Transcript: 2018 Heart Month Webinar
Cardiac Rehab Roundtable

Shanen Wright:
Hello and welcome to Cardiac Rehab Roundtable, a Home Health Quality Improvement National Campaign 2018 Heart Month webinar. We're pleased that so many of you have joined us today to hear from our expert panel of presenters and keep in mind that most of you are listening through your computer speakers today. However, you will have the opportunity to interact with our presenters at any time using the q&a feature in your WebEx player. If you don't see the q&a window, simply go to the upper right corner of your WebEx player, click on it and you'll see the box. We'll take as many questions as time will allow for at the end of the presentation today, but you can submit your questions at any time.

Today's session has been approved for 1.75 nursing CEUs by the Alabama State Nurses Association, an accredited approver by the American Nurses Credentialing Centers Commission on Accreditation and 1 CCU by the Federation of State Boards of Physical Therapy. The link is provided if you are unsure if your state except FSBPT approved hours. To receive the credits after participating in this 90 minute webinar, you will only need to complete an evaluation. Step by step instructions will be reviewed at the end of today's event.

Upon completion of today's event, we hope that each of you will be able to describe two of the Million Hearts 2022 cardiac rehabilitation priorities, explain three benefits and potential barriers of outpatient cardiac rehabilitation, discuss two alternatives for the home health setting when outpatient cardiac rehab is not possible and list three methods to improve home health patients' cardiac rehabilitation participation.

Our panel of experts has come together today to tell you all about cardiac rehab. First, we have Janet Wright. Janet is the Executive Director of Million Hearts, a national initiative co-led by CDC and CMS with the explicit goal to prevent 1 million heart attacks and strokes in the United States over five years. From 2008 to 2011, Dr. Wright served as Senior Vice President for Science and Quality at the American College of Cardiology. In that role, she provided medical and scientific oversight of clinical guidelines, performance measures, health policy statements and appropriate use criteria, quality improvement projects and the National Cardiovascular Data Registry, a suite of databases containing more than 12 million patient records in both inpatient and outpatient care settings.
Dr. Wright practiced cardiology for many years in Chico, California, and during those years, she served on ACC's Board of Trustees, NCQA's Physician Program Committee and the Center for Information Therapy, a nonprofit organization committed to the provision of personalized health information during each health encounter. Her primary interest with the design and implementation of systems of care to achieve optimal outcomes for patients and the full deployment of hooks, tricks and cues that help people get and stay healthy.

Our second panelist is Kate Traynor. Kate has over 30 years of experience in the field of cardiac rehabilitation. She is the Director of the Massachusetts General Hospital Cardiac Rehab Program, which is an AACDPR, American Association of Cardiovascular and Pulmonary Rehabilitation certified multidisciplinary cardiac rehab program. She is a fellow of the AACDPR and is currently the President-elect of the organization.

Our third panelist is Bud Langham. Bud is a physical therapist based in Dallas, Texas with extensive hospital home health and cardiac rehab experience. He has both provided cardiac rehab services in the clinic and been a director of a cardiac rehab service facility. In his current role as the Chief Clinical Officer of Encompass Health Home Health and Hospice Division, he oversees the cardiac programming for homebound cardiac patients. Bud is a member of the American Physical Therapy Association, serving in both the home health and geriatric sections.

At this time, it is my great pleasure to turn to today's presentation over to Dr. Janet Wright.

Janet Wright: Shanen, you are a hard act to follow Shanen, but I will do my best and I will just say at the outset, I am your warm up act for the experts in cardiac rehab and home health, Kate and Bud, who will follow. I'm very grateful for the opportunity to be with you all today and focus our attention and ideally, our action on getting more people who can benefit from cardiac rehab to get that service. That's really what today is all about. I'm particularly grateful to Cindy Sun and the home health, the HHQI team and to Cynthia Pamon, who's been leading this QI work with CMS.

I want to share with you the framework for Million Hearts. I'll talk broadly for a moment or two but then focus in on cardiac rehabilitation. This is a little change from our first five years, where we really focus primarily on public health or community based action under keeping people healthy and a few specific actions under optimizing care, which are really those things that happen within a healthcare setting and we talked about a focus on populations with a high burden and at high risk, but we were not happy with the degree to which we contributed to some progress in those subsets of the population, so we have
lifted up the concept of priority populations and made our structure, our framework a tripod and I'll go into a little bit more detail here.

In that upper left corner under keeping people healthy are the community based or population level interventions that we are sticking with for Million Hearts 2022, that is reducing sodium like we did, we worked on in the first five years, decreasing tobacco use, and we've added increasing physical activity over on the community side and I'll give you a little bit more detail on what that means in a moment. In the upper right hand corner are the priorities when it comes to healthcare. We are sticking with aspirin, blood pressure, cholesterol and smoking because of the huge impact that improvements in those measures can make on event rates. Getting very high performance levels on aspirin, blood pressure, cholesterol and smoking makes heart attacks and strokes and even kidney disease and dementia begin to drop quickly. As you see, we've added a focus on cardiac rehab here in healthcare and healthcare interventions, as well as engaging people in heart healthy behaviors. As many of you know one of the things that is in this category, it has to do with home monitoring or out of office monitoring of blood pressure.

As I mentioned, we have added a third leg to our framework and that is really driving attention and action on improving outcomes for four subsets of the population, blacks and African Americans with hypertension because the control rates in African Americans and black is much lower than in other races or ethnicities, the 35 to 64 year olds because we are seeing event rates around the country and in fact death rates rise from Maine to California in this particular age group.

Today, we're going to focus in and on people who've already had a heart attack or stroke who can deeply benefit from cardiac rehabilitation. Then the fourth subset we've chosen are those with mental illness or substance use disorders who also smoke. The evidence now shows that people who actually have in an example of substance use, two addictions, tobacco and another, actually are more successful if they try to address both of those at one time. Every time I say that it still surprises me but I've read the studies and I've listened to the experts and they tell me that it is so.

We will move now to a little bit more detail on the strategies under each of those large priority areas. On this slide, you will see the effective strategies at the community or population level, which will lead to reductions in sodium and tobacco use, and an increase in physical activity. You know Million Hearts is nothing if not audaciously ambitious and we are trying to achieve 20% improvements in each of these areas by the end of December of 2021. I'm happy to take any questions that you have about these and although all of these strategies that you see here are evidence based, they come from experts and
review of the literature. We may be undertaking additional strategies, but these are a good, healthy starter set.

Under optimizing care, I think for many of you, this will look very familiar. We have tried to detail again those strategies that work. We’ve seen it either in the literature or we’ve seen it in practice and clearly using teams, including the home health experts and cardiac rehab professionals is one way to help improve the ABCs as well as of course increase referral to, enrollment in, initiation of and participation in cardiac rehab. We'll talk a little bit more about that in the moment. When it comes to improving priority populations, again, I will go over the strategies for the other priorities, priority populations, but we'll focus in on those who’ve had a heart attack or stroke and clearly, what we’re trying to do there is drive participation in rehab, find our way, help people navigate the various obstacles and barriers that you'll find out more about in a moment so that they can achieve the benefits of participation. Some of those strategies that I think Kate will go into in more detail include automatic referral at the time of discharge, so instead of someone having to get a referral if they have an eligible diagnosis and they have no contraindications, there are electronic algorithms and order sets at the time of discharge that will make it more likely that that person is automatically enrolled.

