

Robin Rinker:

Thank you so much, and thank you, all, for joining our quarterly Million Hearts partner call. This is Robin Rinker from the Million Hearts team here at CDC, and as a reminder, this event is being recorded for re-broadcast, and you will all receive access to the recording and transcripts after the call as well as some follow up items. So, we're thrilled you're joining us.

For some logistics and housekeeping here, we really encourage you to submit questions at any time during any of the presentations using the Q&A panel located at the bottom right of your screen. After typing your questions, hit the Send button, and they will go directly to the panel members, and we'll address them during a QA session after our presentations today. We also encourage you to chat with your fellow participants during the call and make some connections here.

So, for our call today, we have a really exciting lineup and we're gonna be discussing the Million Hearts Cardiac Rehab Change package, which is new and hot off the presses for us. So, we have a great lineup of speakers. Hilary Wall, who is our own Million Hearts Science Lead; Jennifer Newman, Director of Cardiac Services at Lake Regional Health Systems; Tammy Garwick, Manager of Cardiac and Pulmonary Rehabilitation at Mount Carmel Health Systems; and Loren Stabile, Cardiac, Pulmonary, and Vascular Rehab Program Manager at The Miriam and Newport Hospitals.

And we have bios for each of these speakers included in the agenda, which should be in a file transfer on your screen, so you can access that right in WebEx.

So, we have a lot to cover today, so without further ado, I'm gonna turn it over to Dr. Wright for the opening remarks. Janet, it's all yours.

Janet Wright:

Thank you, Robin, and good afternoon, everyone. And I think it is afternoon—yes, it is—for everyone. We're just delighted to have you today; have you join us. And we've got, as Robin said, a wonderful set of speakers delivering great content.

I wanna set the stage by saying we are gathered today to focus on a big problem. Only about 20, maybe 30 percent of people who are eligible for cardiac rehab in the country are actually participating. So, if we're gathered to solve a big problem, to get rolling to get that problem fixed, I'm thinking I want to go over four things that we need to do, and the first is to set a bold aim. The second is to

gather and to equip and energize important stakeholders—the needle movers around the country. The third is to implement best practices, to do what works. And the fourth is to track progress and also to celebrate the progress.

So, when I thought about those four things in preparation for today's call, I really felt like I was going down a checklist. But when it comes to setting a bold aim, I'll put a check next to that. As many of you know, we've set the aim of 70 percent performance on—70 percent participation rate in cardiac rehabilitation. And the reason we set that really came from this subgroup of the Cardiac Rehab Collaborative who did the math and found out that, if we reached 70 percent initiation, 70 percent of eligible people made it to their first cardiac rehab session, that would translate to 25,000 lives saved and 180,000 hospitalizations prevented annually. That aim is worth achieving. It's a long way from 20 percent, but again, knowing how we can gather the right folks around the table—starting, really, today—do those best practices, do what works around the country and track and celebrate progress.

So, the other aim I wanted you to know about is the one we've set for the end of this year. It is for December 31st of 2018, and that is to reach at least 5,000,000 people with messages about the value of cardiac rehab. The Collaborative identified a lack of awareness of the value of cardiac rehab among all stakeholders as one of the problems. In fact, that's one of the objectives in the Cardiac Rehab Collaborative's action plan. And so, Haley and Shelby at the end of this call are gonna walk you through some of the resources that are now available to you in this resource toolkit or box of goodies.
[Laughter]

What the team has done is create messages and things that you can drop into newsletters and basically try to lower the hurdles and obstacles for you to reach out to all of your networks to get the message across to people who might be users of cardiac rehab, might have family members, patients, or colleagues who can benefit from it, and we've tried to create some materials that would make it easy for you.

So, going back to those four things, talk about today as a wonderful collection of important stakeholders. The Million Hearts Collaborative is a powerhouse group that can not only help get messages, important messages out, but also create the change at the community level and within health care settings and homes to get the outcomes that we're seeking. I'll call out the Cardiac Rehab Collaborative, which will have its next meeting November 7th.

Haley can give you more details about that, and also highlight the partnership we've developed with AACVPR—really outstanding organization, been at this for a long time, and who has been really our set of subject matter experts to help develop tools and resources, but also generate interest and action.

And then I want to just talk about, a moment, what works. You're gonna hear a lot about what works today. You're gonna hear about it from Hilary Wall, who's helped lead the effort on the development and launch of the change package, and also from Jennifer and Tammy and Lauren, who will show you what is working now, how they're generating results in their community programs.

And then finally, about tracking and celebrating progress, Matt Richey, working with Jessica McNealy, this is a combined CMMI and CDC effort, have created a surveillance plan that will help us understand how and how fast we are making progress in the CMS beneficiary population. That plan has been now modified for use in commercial health plans. So, those of you who work with plans and feel like giving them the methodology to look at who's eligible, what the participation rates are like, and what the completion rates are like among their members, please let us know and we'll get this plan into your hands. And then join us in the collaborative where we will continue to celebrate progress. In the meeting in November, we'll be celebrating the third birthday of the collaborative, and we will use that as a springboard to help us all get towards that 70 percent aim.

