Value-based Care - Where the Rubber Meets the Road

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Disclosures

• Nothing to disclose
Objectives

• Define Value Based Care and how it relates to Cardiac and Pulmonary Rehabilitation
• Explore how effective outcome management leads to the implementation of quality initiatives in support of a Value based Care Model
• Identify techniques prior to Phase II to add quality and participation
• Identify techniques during Phase II rehabilitation that can be utilized to maximize outcomes and participation.
Rising National Health Expenditures
Emerging Value Based Care

What if Future Increases in U.S. National Health Expenditures Are Limited to Rate of Economic Growth?

National health expenditures (trillions)

Health spending growth, 2014–2024:
- $42.4 trillion if same as GDP growth rate;
- $45.3 trillion if same as CMS projections.

Cumulative difference: $2.9 trillion

19.6% of GDP

17.4% of GDP

Based on CMS NHE projection

IF NHE growth at same rate as GDP

Where is the opportunity for cost savings?

![Post-Acute Percentage of Episode Cost Diagram](image)
Triple Aim

- The 3 parts of the Triple Aim, (increasing quality of care, enhancing patient experience and lowering cost) provides a useful framework for measurement of value in health care.

- Combining all 3 parts of the Triple Aim enables measurement of cost-effectiveness, or overall value.

- Value can be conceptualized as the optimization of the Triple Aim, recognizing that different stakeholders may weight the 3 parts differently.

- The combination of care experience and cost enables measurement of efficiency. Similarly, the combination of population health outcomes and care experience enables measurement of effectiveness of care, or comparative effectiveness when comparing alternative treatments.

Health Care Reform (HCR)

- Health care reform is a general rubric used for discussing major health policy creation or changes—for the most part, governmental policy that affects health care delivery in a given place.
  - **Health care reform typically attempts to:**
    - Broaden the population that receives health care coverage through either public sector insurance programs or private sector insurance companies
    - Expand the array of health care providers consumers may choose among
    - Improve the access to health care specialists
    - Improve the quality of health care
    - Give more care to citizens
    - Decrease the cost of health care
Value Based Management (VBM)

- Value based healthcare is defined as the health outcomes or quality achieved in relation to the costs of the care provided. Value can be increased by improving outcomes and quality, reducing costs, or both.

- Under value-based care agreements, providers are rewarded for helping patients improve their health, reduce the effects and incidence of chronic disease, and live healthier lives in an evidence-based way.

- Value-based care differs from a fee-for-service or capitated approach, in which providers are paid based on the amount of healthcare services they deliver.

- The “value” in value-based healthcare is derived from measuring health outcomes against the cost of delivering the outcomes.

Population Health Management

Population health – The health outcomes of a group of individuals, including the distribution of such outcomes within the group.

- Population Risk Stratification Identification processes
- Clinical pathways and evidence-based practice guidelines
- Interprofessional practice models and collaborative agreements with preferred network providers
- Enhancement of patient and caregiver self-care management engagement
- Clinical workflow process and evaluation outcomes
- System reporting/action plans


## Ecosystem of Stakeholders

<table>
<thead>
<tr>
<th>Stakeholder Category</th>
<th>Key Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Healthcare Policy</strong></td>
<td>Lobbyists, Legislators, Researchers</td>
</tr>
<tr>
<td><strong>• Triple Aim</strong></td>
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<tr>
<td><strong>• Health Care Reform</strong></td>
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<tr>
<td><strong>• Value Based Care</strong></td>
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<tr>
<td><strong>Healthcare Systems</strong></td>
<td>Insurance Companies</td>
</tr>
<tr>
<td><strong>• Referrers</strong></td>
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<tr>
<td><strong>• Hospital (system headquarters + local hospital)</strong></td>
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<tr>
<td><strong>• Cardiac and Pulmonary Rehabilitation Teams</strong></td>
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<tr>
<td><strong>Patient</strong></td>
<td>Family members</td>
</tr>
<tr>
<td><strong>• Caregivers</strong></td>
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<tr>
<td><strong>• Social Network</strong></td>
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</table>
Value Based Care Journey

VBC remains a challenging transformational journey, paved with complexity, potential high costs, implementation risks and a cultural change for all stakeholders engaged.

