

2018 Program Certification Are You Ready?

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Cardiac Ancillary Services Manager
Indiana University Health Bloomington Hospital**

- This presentation is a collaborative effort of the AACVPR Program Certification Leadership Team
- We do not have any disclosures other than a passion for program excellence and a strong belief in the AACVPR Program Certification process



The AACVPR Cardiac and Pulmonary Rehabilitation Program Certification process is designed to review programs based on their alignment with the latest evidence-based medicine, expert opinion, current regulations and measurement of individualized patient outcomes, and to recommend certification based on that review

**AACVPR
Board of Directors**

BOD Liaison: Bob Brown

Pulmonary Expert Panel
Chair - Jane Knipper

Cardiac Expert Panel
Chair – Patrick Savage

Certification Application Review Team
Chair – Mark Stout
Vice Chair – Lynn Hegvik/Bob Brown

Remediation Team
Chair – Barb Flato
Vice Chair – Susi Mathis/Bob Brown

Program Certification Staff
Program Manager: Heather Rich
Senior Associate: Chelsea Schillinger

Senior Review Team
Immediate Past Chair – Kim Beyer
Members: Gayla Oakley, Susie Carter
Bonnie Anderson

Ultimate Goal: At least one highly trained and qualified reviewer from each state. Currently there are 45 reviewers representing 28 states!

Application Review Process

- Each application is thoroughly reviewed by trained members of the Application Review Team.
- **Inter-Rater Reliability Testing (IRR)**
 - **IRR** is utilized in the program certification process in order to assess the consistent evaluations of the same application. This strengthens the certification process and helps assure reliability of the review.
 - **10 -15%** of all applications are automatically reassigned to another member of the review team for a second independent review.
 - This helps strengthen the certification application process and help assure reliability of the reviews.
 - Applications recommended for denial during initial review are automatically reviewed by at least two members of the Certification Leadership Team, in addition to BOD liaison.

- **Full Approval**
 - Meets **all** required elements
- **Eligible for Remediation**
 - Application meets **most** required elements
- **Denial**
 - Application **does not meet multiple** required elements after a thorough Program Certification Leadership Team review

- The AACVPR Program Certification Committee are performing audits
 - *Site Audits*
 - *Paper Audits*
 - *Randomly Chosen Programs*

Important to maintain current certification requirements so that you assess your program's adherence every year and apply for certification every 3 years

Timeline for 2018!

GET READY!

- **Data Collection Period: July 1 - December 31, 2017**
- **December 1, 2017:** Application opens
- **February 28, 2018:** Completed applications and payments are due
- **March - May 2018:** Program Certification Committee Review of certification and recertification applications
- **June - Aug 2018:**
 - IRR process
 - Co-Chair Oversight Review
 - BOD Liaison Review
 - AACVPR prepares notifications and certificates
- **August 31, 2018:** AACVPR notifies all programs of application decision
- **Sept - Oct 2018:** Remediation process occurs mid-Sept through Oct
- **Oct - Nov 2018:** Remediation decisions are finalized
- **December 31, 2018:** Notification of remediation decisions



American Association of Cardiovascular
and Pulmonary Rehabilitation

Promoting Health & Preventing Disease

Home About AACVPR Member Center Events & Education Advocacy **Certification** Registry Resources Career Center

AACVPR Program Certification

Program Certification FAQs

AACVPR Professional Certification

Program Cert Application Resources

Program Cert Marketing Toolkit

AACVPR Program Certification



The AACVPR Cardiac and Pulmonary Rehabilitation Program Certification process is the only peer-review accreditation process designed to review individual facilities for adherence to standards and guidelines developed and published by AACVPR and other professional societies.

- [FAQs \(Frequently Asked Questions\) For Program Certification](#)
- [Program Certification Application Resources](#)
Includes: **Highlighted 2016 Application Changes** and **2016 SAMPLE Applications**
- [Program Certification Marketing Toolkit](#)

The certification process and requirements are updated **each year**, and may have changed since your previous certification. Please visit our [Application Resources](#) & [Frequently Asked Questions](#) webpages for the best information about the 2016 application cycle.

AICM [Click here](#) to view a free recording of the 2015 AACVPR Annual Meeting session titled "AACVPR



- Program Certification FAQs
- Program Cert Primary Contact Form
- Program Cert Application Resources
- Program Cert Marketing Toolkit



Join



Education



Events

Program Certification Application Resources

Thank you for your interest in the AACVPR Program Certification process. The certification process and requirements are updated each year and may have changed since your previous certification if you are re-certifying. Please **read the application carefully** and use the information provided on this website for guidance. [Click here](#) for general information about the Certification process. See below for a variety of resources and references to assist your program with the application process.

- Program [Certification Application Frequently Asked Questions](#)
- [Click Here](#) to Start an Application (2017 Application Opens December 1, 2016)
- 2016 Program Certification Annual Meeting Session - Coming Soon!



General Application Resources *(Cardiac & Pulmonary)*

- **NEW** - [JTP Checklists](#)
- [Program Certification Policies & Procedures](#)
- [Outcome Assessment Tools](#)
- [Examples for Quality Improvement Page](#)

Certification

- AACVPR Program C
- AACVPR Profession:

[AACVPR](#)
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Program Profile

- Complete the demographic information on the Program Profile page
- Fill in the program roster with all staff prior to starting the application. Be sure that you have a **Primary** and **Secondary** contact person or you will not be able to go further on the application
- Remember to identify sister programs
 - Sister programs are programs that are related
 - *By Hospital Systems*
 - *Cardiac and Pulmonary Rehab program at one hospital*
- Program must be in operation for **one** year prior to applying

[Home >](#)

Manage Contacts for Cardiac Rehabilitation

Current Contacts

Relationships

In order to complete the roster for **PROGRAM CERTIFICATION**, you must have one for each of the following: Certification Primary Contact, Certification Secondary Contact, Administrator (CEO), Medical Director, Program Director, and Professional staff members (i.e. RN, RRT, Exercise Physiologist, Exercise Specialist, LPN, Dietitian, P.T., Certified Respiratory Therapist, etc. if they are under the direct supervision of the CR/PR manager)

