2018 Pulmonary Program Certification Application

Revised 10/31/17
**2018 AACVPR Program Certification Pulmonary Application**

**Page 1: Program Staff and Competencies**

The following roles must be added to your roster:

- Administrator
- Certification Secondary Contact
- Medical Director
- Program Director

Individuals who provide Pulmonary Rehabilitation services should possess a common core of professional and clinical competencies, regardless of their academic discipline. For the purposes of AACVPR Program Certification, a program must provide evidence of annual assessment of clinical/professional staff competencies (knowledge or skill) as referenced in the Clinical Competency Guidelines for Pulmonary Rehabilitation Professionals [http://journals.lww.com/jcrjournal/Fulltext/2014/09000/Clinical_Competency_Guidelines_for_Pulmonary.1.aspx](http://journals.lww.com/jcrjournal/Fulltext/2014/09000/Clinical_Competency_Guidelines_for_Pulmonary.1.aspx).

Competency may be assessed in several ways - i.e. check-off stations, tests or quizzes, return demonstration, article review with post-test, formal classroom instruction with passing exam scores, etc.

**RESOURCE TIPS:**

- ([https://www.aacvpr.org/Certification/AACVPRProgramCertification/ProgramCertificationApplicationFAQs/tabid/725/Default.aspx#Staff_Competencies](https://www.aacvpr.org/Certification/AACVPRProgramCertification/ProgramCertificationApplicationFAQs/tabid/725/Default.aspx#Staff_Competencies))
- To access the FAQ for this page, click here ([https://www.aacvpr.org/Certification/AACVPR-Program-Certification/Program-CertificationFAQs#Staff_Competencies](https://www.aacvpr.org/Certification/AACVPR-Program-Certification/Program-CertificationFAQs#Staff_Competencies)).

**WHAT YOU NEED TO SUBMIT:**

Please submit completion dates for four (4) different annual competency assessments for each staff member who provides direct and primary patient care and reports to the program director/ coordinator/ manager. Note that there are 12 competency areas and each staff member must be assessed in four (4) different competency areas listed below.

Please DO NOT provide competencies for the program director/ coordinator/ manager and supporting staff including Dietitians, Psychologists, Pharmacists, or other specialists who are involved with patient care, but only in a supportive capacity rather than day-to-day rehabilitation activities.

For each submitted competency, describe in detail how you determined staff is competent in this area. This description must include the following:

1. Objectives for each competency
2. The specific tool or method used for assessment

Note: Simply stating "return demonstration/check-off station" is not sufficient without submitting more detailed information.

TIP: Staff requiring competencies are listed below. Enter “Not Applicable” or “NA” for any unused
2018 AACVPR Program Certification Pulmonary Application

Please provide, the objectives for the competency, the tool or method used to assess staff is competent, and the date of the competency. Mark all staff that possesses each competency.

- Patient assessment and management
- Dyspnea assessment and management
- Oxygen assessment, management, and titration
- Collaborative self management
- Medication/therapeutics
- Disease not related COPD
- Exercise testing
- Exercise training
- Psychosocial management
- Tobacco cessation
- Emergency responses for patient and program personnel
- Universal standard precautions

REQUIRED ELEMENTS FOR THIS PAGE:
- Four annual assessments of four different competencies must be submitted for each staff member (regardless of educational background or discipline) who provides direct and primary patient care and reports to the program director/ coordinator/ manager.
- Submitted competencies MUST be specific to the Clinical Competency Guidelines for Pulmonary Rehabilitation Professionals (http://journals.lww.com/jcrjournal/Fulltext/2014/09000/Clinical_Competency_Guidelines_for_Pulmonary.1.aspx).
- DO NOT submit competencies for the program director/ coordinator/ manager and supporting staff including Dietitians, Psychologists, Pharmacists, or other specialists who are involved with patient care, but only in a supportive capacity rather than day-to-day rehabilitation activities. DO NOT submit competencies for professional and clinical staff members who do NOT report directly to the program director/ coordinator/ manager.
- Competency assessments must be completed within required date range of January 1, 2017 to December 31, 2017.