- Understand market evolution
- Know your populations
- Articulate your value proposition
- Choose defined metrics that aligns stakeholders

http://www.mondaq.com/uk/x/576560/Healthcare/Laying+The+Groundwork+For+ValueBased+Healthcare+In+Europe
Value = Quality / Cost

The Cardiac and Pulmonary Rehabilitation Team can create VALUE by:

- Enhancing Medication Reconciliation to next level of care (inpatient to outpatient to primary care)
- Decreasing hospital length of stay-early mobilization and self care-education
- Decreasing the need for high cost post acute services (right patient for right setting at the right time)
- Preventing 30 day readmission (MI, HF, COPD, PNA)
- Be a part of the hospital tobacco cessation team
- Implementing and evaluating the ≥ 20 AACVPR turn key strategies for referral, enrollment and adherence- e.g D2S (discharge to start)
- Improving the inpatient and outpatient patient experience & satisfaction (Press Ganey & HCAPS)
- Creating lifelong health / wellness
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. To this end the Value Base Care Initiative will create resources which will assist cardiac & pulmonary rehabilitation professions:

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

Defined by the AACVPR- HCRC Subcommittee -VBC Workgroup, 2018
Consider changes 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 experience?

Defined by the AACVPR- HCRC Subcommittee -VBC Workgroup,
Change Management

How can we engage our staff to consider change in support of a value based model?

Outcome focused
Innovative
Efficient yet effective
Control costs
Allow data to drive change
...is everyone’s responsibility.

(Deming, W. Edwards)
Involve staff in the process

- Periodically, share program aggregate outcomes with staff
- Brainstorm sessions to improve an outcome or metric - Encourage creativity
- Involve staff in QI projects - Create enthusiasm
- Connect outcomes to a merit based performance objectives
- Staff action plans linked to program or strategic goals
- Recognize staff for achievement
- Challenge the staff to achieve established targeted outcomes
- Create a willingness to embrace change
- Create a genuine desire & enthusiasm for improving every day
VBC Transformation Opportunities

- **Incremental Change**
  - 5% - 10%
  - Incremental ideas that do not significantly disrupt the organization

- **Operational Improvement**
  - 10% - 15%
  - Departmental improvement ideas that reorganize activities; moderate impact on other departments

- **Redesign Care Delivery Model**
  - 15% - 20%
  - Cross-departmental functioning and program elimination ideas; greatest potential to be disruptive

- **Consolidate roles and responsibilities**
- **Invest in productivity**
- **Leverage technology**
- **Lean process design**
- **Six Sigma**
- **Vendor and supply consolidation**
- **Redesign of staffing and care delivery models**

Outcome Management

Outpatient Registry
AACVPR Cardiac & Pulmonary Registry
Home grown database
Excel spreadsheet within the department
Manual tracking & chart reviews

Inpatient Registry
NCDR Cath PCI registry (ACC)
The STS database for cardiac surgery inpatients