In order to complete the roster for the **REGISTRY**, you must have one for each of the following: Administrator (CEO), Medical Director, Program Director, Registry Principal User, Registry Secondary User and Professional staff members (i.e. RN, RRT, Exercise Physiologist, Exercise Specialist, LPN, Dietitian, P.T., Certified Respiratory Therapist, etc. if they are under the direct supervision of the CR/PR manager)

ID	Name	Email Address	Relationship		
230964	Kate Maude		Registry Secondary User	(change relationship)	(delete)
108387	Kullan Buckrop	kbuckrop@aacvpr.org	Registry Principal User	(change relationship)	
108387	Kullan Buckrop	kbuckrop@aacvpr.org	Registry User	(change relationship)	
235862	test tester	rs@s.com	Certification Secondary Contact	(change relationship)	(delete)
156081	Toya Davis	TODAVIS@AACVPR.ORG	Certification Primary Contact	(change relationship)	(delete)

1

Page size: 5

5 items in 1 pages

Tasks

- [Add a Contact](#)

- Staff Competencies
- Individual Treatment Plan (ITP)
including Exercise Prescription
- Medical Emergencies
- Emergency Preparedness
- Exercise Prescription Policy
- **Performance Measures - NEW**

Staff Competencies

For AACVPR Program Certification, programs must provide evidence of a **minimum of four different** assessed competencies specific to the Core Competencies (CR or PR) for **each staff member**

Must include answers for two questions

1. Objective for the competency?
2. Tool or method used to assess staff are competent?



Ways to assess competency

Check off stations with detail

Test/quizzes

Article review with post test

In-service with post test

***CCRP Certification**

Core Competencies for Cardiac Rehabilitation/Secondary Prevention Professionals:

2010 Update

POSITION STATEMENT OF THE AMERICAN ASSOCIATION OF
CARDIOVASCULAR AND PULMONARY REHABILITATION



Larry F. Hamm, PhD, FAACVPR, Chair; Bonnie K. Sanderson, PhD, RN, FAACVPR; Philip A. Ades, MD, FAACVPR; Kathy Berra, MSN, ANP, FAACVPR; Leonard A. Kaminsky, PhD; Jeffrey L. Roitman, EdD; Mark A. Williams, PhD, FAACVPR

Hamm et al. Journal of Cardiopulmonary Rehabilitation and Prevention 2011; 31:2-10.

Core Competencies - CARDIAC

- Patient assessment
- Nutritional counseling
- Weight management
- Blood pressure management
- Lipid management
- Diabetes management
- Tobacco cessation
- Psychosocial management
- Physical activity counseling
- Exercise training evaluation



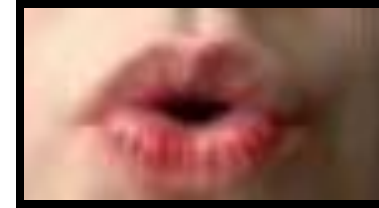
Clinical Competency Guidelines for Pulmonary Rehabilitation Professionals



POSITION STATEMENT OF THE AMERICAN
ASSOCIATION OF CARDIOVASCULAR AND
PULMONARY REHABILITATION

Eileen Collins, PhD, RN, Gerene Bauldoff, PhD, RN ,
Brian Carlin, MD, Rebecca Crouch, PT, DPT,
Charles F. Emery, PhD, Chris Garvey, FNP, MSN, MPA,
Lana Hilling, RCP, Trina Limberg, BS, RRT,
Richard ZuWallack, MD, Linda Nici, MD

Journal of Cardiopulmonary Rehabilitation and Prevention 2014; 34: 291-302



- Patient Assessment and Management
- Dyspnea Assessment and Management
- Oxygen Assessment and Management
- Collaborative Self Management
- Adherence
- Medications/Therapeutics
- Diseases Not Related to COPD
- Exercise Testing
- Exercise Training
- Psychosocial Management
- Tobacco Cessation
- Emergency Responses for Patients and Program Personnel
- Universal Standard Precautions

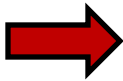
Staff Competencies

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

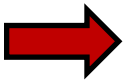
- 1: Objectives
2. The specific tool or method used for assessment

Blood pressure management

Blood Pressure Management Competency Objectives:



Blood Pressure Management Tool or Method Used to Assess Competency



Check all staff that possess this competency

☐

Neil Meredith

Date of Competency:

☐

Kate Murphy

Date of Competency:

2018 Application Highlights

Staff Competencies

- **No significant changes from 2017**
- Competencies must be assessed for all professional/clinical staff who directly report to the Cardiac or Pulmonary Rehab director/coordinator/manager
- Please DO NOT provide competencies for the program director/coordinator/ manager, Dietitians, Psychologists, Pharmacists or other specialists who are involved with patient care, but only in a supportive capacity rather than day-to-day rehabilitation
- **A minimum of four (4) different assessed competencies FOR EACH STAFF MEMBER specific to the published Core Competencies for Cardiac and Pulmonary Rehabilitation**
- Provide competency objectives and the tool or method used to assess that staff is competent. Return demonstration/Check-off station can be used but it must include some detail of the assessment

The Centers for Medicare & Medicaid Services (CMS) 42 CFR 410.49 and 410.47- cardiac rehabilitation and intensive cardiac rehabilitation programs and pulmonary rehabilitation programs

Conditions of Coverage states: *Components of a cardiac rehabilitation and intensive cardiac rehabilitation programs and pulmonary rehabilitation programs must include all of the following:*

- (i)** Physician-prescribed exercise each day cardiac rehabilitation items and services are furnished.
- (ii)** Cardiac risk factor modification, including education, counseling, and behavioral intervention, tailored to the patients' individual needs.
- (iii)** Psychosocial assessment.
- (iv)** Outcomes assessment.
- (v)** An individualized treatment plan detailing how components are utilized for each patient. The individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.”

Because each MAC across the country enforces this regulation differently, it is left up to the individual programs to contact their MAC or AACVPR Reimbursement Chair to learn how your MAC interprets these regulations for your facility/location.

