1	Form Approved OMB No. 0935-XXXX

Evaluating the Implementation of PCOR to
Increase Referral, Enrollment, and Retention through
Automatic Referral to Cardiac Rehabilitation (CR) with Care Coordination

Attachment D

Interviews with Partner Hospital CR Champions

Version: January 8, 2020

1 Purpose of this tool

We will conduct semi-structured key informant interviews with Cardiac Rehab (CR) champions from eight Partner Hospitals (PH) from each cohort to better understand how the characteristic for which they were chosen (e.g., the population they serve) influenced their experience implementing automatic referral with care coordination. The interview will address topics that focus on better understand the decisions that led them to participate in TAKEheart and their experiences to date, how automatic referrals are implemented within their hospitals, the ways in which they have engaged the patient community to help increase CR referrals, how they assess and measure increased CR referrals, and their recommendations to improve future implementation efforts. Having this information will help identify important processes facilitato

opportun

Public reporting burden for this collection of information is estimated to last no more than 90 minutes per response; the estimated time required to complete the interview is 72-88 minutes including informed consent. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-XXXX) AHRQ, 540 Gaither Road, Room #

2 Adr

We will conduct semi-structured key informant interviews with CR Champions from a convenience sample of eight partner hospitals in each of the two cohorts. We will hold one interview for each Champion (n=8). Each interview will last up to an hour and a half (i.e., 90 minutes). Hospitals will be chosen because they share a characteristic of particular interest to AHRQ and the evaluation, such as serving a specific population. Prior to administering the interview, we will obtain informed consent. Upon receiving consent, interviews will be audio recorded (hand-written notes as a backup if consent is not granted) for data analysis and facilitated by three Abt evaluation team members. Two team members will co-facilitate the interview and the third will take notes.

3 Informed consent (Estimated time 5 minutes)

An informed consent document will be provided in the meeting invitation and reviewed at the beginning of the call; consent will be obtained prior to the interview. The document will end with the statement, “If you have questions about the project, contact Cynthia Klein, TAKEheart Project Director, at 404-946-6310, or by email at Cynthia_Klein@abtassoc.com.”

[Phone call preliminary language] Hello. Our names are *[introduce yourselves]*. We work at for a research and evaluation firm called Abt Associates.

The Agency for Healthcare Research and Quality (AHRQ) is providing selected hospitals with assistance to increase referrals to cardiac rehabilitation in a project known as TAKEheart. AHRQ hired Abt Associates to evaluate TAKEheart.

TAKEheart Partner Hospitals will do two things to increase referrals to cardiac rehabilitation: one, implement an automatic referral system which identifies patients who are eligible for

cardiac rehabilitation, and two, hire or assign a “care coordinator” to follow up with those patients.

TAKEheart also includes a Learning Community, a series of virtual meetings which combine education and peer-to-peer sharing.

You were selected to participate in this interview because your hospital is participating in TAKEheart and staff from your hospital attended both the training module on accommodating patient needs and the Affinity Group on *[name session on disparities]*.

Today’s interview will last for no more than 90 minutes, and we very much appreciate your time. Your participation is voluntary. You may choose not to answer questions with no penalty. We value your expertise and look forward to learning about your experiences with implementing automatic referrals with care coordinators.

After this interview, we will write a report for AHRQ that summarizes what we learned from talking with you and other *[Champions/cardiologists]*. The report will be used to…

> *[For cohort 1]* …improve tools and support provided to a second set of hospitals which will implement an automatic referral with care coordinator and improve the resources which will be made available online for other hospitals to use.
>
> *[For cohort 2]* …improve the resources which will be made available online for other hospitals to use.

The reports will not identify the hospitals or the people who participated in the interviews. However, there is a small chance that you could be recognized. We will be sure to keep the information that you share private and do what we can to make sure you to feel comfortable sharing your experiences and opinions.

We will take notes during the interview. We would also like to record the call, so we can listen to it if we have questions when we review the notes. The recording will be deleted when the report is complete. We will not share the recording or a transcript with AHRQ, or anyone else. May we have your permission to record the interview?

> *[If yes, start the recording.]*
>
> *[If no, do not record.]*

Are there any questions before we begin *[address questions, if asked]*?

4 Data collection tool: Interview with PH CR Champions

4.1 Introduction (Time Estimate: 6 Minutes)

In addition to the information that we learned prior to this interview, I’d like to start asking a few questions about your hospital and its relationship with the TAKEheart program.

1) How would you describe the reasons why your hospital was selected to participate in TAKEheart?

   PROBES:

   a. Was it also based on *[mention any other reasons/characteristics that we have documented (e.g., characteristics of the patients they seek to enroll)]*
   b. Can you describe the community in which you work and the types of patients you primarily serve?
   c. Do these patients differ from the patient groups that you seek to engage as part of participating in TAKEheart?

