TAKE heart

AHRQ's Initiative To Increase Use of Cardiac Rehabilitation

Activating Patients to Engage and Complete Cardiac Rehabilitation

Module 9

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DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

AHRQ Agency for Healthcare Research and Quality

TAKEheart Training and Technical Assistance Components

Training sessions guided by the Million Hearts®/AACVPR Cardiac Rehabilitation Change Package (CRCP), located in the Resource Center TAKEheart Website

★ CRCP Resources Pages 10 -13
Table 3: Enrollment & Participation
Table 4: Adherence

Monthly Training Sessions: What to do and Why – Ninth of 10 modules

Implementation Guide (IG): Focus on the How
Supplemental documents which outline the content, and provide specific actions, steps and resources designed to assist with integrating the training material

Partner Hospital Peer Action Groups (PH PAGs): Discussion of the HOW
Meet with coaches to discuss module content, share ideas and offer support to other hospitals in the group

American Hospital Association (AHA)/Health Research and Education Trust (HRET): TAKEheart AHRQ's Initiative to Increase Use of Cardiac Rehabilitation
Module 9: Activating Patients to Engage and Complete Cardiac Rehabilitation
Live Online Activity
January 27, 2022

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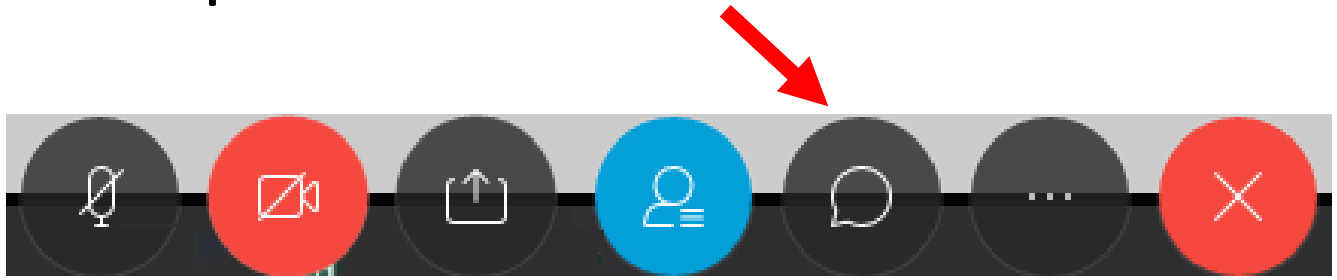
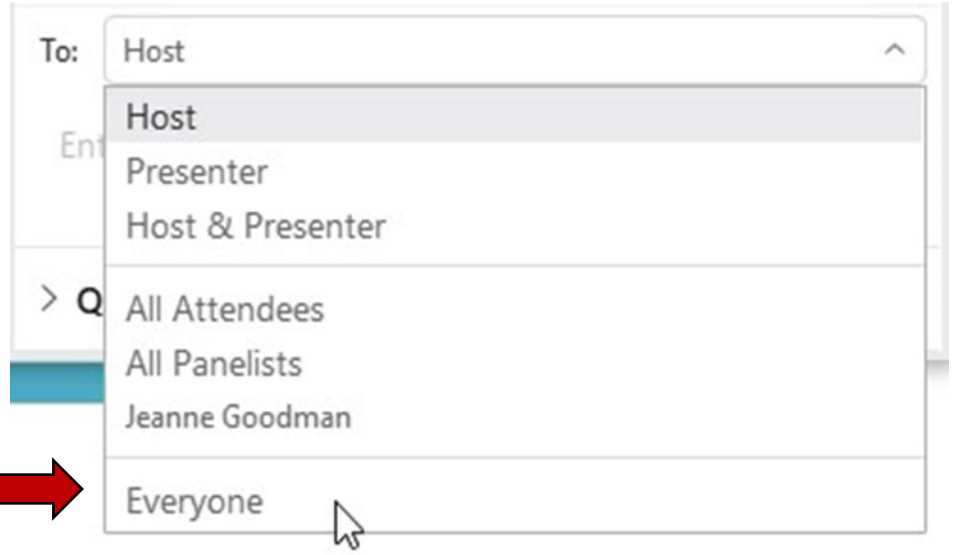
Chat Function