ITP Requirements

- Upload COMPLETED, **HIPAA compliant** Cardiac or Pulmonary ITP
- ITP must be a single comprehensive document. (It does not need to be one page)
- ITP must be for an actual patient that has completed all required elements and steps.
- Assessment and reassessment data must be on the ITP
 - Do not submit assessment tools
- Reassessments should include “**progress toward goal**” information
- ITP must be completed in the data collection period (2017)
- Must include physician signatures and dates at initial assessment, at least one reassessment and at discharge
- Must include at least one “ACTIVE” core component
- *For Pulmonary Rehab, ITP must be submitted for a patient using oxygen*
- Identify the patient’s first day of exercise and the physician signature dates for the initial assessment, each reassessment and discharge/follow-up

Individual Treatment Plan (ITP)

Core Elements:

1. Exercise
2. Nutrition
3. Psychosocial
4. Other Core Components/Risk Factors as applicable to individual patient
5. Oxygen use and titration (required for Pulmonary Rehab application)

Four Required Steps:



1. **Assessment**
2. **Plan:** Includes Goals/Interventions and Education ***including initial exercise prescription with mode, frequency, duration and intensity***
3. **Reassessment:** With MD signature and date at least every 30 days
4. **Discharge/Follow-Up**

Cardiac ITP Requirements

- **Exercise Assessment**
- **Exercise Plan**
 - Goals
 - Interventions
 - *Initial 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**
- **Other Core Components/Risk Factors as appropriate (diabetes, HTN, obesity, medications, tobacco cessation, etc.)**
- **Assessment**
- **Plan**
 - Goals
 - Interventions
 - Education
- **Reassessment**
- **Discharge/Follow-up**

Pulmonary ITP Requirements

- **Oxygen Assessment**
- **Oxygen use & titration Plan**
 - Goals
 - Interventions/Education
- **Oxygen Reassessment**
- **Oxygen Discharge/Follow-up**
- **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**
- **Other Core Components/Risk Factors as appropriate** (Tobacco cessation, Environmental factors, Medications in particular inhaler medications, and Prevention or Management of Exacerbations, etc)
- **Assessment**
- **Plan**
 - Goals
 - Interventions/Education
- **Reassessment**
- **Discharge/Follow-up**



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Plan	
<u>Interventions</u>	
☐	Social service consult
☐	Advance Directives consult
☐	Physician referral
☐	Stress Management
☐	Discuss sleep patterns
☐	Discuss sex and heart disease
☐	Emotional support
☐	Spiritual support
Comments:	
Stress and Wellness:	
Humor:	
Ways of Thinking	
Emotional/Spiritual:	
Signs and symptoms of depression	
Sleep patterns:	
Advance Directives:	
Sex and heart disease:	
<u>Education (Date Completed)</u>	
Goal 1:	
Goal 2:	
Goal 3:	
Goal 4:	
Goal 5:	
<u>Target Goals</u>	

☐	Risk factor education
☐	Medication compliance
☐	Medication knowledge
☐	Cardiac education
Plan	
<u>Interventions</u>	
☐	Smoking cessation consult
☐	Education classes as needed
☐	Class schedule given
☐	Individual educational counseling
☐	Review knowledge test
<u>Education (Date Completed)</u>	
Smoking cessation:	
Effects of diabetes on heart	
Signs/symptoms of	
hypo/hyper-glycemia:	
Daily weights:	
Diuretics:	
CHF symptoms to report:	
Nitro use:	
<u>Target Goals</u>	
Goal 1:	
Goal 2:	
Goal 3:	
Goal 4:	
Goal 5:	
Scheduled appointments:	
Date/time:	
<u>Physician Comments</u>	
☐	No changes, proceed with rehab
☐	Add/change the following:
Physician Signature / Date:	



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Promoting Health & Preventing Disease

PSYCHO/SOCIAL

Discharge

Occupation

☐ Currently working

Job description:

Return to work date:

☐ Retired

☐ Unemployed

☐ Disabled

Comments:

Ferrans and Powers

score:

Improved score: Y N

% of change from

admit:

Hospital Anxiety and Depression score:

Anxiety

Depression

Improved score Y N

Plan

Education needs met Y N

Refer to Social Services Y N

Physician referral Y N

Refer for Advance Directiv Y N

Goals (Met, Not met, In progress, NA)

Goal 1:

Goal 2:

Goal 3:

Goal 4:

Goal 5:

OTHER CORE COMPONENTS

Discharge

Knowledge test score:

Improved score Y N

% of change from
admit:

Diabetes

☐ N/A

Fasting blood glucose:

HbA1C:

Medication changes:

Tobacco Use

☐ N/A

Change in use Y N

Comments:

Stage of Change:

CHF

Checks weight daily Y N

Knows s/s to report Y N

Compliant with medication Y N

Plan

Education needs met Y N

Refer to Diabetes Center Y N

Refer to Smoking Cessati Y N

Goals (Met, Not met, In progress, NA)

Goal 1:

Goal 2:

Goal 3:

Goal 4:

Goal 5:

Discharge notes:



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Promoting Health & Preventing Disease

