ANCHORED TO OUR VALUES

37TH ANNUAL MEETING

SEPTEMBER 21-23, 2022
PALM BEACH COUNTY CONVENTION CENTER • WEST PALM BEACH, FL
Session in a Box: A User’s Guide to VBC Resources for CR/PR Professionals

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Disclosures

Karen - none
Tedd - none
Jonathan - none
Yvette - none
Objectives

- The value of cardiopulmonary rehab in Healthcare and how to have conversations with key people
- Population health and how this impacts the care we deliver across the continuum
- Quality, performance measures and how to utilize data to invoke change
- Practical strategies to implement value-based care principles in any rehab setting
What is Value-Based Care?

Value-Based Care

COST

RESULT

QUALITY

VBC: a change in care delivery

Value-based care is delivering the best quality patient care with regards to the cost of that care through data-driven analysis and service improvement.

How can we modify or tailor the way we are currently delivering care to Cardiac & Pulmonary patients to:

- Optimize program outcomes
- Maintain costs
- Optimize efficiencies
- Improve patient & staff experience?

Defined by the AACVPR- HCRC Subcommittee -VBC Workgroup
VBC Defined by

Patients in CR & PR

CR & PR Clinicians & Teams

CR & PR Care Delivery Systems
Fee-for-Service vs. Value-based Care

- **Fee For Service**
  - Productivity
  - Billable units

- **Value Based Care**
  - Value = Quality/Cost
Application of VBC

VBC in simple terms: A Balancing Act

Achieving Value, Quality & Cost desired by the stakeholders in the CR & PR practice

$$Value = \frac{Quality}{Cost}$$
Value Based Care in CR and PR

The AACVPR value based care initiative provides resources which assist cardiac & pulmonary rehabilitation professionals to:

- Assign accountability
- Target efficiencies
- Strategize operational transformation
- Restructure the care delivery model
- Implement effective technology solutions in management
- Improve the patient and practitioner experience

https://www.aacvpr.org/Value-Based-Care
Association Priorities

**Advocacy**
- Accessibility
- Fiscal viability
- Regulatory impact
- Value Based Care
- Roadmap Two Reform
- Education
  - Lawmakers
  - Providers
  - Consumers

**Certification/Registry/PM**
- Online cert application
- Experts panels
- National registry development
- Outcomes tracking
- Performance Measures

**Strategic Relationships**
- Million Hearts Campaign CR Collaborative-
  strengthen partnerships to advocate increasing CR Referral,
  Enrollment & Adherence

**Affiliate Link:**
- Joint Affiliate membership
- Outstanding Affiliate Award

**Education**
- Webcasts
- Best Practice Essentials series
- Annual Meeting
- Web site

**Research and Innovation**
- Evidence-based care
- Define standards
- Credibility
- Instigating change
- Position papers
- Innovation Award
Value Based Care Resources

Value-Based Care

VALUE-BASED CARE

Value-Based Care Resources

Value-Based Care

Quality patient care is at the core of all we do. Delivering value-based care means providing the best quality patient care with regards to the cost of that care through data-driven analysis and service improvement. The value-based care initiative provides resources which assist cardiac and pulmonary rehabilitation professionals to:

- Assign accountability
- Target efficiencies
- Strategize operational transformation
- Restructure the care delivery model
- Implement effective technology solutions in management
- Ultimately improve the patient and practitioner experience

This webpage contains comprehensive resources for CR and PR professionals aiming to implement value-based care practices at their facility. Click below for webinars, articles, turnkeys, and supplemental resources. AACVPR members can access additional resources in AACVPR Central.

Turnkey Enrollment and Adherence Strategy Documents

These turnkey strategies are valuable resources for improving your cardiac and pulmonary rehabilitation program.

https://www.aacvpr.org/Value-Based-Care

Change Packages

In 2014, AACVPR partnered with Million Hearts and the Centers for Disease Control (CDC) to create the Cardiac Rehabilitation Change Package. In 2019, Million Hearts and the CDC launched the Tobacco Cessation Change Package.

Webinars

AACVPR's Value-Based Care Committee has created a series of webinars to share implementation strategies for value-based care practices from improving referral, enrollment, group screening, adherence, ECG telemetry monitoring, to incorporating a registered dietician.