HOW TO ASK QUESTIONS

To ask a question or make a comment open the chat box



Set the TO: field to **Everyone** so that we can all see your question



Try the chat function now by sending a short greeting to the rest of the group

Implementing an Effective Care Coordination System

Module 6

Preliminary work

- Understanding care coordination
- Identifying gaps, opportunities & underserved populations
- Brainstorming & setting priorities

Module 8

Implementing changes

- Managing capacity
- Preparing staff
- Rolling out changes to the care coordination system

Module 9

Activating patients to engage in CR

- Pulling automatic referral and care coordination together

Learning Goals

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

1. **Analyze** patient and hospital case studies to understand techniques for activating patients to engage in CR.

2. **Apply** lessons learned through the case studies to gaps in your CR program's care coordination workflow.

Today's Presenters

Simone Bailey-Brown, MD
Preventive Cardiologist
Sands-Constellation Heart Institute
Rochester Regional Health Systems

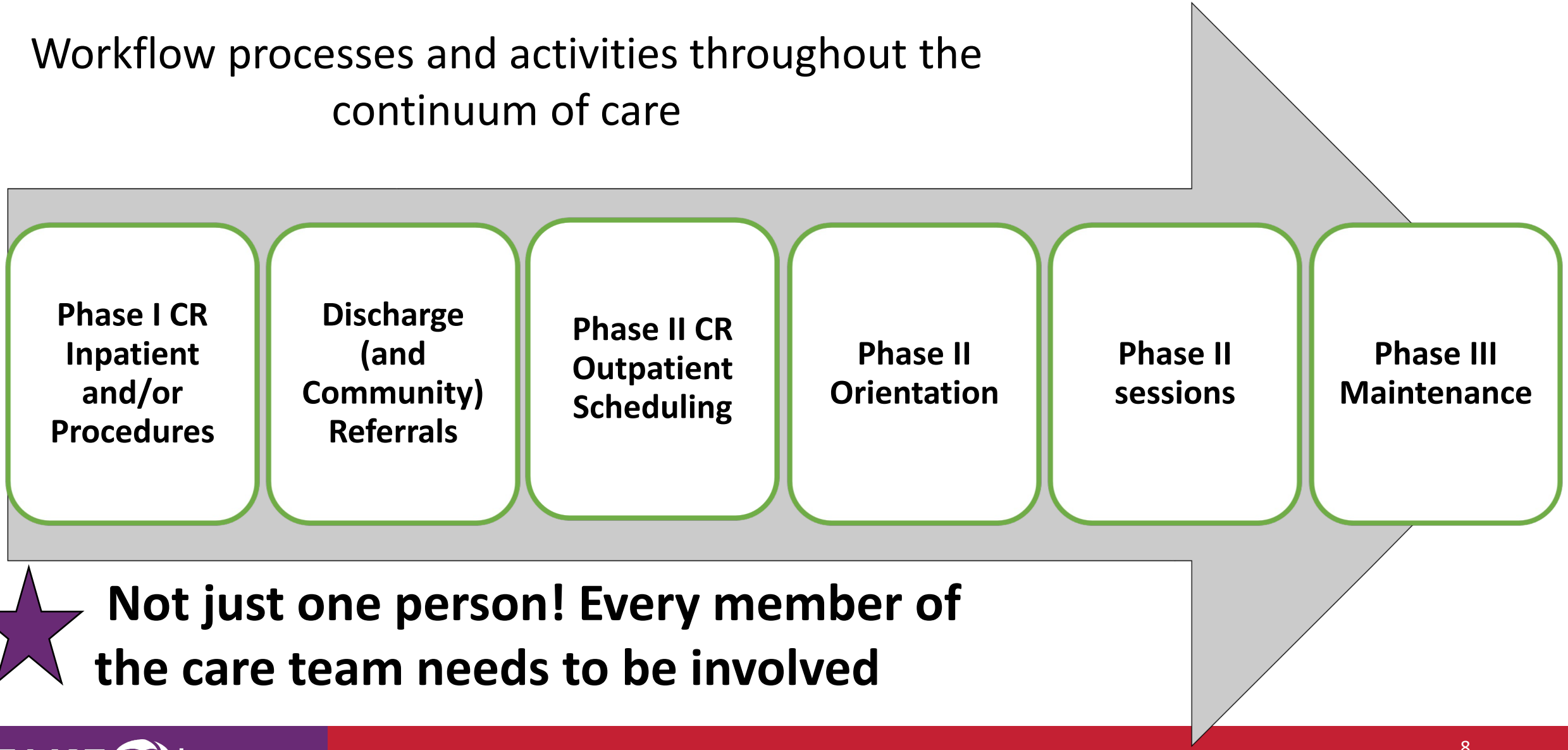
Adam Streb, PA
Physician Assistant
Rochester Regional Health Systems