Name:	DOB:	Phase:	
Risk Factor Assessment	Risk Factor Assessment	Risk Factor Assessment	Risk Factor Assessment
Initial Assessment Date:	Re-Assessment Date:	Re-Assessment Date:	Follow-up/Discharge Date:
Stages of Change: pre-contemp	Stages of Change: pre-contemp	Stages of Change: pre-contemp	Stages of Change: pre-contemp
contemp,prep,act,maint,relapse	contemp,prep,act,maint,relapse	contemp,prep,act,maint,relapse	contemp,prep,act,maint,relapse
CV Knowledge Test Score ____			CV Knowledge Test Score ____
Hypertension Y N Meds Diet	Hypertension Y N Meds Diet	Hypertension Y N Meds Diet	Hypertension Y N Meds Diet
Rest BP ____ Exercise BP ____	Rest BP ____ Exercise BP ____	Rest BP ____ Exercise BP ____	Rest BP ____ Exercise BP ____
Meds: _____	Meds: _____	Meds: _____	Meds: _____
Lipids (date:____) ☐ No recent labs	Lipids (date:____) ☐ No recent labs	Lipids (date:____) ☐ No recent labs	Lipids (date:____) ☐ No recent labs
Total Chol ____ HDL ____ LDL ____	Total Chol ____ HDL ____ LDL ____	Total Chol ____ HDL ____ LDL ____	Total Chol ____ HDL ____ LDL ____
Trig ____ TC/HDL ratio ____	Trig ____ TC/HDL ratio ____	Trig ____ TC/HDL ratio ____	Trig ____ TC/HDL ratio ____
Lipid lowering med _____	Lipid lowering med _____	Lipid lowering med _____	Lipid lowering med _____
Diabetes Y N N/A	Diabetes Y N N/A	Diabetes Y N N/A	Diabetes Y N N/A
Home monitor Y N Frequency ____	FBS/date ____ HgbA1C/date ____	FBS/date ____ HgbA1C/date ____	FBS/date ____ HgbA1C/date ____
FBS/date ____ HgbA1C/date ____	Diabetes med _____	Diabetes med _____	Diabetes med _____
Diabetes med _____	Referral to DM Education Y N	Referral to DM Education Y N	Referral to DM Education Y N
Referral to DM Education Y N			
Plan/Education	Plan/Education Classes ☐ declined	Plan/Education Classes ☐ declined	Plan/Education Classes ☐ declined
☐ Regular assessment of BP / Lipids / DM	☐ Education class schedule given	☐ Education class schedule given	Risk Factor Education
☐ Weekly body weight assessment	High Cholesterol ____	High Cholesterol ____	Goals Met: Y N
☐ Individual dietitian consultation	Congestive Heart Failure ____	Congestive Heart Failure ____	(attended 5 of 6 classes)
☐ Practice lifestyle modification	What is CAD? ____	What is CAD? ____	
☐ Attend education classes / ☐ schedule	Secondary Prevention CVD ____	Secondary Prevention CVD ____	
	Diabetes and CVD ____	Diabetes and CVD ____	
	Managing Your HTN ____	Managing Your HTN ____	
	☐ EDUCATION CLASSES COMPLETED	☐ EDUCATION CLASSES COMPLETED	
Patient Goals	Patient/Progression Notes:	Patient/Progression Notes:	Patient Goals Met: Y N
1.BP control <140/90 130/80 for DM/CKD			Discharge Plan:
2.Lipids: LDL<100 LDL<70 for CVD			D/C Notes:
3.DM: HgbA1C<7.0%			
4.Attend all education classes			
5.Medication adherence			

- Please note that AACVPR does not endorse any ITP or ITP format published by telemetry or electronic medical record companies
- Your ITP needs to tell the patient's rehab story from initial assessment to discharge from the program. Details are important!

- Name
- Date of birth
- Telephone numbers
- Fax numbers
- Electronic email addresses
- Social Security number
- Medical record number
- Health plan beneficiary numbers
- Account numbers
- Certificate and license numbers
- Vehicle identifiers, serial numbers including license plate numbers
- Medical device identifiers including serial numbers
- Internet universal resource locators (URLs)
- Internet protocol (IP) addresses
- Biometric identifiers including fingerprints and voice prints
- Full face photographic images
- Any other unique identifying number, characteristics or code
- All geographic subdivisions smaller than a state, including county, city, street address, precinct, zip code

2018 Application Highlights

Individual Treatment Plan

- Must include clearly labeled elements and key steps
- The initial exercise prescription requirement will be assessed within the ITP. You will not be asked to submit a separate initial exercise prescription
- There must be a physician signature and date for the initial assessment, at least one reassessment and at discharge
- At reassessment, checking boxes such as “On-going, In-Progress and MET” without any reassessment data or details about progress toward goal will be denied
- Must include at least one “**ACTIVE**” core component - HTN, DM, etc. and assessed as one element (Example: If Diabetes is assessed in Nutrition, Diabetes can’t be used as an Other Core Component)
- **For Pulmonary Rehab, ITP submitted must be for a patient using oxygen**
- Identify the patient’s first day of exercise and MD signature dates
- The completed ITP must be from 2017. If any assessments are not from 2017, the ITP will not meet the certification requirements
- HIPAA violations will lead to an automatic denial of the page

Medical Emergencies

For the purposes of AACVPR certification/recertification, written, department specific policies/protocols are required for the following:



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

- A department specific policy addressing all nine medical emergency conditions. They can be in separate policies and protocols for each specific condition or in one combined policy.
- Policies specific to CR/PR and specific to the role of the CR/PR staff in managing the emergency situation. .
- Medical emergency policies must be detailed beyond calling 911
- Medical emergency policies must address the treatment 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.)
- Resolution is defined as a transfer to another level of care.
- If policy refers to hospital-wide policy, submit all related policies. (i.e. Code Blue Policy, Code White Policy)

TREATMENT

TREATMENT

Resolution

Resolution

PURPOSE:

To establish guidelines concerning the appropriate procedure for the treatment of medical emergencies within Cardiac and Vascular Rehabilitation.

APPLIES TO:

All staff of Cardiac and Vascular Rehabilitation at Lexington Medical Center-Lexington.

POLICY:

Appropriate interventions will be followed for patients who are experiencing medical emergencies. **The referring physician and/or Medical Director will be notified of any changes in the patient's condition requiring medical advice.**

Chest Pain/Angina

1. If a patient develops chest pain/angina, he/she should immediately stop exercise training and rest. A staff member will monitor vital signs, attach heart monitor if not already wearing a monitor, assess heart rhythm and heart rate, and inquire about the character of the pain, i.e. location, intensity, duration, quality, radiation and recent frequency of the pain.
2. If the pain is not relieved by rest, the clinical nurse may initiate the administration of nitroglycerin and/or oxygen therapy. The nurse may give NTG SL 0.4mg (1/150) sublingually as needed at 5 minute intervals for a maximum of 3 doses, titrating to pain and/or blood pressure. Oxygen therapy may be administered at 2 liters/min via nasal cannula. The patient may be laid down on a stretcher to assist with the improvement of the medical condition.
3. The patient's cardiologists and/or primary care physician will be notified or the Program Medical Director can also be contacted.
4. If the chest pain/angina persists or increases, the patient will be transported immediately to Urgent Care for more intensive assessment and treatment. If the patient deteriorates rapidly to the point of an acute emergency, the LMC-Lexington Mayday Protocol will be activated.