“The use of” information collected through measurement of outcomes to improve effectiveness and value of treatments. Goal – is to collect, measure and evaluate outcomes to improve delivery of care.
<table>
<thead>
<tr>
<th>Core Components of Care</th>
<th>Clinical</th>
<th>Behavioral</th>
<th>Health</th>
<th>Service</th>
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</thead>
<tbody>
<tr>
<td>Overall Management</td>
<td>Risk factor profile</td>
<td>Self-efficacy</td>
<td>Morbidity and Mortality</td>
<td>Patient Satisfaction</td>
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<tr>
<td></td>
<td>Evaluation of symptoms</td>
<td>1. Improved knowledge and application of self-care actions</td>
<td>1. Health care utilization</td>
<td>1. Satisfaction with the care received</td>
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<tr>
<td></td>
<td>Hemodynamic regulation</td>
<td>2. Return to desired physical activity level</td>
<td>a. Hospitalizations / readmissions</td>
<td>2. Progress toward goals</td>
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<tr>
<td></td>
<td>Activity of daily living assessment</td>
<td>3. Desire to return to work</td>
<td>b. Emergency room visits</td>
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<tr>
<td>Exercise Testing and Training</td>
<td><strong>Exercise Testing</strong></td>
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<td>c. Physician sick visits</td>
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<td></td>
<td>1. Maximal exercise test</td>
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<td>2. Unfavorable events during supervised sessions</td>
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<td></td>
<td>2. Sub-maximal exercise test (e.g., 6- or 12-minute walk test)</td>
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<td>Health-related quality of life</td>
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<td></td>
<td><strong>Resting Exercise &amp; Recovery Responses</strong></td>
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<td>Return to work / loss of work days</td>
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<td></td>
<td>1. Heart rate and rhythm</td>
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<td>2. Blood pressure</td>
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<td></td>
<td>3. Rating of perceived effort</td>
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<td>4. Exercise METS</td>
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<td>5. Rating of perceived dyspnea</td>
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<td>6. Oxygen saturation level</td>
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<tr>
<td>Strength and Flexibility Training</td>
<td><strong>Strength measures</strong></td>
<td>Exercise Compliance</td>
<td></td>
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<td></td>
<td>(e.g., 1 RM, grip dynamometer)</td>
<td>1. Supervised sessions</td>
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<td></td>
<td>Flexibility measures (e.g., sit-and-reach test, goniometer)</td>
<td>2. Home or outside sessions</td>
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<td></td>
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<td>3. Adherence to exercise prescription</td>
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<td>Lipid Management</td>
<td>Lipid levels</td>
<td>Adherence to diet, exercise, and medications</td>
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<td>Adjustment in medication dosage</td>
<td>Diet and exercise state of change</td>
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<tr>
<td>Hypertension Management</td>
<td>Resting blood pressure</td>
<td>Adherence to diet, exercise, and medications</td>
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<td>Exercise/recovery blood pressure</td>
<td>Diet and exercise stage of change</td>
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<td>Adjustment in medication dosage</td>
<td>Self-monitoring behaviors</td>
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<tr>
<td>Diabetes Management</td>
<td>Blood glucose levels</td>
<td>Adherence to diet, exercise, and medications</td>
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<td>HgA1c</td>
<td>Diet and exercise stage of change</td>
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<td>Adjustment in medication dosage</td>
<td>Self-monitoring behaviors</td>
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<tr>
<td>Nutrition and Weight Management</td>
<td><strong>Anthropometric Measures</strong></td>
<td>Adherence to diet and exercise</td>
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<tr>
<td></td>
<td>1. Height/weight/BMI</td>
<td>Diet and exercise stage of change</td>
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<td>2. Body fat/lean body weight measures</td>
<td>Diet recording logs</td>
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<td></td>
<td>3. Abdominal circumference</td>
<td>Physical activity recording logs</td>
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<td></td>
<td>4. Sum of skinfolds/girths</td>
<td>Diet habit scores</td>
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<tr>
<td></td>
<td>Nutritional biochemical markers</td>
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<tr>
<td>Psychosocial Management</td>
<td><strong>Measurements of Mood</strong></td>
<td>Coping mechanisms</td>
<td></td>
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<tr>
<td></td>
<td>Depression, anxiety, hostility, emotional distress</td>
<td>Stress management and relaxation skills</td>
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<tr>
<td></td>
<td><strong>Measurements of Cognitive Function</strong></td>
<td>Social support network</td>
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<tr>
<td></td>
<td>Memory, orientation, judgment</td>
<td>Sexual dysfunction</td>
<td></td>
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<tr>
<td>Smoking Cessation</td>
<td>Serum cotinine levels</td>
<td>Smoking stage of change</td>
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<tr>
<td></td>
<td>Exhaled carbon monoxide</td>
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<td></td>
<td>Number of cigarettes/cigars smoked per day</td>
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<tr>
<td></td>
<td>Duration of smoking habit (pack-years)</td>
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</tbody>
</table>