Kathy Duckett, MSN, RN
Kathy Duckett Consulting

Tara Rouse, MA, CPHQ, CPXP, BCPA
Patient Partner
Principal, Partnership Health Advisors

When does Care Coordination Take Place?

Workflow processes and activities throughout the continuum of care



Not just one person! Every member of the care team needs to be involved

Create a Patient-Centered Approach to Care

Include	Include the patient and family in discussions to identify needs and concerns. Understand who the patient is and the impact of their condition
Tailor	Tailor care to be culturally sensitive with a focus on effective communication and each patient's abilities.
Educate	Educate the patient and family, using plain language, about the patient's condition, the discharge process, and the value and next steps to CR at every opportunity throughout hospital stay.
Listen	Listen to and honor the patient and family's goals, needs, preferences, observations, and concerns.

Patient Activation and Engagement: What's the Difference?

Patient Activation

- How willing and able is your patient to participate in their own care and manage it
- Low and high levels of patient activation
- Knowing which level your patient is at will determine how ready the patient is to utilize strategies aimed at increasing their engagement.

Patient Engagement Strategies

- Set of strategies or tools to use with the patient at their level of activation or readiness to participate in their care

Why is Patient Activation Is Important?

- Highly activated patients are more likely to engage in positive health behaviors and to have better health outcomes.
- Highly activated patients get more out of their care.
- Highly activated patients have lower costs.

Patient Activation - How

Four Stages of Activation

Hibbard et al., (2004) describe four stages of activation.

Activated patients:

1. Believe they have an important role in their own health care
2. Develop both the knowledge and confidence needed to take an active role in their care and health management, including an understanding of how to access and use the health care and supportive services available to them
3. Translate this confidence and knowledge into action
4. Maintain an active role in their health care, even when faced with challenges to doing so

Patient Activation - How

Tasks that Support Activation

The six core tasks that support activation as identified by Hibbard et al. (2004) are:

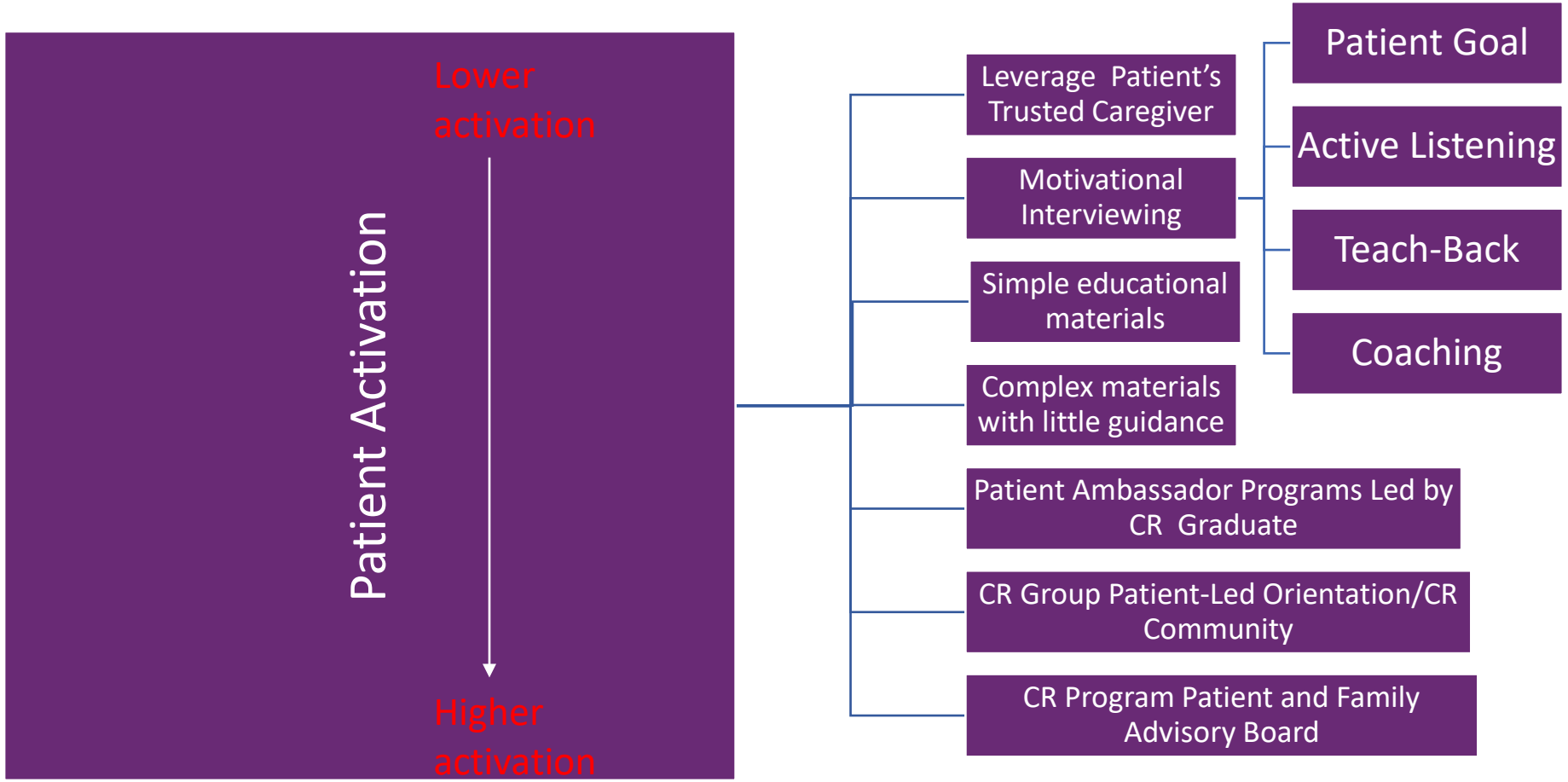
1. Symptom self-management
2. Engagement in actions that support health and functioning maintenance
3. Involvement in treatment decision making
4. Collaboration with health care providers
5. Critical, performance-based selection of providers
6. Navigation of the provider system

Patient Engagement

- Once you have determined your patient's activation level -- using a survey -- use this information to tailor both the EXTENT of engagement and the TYPES of engagement strategies/tools you will use with that patient.

- Extent of engagement
  - Highly activated patients may not need as much care coordination
  - Use your activation survey results to determine extent of engagement needed
  - If in doubt, utilize engagement tools for lower activation patients and then reduce care coordination efforts as the patient becomes more activated and engaged with their care.