Having a liaison visit with the family and that patient before they're discharged to acquaint them with the program of cardiac rehab to find out where the nearest facility is what would be most convenient and also ensuring a pretty rapid enrollment following discharge are all evidence based strategies that can help make sure that we don’t lose someone in that very important transition between hospital and home. We chose these priority populations based on the fact that the outcomes for these four subsets are quite different than outcomes for other people. There are effective and promising interventions and we have thank goodness lots of partners who are very well positioned to reach our priority populations. We realize that we may not have picked a priority population that resonates with you, but we would encourage you to use a similar criteria. Choose your priority population and get to work.

I just want to share a few slides showing some data from an analysis we did on 2013 fee for service beneficiaries. Now, the year is important because in 2013, heart failure had not been fully, heart failure was a new indication for cardiac rehab, so the data you see here will not include beneficiaries who would qualify because of heart failure. The analysis was done prior to that broadening of the coverage. In 2013, there were over 400,000 beneficiaries who are eligible for cardiac rehab and in the chart or the diagram that you see here, you can see that only 20% used cardiac rehab at least once. Of those who enrolled, in other words they got to at least one session, over 50% completed 25 or more. A full course of cardiac rehab is considered to be 36 sessions and 25 is considered to be a good, healthy dose.
We're going to go into this data a little bit more fully on this slide, again busy slide but to orient you, we're looking at the same data from 2013 overall by age group, younger and older than 65, by gender and then by race and ethnicity. The red columns capture those who are both eligible for cardiac rehab and they got to at least one session. The blue bars are those who initiated cardiac rehab and got to at least 25 sessions, that good healthy dose. You see a fair amount of variability there and I'll just show you on the next slide, we'll make this a little bit easier to go over in more detail. You'll see that overall participation, those who are eligible and initiated is quite low. Only 20% of the people who are eligible actually made it to one session and a fair amount of variability by both age and gender and ethnicity.

You know, stepping back from this, you could say it's coming for everybody regardless of your age and gender and ethnicity. It's not great for anybody but it's particularly bad for those younger than age 65 female and any color but white. On the next slide, you see something interesting is that this looks at again, the number of people who got to at least one session and then how many completed at least 25 and except for the age, the difference actually disappears, the differences that we saw earlier by gender and by race and ethnicity. It's such an important point that getting people to at least one session tends to help them overcome all of the many obstacles that helped to get them, that were there were in their way of getting in the door.

It's very important to know that a person cannot sign up for cardiac rehab themselves. They have to be referred and then there are an enormous number of hurdles between the time they are referred and the time they make it to that first session but those who do are at least more than 50% likely to get a good, healthy dose of this thing that helps them live longer, live free of disease and feel better. I'll just show you this, there's a fair amount of variability, both in initiation and in completion across the country. The data are now split out by census regions. As you see here, if we just look at the Mid and South Atlantic, you see pretty low initiation rates, 17% to 19% and yet those who actually make it to one have pretty high completion of at least 25 sessions, over 60%.

On the next slide, you'll see if we look at the West, sorry, West, West, North Central, there you see a really pretty high, in fact, the highest initiation rate. People are getting referred. They’re getting to that first session but actually on the lower side in terms of completion. Then most notably in the East, West, South Central sections of the country, which is encompassing what is known as the stroke belt, very high likelihood of heart disease, cardiovascular disease, the initiation rate is low. Utilization is low overall, but again, of those who get in the door, we’re seeing a pretty high percentage of completing 25 sessions or more so a lot of variability and a lot of things to be thinking about around the country.
One great thing is that a number of individuals and organizations around the country who had been working on cardiac rehabilitation for a long time are I would say sick and tired of only publishing articles that describe the problems or create taxonomies of how to categorize the types of hurdles and barriers. Those really have been pretty well identified. We can always learn more but we know a lot and all of the organizations listed on this chart want to fix this. They want to make sure that their actions are aligning and accelerating the delivery of cardiac rehab to every person in the country who is eligible and I'm so delighted that HQI is part of this collaborative. It meets by phone quarterly and they have designed an action plan.

I'll show you that in a moment, but a subgroup of that cardiac rehab collaborative generated this paper and out of this paper came not only a collection of high impact tested or very promising strategies that can help overcome the various obstacles and barriers, but they also generated an estimate that I think is pretty staggering and very important for all of us to know is that reaching the aim of 70% initiation rate for all of those who are eligible around the country, at least 70%, that would be raising this from 20% to 70% translates to 25,000 lives saved each year and 180,000 hospitalizations prevented, a huge impact on health and care and costs around the country.

I'll just share with you in closing and transferring the microphone to my colleague Kate Traynor, these are the five objectives of the 2018 cardiac rehab collaborative action plan. I'll just say we know that one of the problems with cardiac rehab is not enough people know about its value and its benefit and you're going to hear a lot about that on this seminar today. We know that one of the things, what I think is one of the things you guys could do so beautifully is to make sure that people that you're caring for understand the value, they understand whether they are eligible for cardiac rehab and as soon as possible for you to help them work through their individual barriers so that they can access those services and I think you'll hear very creative ways of getting that care for them if they cannot participate right now in a cardiac rehab program onsite.

This collaborative is committed to increasing the use of best practices. There are some and they're not as widely and systemically applied and so this group is really committed to surfacing those best practices and then making sure that programs know about them, programs and hospitals and clinicians. Building health equity into cardiac rehab, there are remarkable disparities. We only touched on a few, but making sure those go away, including the staffing of the programs. Increasing the sustainability of cardiac rehab programs through innovations, either in the delivery of the program itself, certainly we need payment systems that support innovative delivery systems and then measuring and monitoring and reporting on progress towards getting to 70% and that last...
one is squarely in the hands of the Million Hearts team, both at CMS and CDC and we take that very seriously.

Before I turn it over to Kate, I'll just mention that the Million Hearts team is working closely with AACDPR or on a cardiac rehab change package, so a set of tools and resources to lift up those evidence based strategies to accelerate the implementation of those and we're very excited about the birth of that later this year, ideally before the fall and we certainly will be coming back to you to make sure that you have access to that.

With that, I am delighted to transfer the microphone and the responsibility to Kate Traynor.

Kate Traynor:

Thank you, Janet and to all of you, thank you for inviting me to be part of this illustrious panel today. Before I start, I'd like to just really for a moment talk about Janet and how important and influential the work that she's done. I mean, this is a huge program. Many tenants and tentacles to it, but certainly the focus on cardiac rehab is so very much needed and so very much appreciated. I think Janet is a stellar example of how one person really can make a difference. Thank you, Janet and without any further ado, let's start to talk a little bit about cardiac rehab.

What is cardiac rehab? It is essentially a comprehensive multidisciplinary team and by multidisciplinary, I mean that you will find programs that employ cardiologists, nurses, nutritionists, exercise physiologists, physical therapists and a behavioral medicine specialist, be it a social worker, psychologist or psychiatrist, all surrounding a patient in the program to help them with their lifestyle management and as Janet mentioned, typically these programs allow upwards of 36 sessions over the course of generally 12 to 18 weeks and although, you know this says cardiac rehab is really a strategy and an intervention that has a huge ripple effect.

These secondary prevention programs can help patients to limit the effects of their cardiac illness and certainly to reduce the risk and the goal, obviously, is to prevent further events - infarctions and even sudden death. They have a focus on controlling cardiac symptoms and helping patients to first and foremost recognize those symptoms and to go further, to even stabilize the disease process and in fact reverse as much as possible, depending on the patient's compliance with some of these lifestyle modifications and it isn't just about the physical wellbeing of the patient but the most emotional, psychosocial and vocational aspects of patients and program participants benefit from their participation.
There are 10 key areas when a patient enters a cardiac rehab program that deserve attention or receive attention and are the focus of the interventions. The first begins, not unlike what you do with a patient in home health, health setting with patient assessment and this continues throughout the program so it isn’t a finite point of assessment. Every 30 days, as the patient continues through their 12 or 18 week program, there's a reevaluation of how things are progressing and finally at the end, there’s a measurement of outcomes or a final reevaluation reassessment of how much progress the patient has made in their time in the program. The initial assessment really focuses on baseline information to help identify pertinent and appropriate goals and tailor individual interventions for that person, so the evaluation will be inclusive of obviously cardiac history, pertinent diagnostic testing and lab results, physical exam, as well as the patient's own self-management and self-care and lifestyle management to help us understand to this point what they have done to enhance their own wellbeing.