Revised 9/07 by the AACVPR Outcomes Committee
## AACVPR Pulmonary Metrics

<table>
<thead>
<tr>
<th>Functional status</th>
<th>Dyspnea Measurements</th>
<th>Health Related Quality of Life</th>
<th>Psychosocial</th>
<th>Clinical Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Six Minute Walk test (6MWT)</td>
<td>Modified Medical Research Council Dyspnea Scale MMRC</td>
<td>Medical Outcomes Study Short Form – 36</td>
<td>Patient Health Questionnaire (PHQ-9)</td>
<td>Spirometry</td>
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<tr>
<td>Incremental Shuttle Walking test (ISWT) &amp; Endurance Shuttle Walk test (ESWT)</td>
<td>University of San Diego Shortness of Breath Questionnaire (UCSD SOBQ)</td>
<td>Ferrans &amp; Powers Quality of Life Index – Pulmonary Version III (QLI)</td>
<td>Beck Depression Inventory - 2 (BDI-2)</td>
<td>Peak Inspiratory Flow Rate</td>
</tr>
<tr>
<td></td>
<td>The Borg CR 10 Scale</td>
<td>Dartmouth Primary Care Cooperative (COOP)</td>
<td>Psychosocial Risk Factor Survey (PRFS)</td>
<td>Lung volume measurements</td>
</tr>
<tr>
<td>Baseline &amp; Transition Dyspnea Indexes (BDI/TDI)</td>
<td>Standardized Dyspnea Domain of the CRQ</td>
<td>Hospital Anxiety &amp; Depression Scale (HADS)</td>
<td></td>
<td>DLCO</td>
</tr>
<tr>
<td>Global Chest Questionnaire (GCSQ)</td>
<td>The Functional Assessment of Chronic Illness Therapy-Dyspnea (FACIT-Dyspnea)</td>
<td>Strait Trait Anxiety Inventory (STAI)</td>
<td>Generalized Anxiety Disorder (GAD-7)</td>
<td>Gold Criteria</td>
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<tr>
<td>Multidimensional Dyspnea Profile</td>
<td>St. George’s Respiratory Questionnaire (SGRQ)</td>
<td></td>
<td>Beck Anxiety Inventory (BAI)</td>
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<tr>
<td>Chronic Respiratory Disease Questionnaire</td>
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AACVPR Pulmonary Rehab Outcomes Resource Guide
How is the data being used?
How is the data being used?

- Is it being looked at? Who is looking at it? How often?
- Benchmarking?
- Best practices?
- Is the gap or opportunity being identified?
- What is being done to improve the outcomes?
- Is this data that can be used for research purposes?

Avoid being

Data Rich & Information Poor
Track & Measure

- How is the quality indicator being measured?
- Define the metric
- Establish the target
- Establish the threshold
- Define the numerator & denominator
- Re-evaluate how often?

Evaluate Data

- Can a pattern be identified?
- Is the data trending up or down?
- Inconsistent or consistent?
- Is the data set or sample size large enough to get an accurate representation of the value?
- Are results falling below threshold or close to the target?
- Is a Benchmark available

Key – identify the gap & focus on the opportunity
Capitalize on Opportunity

Closing the gap → ACTION PLAN → Department QI

Define:

• the action items
• how the actions will be implemented
• what’s the time line
• identify the responsible person or party
• establish a target & a threshold
• determine the frequency of monitoring
• establish accountability
Effective Outcome Management leads to QI projects

- Track & Measure Outcomes
- Identify the gap
- Find the Opportunity
- Create an Action Plan
- Develop a QI Project
Quality Improvement

• Continuous quality improvement is an ongoing process for achieving measurable improvement.

• It is a proven technique for increasing
  ▪ efficiency & productivity
  ▪ increasing patient satisfaction
  ▪ building employee morale &
  ▪ improving outcomes

The QI process is imperative when supporting a VBC model
CONTINUOUS
CONTINUOUS
IMPROVEMENT

We implemented Square Wheels last year. You think we need to change again?

Square Wheels™ is a trademark of Performance Management Company
“Practice the philosophy of continuous improvement. Get a little bit better every single day.” —Author unknown

wwwLEANSixSigmaBelgium.com
QI to improve PR Clinical Outcomes
ADL Energy Conservation- Simulation Workshop
Dyspnea, Fatigue & QOL post 6 month intervention

12 stations – 5 ADL’s

- Vacuuming -5 exercises
- Stair climbing -6 exercises
- Bending - 6 exercises
- Reaching - 7 exercises
- Making the Bed - 8 exercises

<table>
<thead>
<tr>
<th></th>
<th>Traditional PR</th>
<th>ADL ECW</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRQ Dyspnea</td>
<td>22%</td>
<td>31%</td>
<td>9%</td>
</tr>
<tr>
<td>CRQ Fatigue</td>
<td>14%</td>
<td>19%</td>
<td>5%</td>
</tr>
<tr>
<td>CAT</td>
<td>5%</td>
<td>14%</td>
<td>9%</td>
</tr>
<tr>
<td>MMRC</td>
<td>10%</td>
<td>24%</td>
<td>14%</td>
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</tbody>
</table>
Capacity Management –