Patient Engagement Strategies



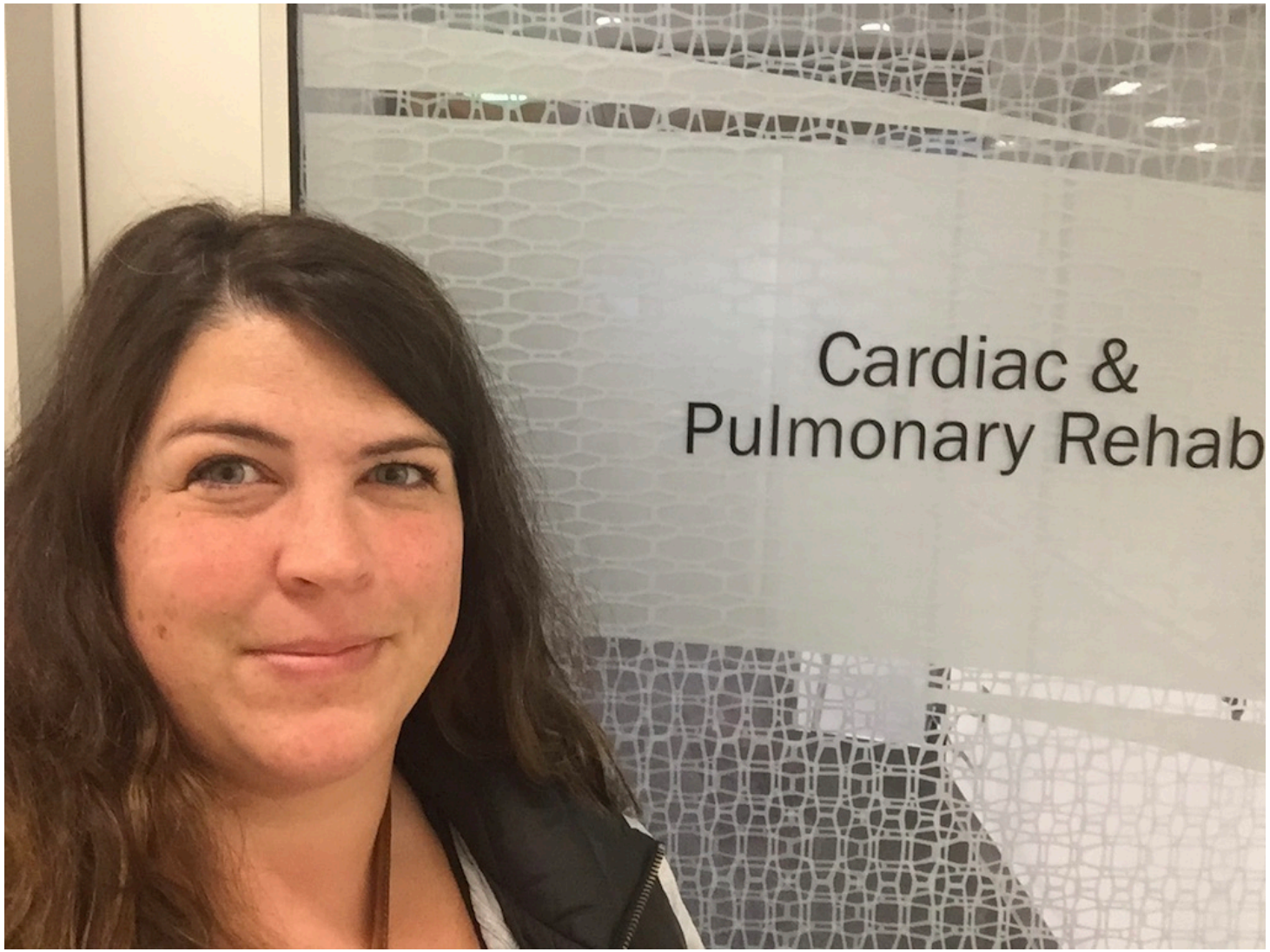
Case Study – Patient Activation

Kathy Duckett, MSN, RN
Kathy Duckett Consulting

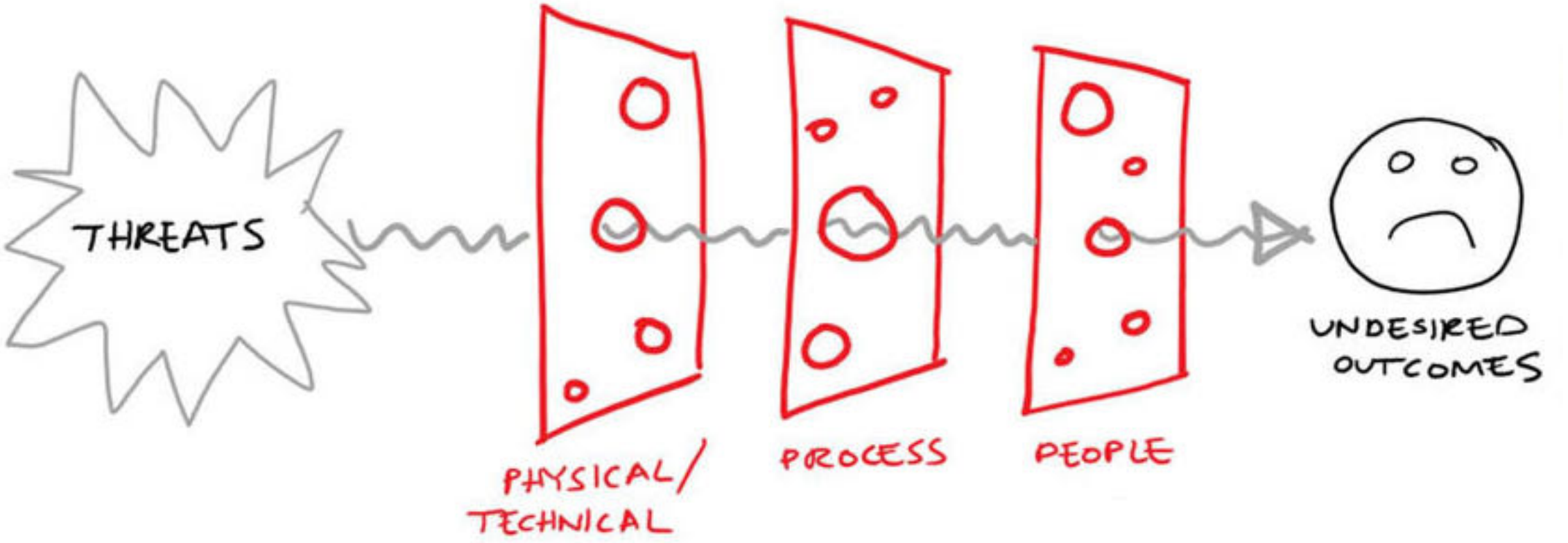
Tara Rouse, MA, CPHQ, CPXP, BCPA
Patient Partner
Principal, Partnership Health Advisors

Tara's Story

Tara's Story



How Can a Patient Not Know They're Referred to CR ?



Kathy's Story - CR Program through a Patient/Clinician Eyes

- Available only Monday – Thursday 7:30 am – 3:30pm
- Small Program – 3 treadmills, 2 bikes
- Personnel – 1 Physical Therapist, 1 Nurse
  - Physical Therapist primary interaction
  - 1 nurse sat a desk – no idea what her role was, never introduced self
  - 1 nurse took vital signs if more than 3 people in class
- Orientation – to machines, routine, program overview
- Parameters individualized, but program standardized
- Education standardized, use of videos
- Inconsistent participation during 3 months attending CR
- Geared toward older, retired men

CR Program through a Patient Eyes

- Knowledge Pretest - focus
  - Current knowledge
    - Disease process
    - Diet
    - Exercise
    - Lifestyle
- Post Test – same as pretest
  - Evaluated improvement knowledge
- Coaching
  - Exercise parameters
  - Vital sign parameters
  - Videos – improve knowledge
- Exercise
  - Focused on endurance
  - No more than 15-20 minutes before taking a break

CR Program through a Clinician Eyes – Improving CR

- Knowledge Pretest (Ask me)
  - All the same knowledge questions
  - Normal exercise – pre procedure
  - Ask if I am satisfied with current exercise, diet, lifestyle to support healthy heart
- During Orientation include Activation questions
  - Establish my activation level to determine an individualized plan for engagement
  - Help me establish my goals for therapy
- Coaching – in addition to usual education, include what matters most to me
  - Establish clear outcome goals – weekly, monthly, end of rehab
  - Concerns regarding exercise post Rehab – how will I fit this into my life without carve-out for Rehab?
  - What other provider do I need to talk with? What referrals do I need during/after the program?
- Knowledge Posttest – establish learning from CR
- Exit Interview and Interview Patients that Drop-Out

  ☑ What worked ☑ What didn't work ☑ What could be improved

Questions for Tara and Kathy

- **Chat question**: What went wrong in these scenarios?