AACVPR is pleased to offer complimentary registration to AACVPR members for all value-based care webinar presentations. Non-members may register for $25. All webinars are recorded for later viewing in the Learning Center. Please note that CE will not be provided. To access these presentations, simply login to your AACVPR profile and navigate to the Learning Center.

View VBC webinars available >>

Value-Based Care at the AACVPR Annual Meeting

Value-based care practices are highlighted each year at the AACVPR Annual Meeting. Presentation recordings are available for purchase in the Learning Center. As a courtesy, we’ve linked the PDF handouts from the presentations for free below.

View the presentation handouts from the selected session >>

News & Views

Here, we've rounded up all the value-based care articles in News & Views.

Additional Reference Documents

AACVPR has developed the Executive Summary for Papers and Summary for Papers as resources for CR implementation and funding. However, AACVPR is not the only organization being the lead in value-based care implementation. Click below to view resources from key industry leaders.

Millions Hearts
Industry Partners
NEW Resource!

- The Hypertension Control Change Package, 2nd Edition is a new resource for professionals to utilize with their patients.
AACVPR Strategic Initiative

Goal #2: Program Quality and Sustainability

- AACVPR will drive program sustainability through integration of VBC and quality initiatives by engaging professionals and programs.
- By Q3 2021 (Value Based Care) develop a “session in a box” for affiliates to provide VBC presentation at the local level that is consistent with the national message.
  - Utilize an outline and framework developed in collaboration with VBC and affiliate leaders at ALF (session objectives, agenda, slide outline). Approved for credits.

A new resource for CR-PR professionals: Session-in-a-Box
Why Session-in-a-Box?

• Concise, easy to follow presentation for CR & PR professionals to use to explain VBC concepts to key stakeholders.

• Learn VBC strategies related to administration, population health, outcomes & value to drive change in rehab
Session-in-a-Box Sections

• Administration
  ▪ The process or activity of running an organization (rehab)

• Population Health
  ▪ an interdisciplinary, customizable approach that allows health departments to connect practice to policy for change to happen locally (https://www.cdc.gov/pophealthtraining/whatis.html)

• Outcomes & Value
  ▪ **Outcomes** are the changes you expect to result from your program
  ▪ **Value** is the usefulness, or importance in comparison with something else
Administration
What Metrics are Important, to Whom and Why?

- **Payers/Hospital Administration**
  - Cost per patient episode
  - Readmission Rate
  - Excess Days in Acute Care (readmission, ED, observation)
  - HCAHPS
  - Mortality

- **Cardiac Rehab Programs**
  - Number of referrals (including source)
  - Time to enrollment
  - Number of patients enrolled
  - Number of visits (total)
  - Number of visits (per patient)
  - Clinical Outcomes
Glossary of Terms

• In the session in a box, you will have a glossary of terms to help you learn terminology that administration is usually quite familiar with.

• As a clinician, they may not be in your normal vocabulary and this will be a valuable resource for you to talk to administration.
• Reducing Hospital Admissions/Readmissions for Patients with COPD through Enrollment in Pulmonary Rehabilitation
  • COPD Patient Barriers to Adherence in Pulmonary Rehabilitation
    • 12-Month Cardiovascular Condition Episode (Bundle)
      • Connecting with Psychosocial Providers
  • CR Referral Performance Measures in a Quality Improvement System
    • Establish a Philanthropic Fund
      • Group Screening
  • Inpatient Liaison for Outpatient CR [inpatient tracking form]
    • Reduce the Delay from Discharge to Enrollment
      • COPD Referral & Enrollment to PR

http://www.aacvpr.org/VBCRepository
Plan-Do-Study-Act

The Plan, Do, Study, Act (PDSA) cycle is a method for rapidly testing a change - by planning it, trying it, observing the results, and acting on what is learned. This is a scientific method used for action-oriented learning.
Plan-Do-Study-Act

- Slides relating to PDSA cycle will be included in the session in a box presentation.
- The Plan-Do-Study-Act cycle is vital to present to administration and to keep them informed of changes in your program.
- Very rarely do projects get greenlighted with no further oversight. You will report back to the committee/administrator and show your progress/data.
But How do I Collect all That Data?