So, with that, let me please hand this over. I think I'm handing it over to my esteemed colleague, Hilary Wall.

Hilary Wall:

Thank you so much, Janet, and I am really thrilled to be here today to talk to you all about our exciting new Million Hearts Cardiac Rehab Change Package. You all heard Janet say that in order to achieve our audacious Million Hearts goal of preventing 1,000,000 acute cardiovascular events, we have set this 70 percent target for eligible patients to participate in cardiac rehab, and this is particularly important for our priority population of patients who have already had a heart attack.

So, what exactly is cardiac rehab? Well, it is a medically supervised secondary prevention program for eligible cardiac patients to improve the patients' health and really improve their overall well-being so that they can get back to their regular activities after a cardiac event. And it typically entails exercise

training, which is what I think everybody thinks of when they think of cardiac rehab, but it also includes risk factor modification, psychosocial assessment, and there's always an individualized treatment plan for each patient. It's usually delivered in 36 sessions over a period of 12 weeks, or I should say it's typically delivered that way, and there's a strong dose response relationship in cardiac rehab. The benefits are greatest if the participant completes all 36 sessions, but many of these benefits have been seen in people participating in 25 or more sessions, so that's sort of what we consider to be a healthy dose.

Now, cardiac rehab is a class 1 recommendation in numerous guidelines, and it's a service that's been around for quite some time. It's largely covered by Medicare and commercial payers for individuals who have had a heart attack, have chronic stable angina, and heart failure—and heart failure is really the newest condition that's been covered. And it's also covered for patients who have had a CABG or angioplasty.

Strong evidence shows that cardiac rehab reduces death from all causes and from cardiovascular causes, and it's also been shown to reduce hospitalizations and reduce medication adherence, functional status, mood, and quality of life.

So, with all of those really strong assets—why, oh why, don't all eligible patients participate in cardiac rehab? You heard Janet say we're sort of at about a 20 to 30 percent participation rate. Well, what I've come to learn is that there are many potential barriers that eligible patients may experience along what I like to call the cardiac rehab continuum, which starts with the initial referral after a qualifying event. Then the patient needs to actually enroll and start initially participating in cardiac rehab, followed by that continued adherence to the program so that patients can get that healthy dose of 25 or more sessions.

And, surprisingly, despite all of that strong evidence, we see a lot of variability in—sorry, I'm just trying to get my slides to go—we see a lot of variability in physician referrals to cardiac rehab. Studies indicate that referral to cardiac rehab varies by the qualifying diagnosis or procedure with the highest percent referral in heart attack patients at about 80 percent, then we see about 60 percent of patients who undergo PCI or angioplasty with stent, but only about 10 percent of qualified heart failure patients are referred. And moreover, we see lower referrals in women and racial ethnic minorities and there can be additional variability by

the actual hospital the patient's seen at, the provider, and the department where the patient gets treated.

But let's go ahead and assume that we can tackle all the barriers related to referral. There are then additional barriers related to enrollment and participation. So, first, again, participation varies by qualifier, and we see similar patterns that we saw in referral where heart attack patients are more likely to enroll and participate, and patients with heart failure are less likely to do so. And then there are lower participation rates among people of color, women, and people with comorbidities or low socioeconomic status. And this really, I think stresses the need for very much systematic changes and automation to ensure that all eligible patients can receive the cardiac rehab that they need.

We then see significant geographic variation in participation across the country, and this could just be, there may not be cardiac rehab programs in the vicinity of where the patient lives, so they're not easily accessible. And this points to the need to really leverage technology and innovation through home based and hybrid cardiac rehab programs.

And then we know there are a whole host of barriers related to the patient experience, trying to get to the programs including things like transportation, finding and paying for parking, getting to a program that's open when they're actually available to attend, which is even worse if they work, and then finding a program, as I said, that's sort of in close proximity to where they live.

And then copayment is another common barrier for participation. If a patient is required to pay a \$40.00 copay every time they go to cardiac rehab and we expect them to attend three times per week for 12 weeks, that's a lot of money for most people.

So, let's talk quickly about getting those people to attend 36 sessions over 12 weeks, in some preliminary data analysis of 2013 Medicare fee for service beneficiaries, there were approximately 450,000 beneficiaries who had a qualifying condition that would make them eligible for cardiac rehab. Of that group of beneficiaries, only 20 percent used cardiac rehab at least once, and among those who actually used cardiac rehab once, 57 percent completed 25 or more sessions. So, you do the math on that, that only equates to about 51,000 people or 12 percent of that 450,000 who were eligible that actually initiated cardiac rehab and received that recommended healthy dose. So, I definitely, definitely think that we can do better.