QI to Improve Patient Flow in PR

Interventions: reduce sessions to 24, add Fri makeup class, 2 week limit MLOA

- Improved Completion Rates (38% - 63%)
- Reduction in Absentee Rate (27% - 18.5%)
- A more timely discharge (18-24 wks to 12-15 wks)
- Improved Patient Flow & Through Put – Eliminate wait list
- Improved Access to Care (48% - 68%)
- More Completed Data for Outcome Tracking
- Additional Revenue from reduced absences & improved through put
Patient Experience
QI to reduce drop out during first 9 sessions in noncompliant pts
Intervention-Implement a Patient Ambassador Program

![Graph showing reduction in drop-out rates]

- Start of Ambassador Program
- 20.6% reduction
Increase referrals to CR from outpatient OV

Intervention:
MD focus: Add Best Practice Alert (BPA) in EMR on all cardiology office visits

- Already established an inpatient CR consult
- Barriers to inpatient referral to outpatient rehab
  - MD’s want to clear patients for CR enrollment during Office Visit.
  - APP’s are discharging patients
  - Strength of referral from patients cardiologist dictates capture
Pop Up Reminder: Physician outpatient clinics
Understand the continuum of care and how rehabilitation can have an impact…

- Inpatient acute medical / surgical (Phase I)
- Inpatient acute / subacute rehab
- Transition – homecare
- Outpatient (Phase II)
- Lifelong (maintenance- Phase III/IV)
Value = Quality / Cost

The Cardiac and Pulmonary Rehabilitation Team can create VALUE by:

- Improving the patient experience
- Improving patient outcomes
- Decreasing hospital length of stay
- Reducing hospital costs
- Decreasing the need for post acute inpatient services
- Preventing readmissions
- Creating lifelong health / wellness
Inpatient acute medical / surgical

- Rehabilitation as part of admission order sets
  - **Consultation order**
    - Staff connect with patient
    - Education
    - Ambulation
    - Part of multi-disciplinary team huddles
    - Determine if additional testing is needed (PFT)
    - Orientation to department through videos or tours
  - **Outpatient order**
    - Attend disease specific grand rounds to collaborate with physicians concerning start time and appropriate diagnosis
    - Outpatient order is retrievable from the EMR
    - No need to fax the physician’s office
Inpatient acute medical / surgical

- Inpatient Staff
  - Nursing staff
  - Physical therapists
  - Exercise Physiologists
  - Patient Care Assistants
  - Physicians
  - Advanced Practice Providers
  - Dietitians

- All hospital staff speak to rehabilitation benefits
Inpatient acute medical / surgical

- Rehabilitation as part of discharge instructions

- Information specific to discharge diagnosis

- Outpatient Appointment
  - First appointment scheduled
  - Group Orientation
  - Standing program introduction
Inpatient acute / subacute rehab

- Collaborate with acute and subacute rehabilitation facilities.
- Educate the rehab facility staff on benefits of cardiac and pulmonary rehabilitation
- Be part of the acute and subacute rehabilitation discharge process
Transition – homecare

• Collaborate with community care agencies

• Unable to participate in rehabilitation if receiving community care (homecare) for PT, OT, vital signs

• Community care facilitate enrollment in outpatient rehabilitation

• Educate community care staff regarding rehabilitation program and services
Outpatient Settings other than Rehabilitation

• Heart Failure Clinics
  • Follow Heart Failure patients from discharge until 6 week wait time for cardiac rehab.
  • For all patients with an EF ≤ 35%, referral sent to cardiologist to refer patient to outpatient cardiac rehabilitation.

• Pulmonary Function Tests
  • Class II or greater PFT, automatic referral sent to pulmonologist for outpatient Pulmonary Rehabilitation
Getting them in the Door

• Inverse relationship between time to enrollment and participation
  • Estimated that participation decreases by 1% every day past discharge
• Minimize the window of time between discharge and the first appointment
• Metric needed:
  • Average time to enrollment
  • Identify number of appointment slots available
Getting them in the Door

- Evaluation Process can impede start due to availability of time for 1 on 1 setting
- Solution: Group Evaluation and Orientation
  - Identify the parts of the screening process that are repeated with every new patient
    - Consent/admission paperwork, surveys, goal setting questionnaires
    - Non-billable Service, as the patient is not exercising and/or signature of ITP
- Follow up visit
  - 6 min walk test, depression screen review, medicine reconciliation
Group Evaluation Outline

- Complete all the paper work
  - Admissions, surveys, etc
- Education
  - Risk factor modification
  - Patient sets the goals
- The “why” for cardiac rehab
  - Our goal is to create independent patients!
Is Your ECG availability limiting enrollment?