THE FOLLOWING WILL RESULT IN AUTOMATIC DENIAL OF THIS PAGE:
- Failure to submit required evidence of four assessments for four different competencies for each staff member who provides direct patient care and reports to the program director/ coordinator/ manager. PLEASE NOTE: ACLS/BLS no longer qualifies as a competency due to the variation in state and practice guidelines.
- Each competency submitted is not specific to the Clinical Competency Guidelines for Pulmonary Rehabilitation Professionals (http://journals.lww.com/jcrjournal/Fulltext/2014/09000/Clinical_Competency_Guidelines_for_Pulmonary.1.aspx).
2018 AACVPR Program Certification Pulmonary Application

- Submitted competencies do not match the professional/clinical staff who provide direct and primary patient care and directly report to the program director/ coordinator/ manager as listed on the Staff Roster.
- Submitted competencies are general in nature only - i.e. general hospital in-services or required education, emergency or safety in-services such as fire drills, infection control, safety inspections, or health and safety reviews.
- Submitted staff competencies are dated outside the required date range of January 1, 2017 to December 31, 2017.
2018 AACVPR Program Certification Pulmonary Application

Page 2: Individualized Treatment Plan

The Individualized Treatment Plan (ITP) is a summary of the planned care of the patient from initial assessment to discharge from the Pulmonary Rehabilitation program. In accordance with CMS Guidelines, a physician’s signature is required at initial assessment and at least every 30 calendar days thereafter, including discharge.

Please note: For the purposes of Program Certification, AACVPR is assessing your ITP based on the CMS 30 calendar day rule. Please check with your local MAC regarding specific dating requirements for your state to assure that you are in compliance.

An initial written INDIVIDUALIZED EXERCISE PRESCRIPTION, with a physician signature and date must be in place for each patient in Pulmonary Rehabilitation. Your individualized exercise prescription will be assessed using the ITP submitted on this page of your application. Per CMS Guidelines (https://www.aacvpr.org/Advocacy/Regulatory-Legislative-Actions/Final-Medicare-Rules-for-CR-andPR/PulmonaryRules2011) the submitted physician-signed initial exercise prescription must be a component of the ITP.

For the purposes of AACVPR Program Certification, an ITP must be developed and completed for each patient in the Pulmonary Rehabilitation program and must include all of the following CLEARLY LABELED elements and steps:

**REQUIRED ELEMENTS:**
- Exercise
- Nutrition
- Psychosocial
- Oxygen (actual patient must be on oxygen)
- Other Core Components/Risk Factors as required for individual patient

**REQUIRED STEPS:**
- Assessment*
- Plan: Goals/Intervention/Education*
- Reassessment**
- Discharge/Follow-up*

* Step must include oxygen use/titration for Pulmonary Rehabilitation

** Reassessment must include comments on progress to goal (comments such as "Ongoing", "Met", or "in Progress" require a more detailed explanation)

ITP must include the following CLEARLY LABELED ITEMS: ALL THE ITEMS IN RED BELOW MUST BE LABELED ON YOUR SUBMITTED ITP.

Exercise Assessment**
Exercise Plan
  - Goals
  - Interventions
  - Exercise Prescription‡ including Mode, Frequency, Duration, Intensity

Revised on 10/31/17
Page 5 of 23
2018 AACVPR Program Certification Pulmonary Application

Education
Exercise Reassessment**
Exercise Discharge/Follow-up**
Nutrition Assessment
Nutrition Plan
  Goals
  Interventions
  Education
Nutrition Reassessment
Nutrition Discharge/Follow-up
Psychosocial Assessment
Psychosocial Plan
  Goals
  Interventions
  Education
Psychosocial Reassessment
Psychosocial Discharge/Follow-up
Oxygen Assessment
Oxygen Plan
  Goals
  Interventions
  Education
Oxygen Reassessment
Oxygen Discharge/Follow-up
Other Core Components/Risk Factors*** Assessments (as appropriate)
Other Core Components/Risk Factors Plan
  Goals
  Interventions
  Education
Other Core Components/Risk Factors Reassessment
Other Core Components/Risk Factors Discharge/Follow-up

** Oxygen use & titration must be included for Pulmonary Rehabilitation Program Certification

*** Other Core Components/Risk Factors may include items such as tobacco cessation, environmental factors, medications (in particular inhaler medications), and prevention management of exacerbations, etc. These items may be labeled simply as “Other” or “Risk”.

‡ Exercise Prescription on your ITP must include:
  • Exercise mode (treadmill, arm bike, crosstrainer, etc.) prescribed for the patient
  • Exercise frequency (days per week) prescribed for the patient
  • Exercise duration (minutes) prescribed for the patient
  • Exercise intensity prescribed for the patient (Note: Intensity targets must be within AACVPR and ACSM published guidelines)

RESOURCE TIPS:
  • To access the FAQ for this page, click here (https://www.aacvpr.org/Certification/AACVPR-Program-Certification/Program-Certification-FAQs#ITPs).
2018 AACVPR Program Certification Pulmonary Application

- To access the "ITP Checklists" reference document, go to the Application Resources Page (https://www.aacvpr.org/Certification/AACVPRProgram-Certification/Program-Cert-Application-Resources).

