Pathway
Chest Pain Choice

Implementation Team Manual

Credits here (PCORI, Mayo, UAB, KP, etc)

Implementation Team Manual (READ ME FIRST!)

Hello,
This manual is intended to serve as a guide for organizations aiming to implement Shared Decision Making (SDM) for patients presenting to the emergency department with chest pain potentially due to acute coronary syndrome. It assumes you want to use the Chest Pain Choice Decision Aid as a key tool for achieving this. That's right; the Decision Aid is NOT, in and of itself, SDM. Rather, it's a tool for making SDM fit more naturally and efficiently into the clinical encounter. As a member of the implementation team, you, more than anyone else in your organization, should know this! What? You're confused? You don't even HAVE an implementation team!?

No worries.

That's what this toolkit is for. We've broken it down into 3 "easy" steps. ☺

STEP 1: Assemble the Implementation Team

There's no way around it. The most effective and efficient way to achieve success is to bring together people from your organization with different connections and experiences and with different types of influence and expertise. If your organization has a pre-established quality improvement team or other multidisciplinary team that is used to implementing organizational initiatives, those folks would be a great start. If that team has pre-existing procedures and common strategies that have worked in the past, that's even better! If not, no worries. Here's who you need:

1. **The clinician champion:** Usually this person is a physician that is respected by his or her colleagues for having sound clinical judgement and for providing patient-centered care. The ideal clinician champion also is a good communicator. Most importantly, the individual has to be EXCITED about SDM and Chest Pain Choice, must use the tool in practice, and must make an intentional effort to encourage his or her colleagues to use it as well during implementation.
2. **The project director:** This can be anyone with authority to provide overall project orientation and make decisions related to resource commitment and allocation. Because multiple departments and service lines are in play (e.g. clinical care, information technology, emergency medicine, cardiology, primary care), it usually means someone from the C-suite level and/or Departmental leadership.
3. **Information technology liaisons:** In order to integrate the tool into the electronic environment you will need someone from information technology leadership that can allocate resources and assign the project to the appropriate individual(s). It is helpful to invite the individuals that are assigned to the project (the "worker bees") to join the team as early in the process as possible.
4. **The quality expert:** We've found it is helpful to engage a person at your organization who manages quality metrics and improvement initiatives. This individual will likely know how to best synergize the project with ongoing priorities. He or she will also be able to help the team to think through the implications of the project on quality measures and how these can be optimized.
5. **The project manager:** This person needs to keep everyone on task. He or she will have organizational skills and will be responsible for arranging meetings and tracking progress. This could be a nurse or an administrative assistant if a dedicated project manager is not available. Whoever it is, the person needs to have the confidence and authority to "bug" people.
6. **The clinical workflow informants:** This person/these people are usually nurse managers or administrators for clinical sites or service lines. They know how the emergency department operates from check-in to check-out and can be the "go-to" contacts to support implementation and to tell you what is and isn't working.
7. **The integrator:** This is not any particular person, but is the person everyone knows should be involved in the project. He/she gets stuff done and is respected around the

organization, perhaps because of his or her track record. This person may be the "EMR guru" who also happens to be a clinician, for example.

In recruiting the team, it is best to reach out to leadership first (assuming you are not leadership). You can send the following SBAR along with a link to the video demo of the tool (link):

> **S:** Shared decision making has been shown to improve the patient experience of care and safely decrease resource use in patients with low risk chest pain, yet we do not do this routinely in practice at (our organization).
>
> **B:** High quality evidence supports the use of shared decision making to communicate to patients their risk for a cardiac event and to engage them in risk-tailored, shared decision-making conversations when deciding whether to admit them to the hospital for further evaluation or to arrange outpatient follow-up. Currently, clinicians often calculate a patient's HEART score, but there is no systematic support for shared decision making. The Chest Pain Choice decision aid has been proven in multiple trials and is well accepted by clinicians. It is also free to use and can be automated into the EMR workflow.
>
> **A:** I have used the Chest Pain Choice tool in my practice and patients really like it. I find it helps me in my efforts to provide efficient, patient-centered care. Mayo and the University of Alabama at Birmingham have collaborated to co-create a toolkit that guides organizations in implementing the tool into practice and integrating it into the EMR (link). There is a clinical program for both Cerner and Epic. I think we should be able to do this relatively easily.
>
> **R:** We assemble a team to explore feasibility of implementing the Chest Pain Choice Decision Aid in our practice.

STEP 2: Preparing the team

Once your team is assembled, you will need to become experts in both SDM and the Chest Pain Choice tool. Block a half day on the calendar for the team's kickoff workshop. It is important that everyone is there. It helps if everyone brings a laptop or tablet to practice with the tool; we will also bring paper copies of the tool. You will also need to print out enough copies of the organizational assessment (link) for everyone to have one. Finally, you will need to record the group's thoughts and plans, so a whiteboard or flipchart will be needed.