- According to AACVPR Registry projections 90% of programs are monitoring every session.
- Research shows that continuous ECG monitoring during supervised exercise is of little value, doesn’t change treatment.
- Excessive monitoring may lessen a patients’ self-efficacy to exercise independently.
- AACVPR recommends monitoring based on clinical need:
  - Why are you monitoring your pulmonary patient?
  - Number of monitors should not be limiting factor.
ECG Safety

• It is safe to take the patients off the monitor
  • Adverse events (cardiac arrest, sudden death, or MI) are very low – 1 event in 400,000 to 800,000 hours
  • Unexpected rhythm changes usually occur during the first 2-4 weeks
• Your best tool is your clinical judgement
Is Your ECG availability limiting enrollment?

- How do we move people off the monitor?
  - Risk Stratification to the removal of the telemetry
    - Low risk 6 - 12 sessions
    - Moderate risk 12 - 18 sessions
    - High risk 18 - 24 sessions
  - 12 lead exercise ECG at enrollment. No monitor after screening
  - Medical Director and Staff support
  - Use CPT code 93797
    - Check insurance verification
  - Use CPT code 93797
  - Check insurance verification
Program Adherence

- Program model that works for patient (CMS states 36 sessions in 36 weeks. Does not state how many days per week)
- Women only classes
- Missed class options (Coming to another class or day)
- Patient motivation. Why wait until end to reward?
- Sessions per day (PR versus CR- can be done concurrently)
- Hours are to patient schedule and not staff schedule
- Open gym model
- Cardiac Rehab app
Program Adherence

- Patient engaged in program with self-efficacy.
  - Write diaries
  - Record session information
  - Pt evaluates own progress
  - Goal to teach the patient to be independent
### My Exercise Prescription

<table>
<thead>
<tr>
<th>R/T:</th>
<th>Lower Body (LB)</th>
<th>Upper Body (UBE)</th>
<th>AirDyne (AD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RD:</td>
<td>NuStep (NS)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>BHS:</td>
<td>Stationary Bike (SB)</td>
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</tbody>
</table>

**Warmup:** 5 min, 10 min

**Cooldown:** 5 min, 10 min

**Risk Progression/Total Duration:**

- **Low:** 1:3, min. 4-end, min. M. 12
- **Mod:** 1:3, min. 4-end, min. M. 12
- **High:** 1:5, min. 4-end, min. M. 12

**Key:**

- RR: Resting Heart Rate
- Wkld: Level, watts, speed, grade
- BSB: Blood Sugar
- RPE: Exertion Scale
- Mode: Equipment
- EXHR: Exercise Heart Rate
- EXBP: Exercise Blood Pressure
- EBP: Ending Blood Pressure

**Date**

<table>
<thead>
<tr>
<th>Date</th>
<th>RR</th>
<th>WT</th>
<th>REP</th>
<th>BS</th>
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**Functional Capacity Test**

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**AACVPR Annual Meeting**

**On Track to Innovate**
Embrace Technology

- Explore interfacing the program’s monitoring system with EMR and/or billing.
  - Reduce cost of paper
  - Allows more time with the patient
- AACVPR Registry
  - Tracks performance measures
- Text/emails reminders of sessions
- Telehealth/hybrid programs
Turn-Key Strategies

• Look under the value-based care tab on the AACVPR website for strategies
  ▪ Administration
    • Group Screening, Inpatient Liaison, etc.
  ▪ Exercise
    • Accelerated Programs, ECG Monitoring, Open Gym
  ▪ Behavior
    • Medication adherence, Self-management, Standard of care for Depression
  ▪ Nutrition
    • Incorporating RDs
AACVPR and Million Hearts
Leading the Drive to 70%

- Hitting the 70% target is going to require:
  - more programs
  - bigger programs
  - more efficiently operated programs

- A 70% participation rate estimated to save 25,000 lives and prevent 180,000 hospitalizations, annually.
IF YOU ALWAYS DO WHAT YOU ALWAYS DID, YOU’LL ALWAYS GET WHAT YOU ALWAYS GOT.

- HENRY FORD