**WHAT YOU NEED TO UPLOAD:**
- Upload your completed Pulmonary Individual Treatment Plan with an initial Exercise Prescription included as a component. **ITP must be HIPAA compliant.**
- Uploaded ITP must be for an actual patient that has completed all required elements for the initial assessment, at least one reassessment, and discharge. **Please select one (1) patient with at least one active additional core component/risk factor that is not addressed elsewhere on the ITP.**

**Patient’s Exercise Date:**
Please indicate the patient's first day of exercise. *(This is the date of the first exercise session after the assessment session.)*

**Physician’s Signature Date:**
Please indicate all (in chronological order) **physician signature dates**, including each reassessment date(s) and discharge date(s), separated by commas

**REQUIRED ELEMENTS FOR THIS PAGE:**
- Submitted ITP must be a comprehensive document including all required information. (It does not need to be one page.) Supporting documentation will not be reviewed (i.e. assessment tools, letters to physicians/patients, individual physician correspondence, and daily exercise session reports, etc.)
- Submitted ITP must be for an actual patient that has completed all required elements listed above and must include physician signature and dates.
- Submitted ITP must have initial assessment, at least one reassessment, discharge, and one active additional core component/risk factor.
- All required elements and steps of the submitted ITP are clearly labeled.
- Assessment and reassessment data must be on the ITP, but individual assessment tools should not be submitted.
- NOTE: If submitting an ITP from an Electronic Medical Record (EMR) or telemetry monitoring system that provides a document called the Exercise Prescription, it MUST include all required elements listed above.
- The date of patients first day of exercise and physician signature date(s), including each reassessment and discharge.
- Submitted ITP must be dated between January 1, 2017 and December 31, 2017.

**THE FOLLOWING WILL RESULT IN AUTOMATIC DENIAL OF THIS PAGE:**
- Failure to submit a completed ITP with physician signature and dates from an actual patient who completed your program.
- Subsequent physician signature(s) and date(s) did not occur at least every 30 days after the initial physician signature and date.
- No assessment or reassessment data provided - i.e. check boxes only indicating done but no data given.
- Submitted ITP does not have initial assessment, at least one reassessment, and discharge.
• Submitted active additional core component/risk factor was addressed elsewhere on the ITP.
• Required elements of the submitted ITP are not clearly labeled.
• Reassessment does not include comments on a progress to goal or simply stated comments such as "ongoing", "met", or "in progress".
• Personal Health Information (PHI) is present/visible on the uploaded documents (HIPAA violation).
• Submitted ITP is dated outside the required date range of January 1, 2017 to December 31, 2017.
Page 3: Medical Emergencies

For the purposes of AACVPR Program Certification, written program specific policies/protocols must be in place to address the treatment of NINE of the most commonly seen Pulmonary Rehabilitation clinical situations that ARE or COULD LEAD TO a life threatening Medical Emergency.

The policies/protocols must explain your care of the patient from onset of signs and symptoms until resolution of the emergency (transfer to ED, hospital admission, resolution of symptoms, discharge home, etc.) for EACH of the following:

- Cardiopulmonary Arrest
- Angina/Chest Pain
- Acute Dyspnea
- Tachycardia
- Bradycardia
- Hypertension
- Hypotension
- Hyperglycemia
- Hypoglycemia

**RESOURCE TIPS:**
- To access the FAQ for this page, click here ([https://www.aacvpr.org/Certification/AACVPR-Program-Certification/Program-Certification-FAQs#Medical_Emerg](https://www.aacvpr.org/Certification/AACVPR-Program-Certification/Program-Certification-FAQs#Medical_Emerg)).

**WHAT YOU NEED TO UPLOAD:**
Please upload your program specific medical emergency policies/protocols document(s) for the nine medical emergencies listed above.