So, cardiac rehab is a program that's been around for decades with a fairly set curriculum format and delivery system. But, given this new context for cardiac rehab where Million Hearts and others that participate in the Collaborative and beyond are really pushing to achieve very high levels of cardiac rehab participation. This will mean a potential influx of patients that can't necessarily be accommodated by current methods and delivery systems that our brick and mortar programs used. So, change will be necessary for most, and for some, it will be very hard.

So, to help cardiac rehab programs deliver the much, needed changes, CDC, in collaboration with the American Association of Cardiovascular and Pulmonary Rehabilitation, or AACVPR, we've developed a change package that captures best practices in cardiac rehab to help health care professionals and practices nationwide improve their patients' utilization of cardiac rehab.

So, through our tremendous collaboration, we were able to tap into cardiac rehab professionals, researchers, and truly exemplar programs in the field to gather tested strategies and tools to increase all aspects of cardiac rehab utilization, and I am absolutely thrilled that we have three of those exemplar programs on our call today who will share their very exciting work with you.

You can access the full change package using the URL on this slide, but I'm gonna quickly review its different components. If you're not familiar with this phrase, "change package," it's just really a well-known quality improvement tool comprised of evidence and practice-based changes that support improvement in a given care process. And ours is broken down into change concepts. These are sometimes referred to as key drivers, and there's change ideas, which are more specific, actionable strategies for changing a given process, and then for each change idea, we, again, reached out to those cardiac rehab programs and professionals to identify tested tools that can help make an impact in cardiac rehab utilization.

There are four types of tools that are showcased in the cardiac rehab change package. We have AACVPR strategies. These are high level sort of issue briefs with concise guidance to aid implementation of programmatic strategies. We have case studies which are more detailed examinations of how a specific cardiac rehab program was able to make a given change. We have program specific tools, and those are the real tangible resources that have been implemented by cardiac rehab programs or researchers and

can be adopted as is or adapted to meet other programs' needs. And then we have organization specific tools. These are resources from clinical and public health organizations that really support cardiac rehab—groups like CDC, American Heart Association, American College of Cardiology, et cetera.

So, the Change Package is organized into four broad buckets. We start with systems change, and then that really gets added to those three aspects of the cardiac rehab continuum I showed you before—referrals, enrollment and participation, and adherence. And depending on a health care setting's quality improvement needs, efforts could start at the systems change side of the equation, or they could start further down the continuum.

So, why don't we go quickly through some examples? Change concepts for referrals include standardized processes, electronic referrals, and my favorite, health systems data to drive improvement. So, maybe clinical staff in a hospital want to increase referrals by using data to drive improvement, right? There are these six change ideas that one can focus on and I'm not gonna read through all of them, but let's say the program decides to implement a registry to identify, track, and manage patients who are referred to a cardiac rehab program so that they can share those data with quality improvement staff and clinician. The Change Package then provides several sample dashboards that can be replicated or adapted. And adherence includes strategies that are about understanding patient characteristics that are predictive of program dropout and deploying strategies to encourage adherence so that patients can get that healthy dose of cardiac rehab.

So, a cardiac rehab program may want to work on adherence by improving patient engagements. There are three main change ideas, and the program decides it wants to employ patient ambassadors, and then the change package then provides them all the tools that we need to do so, and we're gonna hear a lot more about that particular change idea in just a second.

So, I'll refer you to the Million Hearts Cardiac Rehabilitation webpage for more information to access to the Change Package and a whole host of tools and resources for clinicians, cardiac rehab teams, and the eligible patients, we also have some great communications materials which Shelby's gonna talk to you about and you can get involved in the Cardiac Rehab Collaborative, and Haley will give you more information about that.

So, with that, I will say thank you and we're gonna hold questions until the end, so I'll now turn it over to Jennifer Newman with Lake Regional Health System.

Jennifer Newman: Thank you, Hilary. So grateful to be here today to be able to share some of the exciting things that we've been doing here in our program. As they so kindly introduced me, I am the Director of Cardiac Services here at Lake Regional Health System, and we are situated in the center of Missouri in the Lake of the Ozarks, which is a resort area, to sort of give you an idea of the demographic that we are working with here.

And I'm very excited to—excuse me, there we go. We have five physical locations situated over about a 50-mile radius across the Lake of the Ozarks. So, we have a lot of challenges. We run about 50,000 patients a year through these five locations. And I briefly wanna talk about how we participated in this package. Hilary did a great job of going over the basics, and we were able to contribute to three of the four buckets and provide tools that we have used. It was a pretty exciting day for me when I started to hear about the goals of the Million Hearts, because I'm very data driven as well, just like Hilary. And what I realized really quickly is that we were almost there. We are looking at about a 60 percent average enrollment rate for our patients over the last three years. So, when I saw that goal of 70 percent, I thought, “Boy, we have an amazing team, and we need to share the things that we're doing.” So, very excited to be a part of this.

