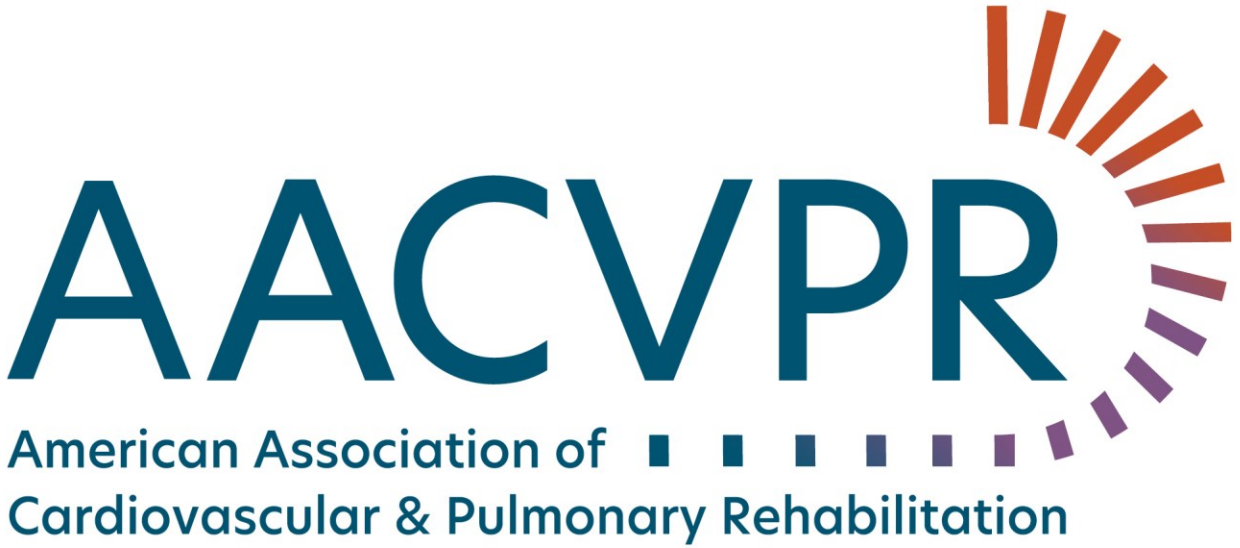

AACVPR
American Association of
Cardiovascular & Pulmonary Rehabilitation

2026 Program Certification Weekly Reviewer Meeting Tuesday, April 7, 2026

Certification Chair – Julie Dunagan, MS, CCRP, FAACVPR
Remediation Chair – Kara Sweere, RN, RCEP, CCRP, FAACVPR

Clarification on Physician Signatures and EMRs

For the new question within the ITP Review page where we ask if the ITP is from an EMR, we would like to clarify that on you will only need to flag the ITP if the signature is electronic signed within the EMR.

We have clarified the question language within the application and are including examples of what should be marked for review and what should not be marked for review.

- If EMR ITP and it is electronically signed, then “Yes” should be selected.
- If telemetry ITP and it scanned into EMR and signed within the actual EMR, then this should be selected.
- If telemetry ITP and it is electronically signed on the actual telemetry ITP or there is hand written signature then this should NOT be selected.
- Any hand written ITP with hand written signatures does not need this to be selected.

