2021 Pulmonary Program Certification Application
3-Steps to Getting Your 2021 Application Started

1. Update Primary Contact Form

1. Select primary contact
2. Verify program name and address
3. Under “Program Address 2” identify program track (cardiac or pulmonary rehab)
4. Please allow up to 72 hours for primary contact form updates confirmation before moving to step 2

Click Here to access primary contact form

2. Update Program Demographics & Staff Roster

1. Identify key staff (Secondary Contact, Medical Director, Program Director, etc.)
2. Verify facility type (privately owned, hospital based, etc.)
3. Specify Maintenance Programs Offered
4. Denote Sister Programs (Programs from your hospital system that are recertifying through AACVPR or are also applying for the first time)
5. Indicate # of Referrals per year

Click Here for “My Profile” update instructions

3. Review 2021 Program Certification Application Outlines & "Required" Performance Measures

1. Review 2021 Cardiac & Pulmonary Application Requirements
2. Review Required Cardiac Rehab Performance Measures: Improvement in Functional Capacity, Optimal Blood Pressure Control, Tobacco Use Intervention, & Improvement in Depression
3. Review Required Pulmonary Rehabilitation Measures: Improvement in Dyspnea, Improvement in Functional Capacity, & Improvement in Quality of Life

Click Here for Program Certification Performance Measures Resource Page

Ready to start the 2021 program certification application? (*)Application opens December 1, 2020)
1. Log on to the AACVPR website
2. Click the "My Programs" tab in top right corner
4. Select the appropriate program "dashboard"

*Note: If no program is listed contact the AACVPR certification team at certification@aacvpr.org
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


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.

PR Certificate EXEMPTION: The PR Certificate is recognized as evidence of professional competency in the 2020 Program Certification application, staff who earned the PR Certificate are exempt from the requirements for one application cycle. However, the required information must still be submitted for all staff who did not receive a PR Certificate.

RESOURCE TIPS:

- To access the FAQ for this page, click here (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 10 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.

Staff requiring competencies are listed below. 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, 2020 to February 28, 2021.

THE FOLLOWING WILL RESULT IN AUTOMATIC DENIAL OF THIS PAGE:
- 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).
- Competency description simply states "return demonstration/ check-off station".
- 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.
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). Reassessment must also include oxygen use and titration, for example: listing SPO2 liters used.

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**
- 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**

**Other Core Components/Risk Factors Plan**
- Goals
- Interventions
- Education

**Other Core Components/Risk Factors Reassessment**
**Other Core Components/Risk Factors Discharge/Follow-up**

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**‡ 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

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**‡ 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”. The Other Core Component/Risk Factors must be actively managed and have details on all required steps included for initial, reassessment and discharge/follow-up.**
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).
- 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).

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.
- Education cannot be its own header; it needs to be within the required steps of each element.
- Submitted ITP must be dated between January 1, 2020 and February 28, 2021.
• 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/plan at least one reassessment and discharge for exercise element.
• Submitted ITP does not have initial assessment/plan at least one reassessment and discharge for psychosocial element.
• Submitted ITP does not have initial assessment/plan at least one reassessment and discharge for nutrition element.
• Submitted ITP does not have initial assessment/plan at least one reassessment and discharge for other core components element.
• Submitted active additional core component/risk factor was addressed elsewhere on the ITP.
• Required elements of the submitted ITP are not clearly labeled.
• Reassessment/discharge 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).
• Missing required components of the exercise prescription
  • Education is listed as a header instead of within the required step(s) of each elements
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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).

WHAT YOU NEED TO UPLOAD:
Please upload your program specific medical emergency policies/protocols document(s) for the nine medical emergencies listed above. You are required to upload a single PDF document for your Medical Emergencies policy.

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.
- Submitted policies do not include specific details related to the role of the Cardiac Rehabilitation staff in medical emergency management of all medical emergency conditions.
- Failure to submit all additional referenced policies.
- Submitted policies are ACLS algorithms 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. Readiness must be clearly indicated with evidence of testing of the Defibrillator/AED with a specific method of readiness verification. Portable oxygen readiness must be clearly indicated with a specific verification, not just a check mark that it is available. An explanation must be provided for any dates without verification of readiness (e.g. "closed" or "holiday" must be written) during that month. You are required to upload a single PDF document for verification.

- Does your program have Defibrillator/AED, Portable oxygen 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, 2020 and February 28, 2021.

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
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- 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 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, 2020 and February 28, 2021.

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 provide explanation of dates without verification of emergency readiness (i.e. "closed" or "holiday" must be written) during the month submitted.
- 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.
- HIPAA violation contains patient information in descriptions.
- Does not have verification of readiness clearly indicated for Defibrillator/AED and/or Portable oxygen.
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.

RESOURCES:
- 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.
- You are required to upload a single PDF document for your Exercise Prescription policy.

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.
- Failure to submit an exercise prescription policy that addresses frequency.
- Failure to submit an exercise prescription policy that addresses duration.
- Failure to submit an exercise prescription policy that addresses intensity
- 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.
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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:

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:

- January 1st 2020 – February 28th 2021

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 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 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 January 1, 2020 - February 28, 2021
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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:

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).

RESOURCES TIPS:

- Performance measure specifications
  (http://www.aacvpr.org/Portals/0/Program%20Certification/Performance%20Measures/Measures/PR%20Dyspnea%20Performance%20Measure_10.24.16.pdf)
- 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
- January 1st 2020 – February 28th 2021

Attribution
- Pulmonary Rehabilitation staff

Sources of Data
- Medical record, Pulmonary Rehabilitation records
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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.
- 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)

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.

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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, 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 January 1, 2020 - February 28, 2021

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Page 8: Improvement in Health-Related Quality of Life

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:

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:

- Performance measure specifications
  (http://www.aacvpr.org/Portals/0/Program%20Certification/Performance%20Measures/Measures/PR%20HRQOL%20Performance%20Measure_10.24.16.pdf)
- Algorithm
  (http://www.aacvpr.org/Portals/0/Program%20Certification/Performance%20Measures/Improvement%20in%20HRQOL%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 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

- January 1st 2020 – February 28th 2021

Attribution

- Pulmonary Rehabilitation staff

Sources of Data

- Medical record, Pulmonary Rehabilitation records

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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.
• Chronic Respiratory Disease Questionnaire (CRQ)
• St. George’s Respiratory Questionnaire (SGRQ)
• COPD Assessment Test (CAT)

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.
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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:
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  - Submitted data not within the data collection period January 1, 2020 - February 28, 2021
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).