So, under the Systems Change—Make CR a Health System Priority. And what I found when I took over the leadership role here is not unlike what many managers and directors voiced to me that the cardiac rehab area is just very much sort of in the basement on the far end of the building and is just not something that's well understood across an organization, when really, it is such a shining jewel that should be on the front.

So, I started getting very engaged at various levels within hospital leadership and presented to the Board of Trustees so that they would understand what we were really doing there and what kind of impact that we were having across not just our immediate area, but globally, on bigger things like the CHF readmission rate and CABG readmission rate, so just really having someone to voice what cardiac rehab potentially could do beyond the capture of the dollars and cents which, when you compare it to the cardiac cath lab or any other component of care, does seem, from a dollars on the paper perspective, to seem like we're kind of small potatoes.

But when you can voice and explain to people on board levels and director levels—look, this is what we're doing here, guys. This is what is important. We are changing people's lives. It's not hard to get them very passionate about it if you communicate that strongly.

Also, getting the Cardiac Rehab center as a focal point for an employee benefit perspective. We took on being sort of champions for our work force to say, "Hey, everyone needs exercise, not just patients living with heart disease." So, really just sort of getting our cardiac rehab space and name out and amongst the organization really helped me to advance that cause.

Another component we contributed to was under the bucket of referrals. I'm really big on standardization. Across five locations, when I arrived, I discovered there to be very little standardization, lots of variance, so I'm a big advocate of process mapping and really walking through things so that the staff can do the care for the patient in the exact same way every time, so we're giving that patient the results that they came here for.

We've also contributed our physician referral and order policy. I highly encourage cardiac rehab managers across this country—please, do not reinvent the wheel. We have a country full of smart, skilled providers. They will share. So, really just reaching out to other decision makers and managers and saying, "Hey, this is what I have. What do you think?" and opening up those networks. Thankfully, the AACVPR and our state level organizations, our joint affiliates are a great mechanism to do that. Also, we contributed our admission guidelines. These are taken straight off of the AACVPR guidelines as well.

We also participated in enrollment and participation. Patient education, obviously, is always gonna be a big focus for us, and we targeted those inpatients. We have them sort of as a captive audience, forgive the expression. But we've really beefed up that bed of referral source to get those patients in that all meet criteria.

And a big thing—and again, I'm sure Hilary will be giving me the mental thumbs-up here—I've forced the use of data to drive our improvement, because the common perception among a lot of cardiac rehab professionals is that our patients love us, we do a great job, we have great patient satisfaction scores. And my challenge to that is, that's really not enough. We have a fabulous environment to work in, it's normally quite positive, so what else do we have to give them? Let's talk about functional capacity.

Let's talk about time from door to door referral rates, things like that.

So, I really focused on the data, the numbers, and it was a little unsettling for them to learn that—hey, we're not getting these patients in as fast as we think that we are, but because we've never measured the data, it's a little challenging at first, but now they won't hardly make a left turn in the department without the data behind it, so it's been a great behavior to reinforce.

So, using spreadsheets, things like that. Lots and lots and lots of process mapping to again, hopefully, completely eliminate that variation.

We set some very strict timelines for our patient intake. I pit the staff against one another and have them compete, small measures like that to just really get people engaged and realize what we're here doing. And again, I believe, as Hilary said, we're gonna hold questions to the end. So, I will pass controls to our next speaker.

Loren Stabile:

Alright, everyone. So, my brief presentation today will focus on the Patient Ambassador Program that was implemented at the Miriam Hospital Cardiac Rehab Program located in Providence, Rhode Island. And over the next eight minutes, I hope to share with you the motivation behind the implementation of the Patient Ambassador Program, introduced to you the core components that make up the Patient Ambassador Program, and then talk a little bit about the impact that this program has had both on our patient experience and on our dropout rate.

So, the Patient Ambassador Program was implemented at our cardiac rehab facility a little over three and a half years ago. And it's actually initiated as a result of our department quality improvement process. So, each quarter, we analyze data pertaining to the five indicators you see on the screen. And by tracking the dropout rate, it allows us to evaluate not only the number of patients who don't complete the program, but the reason why they drop out and at what point within the program that they end up leaving.

So, the next few slides just represent the 2014 data that led to the start of the Patient Ambassador Program. And so, in 2014, our cardiac rehab facility experienced a 24 percent dropout rate, which was not at all that alarming since it was down from the prior year. However, I was more concerned with the high percentage of patients dropping out due to the last reason on the slide, being

noncompliant. These are the patients who receive a phone call from the staff when they miss a class and they say they'll be back; however, they typically don't show up, or even better, they don't return the phone call.