**REQUIRED ELEMENTS FOR THIS PAGE**

- A department policy addressing all of the medical emergency conditions listed above. These can be in separate policies/protocols for each specific condition or in one combined policy.
- If the rehabilitation-specific policy references a separate department or hospital-wide policy, submit all related policies in the application. (If these additional policies are not submitted, the page will be denied).
- Medical emergency policies must be detailed (beyond calling 911) and specific to the role of the Pulmonary Rehabilitation staff in managing the emergency situation. If the rehab specific policy refers to any other policy, submit all related policies in the application.
- Medical emergency policies must address the Pulmonary Rehabilitation department's treatment of the patient from onset of signs and symptoms until resolution of the emergency (i.e. transfer to ED, hospital admission, resolution of symptoms, discharge home, etc.)
THE FOLLOWING WILL RESULT IN AUTOMATIC DENIAL OF THIS PAGE

- Failure to submit department policies addressing all nine of the medical emergency conditions listed above.
- Submitted policies do not include specific details related to the role of the Pulmonary Rehabilitation staff in medical emergency management of all medical emergency conditions listed above.
- Submitted policies depend on/call 911/EMS alone to manage the entire emergency situation.
- Failure to submit all additional referenced policies.
- Submitted policies are ACLS protocols only.
Page 4: Emergency Preparedness

For the purposes of AACVPR Program Certification, programs must demonstrate the readiness to be prepared for the most common medical emergencies. This includes providing evidence that medical emergency equipment and supplies are immediately available to the Pulmonary Rehabilitation department. There must be documentation verifying the readiness of the emergency equipment for each day the program is in operation. Additionally, programs applying for Program Certification are required to submit evidence of four (4) annual department medical emergency in-services related to the nine medical emergencies listed on Medical Emergencies page of the certification application.

RESOURCE TIPS:
- To access the FAQ for this page, click here (https://www.aacvpr.org/Certification/AACVPR-Program-Certification/Program-Certification-FAQs#Emergency).

WHAT YOU NEED TO SUBMIT:

PART 1:
Upload one calendar (1) month's documentation of daily verification of readiness of the Defibrillator/AED and Portable Oxygen for each day the program is in operation.
- Does your program have Defibrillator/AED, Portable oxygen, and airway management equipment immediately available. (YES/NO)

PART 2:
For the purposes of AACVPR Program Certification, a program is required to submit evidence of four (4) annual department medical emergency in-services related to the nine medical emergencies listed on the Medical Emergencies page of the certification application.

Submitted in-services may include an education or training session, a mock scenario, or a review of an actual scenario. General hospital emergency and safety drills and in-services such as fire drills, infection control, safety inspections, or health and safety reviews are not acceptable.

Please provide the dates and a brief narrative description of four (4) medical emergency in-services. In-services must be specific to Pulmonary Rehabilitation and the NINE medical emergencies listed on the Medical Emergencies page of the certification application must be held between January 1, 2017 and December 31, 2017.

Brief description of medical emergency in-service and date of in-service for 4 of the following medical emergency in-services.
- Cardiopulmonary Arrest
- Angina/Chest Pain
- Acute Dyspnea
- Tachycardia
- Bradycardia
- Hypertension
- Hypotension
- Hyperglycemia
Hypoglycemia

REQUIRED ELEMENTS FOR THIS PAGE:
- Documentation of verification of readiness for Defibrillator/AED and Portable Oxygen for each day the program is in operation for one calendar (1) month
- Indication of whether Defibrillator/AED, Portable Oxygen, and airway management equipment are immediately available.
- Dates and brief description of four (4) medical emergency in-services from the nine medical emergencies listed on the Medical Emergencies page of the certification application specific to Pulmonary Rehabilitation held between January 1, 2017 and December 31, 2017.

THE FOLLOWING WILL RESULT IN AUTOMATIC DENIAL OF THIS PAGE:
- Failure to provide one (1) calendar month's documentation of verification of readiness for Defibrillator/AED and Portable Oxygen.
- Failure to have Defibrillator/AED, Portable Oxygen, and airway management equipment immediately available for each day the program is in operation.
- Failure to submit dates and brief description of four (4) medical emergency in-services from the nine medical emergencies listed on the Medical Emergencies page of the certification application to Pulmonary Rehabilitation.
- Submitted medical emergency in-services not specific to Pulmonary Rehabilitation - i.e. general hospital emergency and safety drills and in-services such as fire drills, infection control, safety inspections, or health and safety reviews.
- Submitted medical emergency in-services dates outside required range of January 1, 2017 to December 31, 2017.
Page 5: Exercise Prescription Policy

For the purposes of AACVPR Program Certification, two items are required for this page.

1. A written policy must be in place that details how an initial exercise prescription for outpatient Pulmonary Rehab is developed and modified for each Pulmonary Rehabilitation patient. The exercise prescription policy must contain all of the following required elements:
   - Exercise mode (treadmill, arm bike, cross-trainer, etc.) of exercise prescribed for the patient
   - Exercise frequency (days per week) prescribed for the patient
   - Exercise duration (minutes) prescribed for the patient
   - Exercise intensity prescribed for the patient (Note: Intensity must be within AACVPR and ACSM published guidelines)

2. A written policy on oxygen saturation & titration. Policy must detail assessment and treatment of oxygen saturation at rest and during the exercise session.