We are all busy and sometimes data collections seems like another task piled on our plates but…

• Data doesn’t always have to be collected at the department level.
• Most hospitals are participating in outcome registries and many of those have items directly relating to referrals, attendance, and disease cohorts.
• Check to see what yours is doing, and how you can leverage that to affect change in your department.
Program Level

• How do I implement change within my program?
• Listen to staff: what do they want to improve? Where do they see inefficiencies?
• Empower staff to make changes. Staff, ask your supervisor/manager about making changes.
• It can seem daunting with limited staff. Tackle one little project at a time. Break bigger projects into smaller, measurable steps.
Review Progress

- Remember to look at data points before and after your changes. Is it making a difference?

- Remember it may be as simple as doing chart reviews and marking whether staff is following through on the changes.

- Don’t be afraid to change back to the old way if the new way isn’t working. Or tweak the process even further and evaluate again.
Administration Summary

• Don’t be afraid to get out in the hospital! Show the great work you are doing in the rehab setting.
• Look to highlight the changes you have already made without a directive.
• Use the session in a box presentation from your state(s) annual conference to drive change.
• Look for examples in the value based care section on the AACVPR website.
Population Health
Definitions

- **Public Health**: is the science of protecting and improving the health of people and their communities, through promoting healthy lifestyles, researching disease.

- **Population Health**: an opportunity for health care systems, agencies, and organizations to work together in order to improve the health outcomes of the communities they serve.
Definitions

- **Social Determinants of Health (SDOH):** 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.

- **Population Health Management:** Improving clinical health outcomes in a defined group of individuals through improved care coordination and patient engagement supported by appropriate care models.
Social Determinants of Health

Community & Public Health
- Housing
- Food
- Transportation
- Employment
- Social Connections
- Safety

Population Health

Clinical Services
- Preventative Care
- Behavioral Health
- Chronic Disease Management
- Acute Care
- Specialty Care
**SDOH, PHM & CR/PR**

Example Considerations for addressing SDOH to help prevent ASCVD events

<table>
<thead>
<tr>
<th>Topic/Domain</th>
<th>Example Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular risk</td>
<td>Adults should be routinely assessed for psychosocial stressors and provided with appropriate counseling.</td>
</tr>
<tr>
<td></td>
<td>Health literacy should be assessed every 4 to 6 y to maximize recommendation effectiveness.</td>
</tr>
<tr>
<td>Diet</td>
<td>In addition to the prescription of diet modifications, body size perception, as well as social and cultural influences, should be assessed.</td>
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<tr>
<td></td>
<td>Potential barriers to adhering to a heart-healthy diet should be assessed, including food access and economic factors; these</td>
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<tr>
<td></td>
<td>factors may be particularly relevant to persons from vulnerable populations, such as individuals residing in either inner-city or rural environments, those</td>
</tr>
<tr>
<td></td>
<td>at socioeconomic disadvantage, and those of advanced age*.</td>
</tr>
<tr>
<td>Exercise and physical activity</td>
<td>In addition to the prescription of exercise, neighborhood environment and access to facilities for physical activity should be assessed.</td>
</tr>
<tr>
<td>Obesity and weight loss</td>
<td>Lifestyle counseling for weight loss should include assessment of and interventional recommendations for psychosocial stressors, sleep hygiene, and other</td>
</tr>
<tr>
<td></td>
<td>individualized barriers.</td>
</tr>
<tr>
<td></td>
<td>Weight maintenance should be promoted in patients with overweight/obesity who are unable to achieve recommended weight loss.</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>In addition to the prescription of type 2 diabetes mellitus interventions, environmental and psychosocial factors, including depression, stress, self-efficacy,</td>
</tr>
<tr>
<td></td>
<td>and social support, should be assessed to improve achievement of glycemic control and adherence to treatment.</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>Short sleep duration (&lt;6 h) and poor-quality sleep are associated with high blood pressure and should be considered.</td>
</tr>
<tr>
<td></td>
<td>Because other lifestyle habits can impact blood pressure, access to a healthy, low-sodium diet and viable exercise options should also be considered.</td>
</tr>
<tr>
<td>Tobacco treatment</td>
<td>Social support is another potential determinant of tobacco use. Therefore, in adults who use tobacco, assistance and arrangement for individualized and group</td>
</tr>
<tr>
<td></td>
<td>social support counseling are recommended.</td>
</tr>
</tbody>
</table>

*Advanced age generally refers to age ≥75 years. ASCVD indicates atherosclerotic cardiovascular disease.
Documentation