- **Chat question**: What engagement strategies mentioned by the speakers will you incorporate in your CR program to activate patients?

How Well Do You Know Your Patients?

Part of empowering the patient is removal of the barriers that prevent attendance/completion of CR

Studies have shown these populations are less likely to participate in CR

If you are

A young or older adult
Female
Black
Hispanic
Less educated
Lacking insurance

What is your CR program catchment area?

- Geography (just a few of many examples):
  - Data on zip codes of most frequent and eligible patients
  - Transportation issues by zip code clusters
  - Major industries that would impact ways to teach CR/schedules (e.g., large farms, meat processing plant, IT company, etc.,)
- Demographics (just a few of many examples):
  - Cultures served
  - Languages spoken
  - Community centers that would impact ways to teach CR/schedules
  - Major insurances (cover CR, large co-pays, etc.,)

Social Determinants of Health - SDOH

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

KFF
HENRY J KAISER FAMILY FOUNDATION

Connecting SDOH to CR Programs

Impacts of SDOH	Improved Care Coordination
SDOH affects health and personal and social circumstances often correlated with race, education, income, residence, age, health status	Determine how your CR program assesses a patient's readiness and ability to engage in your CR program. Ask your patients about their goal and what they need to be successful with CR.
SDOH can affect physical, time, and financial access to care	Determine what barriers prevent your patients from attending your CR program, such as poverty, education, lack of transportation, and extended family obligations.
SDOH barriers can sometimes be changed.	Determine what barriers you can change such as food insecurity or moving a bus stop.

Case Study – Patient Ambassador Program

Simone Bailey-Brown, MD
Preventive Cardiologist
Sands-Constellation Heart Institute
Rochester Regional Health Systems

Cardiac Rehabilitation Ambassador Program: A Strategy to Increase Enrollment in Cardiac Rehabilitation - Rochester Regional Health

Adam Streb, PA
Physician Assistant
Rochester Regional Health Systems

Rochester Regional Health Background

- Large health system providing health care throughout Western New York, the Finger Lakes and St Lawrence County
- 4 Cardiac rehabilitation centers
- In 2020, at our largest location, we enrolled 431 new patients and had a total of 7,505 patient visits. There are an average of 17 visits per patient.
- Previous referral system depended on patient referrals by the outpatient providers at follow up visits post hospital admission
- In Feb 2021, Adam agreed to be our CR ambassador to give provider level endorsement of CR to patients prior to discharge and to place the CR order on those patients
- In May 2021 we implemented an automatic referral system in order to standardize the process and overcome provider related factors which drive disparities

Why a Cardiac Rehab Ambassador ?

- Bridge gap in enrollment
  - Initial provider contact
  - Dedicated time
- Serve as a resource
  - Advertise benefits
  - Not just about exercise
  - Empower patients
  - Answer questions and calm fears
  - Serve as a resource for other providers
- Offload an overwhelmed health system
- Overcome barriers that drive disparities
- Monitor EMR Referrals

Typical Encounter

- Scan EMR census to identify appropriate patients
- Enthusiastic presentation of the program
- Answer questions
- Place referral order if not already done
- Provide rehab brochure with contact information
- Document
- Takes about 10-20 minutes per patient

CR starts in the hospital

- Diet discussion and handout
- Smoking cessation
- Exercise discussion
- Share personal stories and make it relevant
- Provide tools to those who might not be interested

Implementation

- Very easy to set up
- Gratifying
- Needs to be the right person
- Unable to see everyone but I see most
- Team based approach and automatic referrals to fill gaps
- Could be job shared