New Question Language Within Application

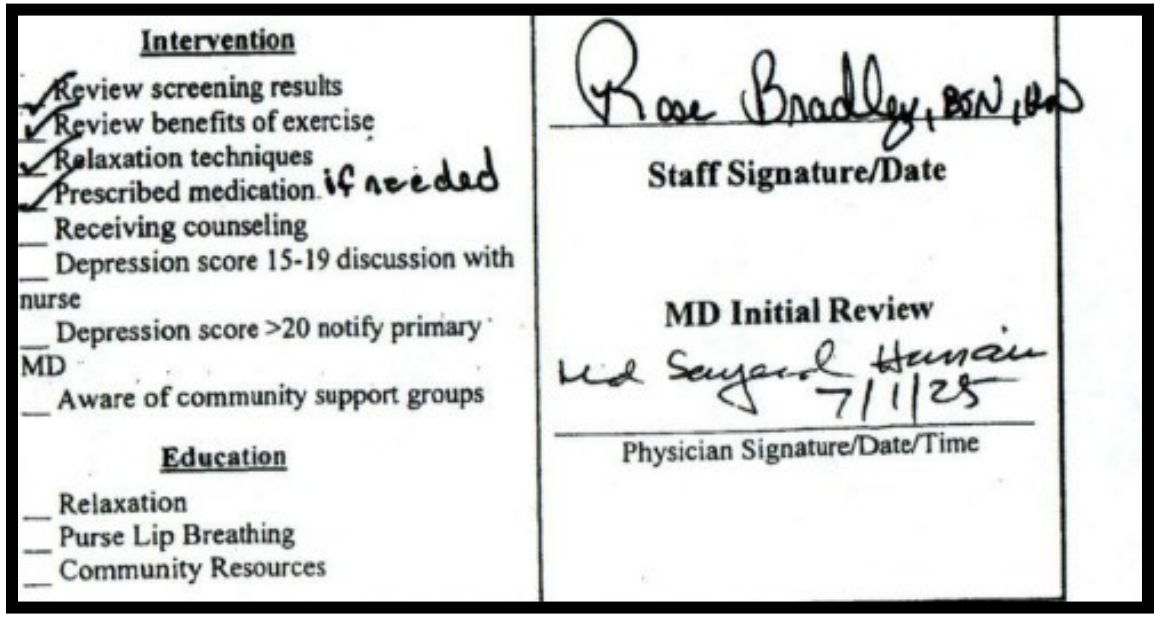
New question: EMR Physician Signature Review: Signature is Electronic & signed within the EMR?

Options:

- Yes, Signature is Electronic and signed within the EMR.
- No, ITP is from telemetry system and signed within the telemetry system or hand written.
- No, ITP is handwritten with handwritten signature

Signatures – Do not need to be flagged

Handwritten ITP & Handwritten Signature



Intervention

- ✓ Review screening results
- ✓ Review benefits of exercise
- ✓ Relaxation techniques
- ✓ Prescribed medication if needed
- __ Receiving counseling
- __ Depression score 15-19 discussion with nurse
- __ Depression score >20 notify primary MD
- __ Aware of community support groups