RESOURCE TIPS:
- To access the FAQ for this page, click here (https://www.aacvpr.org/Certification/AACVPR-Program-Certification/Program-Certification-FAQs#Exercise_Pres).

WHAT YOU NEED TO UPLOAD:
- A written policy for developing and modifying the initial exercise prescription. This policy must detail how each required element is to be determined: mode, frequency, duration, and intensity within AACVPR or ACSM guidelines
- A written policy on oxygen saturation and titration. Policy must detail assessment and treatment of oxygen saturation both at rest and during the exercise session.

REQUIRED ELEMENTS FOR THIS PAGE:
- Exercise prescription policy that describes in detail how all required elements listed above are developed and modified.
- A written policy on oxygen saturation and titration.
- Oxygen saturation and titration policy details assessment & treatment of oxygen saturation at both rest AND during the exercise session.

THE FOLLOWING WILL RESULT IN AUTOMATIC DENIAL OF THIS PAGE:
- Failure to submit an exercise prescription policy that addresses mode, frequency, duration, and intensity in detail.
- Failure to submit a written policy on oxygen saturation and titration.
- Oxygen saturation and titration policy does not detail assessment & treatment of oxygen saturation at both rest AND during the exercise session.
Page 6: Improvement in Functional Capacity

AACVPR Registry Users: How to Use Registry Data for Outcomes Pages
If your program uses the AACVPR Pulmonary Data Registry to track outcomes, you may use the following link to search for appropriate data to submit with your application. Once you have selected data, it can be copied and pasted into questions on this page.

REGISTRY TUTORIAL:
To view a brief video tutorial on how to search for Registry data to submit with your application, click here (https://www.aacvpr.org/Certification/AACVPR-Program-certification/2015RegistryOutcomesIntegrationVideo).

Note: If you don’t participate in the registry, you are still required to complete this page.


OVERVIEW:
For the purposes of AACVPR Program Certification, a program must report the percentage of patients with COPD or Interstitial Lung Disease (ILD) who are found to increase their functional capacity by 30 meters. According to the recent American Thoracic Society / European Respiratory Society (ATS/ERS) field test statement, the minimal important difference (MID) for the 6MWT in adults with chronic respiratory disease is between 25 and 33 meters with a median value across trials of 30 meters (98.43 feet), as measured by a standardized 6 minute walk test (6MWT) after participating in pulmonary rehabilitation (PR).

RESOURCE TIPS:
- Algorithm (http://www.aacvpr.org/Portals/0/Program%20Certification/Performance%20Measures/CR%20Functional%20Capacity%20Performance%20Measure%20Algorithm.pdf)

Measure Description:
The percentage of patients with COPD or Interstitial Lung Disease (ILD) who are found to increase their functional capacity by at least 30 meters (98.43 feet), as measured by a standardized 6 minute walk test (6MWT) after participating in pulmonary rehabilitation (PR).

100% of non-excluded patients must be reported

Program Assessment Period:
- July 1st 2017 - December 31st 2017
2018 AACVPR Program Certification Pulmonary Application

Attribution:
- Pulmonary Rehabilitation staff

Sources of Data:
- Medical record, Pulmonary Rehabilitation records

Rationale & References:
- Please click here (http://www.aacvpr.org/Portals/0/Program%20Certification/Performance%20Measures/Measures/CR%20Functional%20Capacity%20Performance%20Measure_10.24.16.pdf)

Numerator:

Definitions

Assessment of functional capacity during PR using the 6MWT.
- Assessments of 6MWT are to be performed within one week of PR program entry and again within one week of PR program completion. The time period between tests should be no more than 3 months.
- Follow the procedures described in the ATS/ERS field test statement (1,2).
- To perform the 6MWT the patient is instructed to walk as far as possible in 6 minutes. They are allowed to stop and rest during the test, and resume walking as soon as able. All variables are held constant during the test consistent with the ATS / ERS statement (1,2). The total distance covered in 6 minutes is measured (in meters or feet). All patients who increase the distance walked by at least 30 meters (43 feet), as measured by the 6MWT performed at PR entry and again at PR completion, should be included in the numerator.
- Additional information is available in the AACVPR PR Outcomes Resource Guide/Toolkit (2014; update in 2016 planned)

Indicate the total number of patients who are found to increase their functional capacity by at least 30 meters (98.43 feet), as measured by 6MWT distance at PR program entry and completion.