Acute Dyspnea Management

“Acute” = new or different shortness of breath rating ≥ 5 on 1 – 10 scale (5 = severe) for rating perceived dyspnea (RPD)

	During exercise	At Rest
TREATMENT	Stop exercise and have pt sit in chair +	Hold exercise +
	Assess: vital signs, O2 sat, lung sounds	Assess: vital signs, O2 sat, lung sounds, weight change
	↓	↓
TREATMENT	O2 sat <88% apply O2 2-4L n/c If Sat > 88% and SOB decreases with sitting, continue to assess and terminate exercise for the day and notify MD	O2 sat < 88% start O2 at 2-4l n/c If Sat >88% and SOB decreases with sitting, abort exercise for the day and notify MD
	↓	↓
Resolution	Notify patient's MD & follow orders. No MD response or worsening of patients condition, transfer to Med Express via WC	Notify patient's MD & follow orders. No MD response or worsening of patients condition, transfer to Med Express via WC
	↓	↓
	Notify patient's family	Notify patients family
	↓	↓
Resolution	Complete & send Change in Medical Condition Form to MD	Complete & send Change in Medical Condition form to MD

2018 Application Highlights

Medical Emergencies

- **No significant changes from 2017**
- Submission of the required nine (9) medical emergency policies/protocols as listed on the application.
- Policies/protocols must explain your department's care of the patient from the onset of symptoms until resolution of the situation. **Resolution is defined as a transfer to another level of care (transfer to the ED, hospital admission, physician office or discharged to home)**
- Any reference to a supporting policy must also be uploaded into the application. **Example:** Department specific policy for cardiac arrest refers to following the hospital-wide "Code Blue" policy during the emergency. The Code Blue policy must be uploaded.
- Submitting only an ACLS algorithm with no details would not be acceptable.

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 Cardiac Rehabilitation department. There must be documentation verifying the readiness of the emergency equipment for each day the program is in operation.

- **Part 1:** Submission of one month documentation of daily verification of readiness for the **Defibrillator/AED** and **Portable Oxygen** for each day the program is in operation
- **Part 2:** Attestation that Defibrillator/AED, Portable Oxygen and airway management equipment are readily available to the exercise areas
- **Part 3:** Submission of 4 different medical emergency in-services from the nine (9) required medical emergencies on the application



Date of In-Service (Tachycardia)

3/26/2015

Bradycardia

Brief description of medical emergency in-service

The inservice was a review of an actual case when an 84yo male patient noted that his BP was unusually high, 158/72, compared to his normal BP of 126/60, and his heart rate was low at about 34bpm. BP 150/66. Patient was put on the cardiac monitor and monitor showed atrial fib/flutter with PVC's at rate of 28-40bpm. Pt. denied any symptoms other than being "tired". Oxygen was put on the patient at 2l/min via nasal cannula. Call was placed to the patient's cardiologist who advised that we transfer the patient to Urgent Care for further evaluation. Urgent Care was called to come to transport the patient, and report was given to the RN in charge. Urgent Care staff came and transported the patient down to the Urgent Care dept. via stretcher with cardiac monitor. Review of the event determined that proper procedures were followed. The event was discussed with staff as a learning opportunity for some of the newer staff, since this patient was relatively asymptomatic, but had a very low heart rate at times.

- **No significant changes from 2017**
- Complete three areas of focus for this page
- **Part 1:** Upload daily verification of readiness for the **Defibrillator/AED** and **Portable Oxygen**. Make sure to write in “**CLOSED**” for the days not in operation.
- **Part 2:** Attest that the Defibrillator/AED, Portable Oxygen and airway management equipment are readily available to the exercise areas
- **Part 3:** Submission of four (4) different department medical emergency in-services related to the nine (9) medical emergencies specific to CR/PR. These should be conducted between **1/1/2017 through 12/31/17**
 - *In-services can be an education or training session, a mock scenario or a review of an actual emergency.*

Exercise Prescription Policy

- A written policy must be in place that details how an initial exercise prescription for cardiac and pulmonary rehab is developed, modified and advanced toward the patient's discharge goals. The policy must contain all required elements of the exercise prescription: mode, frequency, duration and intensity. Progression guidelines can be included in the policy but they are not a required component for Program Certification
- **Pulmonary Rehab programs must include an oxygen saturation and titration policy. This policy must detail the assessment and treatment of oxygen saturation at rest AND during exercise**



Exercise Prescription for the Cardiovascular and Pulmonary Participant

PURPOSE

1. To establish guidelines for prescribing exercise and activity for Cardiovascular and Pulmonary Rehabilitation (CVPR) participants that ensures their safety during participation.
2. To establish guidelines for exercise prescription which enhance cardiopulmonary endurance, physical fitness, body composition, flexibility, and muscular strength/endurance and for the Pulmonary Rehabilitation (PR) participant respiratory muscle training.
3. To establish guidelines for exercise prescriptions which promote health by reducing risk for future development of recurrence of disease and increase level of independence in Activities of Daily Living (ADL's).

POLICY

1. Exercise will follow specific guidelines set forth in current editions of "Guidelines for Exercise Testing and Prescription" from the American College of Sports Medicine (ACSM) as well as "Guidelines for Cardiac Rehabilitation and Secondary Prevention Programs" and "Guidelines for Pulmonary Rehabilitation Programs" from the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR).
2. The exercise prescription will address the following components giving specific recommendations within the various phases.
 - A. Warm-up
 1. Patient will be instructed to begin exercise on equipment at a slower pace, gradually increasing speed or intensity to facilitate the patient's transition from rest to exercise.
3. Cardiorespiratory endurance
 - A. The exercise prescription will designate the mode, intensity, duration, frequency, and progression of the cardiorespiratory exercise to be performed by the participant.
 1. Mode: the type of activity used