Nutritional counseling is an important cornerstone of cardiac rehabilitation and the focus again on the initial evaluation and assessment is on what is it that the patients are eating, so the dietary composition from the standpoint of calories, as well as the focus on the content of the diet from the standpoint of saturated fat, cholesterol, whole grains, fruits and vegetables, sodium, alcohol and really a look at as well at their eating pattern. Lipids deserve a lot of attention and get that in cardiac rehab, so the lipid panel is the basis for the evaluation understanding where the person is as they begin the program, but looking at the management of that and whether the patient’s actually complying with the plan and you know, these 10 core areas are not mutually exclusive.

They all, as you will see, the management of one will have implications for other of the risk factors or other of the core components, but within the lipid management, certainly there's lifestyle variability or lifestyle factors that will impact their cholesterol management so their exercise patterns certainly, their dietary intake and most importantly to understand whether the patients are complying with their medication management if they’ve been prescribed and probably need to be prescribed a medication for that. The hypertension management, Janet touched on the new goals or the focus on blood pressure management, the goal being less than 130 over 80 and again, once looking at a comprehensive approach to managing that from the standpoint of medication compliance, lifestyle management.

Smoking cessation deserves a few minutes, certainly. It is the number one risk factor as we all know and understand and despite all of the efforts in any of these core areas, if a person continues to smoke cigarettes, it's unlikely that they'll derive a lot of benefit in all of the other lifestyle changes that they make if they continue to smoke. The most important variable here begins to look at this from the standpoint of where are they. Are they an active smoker? Are they
are recent quitter? The goal becomes either move them along that continuum to getting to complete cessation or preventing relapse if they've been a recent quitter.

The focus isn't just on cigarettes, so certainly cigarette smoking, but one has to give consideration for cigars, pipes, tube tobacco, as well as emerging more and more marijuana and certainly their exposures to secondhand smoke. There are a host of strategies at our disposal that we can use to help patients and it's important to know what they've used already and attempted to use and how much success they've had with that but certainly a cornerstone to smoking cessation management is nicotine replacement, which I want you all to understand and know is entirely safe in a cardiac population as well as the fact that there are other medications that can augment that and the other consideration within smoking cessation is what are their stress management strategies and psychosocial support. Often, folks that are smoking are using the nicotine in from cigarettes to treat their mood disorders, so if we get them to stop smoking often, their depressions and other mood disorders come to the fore, so having a really good understanding from the outset of what their other coping mechanisms are will be important or helping them to establish some new coping mechanisms.

Weight management obviously is important the goal being getting patients to an ideal body weight but that probably has to happen depending on what their starting point is in a progressive way but setting a reasonable attainable goal over the course of 12 or 18 week program is really what matters, so we may not ultimately get them to that BMI of 25 but moving them along the continuum toward it at a pace that's manageable and will allow them to be successful is what's very important. There also should be a consideration for waist circumference and measurement of waist circumference. Again, moving them for women to a goal of 35 and to men a goal of 40 inches or less.

Diabetes is an important comorbidity, certainly can wreak havoc with the cardiovascular system and so understanding what their history of their diabetes is, their own self-management and from the standpoint of what their lab values are revealing about their self-management, looking at their A1C and then helping them or understanding more about their lifestyle management, their exercise and activity patterns and certainly their own ability to test and measure and monitor their blood sugars at home. Again, the psychosocial management is important, especially focusing on adjustment to their cardiac illness, the implications that the cardiac illness may have on other aspects of their wellbeing, particularly vocational and looking at what supports they have and what mechanisms are in place to help them and whether or not we need to help them develop some new healthier adaptive strategies. Many of the mechanisms that they may be using may not be particularly helpful or adaptive so we want to help them promote healthy behaviors.
The last two areas really focus on getting patients more active and ascertaining where their baseline activity and exercise habits lie and how to move them to places that will make them a little bit more, help them to be more active and understand the value in that. Physical activity is separate from exercise training and exercise habits and physical activity is really their general activity level throughout the course of the day. They’re the activities of daily living, they’re vocational, they’re recreational and certainly moving them and there’s easy ways to help patients monitor that so you know we’ve begun to use a lot of, you’ll hear a little bit more later I think from Bud’s presentation about some ways to augment and measure those steps, if you will, or other ways of measuring physical activity at home and exercise training is a core component and a very important central concept in cardiac rehab, getting patients to be more physically active in a safe way, so designing a program that’s safe for them from the standpoint of warm up training and cool down but at an intensity that is appropriate for them. The principles of the exercise training lie in focusing on the frequency with which they need to exercise, the intensity which is safe for them and then the time so how much time each day and week should be spent on exercise as well as the modality or how are they going to exercise.

The hope is that we’re going to help them begin or continue a regular habit of exercise. That’s something that will sustain and endure beyond the end of the cardiac rehab program and the one thing that I do want to say quickly, I know, I think Cindy will come back to this at the end of the presentation that there’s a terrific HHQI website that I found, the HHQI University and there are some terrific webinars and educational offerings there that will reinforce some of the information about each of these 10 core areas.

The next slide really should probably be titled not who benefits but who can really avail themselves of this cardiac rehab program. I mean let’s face it, anybody who enters into a healthy lifestyle can benefit, whether they have heart disease or don’t have heart disease. It just makes good sense for all of us but there’s really strong evidence that there’s benefits to participating in programs as Janet pointed out, and that most payers now, with Medicare usually setting the pace and most payers following the lead of Medicare from the standpoint of coverage and criteria and all, this is a program and an intervention that’s available to patients and these are the patients who are eligible for programs. They aren't the only people certainly that will benefit from healthy lifestyle management, but they are the ones that the insurance coverage will provide the benefits for, so certainly it’s those with prior heart attack or stable angina and as Janet mentioned, the most recent addition to this list was the systolic heart failure population, being defined as the group of patients who have, who are at or below an ejection fraction of 35%, not yet available to patients with diastolic heart failure unfortunately.
Anybody who’s had a recent coronary intervention, whether it be a stent angioplasty, hysterectomy, certainly a good candidate for cardiac rehab and then the cardiac surgical populations that’s inclusive of bypass, valve replacement or repair, including TAVER as well as transplantation. I put an asterisk here around the peripheral artery disease population. Their indication is not for cardiac rehab per se, but there’s a new benefit category for patients with symptomatic PAD to get a supervised exercise training, so we’re beginning to include more of that population, and that’s a very recent development. The coverage determination was released this past fall so that’s the group of patients that if you’re seeing them in the home may be eligible for these supervised exercise programs as well.

What is the evidence around cardiac rehab and what does happen when a patient comes in, participates and fully benefits from a long term adherence? There are a number of ways that we see this ripple effect, certainly mortality overall has decreased. It’s an impressive reduction of 11% to 24%. Cardiac mortality also has helped with participation in cardiac rehab, and you can see there an impressive number of 26% to 31% and you know this is good as, if not better than some of our tried and true strategies of getting patients to take aspirin and statins. Hospitalizations are reduced for patients that enter into cardiac rehab and so obviously there’s some cost savings associated with that from the standpoint of healthcare utilization.