4.2 Deciding to Participate in TAKEheart (Time Estimate: 8-12 Minutes)

Next, we would like to talk about what led your hospital to participate in TAKEheart.

1) What led or motivated your hospital to participate in TAKEheart to implement automatic referrals and hire care coordinators?

   PROBES:

   a. Who/what were/are the key stakeholders *[Listen for/ask about roles and organizations]*, decision points, policies, and other internal/external drivers that played a role in your decision to participate?
   b. Do you recall whether there were marketing strategies or messaging helped your hospital decide to participate in TAKEheart?
      a. If so, can you give me an example of what was communicated, and, to whom?
      b. What was it about this approach that made it effective?

      Why did you decided to become a Cardiac Rehabilitation Champion and whether you have other roles or responsibilities at the hospital.

2) What, if any, challenges were encountered that could have prevented your hospital from deciding to participate in TAKEheart?

   PROBES:

   a. What were the main barriers?

      [*Examples:* stakeholders, staff knowledge, staff understanding of what it meant to participate in TAKEheart (i.e., implementing EMRs and automatic referrals with care coordinators), hospital infrastructure]
   b. How did you address and overcome these challenges?
   c. Do these challenges still exist? If so, how are they being addressed?

4.3 Experiences of Participating in TAKEheart (Time Estimate: 15-18 Minutes)

For this part of the interview, we want to focus on the implementation-related trainings and support that you received from our team. As a reminder, we delivered the 10 training modules

that included companion guides for each module. We also facilitated peer action group discussions. The ten training modules and the dates that they were offered are listed here: *[Read the list aloud and display them via WebEx]*.

3) Thinking back to the trainings and support in which you participated/used, which do you recall as being the most helpful, and why?
   PROBES:
      a. What was it about this activity that made it more useful than the others? Was it the content that was covered, the companion guide, the presenter, the way in which it was delivered/made available, or something else?

4) Which trainings or type of support do you recall as not being as useful, any why?
   PROBES:
      a. What about it makes you describe it as not being useful? Was it the content that was covered, the companion guide, the presenter, the way in which it was delivered/made available, or something else?
      b. In your opinion, what can be done to make it more useful?

5) *[Do not ask if it was mentioned in response to questions 3 and 4]* Given that rates of patient participation in CR programs are less than desired and your emphasis on increasing referral rates and participate of *[insert the patient groups that they target]* in particular, we are especially interested in knowing whether you found the *Accommodating Patient Needs, Improving CR Accessibility, Affordability, and Acceptability* training module to be useful. What did you think about the module, the companion guide and the peer action group discussion?
   PROBES:
   a. What about this training module and the supporting resources did you find useful (and why)?
   b. Was there anything that was not helpful (please explain)?
   c. How can we improve this particular module for future use with other partnering hospitals?
      a. What should we include or eliminate?

4.4 Implementing Changes to Increase CR Rates (Time Estimate: 15-18 Minutes)

6) Let’s assume that I don’t know anything about your hospital, can you walk me though how your hospital implements automatic referrals, how decisions are made and how care is coordinated?
   PROBES:
   a. How many care coordinators are at your hospital?
   b. What qualifications are they required to have?
   c. How are care coordinators trained for their roles? And, how often?
   d. How were referrals to CR initially done when you first started as a Champion?

e. What approaches or factors led the hospital to fully implement the process of using automatic referrals with care coordinators to increase CR rates?
    a. [Ask about/listen for:]
        i. Key stakeholders, decision points, policies, and other internal/external drivers
        ii. Descriptions of "pivotal" events that influenced the decision to move forward?

7) What types of policies, programs or initiatives have been developed to help support the implementation of automatic referrals and care coordination?

8) Do you work with other hospital staff/departments to implement automatic referrals and provide care coordination? If so, in what capacity? And, is anything being tailored or done differently for your targeted patient populations?
   PROBES:
    a. Staffing and program management/operation activities
    b. Strategies to increase CR rates (i.e., staffing engagement/awareness; marketing/recruitment)
    c. EMR, IT and other activities related to monitoring/tracking the process of patient referral to discharge
    d. What are some of the ways in which you inform or market what you're doing as part of the Take Heart program to key stakeholders like other hospital staff, cardiologists and community partners help increase referrals?
    e. With regards to the marketing and recruiting activities that you've described, what has worked well to increase referrals? And, what has not worked as well?
    f. What would do (or plan to do) differently to achieve even better results?