2. Intensity: the target heart rate (THR), level of Rated Perceived Exertion (RPE), level of Rated Perceived Dyspnea (RPE for PR patient), and functional capacity at which the participant is to be exercising
 3. Duration: amount of time per exercise
 4. Frequency: number of days of exercise per week
 5. Progression: how the exercise prescription is adjusted in intensity, duration, and/or frequency to meet the stated goals of the individual participant and the exercise program
- B. The exercise prescription will utilize various types of training depending on the level and stage of conditioning.
1. Interval training: work followed by a brief rest period to be followed by work OR short period of increased workload followed by return to previous workload.
 2. Continuous training: imposes a submaximal energy requirement that is consistent throughout the training period.
4. Muscular strength training/weight training
- A. Patients will be shown a weight routine to be performed after aerobic exercise is complete. Patients may utilize free weights/resistance bands/weight machine.
 - B. Patients will be started at lower weight resistance as indicated by assessed ability. Increase resistance as patient tolerates.
 - C. Patients will perform one set of 10 to 15 repetitions of exercises, suggested three times per week.
 - D. Emphasize that exercises should be done slowly, both when contracting and relaxing the muscles.
 - E. Emphasize gradual progression or weight and repetitions as well as utilizing correct breathing technique with resistance exercise.
 - F. Weights will be advanced with the guidance of the CVPR staff.

Exercise Prescription Policy Example



4. After initial assessment patients will begin warm up. Warm up will consist of low intensity exercise on the patient's initial exercise modality.
5. Exercise modality will be any activity that uses the large muscle groups for a sustained period of time and is considered aerobic in nature. Participants will utilize treadmill, hall walking, exercise bike, upper body ergometer, elliptical trainer, NuStep, Air Dyne, REX, etc. PR participants will be encouraged to utilize upper body ergometer or Nu Step for at least 10 minutes each session.
6. Intensity: as determined by the referring physician using any of the above methods. These methods have been described above.
 - A. Cardiac participants - Intensity as determined by any of the above methods, maintaining HR within THR and without increase in cardiac arrhythmias or significant BP abnormalities. A participant's BP will be checked with at least one exercise modality when beginning program. When a participant has demonstrated acceptable BP at rest and with exercise with at least six consecutive exercise sessions, BP will be checked only at rest and if/when assessed necessary. The RPE should fall in the range of 3-4.
 - B. Pulmonary participants - Intensity as determined by the referring physician, pulse oximetry > 90% unless otherwise specified by referring physician, RPE 3-4, Dyspnea scale 3-4, or other symptoms. Pulse oximetry will be checked on each exercise modality to maintain oxygenation > 90%. When a patient's pulse oximetry is adequate on the arm ergometer for at least six exercise sessions, pulse oximetry will no longer be assessed on the arm ergometer unless CVPR assess need to measure.
7. Duration: will depend on the participant's individual response and level of conditioning. Duration should be gradually increased from 10 total minutes to 40 minutes, as the functional capacity and clinical status improve. While in the Phase II program, the aerobic exercise time will be 30 - 40 minutes. When working with debilitated participants, interval training may be utilized initially. By increasing exercise time and decreasing rest time, the participant is gradually progressed to continuous training.
8. Frequency: 2-3 exercise sessions per week in addition to a home exercise program are recommended. Phase II is considered to be 3 sessions per week for 6-12 weeks, depending upon status of patient, patient's continued exercise progression and their insurance coverage.
9. Progression: the exercise prescription is adjusted by the CVPR staff under the supervision of the Medical Director using the guidelines of the ACSM and the AACVPR. The THR range will be established as 60-85% of age predicted maximum HR at the initiation of Phase II Cardiac Rehabilitation and documented in the ITP. When the cardiac participant begins to show signs of conditioning, the exercise intensity and duration will be adjusted so that the participant remains within his/her THR. The duration is increased initially prior to gradually increasing the intensity. The participant's RPE must still remain in the 3-4. Cardiac exercise prescription is updated and signed off in the ITP by the Cardiac Medical Director every 30 days. Progression for the Pulmonary participant is adjusted as exercise tolerance increases using the participant's pulse oximetry, RPE of 3-5 and Dyspnea scale of no greater than 3-4.
10. After the desired functional/exercise capacity has been attained, long-term maintenance is the goal of this exercise program.

- Pulmonary Rehab applicants must include a policy detailing assessment and treatment of oxygen saturation at rest and during the exercise session.
- The policy should provide information in relation to de-saturation during exercise and the specific treatment involved to ensure patient safety and maximal exercise benefit.
- **Example:** If oxygen saturation falls below 88%, initiate supplemental oxygen per nasal cannula at 2 liters/min to achieve an O₂ saturation reading > 88%.

2018 Application Highlights

Exercise Prescription Policy

- Must include an exercise prescription policy that details how the exercise prescription is developed, modified and advanced toward the patient's goals.
- It must include all required exercise prescription components including mode of exercise, frequency, duration and intensity. Progression guidelines are recommended but for Program Certification, they are not required.
- The components of ExRx policy need to be specific and provide detail.
- **Example:** Exercise equipment includes treadmills, bicycles, arm ergometers, rowing machines and weights. Just stating “aerobic equipment is used” adds an element of “gray” to the interpretation.
- **For Pulmonary Rehab applicants, please upload your oxygen saturation and titration policy. It must address management of oxygen at rest and during exercise.**

Performance Measures are here!!



- 7 new Performance Measures have been created to assess the effectiveness and impact of certain areas in your program along with challenging you to measure more meaningful outcomes
- Starting on the 2018 Program Certification application, you will no longer report “Outcome Categories or Domains” (Example: Clinical)
- You will need to start collecting data in 2017 for the 2018 application
- There are 4 Cardiac Rehab PM’s and 3 Pulmonary Rehab PM’s
- Each PM will have specific outcome measurement tools that will be required for use vs. picking any old outcome tool!
- Education modules have been developed for each Performance Measure and all information is available to the membership at www.aacvpr.org/pmresources

- **Measure Description:** The percentage of patients with COPD and ILD who are found to increase their functional capacity by at least 30 meters (98 feet), as measured by a standardized 6 minute walk test (6MWT) after participating in pulmonary rehabilitation (PR)
- **Numerator:** Number of patients who are found to increase their functional capacity by at least 30 meters (98 feet), as measured by 6MWT distance at PR program entry and completion
- **Denominator:** All patients with clinician diagnosed COPD and 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.