The programs can help patients to adhere to medications at the cornerstone and an emphasis as patients come through the program and certainly help in all those other very important areas around mood, quality of life and activity levels or functional status and cardiac rehab is what we call dose dependent, meaning that the more you do, the better off you are, and so we do know from some of the research that Janet put up as well as from a number of other studies that taking advantage of the full benefit can lead to risk reduction of heart attack and death and usually that 25 is considered a goal to get patients to or participants to but that’s certainly at 12 sessions or more, we begin to see that benefit for the person.

There are 14 areas here where you’re going to see the benefit of these secondary prevention programs and what’s most impressive is that of 10 out of these 14, there’s definite benefits and definite effects from participation in cardiac rehab. You can see that from the standpoint of the disease itself so it improves symptoms, it improves the triglyceride or lipid levels, glucose and then we move into the other risk factors that we know underlie cardiac disease and can be so challenging. It has great impact on exercise capacity and even some biological advantages and benefits from the standpoint of endothelial function and muscle strength and endurance, so lots of good reasons why patients need to and should be in these programs.
Really then, if this is a no brainer, what are the issues? They’re multiple and probably not going to be something foreign to you. These are going to be things that are very familiar to you. We just aren't getting enough patients referred to programs, and the reason for that is that there may be a perceived lack of understanding of the benefits of participation in cardiac rehab. Patients and families aren't getting clear signals from their care providers, be those physicians or others caring for them that so oftentimes, cardiac rehab programs are not as well aligned with the other services within their cardiology department as they could be and as Janet touched on, the whole mechanism for referring patients into programs isn’t as efficient and automatic as it needs to be.

There are also patient level barriers and these are probably near and dear and very clear to you. They are from the standpoint of logistics, so transportation getting patients from home to program can be challenging. Cost economics plays a role here from the standpoint of paying for parking, paying for co-payments. Many of them have some cost sharing to these kinds of cardiac rehab interventions and oftentimes, the programs are not as close as we would like them to be to the patients. Always, there are the competing responsibilities. Women in particular, having a problem, often it’s challenging for them to put themselves first and prioritize their own needs and certainly, the cultural language barriers so use of medical interpreters is essential to working with those population of patients that are non-English speaking.

What can we do about it? Certainly hospitals, there are some important implications here and that is to establish cardiac rehab as a hospital priority and to make, help patients move from hospital beds to cardiac rehabilitation programs and that rather than having an opting in in referral of patients to programs, that we have a more automatic process for that and the institution and introduction of electronic medical records has really enhanced our ability to more efficiently have these automatic processes in place and it's real important to engage the team. It does take a team to help patients. As you well know, you have youth teams in your home health settings, but everybody inpatient partnering with outpatient cardiac rehab staff, very important to work together to help move those patients and get those patients where they will get the help and services that are going to be so beneficial to them.

This includes helping to facilitate that bridging of the patient from hospital to home to cardiac rehab. There’s some real good evidence that if the process is automatic and we actually have patients leave the hospital with their first appointments, that will increase the fact that they enroll and get to those cardiac rehab programs and then once patients are in programs, it's incumbent upon the program staff to think about ways of improving the quality of the services they deliver to keep patients adhering and enrolled. That includes sending out reminder cards and making reminder phone calls to keep them in...
and even providing rewards along the way as they continue to matriculate and stay active in the programs.

I’m trying hard to think about the other obstacles that the patients we know or can be obstacles for patients from the standpoint of getting them into programs. The hours, certainly thinking about times of day, different days of the week options that might work for them that there are patients working and we’d like to consider making and availing them of these programs as well, so some early or late sessions important to have as a part of the overall program offering to offset some of those costs, out of pocket costs for patients around the standpoint of transportation to and from and certainly offering ways of helping to target certain groups within programs such as women who we know are having the most difficulty remaining in programs and adhering to program completion, and it’s important if you have these automatic processes that you actually look at how well you’re doing so that we really need to kind of that there is going to be a performance measure that looks at how well programs are or hospitals or performance, the standpoint of referring into programs but then important for programs to look at how well they’re managing the referrals and second, into successfully getting patients to comply with the programs.

This is a busy little slide but just to orient you a little bit the tan lines, really, this is to look at what are the costs by participation in programs, so if patients are getting into programs, how much healthcare are they utilizing versus patients who don’t get into programs and from what you can see, obviously the top darkest tan line to the lower sort of lighter tan lines, so those are the patients in programs, taking full advantage participating in 17 or more sessions and their cost of cardiac rehab, their utilization costs are much lower.

This looks at the role that hospitals play so that if we can begin to get these patients into programs and begin the process in the hospital and bridge them over, that’s going to be one of the most successful ways to do it and so it’s really incumbent that hospitals look at their processes and try hard to improve their processes to get patients where they need to be. These are programs specific, a nice little study that looked at program specific interventions to help increase participation and keep patients engaged and these were three very small little strategies that were used from the standpoint of setting a goal to that point A, which was setting a goal to get patients through the 36 sessions. Point B was providing an educational video to help them understand the benefits and finally, Point C was when they instituted some small rewards for patients at each every sixth sessions that they completed and with every one of those enhancements, you can see that our attendance and participation rates increased.

How does this and how should ideally in an ideal world would this work? That would be, there’s six simple steps, it’s identify the patients, get them visitation from an inpatient navigator or liaison while they’re in the hospital to talk about
getting into the program and scheduling their first visit, referring them into the program and then the program picking them up, getting them in, keeping them in and helping them to complete but I'd like to suggest that there's a step 3A, which is where we can work more closely with you. Those are for the patients that get referred to cardiac rehab but aren't quite ready to start because they need a little bit more time at home to get stronger or gain a little bit more strength or get a little bit of extra assistance. This is where Step 3A is important. It's an important transition and care and it's where we may see patients fall off, so that we can be working with you through educational efforts such as this, as well as encouraging you to reach out to your local programs and talk with them about patients that you see as eligible as you wrap up your services, very helpful to work together to keep patients moving along this continuum into step four, five and six.

There were two great studies and I don't know if these colleagues from NYU are on the phone today but Joey Feinberg and her colleagues at NYU looked at an adaptive, what's called an adaptive cardiac rehab program for use by home health providers and if you haven't seen these studies, I would suggest that you go in and take a look, but what they really did was tried to determine what would it take to provide cardiac rehabilitation in a home health setting and really what were the important aspects of that, and so for patients, what emerged was that patients needed a lot of help from the standpoint of understanding their heart disease and their symptom management, getting support from their families to understand that cardiac rehab is going to help them and getting the support of those caregivers to get them into programs and then identifying and working with them to help them work through the barriers for programs.

Those were the areas for patients that emerged as problems. For the caregivers, there was a number of things that they learned in their examination and one was that clearly there's a gap, both for the home health providers, well this will not be a surprise for you in communications to the patient's health providers, be it physicians or other members of the healthcare team as well as the home health providers needing a little bit more assistance with understanding cardiac rehab, understanding implications of things such as LVADs or technical devices and technologies that are used to manage patients and how to best evaluate and manage and anticipate what a person needs as a result of that.