When I compared the noncompliance rate of 2014 to years past, our dropout due to noncompliance had increased from 14.5 percent to 32.6 percent over the three-year span. I then further analyzed the dropout data for the same time frame to identify when patients were leaving the program. So, are patients leaving early on within the first nine sessions? Are they leaving the program in the middle, or towards the end of the sessions?

And it was evident that a much higher rate of dropout occurred in the first nine sessions or the first three weeks of cardiac rehab. And in all three years, the number one reason for dropout within those first nine sessions was noncompliance. So, my assumption was that these patients were not engaged early on, they didn't feel comfortable, and they didn't adjust well to their experience during their initial three weeks of cardiac rehab.

So, it was easy to see the pattern over the three years, since close to half of all the dropouts were occurring in the first nine sessions due to noncompliance. And in the past year, our cardiac rehab program had already addressed the top four contributing factors that led to dropout. So, it was clear that we really needed to address the fifth and final variable impacting dropout.

So, in 2014, we implemented the Patient Ambassador Program, which we hoped to be a solution. And how did we operationalize this program, or this idea? The framework consisted of seven basic steps, and the first step was to establish a mission and some basic objectives. Our mission was to strive for excellence in quality and customer service by providing a more personalized approach to care. We then established the objectives listed on this slide. So, our goals included easing the transition of incoming cardiac rehab patients, providing peer support through sharing of experiences, providing encouragement regarding the utilization of support services. And then the last goal was actually added more recently over the past year, which is to encourage long term health goals at discharge from cardiac rehab.

The second step was to recruit patients as ambassadors. And the staff created an invitation and invited patients who successfully graduated from rehab and wanted to give back to the program. These patients were all invited to an informational session.

So, at the information session, the mission guidelines or ground rules were reviewed with the interested patients. We wanted patients to understand the expectations before committing, and have the opportunity to ask questions. If they agreed to the guidelines, they provided their availability, and a schedule was established to include a patient ambassador at each rehab class. The Patient Ambassador Program was initially rolled out with 10 ambassadors.

So, the step four, we created a uniform. We wanted our ambassadors to be easily identified. A logo was designed, shirts were made, and name tags were worn. *[Cross talk]*

The step five was to communicate the existence of the Patient Ambassador Program to incoming patients. *[Cross talk]* Each of the 10 ambassadors completed a brief profile regarding who they were and their entire rehab experience, and that was the form that was used on the left. A summary of all 10 patient ambassadors' profiles were added to our welcome letter and mailed to newly enrolled patients who had their first cardiac rehab appointment scheduled.

Patient ambassador profiles, together with their pictures, were also posted on a large bulletin board in the cardiac rehab exercise area. However, during the patient's initial assessment, the patients were also reminded of the Patient Ambassador Program by the clinician who facilitated the intake assessment.

The next step, step six, was to identify a mechanism to measure the patient's experience or satisfaction regarding the interaction they had with the ambassador. We decided to add the questions listed on this slide to our Program Satisfaction Survey. Patients rated how helpful their interaction was and rated the objectives in order of most importance to them.

Here are the results. The first two years after the implementation of the program, 97 percent and then 96 percent of the patients found the Patient Ambassador Program to be somewhat helpful, helpful, or very helpful. The summary of their ratings in order of their helpfulness were the same for both years, rating the number one benefit as—the patient ambassador eased their transition into cardiac rehab. The second was—the patient ambassador provided peer support and sharing of experiences.

Finally, we re-evaluated the dropout rate after the Patient Ambassador Program was implemented, and we saw a 20.6 percent overall reduction in dropouts due to noncompliance since 2014.

Our last and final step was to formulate a letter of thanks to our patient ambassadors. Ambassadors who participated for 12 months would receive a thank you letter and a small pin as a token of appreciation. The Miriam Hospital Patient Ambassador Program is soon approaching the end of our fourth year. Our Ambassador Program and all these tools are available through the Million Hearts Action Guide.

And listed here is my e-mail and phone contact if anybody wants to reach out to me at an alternative date, later date. I will now turn this over to April with the American Heart Association.

April Wallace: Thank you. Do we have Tammy back? I just want to check in.

Tammy Garwick: Here now, I hope.

April Wallace: Alright. Can we reverse to Tammy's slides, so she can go ahead and present?

Tammy Garwick: Well, let me start by apologizing for the technical difficulties I had. I was cruising along very well and didn't realize I was on an actual headset, so I apologize for the confusion.

My name is Tammy Garwick, I am Manager of Cardiac and Pulmonary Rehab at Mount Carmel Health System in Columbus, Ohio. We have three locations located around the metropolitan area, but I want to talk to you a little bit about what is cardiac rehab and how is it offered.

So, traditional cardiac rehab is three days per week—Monday, Wednesday, and either the third day being a Thursday or a Friday. Many programs have found that offering cardiac rehab on Friday evenings has a significant drop in attendance, so they've switched to Monday, Wednesday, Thursday.