Performance Measure for Improvement in Functional Capacity at Completion of Pulmonary Rehabilitation (PR)

MEASURE DESCRIPTION:

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).

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 (98.43 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)

NUMERATOR:

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.

DENOMINATOR:

All 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).

PERIOD OF ASSESSMENT:

Up to twelve months

ATTRIBUTION:

PR program staff

SOURCES OF DATA:

Medical record or other database (e.g., administrative, clinical, registry)

RATIONALE:

The 6 minute walk test (6MWT) is a low-cost, reliable, accurate method to assess exercise capacity and response to treatment in persons with chronic lung disease. The test measures the distance walked on a 30 meter ((98.43 feet) corridor or track in 6 minutes (6MWTD). The test is valid in chronic lung disease, including COPD and ILD (1,2). It functional capacity in chronic lung disease.

Patients are asked to walk as far as possible in 6 minutes along a flat corridor (2). Dyspnea and subjective fatigue are measured before and after the 6MWT using validated measurement scales, such as the Borg C-R dyspnea scale. The distance walked is inversely related to risk of hospitalization in chronic respiratory disease

The GOLD Guidelines recommend that pulmonary rehabilitation be a part of the treatment plan for patients with moderate to severe COPD (4). Pulmonary rehabilitation improves several patient-centered outcomes, including quality of life, dyspnea, and functional capacity. In the updated Cochrane systematic review, improvement in functional capacity following pulmonary rehabilitation, as measured by increased six minute walk distance (6MWTD) of 48 meters; 95% CI: 32 to 65; n = 16 trials was reported (11). Cochrane Systematic Reviews also support PR in ILD and non-malignant dust-related lung diseases for improving patient-centered outcomes including quality of life, dyspnea, and functional capacity (12, 13). In 2002, the American Thoracic Society published guidelines for conducting 6 minute walk testing (4). Enright and Sherrill (1998) first reported reference equations for prediction of total distance walked in 6 minutes by healthy adults, providing predictive reference for the 6MWT (14). A recent review by Singh et al. (15) reported the 6MWT is reliable (intra-class correlation coefficients ranged from 0.82 to 0.99 in seven studies). They also report that the 6MWT has stronger correlations with peak work capacity ($r = 0.59-0.93$) and physical activity ($r = 0.40-0.85$) compared to respiratory function ($r = 0.10-0.59$). They also reported that responsiveness was moderate to high for the 6MWTD, with greater responsiveness to interventions that included exercise training. This review demonstrates the strength of the 6MWT as a test of functional capacity in persons with chronic lung disease (15). This performance measure allows pulmonary rehabilitation programs to assess the impact of interventions on a clinically meaningful assessment of functional capacity.

REFERENCES:

1. Holland AE, Spruit MA, Troosters T, Puhan MA, Pepin V, Saey D, et al. An official European Respiratory Society/American Thoracic Society technical standard: field walking tests in chronic respiratory disease. Eur Respir J 2014 44: 1428–1446.

Performance Measure: Improvement in Dyspnea at Completion of Pulmonary Rehabilitation

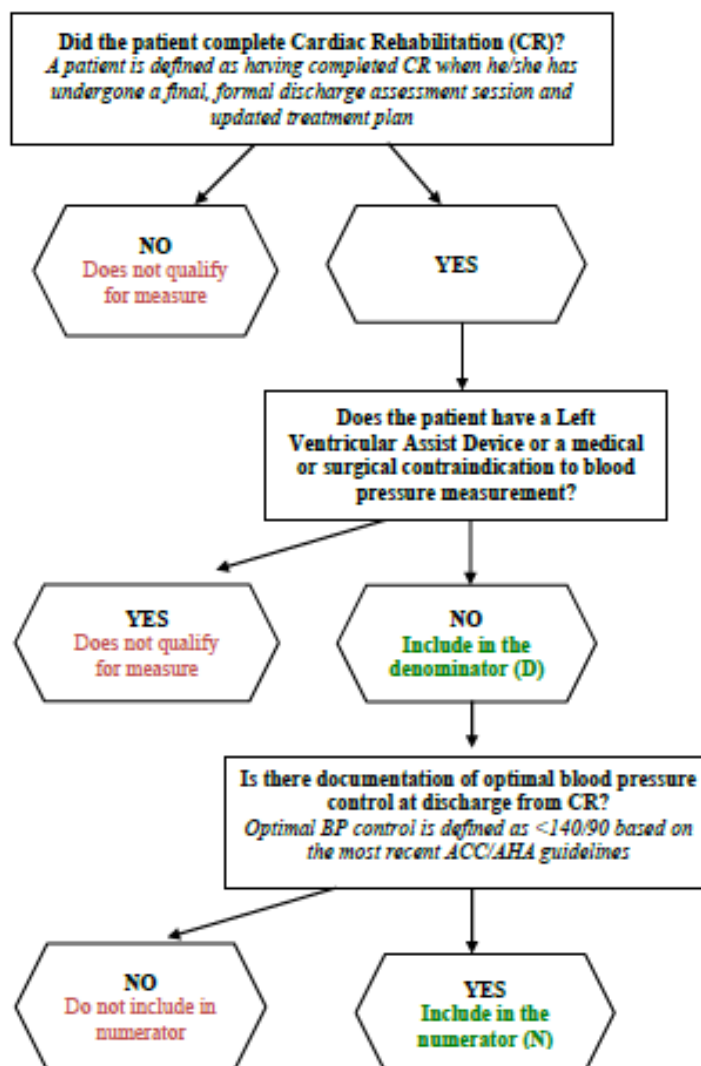
- **Measure Description:** The percentage of patients with a primary diagnosis of COPD or Interstitial Lung Disease (ILD), regardless of other diagnoses, who are found to increase their health-related quality of life score (HRQoL) as measured by a valid and reliable instrument after participating in pulmonary rehabilitation (PR).
- **Numerator:** 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.
- **Denominator:** All patients with a primary, clinician diagnosis of COPD or ILD, regardless of other diagnoses, who are able to complete a mMRC, UCSD SOBQ, or BDI/TDI to assess dyspnea at PR program entry and PR program completion, who have completed at least 10 PR sessions within a 3 month period.