Finally, just a little bit more information about the practical aspects of those 10 core components of cardiac rehab, particularly on exercise and where is Bud's presentation is going to be so very useful for you because he'll give you some tangible ideas about how to progress patients and start patients off as they're getting stronger at home. Finally, along with Janet's efforts with Million Hearts and all, the NIH has stepped up and now has opened and has dedicated research dollars to ways to think about an enhanced participation in cardiac
rehab and so the call for these proposals came through in the fall and we’re all waiting with bated breath to hear a little bit about who the awardees were for these but two key areas that are going to receive some funding and both being of course, increasing utilization of both traditional and community based cardiac rehab programs and then also looking at the targeted population of older adults and helping them to transition into programs and be successful there. Thank you again for your time and what I’d like to do now is pass the gavel to Bud and I’d be happy to take your questions at the end.

Bud Langham: Thank you very much, Kate. I appreciate that, really happy to be here today again. My name is Bud Langham. I’m the Chief Clinical Officer for Encompass Health, the Home Health and Hospice Divisions based out of Dallas, really happy to be talking about cardiac rehab today because I have a very personal connection. About 18 years ago, my dad had a heart attack. He had five bypasses. He did not initiate cardiac rehab despite my frustration and efforts and hustling and bickering. He has had a couple of cardiac events subsequently, and just recently again started cardiac rehab. He initiated with our patient cardiac rehab department and after two sessions, he reached out and said hey, Bud, my cardiologist said I didn't need to go anymore. I said, well I doubt that so I called his cardiologist and I’m happy to say he’s back in cardiac rehab.

Can cardiac rehab be done in the home? That’s a good question. Home-based cardiac rehab has been kind of a growing topic and been a hot topic in the home care setting for a while. I get a lot of questions about this. What we can’t do in the home setting is of course the telemetry and all the structure that goes with an outpatient cardiac rehab setting. I don’t look at home-based cardiac rehab as substitutionary for a facility based phase 2 cardiac rehab. Instead, I view it as very much complementary. We should be there in the home health setting to augment, complement and prepare people to go to a cardiac rehab setting when one is available and when one is not available, we should be able to step in and bring those tenets home as research has shown we can do and execute on a similar program to the best of our abilities and the best of our skills and make sure that patients are well.

The first question that always comes up is it safe. There are a lot of myths. There are a lot of fears around caring for these patients at home and actually doing cardiac rehab. The clinicians that work in our company and in our industry have a lot of questions about exercise and how much can I push, how hard should I work them. It’s a very good question. We’ll get more into that in a bit but it is safe and the evidence has shown that and consensus statements are certainly beginning to support that home is an appropriate alternate setting for cardiac rehab.

Is it effective? Yes. It is as effective, I’ll put it this way, it is as effective as we are in delivering it, which means we have to have a plan. We have to have a
structure, a program. We have to have goals, using quality improvement and lots of education for our teams and our staff and we’ll talk about that a little more in a bit. Then why isn’t everyone doing it? Another good question. I think it is largely around anxiety, fear, worry about payer relationships and what Medicare is going to say about specifically doing cardiac rehab in the home setting and I don’t plan on getting into much of that today in terms of the payer side. I will say that you need to be very deliberate in your documentation. Make sure that the physician who makes the referral to your setting and the payer source and your clinicians are very clear about what the goals of the program are and how they're being carried out in the home.

Home-based cardiac rehab programs, not surprisingly look very similar to traditional facility based cardiac rehab programs. There are very few things that we cannot do in the home if we choose to do so and have a plan to address it. One of the things I’d really like to emphasize around preparing patients for cardiac rehab and implementing the approaches of a good cardiac rehab program is that the home setting for a home care agency is very much the right place to do this. Patients eventually have to survive and thrive we hope in their home and there’s no better place to get that training than actually in that setting. Everyone on the call understands that. Hopefully there’s a lot of amens and clapping going on out there. We have a multidisciplinary team that can intervene to help these patients.

What we don’t always have are the competencies that go along with these interventions and so that can be a little concerning for clinicians who get that referral for a home-based cardiac rehab program. It’s probably been quite a while since the nursing staff or the physical therapy staff or the OTs or SLPs have really been engaged around this kind of population. Maybe it’s been a while since anyone has looked up those good American College of Sports Medicine exercise prescription guidelines. Maybe they have never seen or don’t even know what the AACPR is but they need to go back and sharpen those skills and I think for all of the home care agencies and leaders on the phone, this is a challenge to all of us to go back, go back to our roots of good patient assessment and go back and have our clinicians look at exercise prescription, look at our documentation or programming so that we can meet the needs of these patients.

The first thing we’ve got to be able to do is take care of those folks in transition from an acute care hospital or community physician or perhaps the cardiac rehab facility, ask the right questions in that transition, ask about their precautions. If an exercise test has already been done, then staying current with the literature is important because not so often anymore do we get exercise testing. Instead, we have medical clearance and recommendations from physicians, but if any of that testing or baseline data has been collected, let's
consume that into the home care agency, share that with your clinical staff taking care of the patient so they can understand where they can start.

Medication reconciliation and education, this is at the heart of what we do in home care and it's vital to do this and do this well and repeatedly with our patients in the home care setting in a cardiac rehab program so that we can make sure they understand the why for each of those medications and if we convince them of the why, then they'll figure out the how to get those medication regimens down and consistently managed.

Anatomy and physiology 101, so we've got to go back and do our own homework on those things. Nutrition, activity modification and stress management, so I want to pause this just a second and give a little plug for occupational therapists, if there are any on the call. If there's a specific need and a skilled need for an occupational therapist to be working with a cardiac rehab patient, go ahead and leverage the talents that they have related to that activity modification and stress management. We'll see more about ADLs and IADLs in a minute as well. Leverage their talents because they're really good at taking care of those patients and coaching them on that side of things, energy conservation. If the patient couldn't tolerate being in a facility for outpatient cardiac rehab, probably because they just weren't quite ready and so energy conservation, stress management, activity modification, those things are really, really important. There's no one better at doing that than your occupational therapist.

Now, if there are OTs on the call, then I'm going to challenge you to go back and get your stethoscopes because I need you to auscultate; you need to understand the anatomy and physiology that come along with this disease process, and so now we're kind of back to talking about competency again if you're going to be taking care of these folks. Symptom limited exercise is a crucial intervention for the nursing staff or for the physical therapist in the home care setting to be able to provide that education and teaching for the patient. If a patient has particular impairments related to this disease process or their comorbidities, then a physical therapist is really the expert in exercise prescription and adapting exercise for whatever complications a patient may have in their home setting.

The challenge with exercise in the home setting is the mode of exercise. Our patient homes range from huge assisted living facilities and long hallways that are wonderful for cardiac rehab programs to small apartments with not a lot of space and so we have to be very creative and draw on all of our skills and experience in the home setting to be able to help coach patients into an exercise modality that allows them to achieve the perceived exertion that they require to get to a good exercise level or a heart rate that supports, that they're
providing the right exertion to be able to get the benefits, so symptom limited exercise is important.

ADLs and IADLs, I've already talked about. Community reintegration is always a challenge for patients in the cardiac rehab program. Feeling comfortable going back into the community and being able to walk for 20 minutes in a grocery store and we don't really think about that enough, being able to go get their own groceries, to reach up on the top shelf, the bottom shelf, going to the pharmacy, walking from the parking lot and to the pharmacy and standing in line, those kinds of things are very challenging for these patients and so having really good discussions about community reintegration and then getting back into the cardiac rehab setting are vital.

Finally discharge planning, and ideally that is transitioning back to the cardiac rehab facility, being able to give the cardiac rehab team an idea of where they were when they started with us in the home setting and where they had been able to progress and transition to the outpatient cardiac rehab folks so the documentation, being able to share that in particular with solid outcome measures here at Encompass Health, we leverage tools like the two minute walk test, the six minute walk test, the two minute step test. Those are wonderful to be able to gauge activity tolerance and exercise capacity for patients but to share that information back with the facility is very helpful.