Education

- __ Relaxation
- __ Purse Lip Breathing
- __ Community Resources

Rose Bradley, BSN, RN

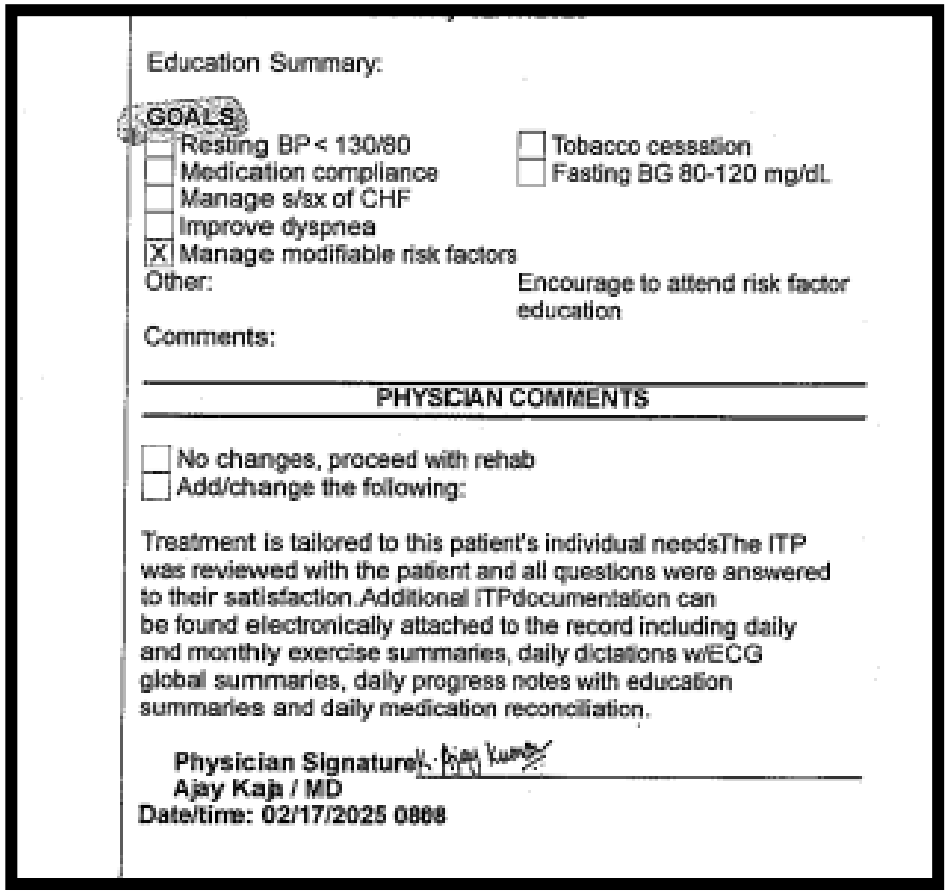
Staff Signature/Date

MD Initial Review

Med Surgical Hospitalist 7/1/25

Physician Signature/Date/Time

Telemetry ITP & Telemetry Signature



Education Summary:

GOALS

- ☐ Resting BP < 130/80
- ☐ Medication compliance
- ☐ Manage s/sx of CHF
- ☐ Improve dyspnea
- ☒ Manage modifiable risk factors
- ☐ Tobacco cessation
- ☐ Fasting BG 80-120 mg/dL

Other: Encourage to attend risk factor education

Comments:

PHYSICIAN COMMENTS

- ☐ No changes, proceed with rehab
- ☐ Add/change the following:

Treatment is tailored to this patient's individual needsThe ITP was reviewed with the patient and all questions were answered to their satisfaction.Additional ITPdocumentation can be found electronically attached to the record including daily and monthly exercise summaries, daily dictations w/ECG global summaries, daily progress notes with education summaries and daily medication reconciliation.

Physician Signature: Ajay Kaja

Ajay Kaja / MD

Date/time: 02/17/2025 0808

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Signature Examples - Flag For Review

EMR Electronic Signatures That SHOULD be flagged for review

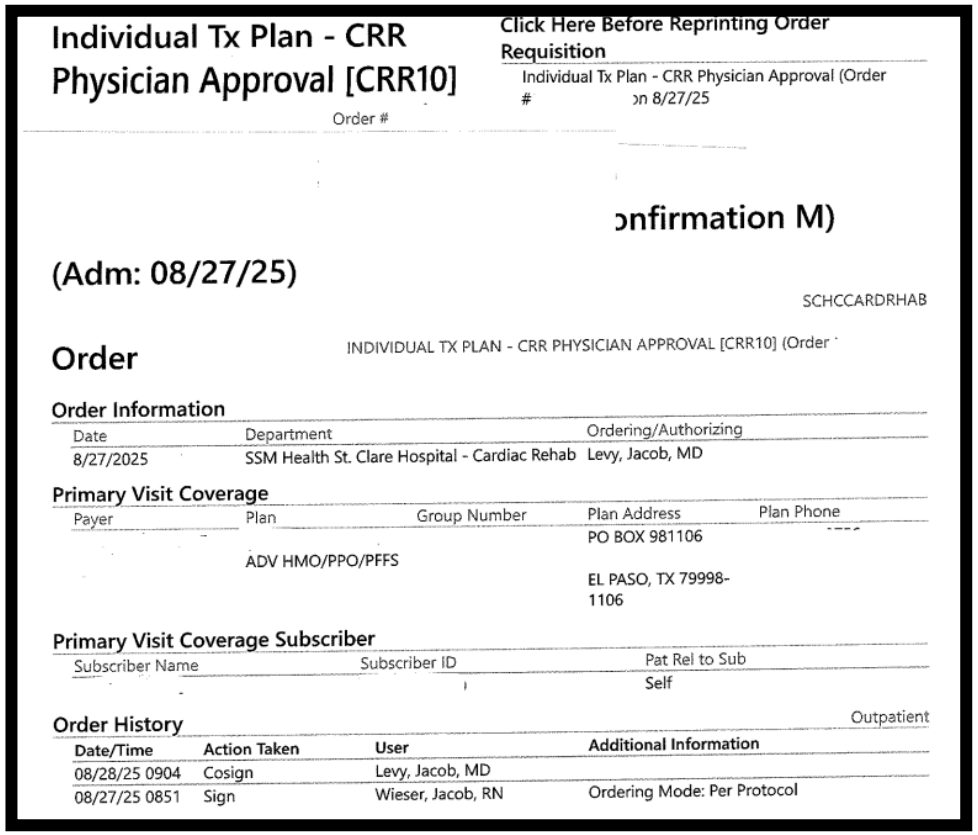
verbalized understanding.)