There is nothing within Medicare guidelines or any other guidelines that say that it must be three days per week. Contemporary rehab is one to seven days per week. We offer our programs Mondays and Wednesdays, and we have a concurrent program on Tuesdays and Thursdays. However, we allow flexibility up to four days per week. This allows a patient who may

be returning to work to get in up to four sessions or more per week before they need to get back to work.

To keep in mind, though, Medicare allows up to two billable sessions per day, as long as those two billable sessions last greater than 91 minutes. It is either a combination of a 93798, which is continuous ECG during cardiac rehab and/or a 93797, which is cardiac rehab without continuous ECG monitoring. Most of the traditional cardiac rehab sessions last one hour, where the contemporary can be anywhere from one hour to two hours or even longer as needed.

Things to keep in mind is, commercial payers do have a little bit of variance in this. Some of the commercial payers have their own risk stratification that determines their length of sessions, and this can cause some variance and change in what was the traditional or the 36 sessions within 36 weeks.

When we talk about those two billable sessions of a 93798 and/or a 93797, the guidelines state it's rehab cardiac rehabilitation with continuous ECG monitoring or cardiac rehab without continuous ECG monitoring. Things that can be offered with these services are one on one with a dietitian, one on ones with a psychologist, well coaching done by staff, additional education whether it's group or one on one so that the patient is receiving the education in the manner that is needed or them in the time that it is needed for them.

So, let's think about the hours that cardiac rehab is offered. When you had to a workout yourself and you're headed to a gymnasium—gymnasium is an old term, excuse me [*Laughter*]—headed to a facility, a recreational facility or something else to that matter, what time of day do you like to go? Those are the hours that we need to be available to offer to our patients. The working professional may need to come in early morning before they come to work, or they may need to have later hours so that they can come after 5:30 when they've gotten off work, or before they've gotten involved with children, activities, or other things.

But at the same time, as our population is aging, it is very hard when that population is dependent upon someone else for their transportation. So, we have to provide hours so that our caregivers or our transportation can get off work to bring that patient to the rehab. Offering cardiac rehabilitation from 9 'til 2 just doesn't work for our working professionals, or those who are needed for transportation.

So, one of the things we did at Mount Carmel Cardiac Rehab is, we created an open gym policy. And part of that is, we like to teach and have the mindset that we're more like a gym for the recovering instead of the disease. It allows patients to come and go as they please. Patients choose who they want to exercise. We announce when there is a group education time, and then the patients can schedule accordingly. So, we will offer education at 10 a.m., and again at 2 p.m., and the patients can schedule around either before or after so that they can group what education is needed for them and come whenever they want, knowing how long they plan to exercise.

Some of the limitations of the open gym concept can be staffing and cardiovascular equipment. We are very fortunate that that has not run into a problem for using either situation. Resistance training is often used if we have run tight on cardiovascular equipment, because we can also incorporate resistance training. Resistance training can include the TheraBall, can include TheraBands, free weights, and activities using their own body weight to teach them for balance and other things and decrease the limitation on equipment.

Many programs are limited when the open gym concept because of telemetry monitoring; however, this should not be a limitation. ECG monitoring, as we talked about before, the CPT codes 93797 is outpatient cardiac rehab without continuous ECG monitoring, and 93798 is outpatient cardiac rehab with continuous ECG monitoring. There is nothing within the Medicare guidelines that states how many of each or other that you must have while in the program. You can have your patients go through an entire cardiac rehab program without an ECG monitoring.

We choose to do a risk stratification at Mount Carmel, so based upon their risk stratification, it's how many times they have on the monitor. This frees up monitor space to allow us to get additional patients in, and not be limited by the number of patients that we can see due to ECG telemetry availability. At any time, though, we are able to put a patient back on an ECG monitor for a session if there is a question or needs arise while the patient is in the program.

As Hilary alluded to earlier, there is also the home base versus facility base. Home based programs allow the patient to exercise at home with staff interaction. The patients record their own exercise sessions. They use an accelerometer to determine exercise capacity

and heart rate. Accelerometers, most of us know them as Fitbits, Garmins, Apple Watches, Polar. If you have five people around you who don't have one of these, I'm surprised, because they've become so popular, almost everybody has at least a Fitbit or an Apple Watch.

Patients use a home blood pressure cuff that has been calibrated or checked against professional staff. Staff checks in with the patients on a regular basis. And this depends upon the patient. Sometimes those calls occur once a week, every other week, or even twice a week, depending on the status of the patient. It allows the patient to make progress without the commitment or cost of additional rehab sessions multiple times per week.

Once again, think of a working professional. It's hard to make that commitment three nights a week if you have, let's say, a middle-aged individual to come to rehab three nights a week from 5 to 6 while their kids are in high school athletic sports and unable to drive. So, this allows them to participate and do exercises at home while still having the connection of the rehab staff.