NOTE: Input only a numeric (e.g. 124, 36, etc) value.

Denominator:

Indicate the total number of patients with clinician diagnosed COPD or ILD at PR program entry who completed PR during the measurement period and who completed at least 10 PR sessions within 3 months of PR program entry.

Denominator Exclusions:
- Patients for whom a 6MWT would be contraindicated due to acute or unstable medical conditions (see detailed list in reference 3 for a complete list).
- Patients who are unable to perform a 6MWT due to orthopedic, neurological, cognitive or psychiatric impairments and/or safety reasons.
- Patients who have not completed at least 10 PR sessions within 3 months of program entry.
Patients with diagnosed pulmonary vascular disease (i.e., pulmonary hypertension) or other primary lung disease process (i.e., lung cancer).

NOTE: Input only a numeric (e.g. 124, 36, etc) value.

Percent Increase:
Below is the percentage(%) of patients with COPD or ILD who are found to increase their functional capacity by at least 30 meters (98.43 feet), as measured by 6MWT distance at PR program entry and completion.

Calculation Instructions: The % of patients with COPD or ILD who improve their 6 minute walk distance by at least 30 meters (93.48 feet) = N / D X 100

*NOTE: This number is calculated from the above values (look into possible pre-formatted formula or add in the box from algorithm)

Free text question/answer required:
What is ONE change that you can make in your rehab process to help you increase your percentage or if you achieved 100%, how do you plan to maintain your percentage as you continually to work to improve your patient outcomes?

REQUIRED ELEMENTS FOR THIS PAGE:
- Provide performance measure numerator
- Provide performance measure denominator
- Provide percentage of patients that met the measure
- Describe one change you plan to make to increase or maintain (if 100% achieved) your percentage

THE FOLLOWING WILL RESULT IN AUTOMATIC DENIAL OF THIS PAGE:
- Failure to submit all required elements requested
- Submitted data not within the data collection period July 1, 2017 - December 31, 2017
Page 7: Improvements in Dyspnea

AACVPR Registry Users: How to Use Registry Data for Outcomes Pages
If your program uses the AACVPR Pulmonary Data Registry to track outcomes, you may use the following link to search for appropriate data to submit with your application. Once you have selected data, it can be copied and pasted into questions on this page.

REGISTRY TUTORIAL:
To view a brief video tutorial on how to search for Registry data to submit with your application, click here (https://www.aacvpr.org/Certification/AACVPR-Program-certification/2015RegistryOutcomesIntegrationVideo).

Note: If you don’t participate in the registry, you are still required to complete this page.


OVERVIEW:
For the purposes of AACVPR Program Certification, a program must report the percentage of patients with a primary diagnosis of COPD or Interstitial Lung Disease (ILD), regardless of other diagnoses, who are found to improve their global perception of dyspnea by the MCID, as measured by a valid and reliable instrument after participating in pulmonary rehabilitation (PR).

RESOURCE TIPS:
- Algorithm (http://www.aacvpr.org/Portals/0/Program%20Certification/Performance%20Measures/Improvement%20in%20Dyspnea%20Performance%20Measure%20Algorithm.pdf)

Measure Description:
The percentage of patients with a primary diagnosis of COPD or Interstitial Lung Disease (ILD), regardless of other diagnoses, who are found to improve their global perception of dyspnea by the MCID, as measured by a valid and reliable instrument after participating in pulmonary rehabilitation (PR).

100% of non-excluded patients must be reported

Period of Assessment
- July 1st, 2017 - December 31st, 2017

Attribution
- Pulmonary Rehabilitation staff

Sources of Data
- Medical record, Pulmonary Rehabilitation records
Rationale & References
- Please click here (http://www.aacvpr.org/Portals/0/Program%20Certification/Performance%20Measures/Measures/PR%20Dyspnea%20Performance%20Measure_10.24.16.pdf)

Required Disease-Specific Instruments
- Modified Medical Research Council Scale (mMRC)
- University of California San Diego Shortness of Breath Questionnaire (UCSD SOBQ)
- Baseline Dyspnea Index (BDI) / Transitional Dyspnea Index (TDI)

For more information about the above instruments click here (http://www.aacvpr.org/Portals/0/Program%20Certification/Performance%20Measures/Measures/PR%20Dyspnea%20Performance%20Measure_10.24.16.pdf)

Please indicate which assessment tool was administered by your program.