Symptom limited exercise in the home, when we train on this and when we think about how we provide this care for our patients, the first thing we have to take into account are the patient's goals. Exercise is no fun if it doesn't align with something that you really like to do, so we when we do this, take into account the patient goals. No one likes to walk on a treadmill or a dreadmill, if you will, all day long. No one likes to do that. Folks don’t always like to sit and pedal a bicycle either and so try to find out what your patients' goals are, and if they want to get back to golfing, then incorporate an activity that aligns with golfing. Maybe it is just walking but incorporate some fun too and bring, get their putter out. If their goals are to go back and walk with a group, if their goals are to get back to bicycling, if their goals are to dance, get back to dancing, if their goals are just to be at home and be a homemaker, you can get a perceived exertion of 4-5-6 pretty easily just doing regular home activities.

You just have to be creative with your patients and encourage your clinicians to be creative with their patients. The mode of exercise is really irrelevant. What is really relevant for these patients is getting them up to that perceived exertion level where they actually are starting to get just little short of breath. They're working a little bit and when you start to see that, you know those benefits are going to be imparted. The exercise doesn't have to happen all at once, and so breaking it up throughout the day is very beneficial.
Assessment, we've already talked about assessment. Exercise prescription, again find something they like to do and put a plan in place and ensure there's a method to follow up. I really like to coach our folks at Encompass to break the exercise up in doses throughout the day. You get the same impact from exercise the research has shown us, if you break it up into 10-minute chunks as you would if you did 30 minutes of continuous exercise and so why not go ahead and break it up. Make it easy for them to do. If you make him, if you prescribe a program for patients that's too difficult to achieve, you are headed toward failure.

Precautions are very important to understand. We focus very heavily on symptom limited exercise in the home setting. We don't have access easily to telemetry and those kinds of tools, and so what we really focus on is, how are you feeling, what is your perceived exertion? What is your perceived dyspnea? We use a zero to 10 scale. We have that embedded in our EHR, home care home based and we really coach on precautions related to symptom limited exercise, when to stop, how to respond and what to do.

This is where as a home health agency, you have to have a program in place with procedures and protocols and competency in terms of training to ensure that your patients are going to be safe. Outcome measures are important in today's healthcare environment, and frankly, they have been forever. We just haven't always done it. We employ, we've already mentioned, two minute, six minute walk test, the two minute step test and there are a number of other outcome measures that are available and you can find them online.

NIH database has a number of tools like that but you can really find a number of these measures to help you objectively discern if patients are making measurable progress in their goals. Modes of exercise, we've already discussed and there's a ton of conversation that could be had around that as well. I would just focus on keeping it enjoyable for the patient and something that is easy for them to repeat in the home.

My last slide is really about the role technology. There are rapid advances occurring in technology that can help us care for patients both in the home and outside the home. In terms of monitoring, you have personal emergency response systems. That's the I've fallen and I can't get up kind of a button. There are all kinds of new and exciting features in those devices. Many of those devices have gyroscopes or accelerometers in them so that they can actually protect not only falls and near falls, but activity and I think to be able to collect that data to see trended levels of activity for our patients day over day over day is very exciting to me because we can definitely see a correlation between decreasing activity levels and increasing risk of adverse events. Tele-rehab and tele-nursing is something I think that we are going to have to become more comfortable with in the home care space.
Finding the right tools to be able to perform those interventions is really key and not unchallenging. Also our attitudes for our clinicians around tele-rehab and tele-nursing are going to have to change and that's going to have to happen by those of us on the call leading the way and ensuring that we will help them find the technologies, the programs, the tools and pathways to impart improvement both with remote or telephonic interactions. Wearables, I think we see these more and more every single day. I've got on my Apple Watch. It collects a lot of my data for activity and exercise. Our patients are starting to collect more and more and more of these devices as well. These kinds of devices like Fitbit can certainly help you for patients who already have a device like this that they wear, why not establish a baseline with their prior history and then track that, have them self-report their steps in a day back to you in terms of tracking their improvement in their activity.

Wearables are going to be our friends in the future. There are a number of apps, we could take balance of our time and just read the list of apps related to this setting and disease process and the interventions and we still wouldn't be able to finish.

Lastly, what's next. I'm not sure, but I'm excited. There are so many new innovations happening around technology and in particular, the cardiopulmonary patient population. The ones that I am particularly excited about are wearables that are more passive data collectors, patches and sensors that are attached to the skin and I'm very excited about how the gamification of rehab and rehab in the home continues to accelerate with the technologies that we're seeing.

We all know that our clients love to, the patients love to play games, Candy Crush and all of those games. Getting them to consider cardiac rehab and earn coins or tokens, or just kudos artificially through a game or an app I think is a real part of our future as well in terms of incentivizing patients to participate and stay engaged. I appreciate the time today. There is some recommended reading here, but I think I'm going to go ahead and hand the presentation over to my friend Shanen.

Shanen Wright: Thank you so much, Bud, great presentation. Thank you to Kate and Janet as well. I know everyone enjoyed the information you presented today and we've received a lot of great questions that have come in as well so we are going to address some of those at this time. This first one I'm just going to throw out to the group and whoever would like to answer, please feel free to jump right in. The first question asks does Medicare fee for service require a copay for cardiac rehab and are there any types of financial support for the patient's copay?
Kate Traynor: This is Kate, I can take that one. With Medicare fee for service, a patient has a co-insurance, which is just a little bit different than a co-payment. There’s a contracted rate for cardiac rehab that a hospital is paid at and then the patient’s co-payment is generally in the neighborhood of about 20%, so the Medicare will cover 80% of the rate the reimbursement rate and the patient’s co-insurance is 20%. For those that have a supplemental plan, that 20% co-insurance would be covered by their supplemental insurance.

Shanen Wright: Thank you, Kate. Another question for anyone in the group, how does utilizing occupational therapy affect the 36 visit limit or do you do that service side by side, meaning that the occupational therapist bills OT codes like a regular outpatient?

Bud Langham: Kate, do you want to take that one related to the facility based cardiac rehab.

Shanen Wright: I’m happy to talk about the facility based rehab. Each of the multidisciplinary team members do not bill their service individually. There are two codes that are available to be used in the setting of outpatient cardiac rehabilitation programs. One is a code to cover patients who are exercising wearing a telemetry monitor and the other is the components of the program that are not monitored. That could be inclusive of a session where they don’t wear telemetry monitoring or all of their educational sessions, their opportunities to meet with a nutritionist, maybe meet with a social worker or a mental health professional so there’s no separate billing for occupational therapy or physical therapy or exercise physiology time or nutrition time.

It’s two codes that are utilized in that setting. I hope that answers the question adequately. I didn’t know if that was meant, Bud also perhaps for the home health setting.

Bud Langham: Yeah, in the outpatient cardiac rehab, they’re going to build those two 99 CPT codes. In the home health setting, there is no 36 visit cap. There is no 36 visit requirement. That is the established best practice guidance for the outpatient cardiac rehab guidelines according to ACPPR and that is the coverage under CMS with some exceptions. In the home health setting, your guidelines are going to be whatever your payer has already negotiated with you. For the Medicare population, the home health setting, an OT visit is just going to be billed as any other OT visit inside the PPS system.

With any other payer, it would be whatever your contracted rate and setup is with them, but I do want to say that you can have a patient receiving outpatient therapy services at the same time they are receiving outpatient cardiac rehab. Those codes are not duplicative in nature. They don’t exclude each other. The
patient might be quite tired, but if they need both services, they could have them simultaneously.

Janet Wright: Hi Shanen, this is Janet. Could I squeeze in a thought?