And I think it's—

April Wallace: Thank you, Tammy.

Tammy Garwick: - are we going to April?

April Wallace: Yes, we're gonna go to me now. We have a couple minutes for questions for our speakers. So, again, thank you so much to our speakers for your wonderful presentations.

I'm sorry. If you have any questions, as a reminder, please submit those questions in the chat box that can be located in the right-hand corner, bottom right-hand corner of your screen.

Right now, we have a couple of questions from our presenters. The first question that we have is—is Medicare going to cover diastolic heart failure any time soon? And I think that question was directed towards either Dr. Wright or Hilary.

Hilary Wall: This is Hilary. I'm not certain of that. I'm no Medicare coverage expert. I don't know if Janet is still available and has any insights.

April Wallace: Okay. Well, we can take that question and definitely get back to you and hope for an answer. And for all of those questions that we

are not able to get to, again, we will triage all of those questions to our presenters for follow up.

The second question we received—are patients with afib without an event eligible to participate in cardiac rehab? That may be another one we need to—

Hilary Wall: Yeah, I'm sorry—what was the question?

April Wallace: It was, are patients with afib without an event eligible to participate? That may be another eligibility question we have to do some sort of follow up with that.

Jennifer Newman: I can answer that for you. This is Jennifer Newman. At this time, afib by itself as a diagnosis does not qualify a Medicare patient for cardiac rehab. You have to have had an event.

Tammy Garwick: There are some other commercial payers who will—

Jennifer Newman: Perhaps. Perhaps, yes.

Tammy Garwick: - [Cross talk] but that takes a little bit more investigation. But as a global one, I would agree with Jennifer—it is not yet defined as a covered diagnosis.

April Wallace: Great, thank you. The next questions are—are these tools free? And that is to, I believe, Hilary.

Hilary Wall: Oh, definitely. I mean, so, if you go to that URL that I included on one of the slides for the Change Package, in it, it's organized in such a way that all of the tools are hyperlinked. So, they're all available for free for your downloading pleasure, and the programs from which we got the tools were gracious enough to share them with us and make them available to all who were interested.

April Wallace: Thank you, Hilary. Loren, I believe this is a question for you—does your community have Mended Hearts? This person says, “We have considered a similar program using Mended Hearts visitors, and do you have any suggestions to incorporate Mended Hearts and the Patient Ambassador Program?”

Loren Stabile: Yes. So, first of all, is my mic on, can you hear me?

April Wallace: Yes, we can hear you.

Loren Stabile: Oh, okay. I just wanted to make sure I wasn't muted. So, we had a Mended Hearts program in Rhode Island, and for the last several years, the participation in Mended Hearts diminished, and it wasn't very active.

So, I certainly can see how Mended Hearts could be integrated into a Patient Ambassador Program, because these are typical patients who are part of this support group who have been through cardiac rehab. We just wanted these particular patients to know our program and to have successfully completed our program so that they then in turn can speak to the newer patients coming in. So, they developed kind of a buddy-buddy relationship with the patients that were new, and they felt comfortable speaking to the program and what the program did for them.

I don't see why you couldn't work alongside with the Mended Hearts group.

Jennifer Newman: I have some commentary on that as well, if I may—this is Jennifer Newman, again, here from Missouri. And we do have a Mended Hearts chapter, a formal Mended Hearts chapter that's affiliated with the national and I believe possibly even international folks at this point. And we have a patient visitor program where we screen our inpatients for appropriateness of having a lay visitor, and then those Mended Hearts members volunteer, and after the appropriate training, go into the bedside and speak with the patients post procedure and the families and invite them to the meetings which are monthly.

And we have waxes and wanes as well in our participation. It really depends on who's leading that, so you have to have a good, engaged patient advocacy person that is not a staff member. So, largely, the success of those chapters have to do with the community members. But they are—they do have a lot of resources within the Mended Hearts International that could help get a chapter going and then sustain a chapter if you did have some dedicated volunteers that would be willing to commit a few hours a month to it.

April Wallace: Thank you, all, for the feedback. In the interest of time, again, we are going to capture all of your questions. We thank you for submitting them. We will do appropriate follow up with each of our speakers.

I will now pass the mic to Robin Rinker from the CDC to share some updates from Million Hearts.

Robin Rinker: Thanks so much, April. And I am actually going to open the floor to some of my colleagues here at CDC—Shelby Barnes and Haley Stolp to share a few more words about the Cardiac Rehab Toolkit and other cardiac rehab activities going on at CDC.

Shelby Barnes: Thanks, Robin. This is Shelby Barnes with the Million Hearts team, and I briefly wanted to just talk about the Million Hearts Cardiac Rehabilitation Communications Toolkit. Janet did a great job sort of laying the foundation and sharing with you the asks that we have with the Communications Toolkit.