PROVIDER ATTESTATION
I have reviewed and agree with the Individual treatment Plan: goals/progress/outcomes.

Current Participants as of 10/6/2025

Name	Type	Comments	Contact Info
Rodrigo Jesus Mendirichaga Magana, MD	Physician		603-516-4265

Electronically signed by Rodrigo Jesus Mendirichaga Magana, MD at 10/6/2025 1532 EDT



Individual Tx Plan - CRR Physician Approval [CRR10]

Click Here Before Reprinting Order Requisition

Individual Tx Plan - CRR Physician Approval (Order #) on 8/27/25

Order #

onfirmation M)

(Adm: 08/27/25)

SCHCCARDRHAB

Order

INDIVIDUAL TX PLAN - CRR PHYSICIAN APPROVAL [CRR10] (Order

Order Information

Date	Department	Ordering/Authorizing
8/27/2025	SSM Health St. Clare Hospital - Cardiac Rehab	Levy, Jacob, MD

Primary Visit Coverage

Payer	Plan	Group Number	Plan Address	Plan Phone
	ADV HMO/PPO/PFFS		PO BOX 981106 EL PASO, TX 79998-1106	

Primary Visit Coverage Subscriber

Subscriber Name	Subscriber ID	Pat Rel to Sub
		Self

Order History

Outpatient

Date/Time	Action Taken	User	Additional Information
08/28/25 0904	Cosign	Levy, Jacob, MD	
08/27/25 0851	Sign	Wieser, Jacob, RN	Ordering Mode: Per Protocol

AACVPR

Reviewer Question (Emergency Preparedness)

Q: Question regarding example provided for emergency preparedness scenario where patient names were given. Wanted to clarify if this was HIPPA violation or fake patient data.

A: Deny because it is not clear that this is a mock event.