9) As you currently implement automatic referrals and provide care coordination what, if any, changes have been made in relation to:
    a. **Ask about/listen for:**
        i. Staffing (e.g., # of care coordinators, experience/expertise of care coordinators)
        ii. Benchmarks for how you define increased CR rates (e.g., specify quality measures)
        iii. Strategies to increase awareness/understanding and engage hospital staff, cardiologists, patients and family members
        iv. Strategies for advertising/recruiting staff, partners, patients, etc. to increase CR rates (e.g., characteristics of priority populations)?

   PROBES:
    a. Why were these changes necessary?
    b. How did the changes help or hinder implementing the automatic referrals with care coordinators?

4.5 Engaging the Patient Community (Time Estimate: 10-12 Minutes)

10) Are there certain subgroups that you target for the automatic referrals with care coordinators who may otherwise characterized as being underserved or have unmet CR-related needs? How did you go about identifying *[insert patient population of interest]* as the population to focus on for a program like TAKEheart?

    PROBES:

    a. Why focus on this population over others?
        a. *[Ask about/listen for:]*
            i. Unmet CR needs, sociodemographic characteristics (e.g., race/ethnicity, gender); specific health conditions; challenges accessing care; neighborhood characteristics, etc.
    b. How are you engaging and marketing your services to these patients and their families?
        a. How does this differ from what you're doing for other groups of patients?
    c. How are you addressing disparities or the social determinants of health to better engage and/or increase CR referrals for these patient populations?
    d. How did your hospitals tailor automatic referrals with care coordinators to address the unique needs of these patients?

11) How did you learn about the needs, barriers or gaps in CR-related care/treatment for this/these group(s)?

    PROBES:

    a. What did you use/do to obtain this information (i.e., conduct a needs assessment or similar data collection activity to identify priority needs/barriers/gaps)?
    b. Did you incorporate the milestone "Map out current process from time of referral/discharge to appointment & identify patient, program, and system barriers" into your Action Plan?
    c. How did this improve your ability to develop/adapt the automatic referrals with care coordinators to better engage or meet the needs of these particular patients?

12) Have you needed to identify new types of CR programs (e.g., home-based CR programs and/or programs that uniquely serve these (or other) patient populations; address patient-level barriers (transportation, comfort/familiarity, program hours, "open gym model" etc.)?

    PROBES:

    a. What have been the benefits of partnering with these programs?
    b. Have these partnerships been a burden in any way? If so, how?
    c. What types of results or outcomes have you observed?
    d. How do the approaches that you described compare to what you're doing for the general population of patients that you serve as part of the TAKEheart program?

13) What has been done (or is planned) to try to continue to increase CR referrals from both the general populations of patients and the sub group of patients?

4.6 Assessing the Implementation of Automatic Referrals with Care Coordinators (Time Estimate: 8-12 Minutes)

14) What would you say are the strengths of using automatic referrals and care coordinators to increase CR rates?
PROBES:
    a. What, if anything, can be done to sustain or improve the strengths that you mentioned *[Reference answers to #14]*
    b. Is this unique to your hospital? Or, do you think that this is something that can be replicated in similar settings? Why/why not?

15) What factors in *[your hospital]* <u>facilitated</u> developing an automatic referral?
PROBES:
    a. Prior experience customizing EMR?
    b. Attitudes about EMR in the cardiology department?
    c. Hospital or cardiology department culture of using information technology?

16) What factors in *[your hospital]* <u>facilitated</u> implementing the care coordinator role?
PROBES:
    a. Did the cardiology department have a multidisciplinary team structure?

17) What factors in *[your hospital]* <u>impeded</u> developing an automatic referral?
PROBES:
    a. Were funding or staff diverted to other projects? If so, by IT leadership or other management?
    b. Did testing reveal unanticipated problems with design?

18) What factors in *[your hospital]* <u>impeded</u> implementing the care coordinator role?
PROBES:
    a. Was there resistance to using resources for a care coordinator? If so, from leadership of the department which would fund the care coordinator or other management?
    b. Was there turnover in the position?

19) How will you know if you've been successful? How do you measure success?
PROBES:
    d. What types of outcomes does you and/or your hospital anticipate?
    e. How is "success" defined at your hospital? Is it defined by:
        a. Achieving specific benchmarks (e.g., 70% per Million Hearts).
        b. Reducing disparities in referral rates across sub-populations?

c. Reducing disparities in enrollment rates across sub-populations?

20) What can be done to help you make automatic referrals and care coordination more effective?

   a. *PROBES FOR COHORT 1:* Ask about training and technical assistance activities
   b. *PROBE FOR COHORT 2:* Ask about implementation tools and resources

4.7 Closing (Time Estimate: 5 Minutes)

21) Before we end, is there anything else that you'd like to share?

22) Do you have any questions for us? *[Address questions.]*

This concludes the interview. Your contributions are very valuable and we appreciated hearing from all of you. Thank you for your time and participation.