Here is the agenda for the kickoff workshop:

1. **Introductions (5-30 mins):** Team dynamics are important; everyone should feel comfortable. If there are people that don't know each other it is a good idea to have an ice-breaker. It does not matter who facilitates the meeting, so long as that person is comfortable doing so and he/she can create an open dialogue. It is important that everyone feels open to give input.
2. **Overview of Purpose (2 mins):** The project director or clinician champion should clearly and succinctly state the purpose of the project and the rationale for the workshop. He or she should state that the goal is to leave with an actionable plan for implementation.
3. **Webinar Session 1 (30 mins):** First watch Session 1 of the implementation team webinar (link). This will provide an overview of SDM and the CPCDA.
4. **CPCDA Video Demo (10 mins):** Next watch the CPCDA video demo provided in the toolkit (link). Pay careful attention to the language used to convey risk. Discuss as time allows.
5. **CPCDA Practice (30 mins):** Now, pair up and practice using the tool (using a laptop or tablet or with a paper version) through role play. You can access it at: https://shareddecisions.mayoclinic.org/decision-aid-information/chest-pain-choice-decision-aid/. Take turns playing the clinician and the patient. You can use your own information (what you know) to populate the variables. When playing the clinician, pay careful attention to your language; try to emulate the wording on the demo. When playing the patient, pay careful attention to your experience. Debrief amongst the group. Consider using the W^3 approach:
    a. **What:** What happened? What stood out? What was different from the norm?
    b. **So What:** Why is that important to you? To your organization?
    c. **Now What:** What actions make sense?
6. **Break (30 mins):** Catch up on emails, use the restroom, grab something to eat.
7. **Organizational Context Assessment (30 mins):** After the break, complete the organizational assessment (link) provided in the toolkit. This is a facilitated discussion. Designate someone to synthesize and record the group's thoughts on a whiteboard or flipchart.
    a. Hand each person a copy of the assessment (link) and give them 5-7 minutes to complete independently.
    b. Then take a few minutes to report out the numbers of each person for each domain of acceptability, feasibility, and appropriateness.

c. Spend the remaining 20 minutes discussing the reasons for the ratings and coming to an agreement on a final rating as a group for each domain/question (from 1 to 10).

8. **Strategy Selection (15 mins):** After conducting the organizational evaluation, consider what strategies you will use to optimize each of the 3 domains. Peruse the CPC-Pathway Implementation Toolkit (link) in making your selections.
    a. **How will you improve appropriateness?**
        i. Use campaign to express importance (helps clinicians know this is encouraged by leadership)
        ii. Develop marketing materials (expresses to patients and public the patient-centered identity of the organization)
        iii. De-implement competing/overlapping tools
    b. How will you improve feasibility?
        i. Develop and email a video of how to use the decision aid at your institution after it is integrated into the EMR (excellent if you know clinicians will watch)
        ii. Communicate the initiative and demonstrate tool at clinician/nursing meetings (essential)
        iii. Have Grand Rounds/CME/education about the topic (good for maintaining interest and expressing the rationale)
    c. How will you improve acceptability?
        i. Putting link to the tool in the EMR (okay)
        ii. Integrating tool fully so that it auto-populates (much better)
9. **Action Plan (15 mins):** After selecting your strategies, organize them into a timeline and delegate responsibility. Do not leave without a plan for a follow-up meeting! Here is a **sample** action plan template and example:

Date	What	Who
Every Tuesday	Send out action items and progress reports weekly	Project manager
Tomorrow	Schedule quarterly team meetings	Project manager
Next standing meeting	Discuss with service line managers	Project director/clinician champion
This week	Determine whether we could use for MOC	Quality expert
This week	Reach out to Mayo about usage reports/tracking	Clinician champion
This week	Engage Cardiology	Clinician champion

TBD	Engage marketing/PR	Project
This week	Begin EMR Integration	IT Liaisons
In 1 month	Pilot testing with super users	Integrator
In 3 months	End EMR Integration	It Liaisons
Fall provider meeting	Go-Live!	Clinician champion
Fall provider meeting	Provider/Clinician Meeting demo	Clinician champion
Day after fall provider meeting	Electronic Video Demo Emailed	Integrator
	Nurse Meeting	Integrator/Workflow informants
Ongoing	Clinical Team Presentations	Clinician champion
	Follow-up clinic site visits/training	Project manager

STEP 3: Executing the plan

The third and final step is to execute the plan. Although it is essential to have a timeline when you develop your plan, we realize this may change. That's okay. The most important thing is that the project manager keeps people engaged through any delays. It is helpful for the implementation team to meet in person and brainstorm solutions to delays when they exist. In our experience, many delays can be avoided or troubleshooted just by maintaining communication.

At most organizations, the effort required to integrate the tool into the EMR should take no more than 1-2 weeks (this can vary based on the complexity of the integration and whether pre-existing strategies exist for your vendor—see EMR Integration Supports (link)). Efforts to communicate the presence of the tool and educate clinicians on how to use it will vary based on the size of your organization and how feasible it is to educate the clinicians. "At the elbow" support is important. We find it is helpful for someone to drop by the emergency department from time to time and just remind the clinicians that the tool is there and demonstrate its use.

If you want to track usage of the CPC decision aid over time, you can work with your IT department to develop reports of when the tool is accessed from within the EMR (provided it is integrated into the EMR). If implementation is not going as well as you'd like, we also offer facilitation services.

We're glad your organization wants to partner with patients in improving care. We look forward to hearing about your successes!