2026 Cardiac Page 4 Emergency Preparedness: Review Page

In-Service Emergency Type 1:	Angina/Chest Pain
Date:	3/21/2025
Description:	Sally, a 77-year-old NSTEMI/PCI patient, is using the arm ergometer when she develops chest pressure, speaks up, and says that her chest feels heavy. nurse 1 directed Sally to stop using the arm ergometer and just sit and rest. They asked her where the pressure is (central chest), if it radiates (no), and how severe it is (8/10). They obtained vitals (Sinus Tach with HR 106, BP 140/70), asked if she had nitroglycerin, and Sally said she gets this pressure sometimes. Sally placed one nitro tab under her tongue and then waited 3-5 minutes. She had mild relief – 6/10. She was given a second nitro with similar results in 3-5 minutes (5/10 with BP of 120/78). A third nitro was given, and they decided to either call 911 or wheel Sally to the ED depending on how stable she seemed. Her chest pressure was 4/10, BP 100/65, HR 92. No other symptoms. Afterwards, they would notify her MDs with an event report and call her emergency contact.
In-Service Emergency Type 2:	Cardiopulmonary Arrest
Date:	6/4/2025
Description:	One of our TAVR diabetic patients Paul (57), is using the Arm Ergometer when he states he just developed chest pain and palpitations that are pounding. Diagram of V-Tach Rhythm The staff has Paul sit in a chair, get his BP – 90/50, and nurse 1 identifies the heart rhythm as V-tach and the rate is 180. Our exercise specialist gets our cardiologist. Paul is lowered to the floor in a supine position, the Defib pads and Lifepak leads are attached to him. The symptoms continue, he remains conscious, and his O2 Sat is 88%. RT places a nasal cannula on him and sets it to 4L. Our director has all other patients go to the waiting room and calls 911. Paul's BP is now 60/40. Following the MD's direction or using the Tachycardia Algorithm in the Code Cart book in the absence of an MD, we synchronized cardioverted Paul at 100 Joules. Paul became unconscious, and nurse 2 checked for breathing and a pulse. Not breathing and no pulse felt. Nurse 3 calls a Code Blue on the phone, CPR is started with compressions, the ambu bag is attached to supplemental O2. His rhythm is V-tach, so as soon as the Lifepak is set at 200J and charged, pt is cleared then shocked. CPR is resumed immediately after shock. If not already done, Nurse places an IV and then Epinephrine 1 mg is given IV push. After 2 minutes of CPR, still no pulse and V-tach. Pt is now defibrillated at 300 J, CPR is resumed, and thankfully EMS arrives and takes over.

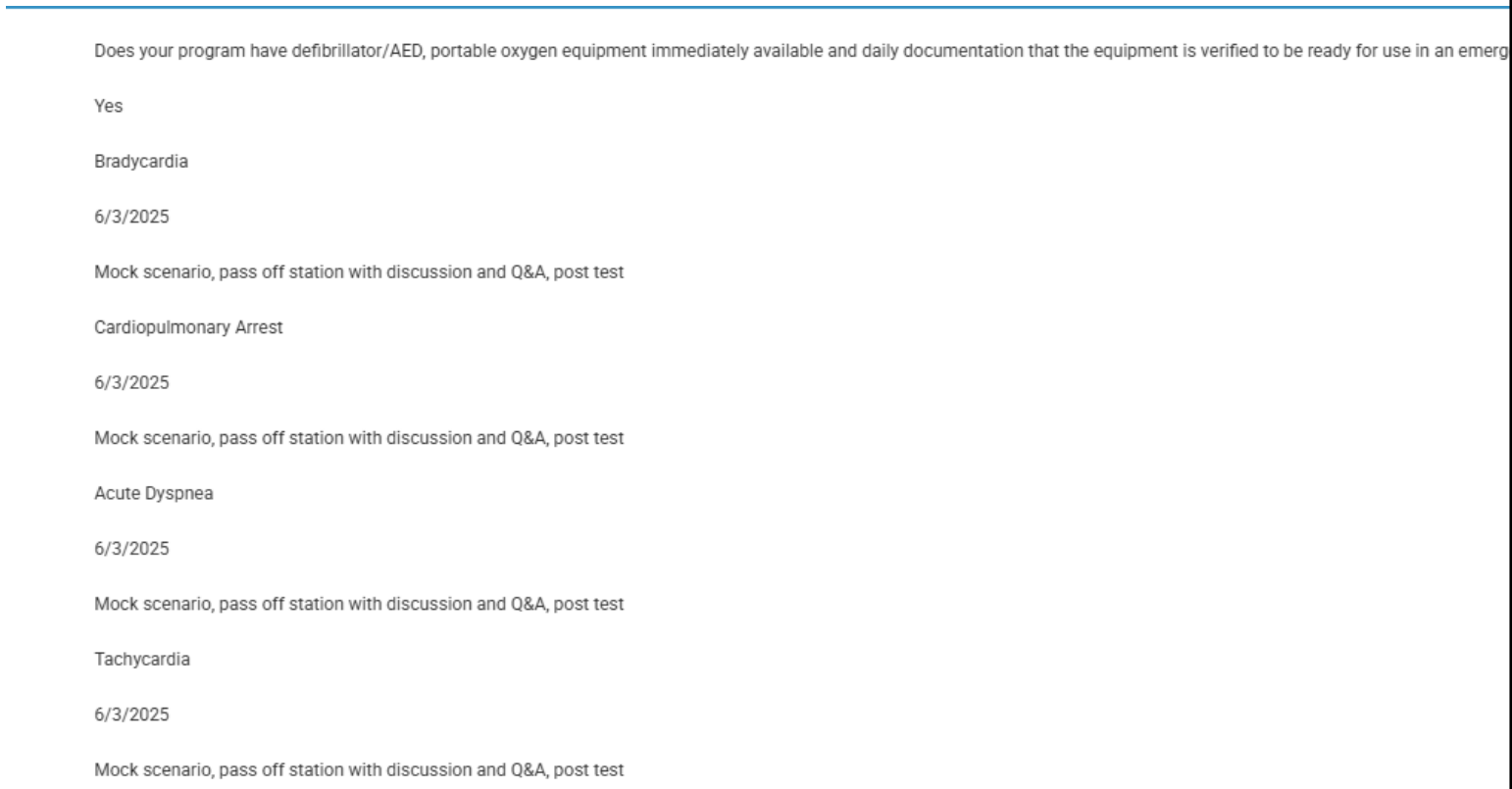
*Question From Reviewer M. Frickel (Emergency Preparedness)