- **Measure Description:** The percentage of patients with COPD and ILD 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)
- **Numerator:** Number of 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.
- **Denominator:** All 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.



- **Measure Description:** Percent of patients participating in the cardiac rehabilitation (CR) program who have optimal blood pressure (BP) control at program discharge, as defined by the most recent ACC/AHA guidelines (<140/90)
- **Numerator:** Number of patients with documented optimal blood pressure at discharge from cardiac rehabilitation
- **Denominator:** Number of patients who are discharged from a cardiac rehabilitation program during the measurement period

CR Optimal Blood Pressure Control Performance Measure Algorithm



Calculation Instructions

The % of patients participating in CR who have optimal BP control at program discharge = $\frac{N}{D} \times 100$

Performance Measure: Improvement in Functional Capacity at Completion of Cardiac Rehabilitation

- **Measure Description:** The percentage of patients who increase their functional capacity after participation in CR as measured by one of the following assessments: (1) symptom-limited graded exercise testing (increase in METs by at least 15%), (2) estimated exercise session peak METs (increase in METs by at least 40%) or (3) six minute walk test (6MWT) distance (increase in distance walked by at least 10%).
- **Numerator:** Number of patients who increase their functional capacity by the percent specified in the measure description from the beginning to the completion of their CR program, as measured by either symptom-limited graded exercise testing, estimated exercise peak METs, or 6MWT distance.
- **Denominator:** Number of patients who completed CR during the measurement period. A patient is defined as having completed CR when he/she has undergone a final, formal discharge assessment session and updated treatment plan.

- **Measure Description:** The percentage of patients with a positive depressive screen who experience a decrease in depressive symptoms as measured by changes in the PHQ-9, BDI II, PRFS or HADS after completion of CR
- **Numerator:** The number of patients with depression scores of mild or greater on CR admission screening who reduce symptom severity by at least one level by the time they complete the CR program.
- **Denominator:** The total number of patients with depression scores of mild or greater on CR admission screening who complete the CR program.

- **Measure Description:** Percent of patients participating in the cardiac rehabilitation (CR) program who received a tobacco cessation intervention if identified as a tobacco user AND received a relapse prevention intervention if identified as a recent tobacco user.
- **Numerator:** Patients who received a tobacco cessation intervention* if identified as a current tobacco user** **OR** Patients who received a relapse prevention intervention† if identified as a recent tobacco user††

To qualify for the numerator, the tobacco cessation or relapse prevention intervention must be documented in the patient's outpatient cardiac rehabilitation record. If a patient had previously received a treatment referral or pharmacotherapy from another clinician (such as the patient's primary physician or cardiologist), these interventions must be documented in the cardiac rehabilitation record in order to qualify for this performance measure.

- **Denominator:** Number of participants in the cardiac rehabilitation program during the measurement period who were identified as either a current or recent tobacco user at program entry. This includes all participants in the cardiac rehabilitation program regardless of length of participation in program (1 or more sessions.)

Performance Measure Requirements

- For each measure, please indicate the tool used, if indicated
- Indicate the numerator and denominator for the measure
- Calculate the Percent Increase
- “What is ONE change that you can make in your rehab process to help 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?”



- Education Resources – full listing of each measure
- Webcasts
- Flow Charts to assist with patient selection
- Education modules for each Performance Measure
- Data collection for the 2018 Program Certification Application will start April 1, 2017
- Visit <http://www.aacvpr.org/PMresources> for more information



Value in healthcare means efficient care with meaningful positive outcomes. Cardiac and pulmonary rehabilitation programs must be able to show their administrators, referring providers and C-suite that they improve patient outcomes and add value to cardiovascular and pulmonary services.

With this in mind, the Quality of Care Committee (QCC), in conjunction with members of the Program Certification and Registry Committees, developed six core outcomes measures and one process measure that programs can use to assess whether the care that they provide is linked to meaningful patient outcomes or whether they need to change the way they provide the care to improve outcomes. Developing these measures followed the basic principles of measure development outlined by the ACC/AHA Task Force on Performance Measures. Basically,

quality measures must include the following characteristics:

- Be based in scientific evidence
- Be clinically meaningful
- Be clearly defined
- Be reproducible across programs
- Use valid, reliable tools for measurement
- Be obtainable with reasonable cost and effort and in a reasonable time frame
- Have low likelihood of negative unintended consequences
- Allow those held accountable for the measure to track improvement as they change how they deliver care in order to improve the measure result

Over more than a year, the QCC used a series of structured surveys and discussions, based on the aforementioned characteristics, that included program managers, AACVPR leaders, medical directors and others to narrow down the categories to use for measures and then to

develop the measures. The measures were then tested for reliability and feasibility by 10 programs and then edited, based on test results. Two pulmonary measures did not need to be developed or tested because they were already endorsed by the National Quality Forum to meet the necessary characteristics.

These quality measures will be used for 2018 Program Certification, with data collection beginning in 2017, and are listed below. Future articles in this column will review how to use these measures to assess and improve your program.

Pulmonary Rehabilitation Outcomes Measures

- Improvement in Functional Capacity
- Improvement in Dyspnea
- Improvement in Health-Related Quality of Life

Cardiac Rehabilitation Outcomes Measures

- Improvement in Functional Capacity
- Blood Pressure Control
- Improvement in Depression

Cardiac Rehabilitation Process Measure

- Tobacco Use Intervention

Resources to learn more about how to use these measures in your program [here](#). ■

Value in healthcare means efficient care with meaningful positive outcomes.



- Visit www.aacvpr.org to look at the Application Draft copies
- Utilize the Certification FAQ's and resources
- Carefully read and review each page of the application
- Get prepared now and schedule competencies and emergency in-services
- Select an ITP that represents your program and tells the patient's story. The ITP must meet all stated requirements
- Medical Emergencies must provide detail about your department's management of an emergency situation. Key Point: Onset of symptoms to resolution of the issue
- Performance Measures: Put into place the specific tools and practice for each measure
- Remember: Data collection for 2018 starts April 1, 2017



Good Luck!!