Bud Langham: Certainly.

Janet Wright: Oh great. The question about how hospitals manage the copays and Kate or Bud, you may have additional comments. We have heard from some programs that they’ve established funds. It’s usually from a philanthropic source to help individuals who could participate if they had some financial assistance with that copay. What we don’t know or what I don’t know is how pervasive that practice is but we’ve definitely heard from a couple of programs that they have helped their patients overcome the financial obstacle through that mechanism.

Shanen Wright: Thank you, Dr. Wight, and thank you, Bud and Kate as well. Our next question I think is directed to you, Janet. This one asks, so how have the statistics changed now with the inclusion of failure as a cardiac rehab diagnosis?

Janet Wright: Great question, and again, Kate, I hope to hear your voice. I’ll say what I know. I know of one published paper that looked at referrals for those who have a diagnosis of heart failure pretty early on, after it became an indication and the referral rates were still quite low and as were the participation rates consequently, and so I believe the general feeling is that we are not yet jammed up the processes and overcome some additional obstacles to getting to both identifying those people who are eligible, getting them enrolled and getting to participate. One of the reasons the heart failure population has a couple of extra challenges is because they cannot, unlike someone who has a procedure for a heart attack or new diagnosis of stable angina, all those people can be referred almost directly from the hospital and encouraged to start cardiac rehab within a very short period of time. I think the goal is to get them enrolled, get to their first session in less than 21 days from the time of discharge. On the other hand, someone with heart failure cannot start cardiac rehab until they have been stable for a period, I believe it is six weeks following a hospitalization or diagnosis of heart failure.

They they have this gap. We think about the hospitalization as maybe a teachable moment or time to get all the systems up and running and yet in order to prove their stability and make sure that they’re entering cardiac rehab on their best foot, there’s usually this time interval. That’s my understanding, Kate, please correct if I mispoke on this and add to it.

Kate Traynor: No Janet. In fact, as usual, you’re right on the money. Oftentimes, when changes are made in coverage policies, it does take a little while before we begin to see
the implications of that change or what difference that changes made so I think we may be a little bit early on. We do have seen as Janet said at least one or two early studies that still show participation rates even inclusive of the systolic heart failure population remaining somewhat low so obviously the initiatives such as Million Hearts and all are going to be important and essential to help move that needle.

Certainly, we’re hoping that over time, we will begin to see those statistics relative to this population are going to trend in the right direction.

Bud Langham: This is Bud. I would just add as well. That six week window is an incredible opportunity for home health agencies with programs like this to step in and bridge the gap to get our patients ready for outpatient cardiac rehab.

Janet Wright: Bud, I'm so glad you said that. This is Janet. I'm so excited about the opportunity, this wonderful sweet spot for home health, not saying it’s the only sweet spot but it seems like one that is a perfect fit.

Bud Langham: Yep.

Shanen Wright: All right, our next question, I think this is directed to you, Kate. This is three one hour sessions per week for 12 weeks. It seems like a potential barrier for some population, like working people or people with kids. Are expanded hours offered, maybe after office hours and weekend sessions maybe?

Kate Traynor: Thank you for this question, whoever sent it and it provides me an opportunity to talk about something that I had been remiss about including, so I think that the notion of a three time a week one hour program is somewhat by the by. The programs have definitely begun to innovate as you can see from some of the data that was presented this afternoon. The programs need to take a hard look at what's working well and what isn't working, and certainly requiring people to come in three times a week just is impractical. We’re beginning to see programs change in a number of ways. One is by bundling together sessions so that they’re inclusive of both exercise and some education and decreasing the number of times that they come per week and factoring and providing more services within the context of each of the visits.

The second is that there’s combinations now of programs, what we call hybrid programs, if you will, where patients begin in the facility or center based program and then they continue to be engaged with the cardiac rehab facility and program but at home and so that through some of the wearable technologies and things that Bud referenced or other creative ways of using telehealth or virtual visits, the program staff can reach out to patients in their
homes at a more convenient time to help them continue their lifestyle management programs. That’s emerging more and more.

The third that I wanted to mention is that yes in fact I think programs are thinking hard and looking and considering ways of offering more times and more options for people who the traditional daytime day, weekday availabilities don’t work. We certainly have looked at that and you know we offer an early morning, late afternoon, early evening session for those who in particular are working still. That seems to be the two times that they will gravitate to. I don’t personally offer a weekend session as of yet, although I think that it won't be long before we're going to need to be a more full service provider from that standpoint, but I do believe there are some programs that have those offerings on weekends, yes.

Shanen Wright: All right, our next question, I’ll throw this out to the group if anyone is aware of it. This person asks do you know of any research regarding vaping or e-cigarettes?

Kate Traynor: This is Kate again. I can talk to that or speak to that a little bit. It’s a challenging area because certainly we don’t want people smoking tobacco or using tobacco products. The challenge is that we don’t always know what are in the e-cigarettes and I think there's been some recent data that suggests that they may not be as safe or as helpful as we had once expected and anticipated them to be. Our focus always is trying to get patients to utilize adaptive strategies or strategies that we know to both be helpful as well as effective and I’m not sure that the studies are there just yet, frankly, in terms of e-cigarettes or the vaping.

Shanen Wright: All right, thank you. Kate. I think the next question is for you as well. This person asks, is there a standard for blood pressure threshold at which a cardiac rehab exercise session as possible? Is there a number that is too high to exercise in the moment? This person’s also wondering when the patient should be sent back to primary care for better blood pressure therapy before they could start exercise.

Kate Traynor: Yes, obviously every program as expected to have policies around safety of exercise and what will disallow somebody from participating in any given day for from the standpoint of blood pressure numbers as well as blood sugar or some other parameters. As patients enter each day, much like you entering the home each day evaluating and assessing where people are before you begin your intervention, the blood pressure management is a part of that. Certainly, if we're seeing resting blood pressures at or above a systolic number of 200 millimeters of mercury or a diastolic of 100 and more, we absolutely will not begin exercise and if we begin to see even elevated blood pressures, less than 200 over 100, but certainly elevated beyond goals of 130 over 80, we’re in dialogue constantly and need to be in dialogue much as you would be in your
home health setting back to the providers to say that we’re not quite at goal and we need, how can we best manage this together to help the patients obtain a safer parameter.

Those, that would probably be the clearest cut off that I could give you if you’re looking for a specific number.

Shanen Wright: Thank you, Kate. Next question, another one for anyone in the group, this person asks, why do women have a difficult time complying with the program?

Kate Traynor: I touched on that a little bit in my presentation. I mean, certainly the women are generally the caretakers in the family, and as a result of that role and their perceived obligations to others around them, the focus is generally outward and just thinking about everything else that they need to do in the course of the day for the people around them that they love and care about and it's very difficult for them to stop and do what they sometimes perceive to be selfish, which is prioritize their own needs. That is probably the crux of the matter when it comes to keeping women in programs and helping them to be successful and get through to completion. I don't know if Bud or Janet have other perspectives on that, but certainly that's both in the studies as well as our practical experience with women and what we're coming up against.

Janet Wright: Thanks, Kate. I did put some thoughts into the chat box but I will also share a quote from someone who, the cardiac rehab collaborative started as a group of people who again wanted to put their shoulders to the wheel to help more people get the service and they came together in a one day meeting in Washington back in November of 2015 and at that meeting, we had not only some federal agencies but also a lot of private sector organizations, reps from private sector organizations and we had a handful of people who were cardiac rehab users and they brought their spouses.