AACVPR

Reviewer Question (Emergency Preparedness)

Q: For Emergency Preparedness, is this enough description to meet requirements? I'm going with yes, because it is the bare minimum.

A: Deny. Not enough detail to determine what the mock code was actually covering.



Does your program have defibrillator/AED, portable oxygen equipment immediately available and daily documentation that the equipment is verified to be ready for use in an emerg

Yes

Bradycardia

6/3/2025

Mock scenario, pass off station with discussion and Q&A, post test

Cardiopulmonary Arrest

6/3/2025

Mock scenario, pass off station with discussion and Q&A, post test

Acute Dyspnea

6/3/2025

Mock scenario, pass off station with discussion and Q&A, post test

Tachycardia

6/3/2025

Mock scenario, pass off station with discussion and Q&A, post test

*Question From Reviewer M. Frickel (Emergency Preparedness)

AACVPR

Reviewer Question (New Plans - Adherence PM)

Q: I do not see any NEW PLAN(s) for implementation and the program only achieved 100% with the Tobacco domain which I approved. The rest of the implementations for a new plan do not exist, just the current plans they have made.

A: Deny. Not a new plan, only talking about what the program did already within the last year.

Northwest Medical Center (19540): 2026 Cardiovascular Certification Application

2026 Cardiac Page 11 Adherence Performance Measure

REVIEWER COMMENTS:

The adherence performance outlined below does not appear to present a new plan to improve adherence. While several changes have been made, they do not represent a newly developed approach. I would appreciate the Board's perspective on this.

ANSWER:

This past year we worked to make exercise class times more amenable to patients who have busy lives. We added in extra am class (7:30 am) to meet the needs of our patients, and though we have delineated cardiac rehab classes at MWF and pulmonary rehab as TTh, we opened up all our classes to both so patients can have ease of access between their appointments and active lives. Additionally, we added 2 more monitors to our Scottcare monitor capability for a total of 16, allowing us to accommodate for drop ins and not be saturated at any one time. This has also helped us accommodate busier mornings in the summer Tucson months, and busier afternoon's in the winter. Since we are aware we usually loose our avid exercisers first—those who prefer to return to their hiking, cycling, running Tucson lifestyles—as a team we assign certain staff members who would challenge such individuals, and help them meet their goals long term, rather than get frustrated at the surrounding pace of cardiac rehab patients who may have orthopedic limitations or different goals entirely. We also continue to see greater retention with focused time spent during 30-day reassessments, and we made it a point to take time to talk with those patients who have questions and concerns. We have also added a "Cardiac Rehab Benefits" page to a cardiac rehab education folder we explain to patients day one so they understand the value. We have them sign an accountability statement, encouraging them to call when they will not be here for their assigned time. This past year, we also changed our rhetoric regarding the rehab, calling it a "clinic" to patients and not simply "the gym" to encourage consistent participation. If co-payments are too high for patients and they are considering ending CR after session one, we encourage them with understanding, letting them know that, "Even if they were to attend at least 12 sessions (and not the full 36 available), we could give them tools to be successful, and they would derive great benefit." Every cardiac rehab staff member has been here for 10 plus years and patients who graduate with us repeatedly comment on how much they appreciated the time we took with them to develop a kind rapport and how well our staff work together.