Numerator:

Definitions

Assessment of dyspnea.
- The time period should be performed within one week of PR program entry and again within one week of PR program completion. The time period between tests should be no more than 3 months.
- Is conducted using the Modified Medical Research Council Scale (mMRC), the University of California, San Diego Shortness of Breath Questionnaire (USCD SOBQ), or the Baseline and Transition Dyspnea Indices (BDI/TDI)
- Will include impact based on the change in score. The minimum clinical important difference (MCID) for the specific tool will be used as the unit of measure.

Indicate the number of patients with a primary, clinician diagnosed, COPD or ILD, regardless of other diagnoses, who have participated in PR and have been found to improve their dyspnea score by the minimum clinical important difference (MCID – AACVPR PR Outcomes Toolkit) as measured by the Modified Medical Research Council Scale (mMRC – 1 unit), the University of California San Diego Shortness of Breath Questionnaire (USCD SOBQ – 5 points), or the Baseline and Transition Dyspnea Indices (BDI/TDI – 1 unit) from the beginning to the end of PR

NOTE: Input only a numeric (e.g. 124, 36, etc) value.

Denominator:

Indicate the total number of patients with clinician diagnosed COPD or ILD at PR program entry who completed PR during the measurement period and who completed at least 10 PR sessions within 3 months of PR program entry.

Denominator Exclusions:
- Inability to complete the dyspnea instruments with reasonable accommodations
- Presence of comprehension limitation that precludes completion of the instrument
2018 AACVPR Program Certification Pulmonary Application

- Lack of availability of the tool used by the PR program in a language understood by the patient

Examples of Reasonable Accommodations:
- Read instrument instructions and questions to patient
- Fill in instrument answers as directed by the patient

**NOTE**: Input only a numeric (e.g. 124, 36, etc) value.

**Percent Increase:**
Below is the percentage(%) of patients with a primary, clinician diagnosis of COPD or ILD, regardless of other diagnoses, who have participated in PR and who are found to increase their dyspnea score by the minimum clinical important difference (MCID) as measured by the Modified Medical Research Council Scale (mMRC), the University of California San Diego Shortness of Breath Questionnaire (USCD SOBQ), or the Baseline and Transition Dyspnea Indices (BDI/TDI) at the beginning and the end of PR.

**Calculation Instructions**: The % of patients with COPD or ILD who improve their dyspnea score by at least the MCID = N /D x 100

*NOTE*: This value is calculated by your values input in the above questions

**Free text question/answer required**: What is ONE change that you can make in your rehab process to help you increase your percentage or if you achieved 100%, how do you plan to maintain your percentage as you continually to work to improve your patient outcomes?

**REQUIRED ELEMENTS FOR THIS PAGE:**
- Provide performance measure numerator
- Provide performance measure denominator
- Provide percentage of patients that met the measure
- Describe one change you plan to make to increase or maintain (if 100% achieved) your percentage

**THE FOLLOWING WILL RESULT IN AUTOMATIC DENIAL OF THIS PAGE:**
- Failure to submit all required elements requested
- Submitted data not within the data collection period July 1, 2017 - December 31, 2017
2018 AACVPR Program Certification Pulmonary Application

Page 8: Improvement in Health-Related Quality of Life

AACVPR Registry Users: How to Use Registry Data for Outcomes Pages

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*Note:* If you don’t participate in the registry, you are still required to complete this page.


**OVERVIEW:**

For the purposes of AACVPR Program Certification, a program must report the percentage of patients with a primary diagnosis of COPD or Interstitial Lung Disease (ILD), regardless of other diagnoses, who are found to increase their health-related quality of life score (HRQoL) as measured by a valid and reliable instrument after participating in pulmonary rehabilitation (PR).

**RESOURCE TIPS:**

**Measure Description:**

The percentage of patients with a primary diagnosis of COPD or Interstitial Lung Disease (ILD), regardless of other diagnoses, who are found to increase their health-related quality of life score (HRQoL) as measured by a valid and reliable instrument after participating in pulmonary rehabilitation (PR).

100% of non-excluded patients must be reported

**Period of Assessment**
- July 1st, 2017 - December 31st, 2017

**Attribution**
- Pulmonary Rehabilitation staff

**Sources of Data**
Medical record, Pulmonary Rehabilitation records

Rationale & References
- Please click here (http://www.aacvpr.org/Portals/0/Program%20Certification/Performance%20Measures/Measures/PR%20HRQOL%20Performance%20Measure_10.24.16.pdf)

Required Disease-Specific Instruments
- Chronic Respiratory Disease Questionnaire (CRQ)
- St. George’s Respiratory Questionnaire (SGRQ)
- COPD Assessment Test (CAT)

For more information about the above instruments click here (http://www.aacvpr.org/Portals/0/Program%20Certification/Performance%20Measures/Measures/PR%20HRQOL%20Performance%20Measure_10.24.16.pdf)

Please indicate which assessment tool was administered by your program.

