical Center—Financial Incentives to Improve Cardiac Rehabilitation Attendance Among Medicaid Enrollees](#)
Q&A with Dr. Diann Gaalema about the implementation of financial incentives for CR patients enrolled in Medicaid.
15. [AACVPR Cardiac Rehabilitation Adherence Strategy—Use of Text Messaging and Mobile Applications](#)
An implementation guide for mobile monitoring of CR.
16. [Case Study: Miriam Hospital Center for Cardiac Fitness—Patient Ambassador Program](#)
Q&A with Miriam Hospital, which implemented a patient ambassador program to reduce the rate of patient drop-out, emphasizing the importance of personalized support for retaining patients.