*Question From V. Yandle (New Plans – Adherence PM)

Reviewer Question (New Plans – Enrollment PM)

Q: Does the enrollment performance offer a new plan?

A: No, deny because the plan clearly references 2025 and that is within the past year and not a new plan.

2026 Cardiac Page 10 Enrollment Performance Measure: Review Page

REVIEWER COMMENTS:

The Enrollment performance outlined below does not appear to present a new plan to improve adherence. While several changes have been made, they do not represent a newly developed approach. I would appreciate the Board's perspective on this.

ANSWER:

This year we faced the loss of two cardiovascular surgeons and two major referring interventional cardiologists. To augment enrollment and account for this loss, we improved our phase one interventions to increase patient and family buy-in post stents and CV surgeries. For example, our clinic is a short walk inside the hospital from CVICU, and it has been a good milestone to walk phase one patient's post-surgery directly from CVICU to the clinic, showing them where they will recover in cardiac rehab. Whenever these fresh open-heart patients walk to us safely assisted with walker/IV pumps/monitor, we give them a warm welcome and create an initial rapport so they feel good about coming to us four weeks post-surgery. Since we have moved to the ITP model of obtaining a medical history over the phone prior to an in-person exercise intake, in 2025 we began to obtain the phone intake portion during phase one in the hospital, which has created additional buy-in for patient and family members, and when we call to schedule the patients, the value of cardiac rehab has already been demonstrated to them. In addition, we worked this past year with the cardiac cath lab director to add to doctor's computer order favorites an automatic cardiac rehab order to generate post stent. In the past year, our phase one staff has created a strong rapport with our one remaining CT surgeon, and she has buy in with the value of cardiac rehab, writing many of our referrals this past year.

*Question From V. Yandle (New Plans – Enrollment PM)

Reviewer Question (New Plans – Depression PM)

Q: Does the Depress review page provide a new plan?

A: Deny. Details say new this past year, not a new plan.

2026 Cardiac Page 9 Improvement In Depression: Review Page

REVIEWER COMMENTS:

The Improvement in Depression outlined below does not appear to present a new plan to improve adherence. While several changes have been made, they do not represent a newly developed approach. I would appreciate the Board's perspective on this.

ANSWER:

We have seen this measure improve in our clinic. Every staff member has been at our clinic for ten years or more, and as a team, we focus on mental health as a priority, allowing time to listen to patients' needs and concerns, referring them to their physicians or counselors when necessary during initial evaluations and re-assessments. New this past year, we have solely focused on patients with a score of 5 or greater during our exercise intakes, with a collaborative discussion regarding recent stressors or mood changes as they relate to any sleep disturbances, appetite, fatigue, etc. If patients' PHQ-9 is 10 or higher, we have patients answer a brief form to rule out suicidal ideations and contact their physician if necessary. During our intitial ITP/exercise intake discussion, we combine our PHQ-9 discussion with our conversation about stressors to develop effective coping strategies such as regular exercise at cardiac rehab to improve energy and mood, discussing patient nutrition to improve appetite, inquiring about patient interests to encourage patient engagement, and determining if patient has supportive loved ones. Ultimately, for those with a score of five or higher, after first identifying if their needs for safety, dignity, nutrition and community are being met, we encourage them to talk about current stressors and fears, how they currently cope, and in collaboration we offer healthy alternatives, such as writing down three "glimmers" or highlights at the end of each day which can help with the neuroplasticity of the brain, engaging in regular exercise to improve mood, and reading, meditation or prayer (if appropriate to the person) to bring hope. New this past year, if a patient has a particular hobby or interest and we know they are struggling emotionally, we encourage them to bring in photos or examples of their craft or hobby that we can all celebrate and enjoy. We have had artists, crafters, woodcrafters, writers, and poets share their interests and talents with us and it builds community for them. Overall, with experience caring for this vulnerable population we serve, we exercise compassionate listening, recognizing that loneliness and fear over health are two of the major issues our patients face, and we work to engender trust and rapport to help alleviate their initial reservations regarding not only actively engaging to improve their health but also improve their quality of life.