Numerator:

Definitions

Assessment of health-related quality of life (HRQoL)
- Should be performed within one week of PR program entry and again within one week of PR program completion. The time period between tests should be no more than 3 months.
- Is conducted using one of the following valid and reliable instruments Chronic Respiratory Disease Questionnaire (CRQ), the St. George’s Respiratory Questionnaire (SGRQ), or the COPD Assessment Test (CAT).
- Will include impact based on the change in score. The Minimum Clinical Important Difference (MCID) for the specific tool will be used as the unit of measure.
- Additional information is available in the AACVPR PR Outcomes Resource Guide/Toolkit (2016)

Indicate the total number of patients with a primary, clinician diagnosed, COPD or ILD, regardless of other diagnoses, who have participated in PR and have been found to improve their HRQoL score by the Minimum Clinical Important Difference (MCID – AACVPR PR Outcomes Toolkit)) as measured by the Chronic Respiratory Disease Questionnaire (CRQ – 0.5 units), St. George’s Respiratory Questionnaire (SGRQ – 4 units), the COPD Assessment Test (CAT – 2 units) at the beginning and the end of PR.

NOTE: Input only a numeric (e.g. 124, 36, etc) value.

Denominator:

Indicate the number of patients with a primary, clinician diagnosis of COPD or ILD, regardless of other diagnoses, who are able to complete a CRQ, SGRQ, or CAT to assess HRQoL at PR program entry and PR program completion, who have completed at least 10 PR sessions within a 3 month period.
Denominator Exclusions:
- Inability to complete the dyspnea instruments with reasonable accommodations
- Presence of comprehension limitation that precludes completion of the instrument
- Lack of availability of the tool used by the PR program in a language understood by the patient

Examples of Reasonable Accommodations:
- Read instrument instructions and questions to patient
- Fill in instrument answers as directed by the patient

NOTE: Input only a numeric (e.g. 124, 36, etc) value.

Percent Increase:
Below is the percentage(%) of patients with a primary diagnosis of COPD or Interstitial Lung Disease (ILD), regardless of other diagnoses, who have participated in PR and are found to increase their HRQoL score by the minimum clinical important difference (MCID) as measured by the Chronic Respiratory Disease Questionnaire (CRQ), St. George’s Respiratory Questionnaire (SGRQ), the COPD Assessment Test (CAT) at the beginning and the end of PR.

Calculation Instructions: The % of patients with COPD or ILD who improve their HRQoL score by at least the MCID = N / D x 100

*NOTE: This value is calculated by your values input in the above questions

Free text question/answer required:
What is ONE change that you can make in your rehab process to help you increase your percentage or if you achieved 100%, how do you plan to maintain your percentage as you continually to work to improve your patient outcomes?

REQUIRED ELEMENTS FOR THIS PAGE:
- Provide performance measure numerator
- Provide performance measure denominator
- Provide percentage of patients that met the measure
- Describe one change you plan to make to increase or maintain (if 100% achieved) your percentage

THE FOLLOWING WILL RESULT IN AUTOMATIC DENIAL OF THIS PAGE:
- Failure to submit all required elements requested
- Submitted data not within the data collection period July 1, 2017 - December 31, 2017
Attestation Statements:

- I attest that all material and information submitted with this application is true and accurately represents program operations at this facility.
- I understand additional documentation will not be accepted after submission.
- I understand that AACVPR is unable to accept documentation with visible Personal Health Information (PHI). I understand that such documentation will be destroyed by AACVPR if received and may be cause for denial of AACVPR Program Certification.
- I understand that AACVPR Program Certification does not guarantee reimbursement.
- I agree to allow AACVPR to utilize any submitted documents from my application for training examples.
- I understand that AACVPR may conduct periodic audits at any time during the three year certification period to ensure that the current requirements of Program Certification are being met. This may include a site visit or a request for submission of materials. Failure to provide the requested items or submission of items that do not meet the most current requirements could result in penalties related to certification status.
- I understand that it is the responsibility of the applicant to assure that materials submitted for review are accurate and complete, and that there will be no written or verbal notification related to submission errors or omissions prior to the review decision.

REMINDER: Before submitting your application, please confirm that all requested documents are attached, readable, and complete (i.e., no missing pages). It is your responsibility to review your completed application and confirm that all documentation is uploaded correctly. No documentation will be accepted after submission of your application. 
Missing or unreadable documentation will result in denial of the affected page(s).