We kicked the meeting off. In fact, a couple of the folks who had participated in cardiac rehab launched the meeting for us and then stayed, of course, participating in the work groups and really the drafting of our first action plan. The spouse of one of the users said from the microphone that morning that when she first walked in with her husband John to his first session she said, I walked in and I said to John this looks like a man's gym, I would never work out here and so she also shared later concerns about her hair and sweating and other aspects that just made exercising uncomfortable, but we also know as Kate said, it is the enormous responsibilities that often rest totally on the shoulders of the woman in the family and the tendency not to put her needs near the top of that list.
Shanen Wright: Thank you, Janet. Our next question is directed to Bud. This person says, could you please give us feedback on use of the term cardiac rehab in home health? We are trying to train our therapist appropriately and provide care but had been under the impression that we cannot use the term cardiac rehab for what we're doing.

Bud Langham: Yeah, I've heard that a while for some time as well. I don't know how that got started. It is the correct description of what we are doing. I think what people are afraid of is implying that we are actually doing what Kate does in the clinic with those two CPT codes as outpatient phase 2 cardiac rehab and that's not the case. I tell our staff at Encompass Health, describe what you're doing. Call it what it is, but in your documentation, we are still held accountable for the same documentation as we would be with any other patients and so go ahead and be descriptive about the interventions, the education and everything else that you're doing. Just because a reviewer or a payer sees the word cardiac rehab in our notes, it's not going to be an automatic denial. If it is, if you get a denial, just because you use that term, and while I've heard that, I've never seen it, then reach out to the payer and discuss it and explain to them what you're doing and how it is such a profound benefit to them, to their company and to that particular patient and fight for appropriate care that that patient needs in the home, but I think if we say cardiac rehab, it's going to be denied is just a terrible myth and we need to put it to bed.

Shanen Wright: Thank you, Bud. I think we have time for one more of our questions today, but those of you who asked questions we were not able to get to due to the timing, know that we will pass those along with our expert panelists and we'll get an answer back to you. For our final question from the audience today, this individual says I am currently experiencing the six week gap with my father and it's challenging to keep him engaged and excited about the program. Any ideas?

Kate Traynor: This is Kate, so I'd be happy to talk with you about that. I think a couple of things. One is and this happens a lot, patients who are waiting a long time to get into programs, if you make a call to that program and try to impart to them how important it is for you and how anxious you are to get started and are you on their waiting list or what have you, I think certainly that's important for patients to advocate for themselves. Secondly, if you can get the patient's physicians to advocate for you, so ask their physician to make the call to perhaps prioritize your participation or your dad's participation.

I'm sorry to hear this. It's a little bit frustrating. Obviously, we don't want people, we want to strike while the iron's hot and grab a hold of those patients when they're interested and motivated. Maybe today, I'm hoping after hearing today's presentation that you yourself will now feel a little bit more empowered and a little bit more knowledgeable about how to help your dad in those six weeks, so I wish you luck with that. I'm sorry that the program hasn't been as
responsive. If there are other programs in the area, perhaps their time to entry is a little bit less and maybe worth a phone call to them to check that out.

Bud Langham: I would add to that, if he's at home in that gap, ask him what his goals are. You know your dad better than any of us. Find out what motivates him, what would be a motivational factor and use it. If it's donuts, then by all means have him once he walks a certain amount of distance or time, then give that man a donut. Game-ify it and make his goals easy to reach and very simple until he consecutively reaches those goals and make them a little bit harder so he gets in the habit of striving for something that is accomplishable and then tell him all the while you are preparing to step on the scene in that phase 2 cardiac rehab program and light the world on fire. They'll be so impressed with you.

You got to find out what motivates them and then use that.

Shanen Wright: Thank you, Bud. Thank you, Kate and thank you, Janet. If you have additional questions or would like to get in touch with any of today's panelists, you can contact us anytime at hhqi@qualityinsights.org and now, Cindy Sun with some more information.

Cindy Sun: Thanks, Shanen and hello, everyone, I just wanted to quickly go through a few resources that you will find as you're trying to transition into encouraging a patient to participate in cardiac rehab. The first one you'll see on the left hand side is the AACVPR's or zip code by state or city. The idea here is where are the cardiac rehab facilities in your patient's area. If you're already familiar with it, great, but I find that many are not so we wanted to provide these. All of these are located under the HHQI's resources that Kate mentioned earlier.

You can see the on the left is the AACVPR program directory. This is a web page capture that you can see as soon as you click on the link. On the left side is the CDC interactive map. This is just like all the other CDC maps. It is a wealth of information that's phenomenal. It does take a few minutes to load but give it some time as you're going through that.

Then the next slide, we're just going to talk quickly about HHQI cardiac rehab video playlist. The YouTube Video Channel does have multiple – as you can see – 12 videos and these are for both clinicians and patients. They're very short. They're very informative, and they cut to the chase. The next slide is talking about a few resources as far as tools go. On the left, you can see AACVPR cardiac rehab information sheet that's available for download, and on the right is actually a screen capture of the home of the American Heart Association Cardiac Rehab: Your Roadmap to Recovery. That is an interactive site. It can provide you additional resources that you can provide your patients, whether
you're going to this site in the home or you're going into that site before you actually go into the home to see what is available.

As we all know, anytime we change anything in quality improvement, we want to make sure that it's measured and assessed. To help with this is HHQI's home health cardiovascular data met, excuse me data registry starting on March 15, the new measure, which is the adaptation of NHQ 643, which is cardiac rehab in the outpatient setting. This simple question, you'll have the option to assess, did the patient receive a referral to cardiac rehab, yes or no. Remember, this is upon discharge. This is after the patient is discharged from the Home Health setting is when they show up in the registry. This will be a new measure. In addition to that, you're also going to see a new statin measure, which is the cholesterol lowering statin measure, which is saying simply was the patient taking a statin.

If you have any additional questions in regards to the HHCDR, definitely let us know. Finally, I think the part that most of you are waiting to hear about, how to get your continuing education for attending today's session. Remember, today is 1.75 nursing CEs and 1.0 PT CE. In order to do that, you've watched this 90 minute webinar and now you need to register for the course. It is very simple and complete an evaluation and then you'll get your certificate.

All right. You've all heard this before, probably so we're going to go through it quickly. Do remember it sounds convoluted, it sounds complex but it's actually quite simple. If you get your CEs, you go to the HHQI University, register or login. If you do not know if you have an account already, contact us and we'll be glad to help you figure that out.

Once you're logged in, click on the cardiac roundtable rehab roundtable course. That is found in the cardiovascular health course catalog.

Once you do that, click on enroll under the apple icon. Click on the my account, you'll notice to have small that word is my account. It's in the green box, click on the go icon next to the course in the view column, click on the go icon again in the action column next to lesson one.

After you completed the evaluation, you can print your certificate. The instructions are here. You go to my account and that's on the black toolbar and your certificate will be in the left side of your screen. If you have any problems with this, contact us. We're located at hhqi@qualityinsights.org. I'm going to turn this back over to Shanen for final thoughts. Thank you.

Shanen Wright: Thank you. Cindy and thank you so much for attending our webinar today. We'd also like to thank all of you for helping us reach a key milestone just today at
HHQI. This morning at 9:35am Eastern time, we welcomed our 20,000th participant to the initiative, and while we're celebrating the landmark, it's merely a start. We encourage all of you to please share with your friends, neighbors, colleagues and co-workers about all of the resources that HHQI has to offer, all of which are absolutely free. Please help us spread the word so we can continue to grow beyond 20,000 participants. On behalf of Janet, Kate, Bud Cindy and the entire HHQI team, thank you for joining us for today's webinar, the Cardiac Rehab Roundtable. Have a great day.