General Risk Score
- Age: 74
- All Admissions Count: 0
- All ED Visits Count: 2
- Has Chronic Obstructive Pulmonary Disease: Yes
- Has Diabetes: No
- Has Chronic Kidney Disease: No
- Has Congestive Heart Failure: No
- Has Liver Disease: Yes
- Has Depression: Yes
- Current PCP: Terri Lynn Brody, MD
- Has Medicaid: Yes

Social Determinants of Health
- Tobacco Use: High Risk
- Jun 22 2022
- Financial Resource Strain: Not on file
- Stress: Not on file
- Depression: At risk
- Jun 14 2022
- Food Insecurity: Not on file
- Alcohol Use: Not on file
- Physical Activity: Not on file
- Social Connections: Not on file
- Housing Stability: Not on file
Documentation

General Risk Score
0 - 3 Points: Low Risk
4 - 5 Points: Medium Risk
6 - 15 Points: High Risk

Details
0 Age: 61
- Current as of yesterday
0 All Admissions Count (1 yr): 0
- Current as of yesterday
3 All ED Visits Count (1 yr): 5
- Current as of yesterday

1 Has Chronic Obstructive Pulmonary Disease: Yes
- Current as of yesterday
0 Has Diabetes: No
- Current as of yesterday
0 Has Chronic Kidney Disease: No
- Current as of yesterday

1 Has Congestive Heart Failure: Yes
- Current as of yesterday
0 Has Liver Disease: No
- Current as of yesterday

1 Has Depression: Yes
- Current as of yesterday
0 Current PCP: Taffy Dien, MD
- Current as of yesterday
1 Has Medicare: Yes
- Current as of yesterday

PROBLEM LIST
Cardiovascular and Mediastinum
- Diastolic heart failure, unspecified HF chronicity (CMS Dx)
- Hypertension
PVD (peripheral vascular disease) (CMS Dx)
Respiratory
OSA and COPD overlap syndrome (CMS Dx)

Social Determinants of Health
Tobacco Use
- Jul 26, 2022: Medium Risk
- Alcohol Use
- Not on file

Financial Resource Strain
- Not on file
Stress
- Not on file
Depression
- Jul 25, 2022: Not at risk
- Physical Activity
- Not on file
Social Connections
- Not on file
Housing Stability
- Not on file

Active Plans
Cardiac Care Plan
- BP Monitoring Noncompliance
  - No active tasks
- Abnormal Blood Pressure
  - No active tasks

Food Insecurity
- Jul 19, 2022: No Food Insecurity
  - Wished About Running Out of Food in the Last Year
    - Never true
  - Ran Out of Food in the Last Year
    - Never true
Simplifying Value, Quality & Performance

Value = current state of health -> To desired state of health achieved/Cost of intervention/s

Quality = current quality of life -> To desired quality of life experienced/type of intervention/s × Cost/intervention

Performance (The outcome of interventions among CR & PR eligible patient populations) = Baseline metrics (clinical & behavioral) -> Improved patient and clinical reported outcomes
How does it all connect Value, Quality and Performance

Cardiac & Pulmonary Rehabilitation Services/Programs

Priority = Value

Data you track = Quality

Targets set = Performance

Population Health Management/ SDOH

Patients – finance, insurance, lack of support, education, access to produce,

Providers – EHR issues, lack of tools, burden imposed due to system inefficiency

Systems – lack of systematic, lack of wholesome approach

(JDavid, 2022)
Performance Measures - Overview

- Guideline based
  - ACC/AHA, 2018 Quality and Clinical Performance Measures
  - find any specific guideline for PR)

- Program based
  - Clinical Metrics (LOS, 30-day readmission, major adverse cardiovascular event (MACE), mortality & morbidity)
  - Patient reported outcomes (physical, psychosocial)
  - Organizational Metrics (Patient experience-HCAPHS)
Performance Measures – Overview

- Organizational Metrics
  - Patient Satisfaction

- CR/PR Specific Metrics
  - Measurements (Phase I/Phase II/Phase III specific elements)
Performance Measures – Examples

- **CR/PR Program Specific Metrics**
  - Measurements (Phase I/Phase II/Phase III specific elements)
    - Include Core Components of CR & PR
    - Clinical Outcomes - exercise testing and responses, BP, A1c, Lipid levels, 6MWT, Dyspnea assessment, quality of life assessment
    - Behavioral Outcomes – smoking cessation, adherence to diet and exercise, use of effective coping mechanisms
    - Morbidity and Mortality – Readmission, emergency room visits, sick days, loss of workdays, return to work
Performance Measures – Examples cont.