Impact

2021	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	YTD	2019 totals	2020 totals
Phase II Visits	561	583	771	878	922	980	917	985	952	7,549	7,505	9,453
New Patients	32	36	43	53	47	50	42	50	52	405	431	511
Total Visits for Discharged Patients	456	421	438	301	341	556	350	591	653	4,107	5,406	8,012
Average Visits / Discharged Patient	18	25	24	27	19	29	25	28	27	24	17	19

Impact of Cardiac Ambassador Program

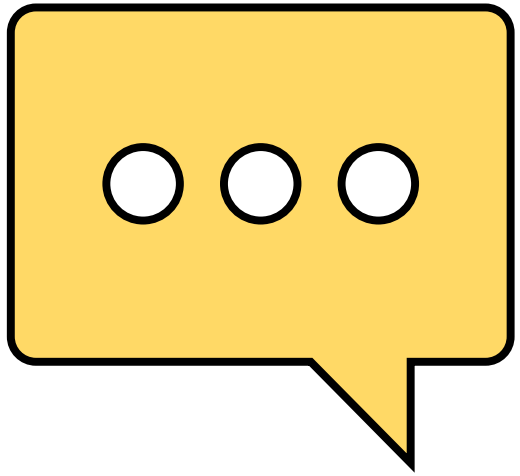
- Positive feedback from patients
- Increases awareness among fellows and APPs
- Pairs well with our automatic referral program
- Increased referrals to the program and has forced us to look at creative strategies to ensure the flow of patients through the program, to overcome backlog and delays in patient start times.

****These issues are further compounded by COVID-19 restrictions on class size and staffing shortages.**

Future Plans

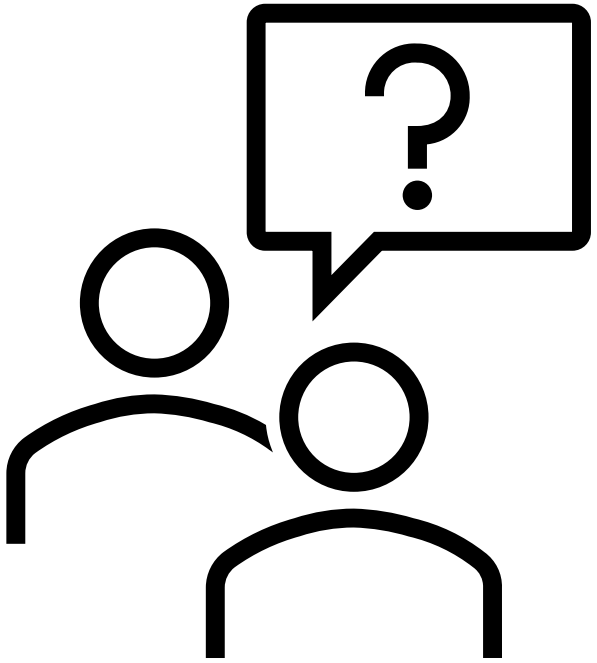
- Schedule first visit prior to leaving the hospital – zoom group orientations planned to decrease time to first CR contact with patients
- Formally assess impact on rate of referral of eligible patients
- Expand utilization of virtual CR - platform in place but currently limited by insurance coverage

Audience Sharing



Key Insight: **In the chat box, tell us one useful insight you will take away from today's training session.**

Q&A



Action Steps

Feel free to contact coaches with questions

Continue	Working with your team: determine patient activation to engagement levels, analyze your catchment area for barriers to CR, and determine priorities to change and a process for the change
Explore	Steps, actions and resources available in the Module 9 Implementation Guide
Discuss	Progress, challenges and solutions in your PH-PAG

Next Up: Module 10

LAST MODULE - February 24, 2022, 3pm-4pm ET

Using Remote and Hybrid Cardiac Rehabilitation to Expand System Capacity and Patient-Centeredness

Registration link:

https://abtassociates.webex.com/abtassociates/j.php?RGID=r29f30d5d53b62e3aaacd2a611104af27