And I think we're gonna go back to that slide, but if not, I just wanted to share—so, this toolkit was assembled based upon insights and feedback that we received from a wide variety of our partners, and as you know, there was a charge for Million Hearts to really drive a lot of the cardiac rehabilitation messaging. So, we created this toolkit with the hopes that it will equip our partners with resources and messages to spread awareness about the value of cardiac rehabilitation.

And so, Janet mentioned through this effort, we've set a goal of reaching 5,000,000 people with these messages, and so, we are tracking those efforts. And so, if you do end up sharing—which we hope you do—share these messages, we hope that you'll be able to share the reach of those with us through our MillionHeartsCRC@CDC.gov e-mail. And so, basically, the toolkit has a wide range of resources for you, including key messages with examples like, “Cardiac rehabilitation saves lives” and another one is, “A strong recommendation by a patient physician can greatly increase the likelihood of participation.” We have some great educational materials from AACVPR and a Million Hearts infographic.

We have a suite of social media content. We are using the hashtag #CRSavesLives to help us capture the reach of not only our messages but our partners’ messages as well. And another neat feature we have is the syndicated web content.

So, you can basically put the Million Hearts Cardiac Rehab webpage on your own website. So, there is a link on the toolkit that will take you to the CDC public health media library, and if you just pull in your comms person or someone that knows how to embed that code, you can easily do that on your webpages, and that updates in real time as we update that sort of stuff.

And then lastly, just the e-mail is at the bottom. If you have any questions, you can e-mail that or send us the reach of your messages. And then the link at the bottom there is to the Communications Toolkit itself. Thanks.

Haley:

This is Haley. I just wanna add that the American Heart Association Health Research and Educational Trust has had an opportunity on their Huddle for Care platform to capture success stories around cardiac rehab, and we'd encourage any hospital or health system out there that has worked in cardiac rehab and improved outcomes to share the success—including those that presented on today's call—share their success stories on Huddle for Care and submit a story, so if you put that into Google, it should pop up, we'll send a link out afterwards.

Also, regarding our Cardiac Rehab Collaborative, our quarter phone call, again, is November 7th. That's from 12:30 to 2 p.m. This is a group of about 180 members or 80 organizations that have committed to the cause of increasing cardiac rehab participation to 70 percent. Our call will be closing out the year and celebrating the achievements of the Cardiac Rehab Collaborative, which are pretty substantial this year. We'll have a best practice focus on improving program efficiencies, so speaking to some of those changes that were even shared during today's call and highlighting what pearls and pitfalls people have experienced in improving efficiency in programs for the cause of increasing enrollment, and then we'll walk through our five objectives to ensure that we're capturing all that's being done in the world of communications, policy work, monitoring, and promoting those best practices in the change package.

Feel free to e-mail—again, that address, MillionHeartsCRC@cdc.gov if you'd care to join the Cardiac Rehab Collaborative. Thanks.

Robin Rinker:

And that's all from CDC. I know we have some updates from our colleague, Amy Knight, at AACVPR. Amy?

Amy Knight:

Hi. My name's Amy Knight, I'm a board member of the American Association of Cardiovascular and Pulmonary Rehabilitation. It was our honor to work in collaboration with the CDC and the partners on Million Hearts to develop and to work to finalizing in a really amazing turnaround time the Cardiac Change Package. It's work that many people were involved in. We're so impressed with the timeliness in the turnaround and just the mechanisms that CDC operates to get this kinda thing done.

On behalf of AACVPR, we were honored to have Dr. Betsy Thompson present at our annual meeting in September, and we launched the Cardiac Rehab Change Package to all attendees at this meeting. In addition, part of AACVPR's core strategic mission and goals include a concept of value based care, which is instrumental to the kinds of turnkeys and resources that are within the Cardiac Change Package.

Part of our objectives for the remainder of the year and into next year will continue to promote these resources on our webpage. We have a repository page for these resources as well as other turnkeys which we are continuing to develop to help streamline and guide programs and practices to better care and more adherence and enrollment and referrals. To that end, we also produced three webinars that are more case based programs that we shared with over 1,000 members over the summer, three different programs highlighting some of the projects we talked about today. We will continue that into next spring. We also have partnerships with our affiliate members to establish a value-based care initiative at all the regional levels and finally, at our annual meeting, we will continue to focus on Change Package and opportunities for value based care. Thank you.

April Wallace:

Thank you so much, Amy. And we thank you, all, today for joining us. We'd like to thank all of our presenters, those organizations who provided updates. Also, if you have any additional updates that you'd like for us to include in our follow up e-mail, please feel free to submit those in the chat box as well, and we'll include those along with some other resources that were mentioned on today's call.

Thank you for joining. The next partner call will be January 29th, 2019, at 1 p.m. Eastern Standard Time. Have a great day.

[End of Audio]