International Council of Cardiovascular Prevention and Rehabilitation (ICCPR)

<u>ICRR Quality Improvement (QI) Initiatives</u>

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The ICCPR's International Cardiac Rehab Registry (ICRR) includes as a primary objective assessing cardiac rehabilitation (CR) quality in low-resource settings (see protocol here: https://globalcardiacrehab.com/ICRR-Governance), with the ultimately aim of supporting programs to optimize quality in terms of structure, processes, and patient outcomes. ICRR governance includes the user sub-committee, with a mandate to support quality improvement (terms here: https://globalcardiacrehab.com/ICRR-Governance).

ICRR's quality initiatives were developed on the basis of evidence and best practices in CR and beyond.[1-3] Data quality (trust in), intensity (e.g., frequency), timeliness, reach, confidentiality / non-judgmental tone, ease of implementation of QI approaches, and tailoring them to local context have all been considered. We endeavour to educate clinicians, provide support in analyzing and then improving processes, and to provide a fora for discussion on quality. Initiatives and processes will be responsive to program need, such that this will be a living document.

ICRR QI RESOURCES

The ICRR has several features to support quality assessment (see ancillary features information file for more detail): (1) the program survey completed prior to ICRR on-boarding which assesses many structural indicators, and (2) the dashboards displaying 12 process and outcome indicators selected through a delphi process, where (a) site performance is compared to itself over time (first 6 months vs thereafter), and (b) sites are compared to all other sites (there is also a patient-outcomes report where mean scores on 6 of the indicators are shown). Programs have access to this information at all times (i.e., timeliness). These comparisons provide easily-visible benchmarks for programs.

Moreover, (3) through the ICCPR Program Certification scheme (and also based on the program survey and ICRR patient data), 13 quality standards are delineated, based on ICCPR's consensus statement (Grace et al., Heart, 2016), and quality measures / standards from other professional CR societies. Some of these are simply met or not met, but others delineate degree of quality (e.g., % of patients knowing how to control their cholesterol post-program) and hence are of particular utility for our QI efforts. These then form the basis of our quality efforts.

PROGRAM OUTREACH:

The user sub-committee will espouse a "collaborative learning model", engaging programs in the QI process. All ICRR-participating programs are informed about the user sub-committee QI mission at their second on-boarding webcall, when training on post-program data entry is provided. All programs will be provided education about Plan-Do-Study-Act (PDSA) cycles once they have some post-program data entered, and hence the dashboard data are available to them for comparison, and invited to engage with the user sub-committee co-chair for QI at any time.

Once a minimum of 10 CR programs are contributing post-program data to the ICRR, biannually (April 1 and Oct 1), the user sub-committee QI co-chair will peruse the patient-reported outcomes report (values shown by site for administrators) or download the data to examine the other indicators or standards to see where either the greatest quality concern exists, or where there is wide site-to-site variability in quality. Or they will consider quality issues raised by sites following the invitation at the time of on-boarding. Ultimately, one area for QI will be identified twice per year; the user QI co-chair shall engage with the user sub-cttee including the patient partners, and ICRR exec/ steering to support prioritizing QI areas.

The co-chair will then do an environmental scan (including reaching out to liaison group of other CR registries) and literature search for resources to support programs in QI for this indicator. The highest-performing sites (number to be determined based on distribution of data) will be contacted via email by the ICRR Secretary and invited to share best practices with other programs; they will need to consent to sharing of any provided documents in the registry for any future participating programs and with the ICCPR community (they can de-identify them if they wish) and asked about their willingness to share best practices during a webinar on the topic.

The Secretary will then work with responding programs and the co-chair to identify a time to host the hour-long webinar. The webinar will be advertised to all-time ICRR participating programs (but a personal invitation will be sent confidentially by the co-chair to programs performing lowest on the indicator, with again the number to be determined based on the distribution of the data and the correspondence will be sent in a non-judgmental tone), and the ICCPR community, and recorded for subsequent posting on the ICRR website for those where the time zone is not suitable. All expressing interest will be provided the QI materials from the environmental scan and high-performing programs in advance of the webinar (e.g., evidence-based best practices algorithms, clinical pathways, standardized encounter forms, checklists, pocket cards, chart stickers, patient education materials). An expert in QI or the clinical area (as appropriate) will be invited to chair the webinar, and each program will have 5 minutes to share their best practices, and a Q&A will ensue.

After the webinar, all attendees will be asked to participate in monthly follow-up informal videocalls as a "community of practice" to support them in implementing new practices, tailored to their setting (e.g., translation). These will continue until the learning community has no further desire/need for discussion. The lower-performing programs will again be contacted confidentially, with the offer to have a 1-1 call, discuss strategies that could work in the local setting, and offer to review data for change at a subsequent call (over and above what can be seen in the dashboards).

QI activities will be summarized in ICRR reports, posted on the website among other dissemination avenues, and shared through ICCPR social media posts.

New programs contacting the user sub-committee regarding previously-covered QI areas will be provided all the materials and directed to the recorded webinar.

PATIENT OUTREACH:

The ICRR also has a patient lay summary, where post-program patients receive a summary of their progress and information on areas where further risk reduction and/or education may be needed. ICRR will not know the identity of patients, but will support programs to institute processes to follow-up with

patients where guideline targets or education needs are not fulfilled by program completion, and to support patients in continued self-management post-program. This will be achieved by asking programs what would be of most help, doing an environmental scan and literature search, and reaching out to the ICCPR community for tools that can be shared. Likely, a webinar would be held and recorded.

Patients providing an email or mobile number may be contacted with lay ICRR summaries, but there is also a patient page of the registry where we can post materials for patients (https://globalcardiacrehab.com/ICRR-for-Patients). Through this, the user sub-committee could address some of the areas where the greatest gaps are identified, and encourage continued heart-health maintenance.

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1. https://www.sciencedirect.com/science/article/pii/S1386505610000249
2. https://www.ncbi.nlm.nih.gov/books/NBK549284/
3. https://www.ncbi.nlm.nih.gov/books/NBK562575/?term=ahrq%20registr%202020