- Healthcare Effectiveness Data and Information Set (HEDIS)
  - Enrollment – hospital discharge to first billed session
  - Engagement
    - ≥2 sessions in 30 days
    - ≥12 sessions in 90 days
    - ≥24 sessions in 180 days
  - Completion
    - ≥36 sessions in 180 days
Strategies in Implementing VBC

1. Establish patient centered priorities (Value)
2. Perform a gap analysis
3. Utilize systematic approach in quality improvement initiatives (Plan, Do, Study, & Act).
4. Seek support to gather baseline and prospective data
Strategies in Implementing VBC

- Track CR & PR care delivery components
- Visualize gaps in the process in improving outcomes
- Compare performance outcomes rate with national benchmarks
- Engage stakeholders at all levels in addressing barriers
Case Study

Problem: Pulmonary rehab referrals were obtained manually by visiting the pulmonology office or having the office fax referrals.

Background: Before 10/7/20, the pulmonology medical office associated with our hospital used a different EMR than the hospital. We had to manually retrieve referrals from the office, or they would fax them to our department. We would then have to send standing orders back to the referring doctor for signature.

Gap/Barriers: This resulted in up to a weeks’ delay to call a patient for scheduling since we were only retrieving consults weekly.
Case Study – Poster S150 (AACVPR, 2022)

Inpatient Cardiac Rehabilitation Building A Case For Value-Based Care A Quadruple Analytical Approach

Jonathan David, MSN, RN, EBP-C, CCRP, NE-BC, Stanford Health Care, Palo Alto, California

BACKGROUND
The 2018 AHA/ACC Social Determinants of Health guidelines recommend inpatient cardiac rehabilitation (ICR) to improve cardiac risk and recovery among patients after hospital discharge. Stanford Health Care Health Care Improvement prioritized ICR to support early intervention and participation in cardiac rehabilitation (ICR).

METHODS & MATERIALS
A3 Tool – Baseline Data, Issues & Concerns, & Turnkeys

SBAR
CARE TRIANGULATION MODEL

GAP
Value-based care and optimization in implementing A3CAS Value-Based Care Framework Strategies.

QUADRUPLE ANALYSIS

EMR OPTIMIZATION

RESULTS

CONCLUSIONS

REFERENCES

Acknowledgement

Contact Information
Dear Leader,

We seek your support in implementing Turnkey Strategy/s, closing the gaps, and eliminating barriers to best practices in caring for our patients and families in the cardiac rehabilitation program/pulmonary rehabilitation/ cardiopulmonary rehabilitation program.

**Topic:** Example: Referrals to Cardiopulmonary Rehabilitation Program

**Date:** 5/18/2022

**Program Manager/Clinical Lead:** Jonathan David

**Organizational Leader:** Karen Edwards

<table>
<thead>
<tr>
<th>S</th>
<th>• Referrals to the cardiopulmonary program are obtained manually by visiting nursing units and clinics.</th>
</tr>
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</table>
| B | • Patients with an eligible diagnosis benefit from participating in Cardiopulmonary Rehabilitation Program.  
   • Improves early return to regular life routines, promotes cardiovascular/pulmonary wellness, and reduces readmits. |
| A | • Among 3,000 eligible patients during 2020-2021, less than 11% were referred before discharge, and 26% of referrals were obtained manually.  
   • Data collection is manually obtained when possible through chart reviews.  
   • Unable to track 63% of the eligible patient population due to lack of EMR workflows. |
| R | • Automating opt-out order sets with referral to the cardiopulmonary rehabilitation program.  
   • Creating EMR workflows to enable real-time tracking and reporting through dashboard visuals. |
Strategies EMR Data Extraction

• Design EMR workflows for CR & PR.
• Contact information technology team.
• Build and pilot EMR workflows.
• Validate data report.
• Track and review performance.
• Revise process and close gaps in practice.
• Monitor for consistency in patient and clinical outcomes.
• Once achieved, include new measures.
Questions?

Thank you for attending.

Please rate this session in the mobile app
Contact Us

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