*Question From V. Yandle (New Plans Depression PM)

AACVPR

Reviewer Question (New Plans – Blood Pressure PM)

Q: Does the Blood Pressure plan appear to be new?

A: Deny. Program already acknowledges seeing improvements with the plan, so it is not new plan.

2026 Cardiac Page 7 Optimal Blood Pressure Control: Review Page

REVIEWER COMMENTS:

The Optimal BP control outlined below does not appear to present a new plan to improve adherence. While several changes have been made, they do not represent a newly developed approach. I would appreciate the Board's perspective on this.

ANSWER:

We have seen an improvement in achieving optimal blood pressure by noting as staff next to our daily schedule who tends to run high and monitoring different approaches with these patients. Beyond the extra 3-5 minute period of rest we normally give to those we know tend to run high, we also walk away during their measurement to not encourage talking and if the trend continues, we encourage 20 counts of deep abdominal breathing with thoughts of gratitude. We also provide education by introducing a small biofeedback session that can be attached to our phone; the app teaches a patient how they can potentially help regulate their own blood pressure. For those particularly anxious patients who respond to a second measurement with even higher pressures, if abdominal breathing does not initially help, we have introduced nervous system practices to stimulate their vagus nerve, such as pulling on the ears or simple bilateral stimulation (alternatively tapping each thigh). If their hypertensive trend is consistently suboptimal over three sessions, we reach out to their physicians for an evaluation and medication review.

*Question From V. Yandle (New Plans Blood Pressure PM)

AACVPR

Reviewer Question (New Plans – Functional Capacity PM)

Q: Does the Functional Capacity plan appear to be new?

A: Deny. Program not showing anything new that they are doing.

2026 Cardiac Page 6 Improvement in Functional Capacity: Review Page

REVIEWER COMMENTS:

The Improvement in Functional Capacity outlined below does not appear to present a new plan to improve adherence. While several changes have been made, they do not represent a newly developed approach. The program did not achieve 100%. I would appreciate the Board's perspective on this.

ANSWER:

We have seen an improvement in this metric since we began stressing to patients the importance of intensity improvements using multiple approaches. Utilizing the RPE, we explain how, "Today, this may feel difficult, but over time, this will become easier, and your RPE will change. The goal is to keep increasing your intensity level, keeping your RPE in the 12-14 range." Additionally, when they report their RPE between exercises, if they report an 11 "fairly light" or below, we have begun using rhetoric to encourage intensity increases during their next session such as, "Next time, I'd like to see you increase your resistance level (or intensity)," offering to help set that up if patients are unsure. Overall, we recognize that those who don't reach the 40% MET level increase are usually patients who begin on the NuStep for orthopedic or other issues; these patients are hesitant to make big intensity increases due to joint pain, and the lower level modalities do not generally allow for substantial MET level increases. However, we continue to encourage increases based on their reported RPE, transitioning to higher level recumbent bikes if appropriate. During intakes on treadmills, if appropriate, we begin patients on an incline so they get used to the idea of adjusting increases in speed and incline over time. Also, during intakes, we stress to patients the importance of watching their watts and reporting their max watts on a particular modality. As a group, we communicate with each other about who is really appropriate for the popular NuStep's and other lower intensity recumbent bikes so that those patients who can be challenged, and move on to more challenging modalities (upright bike ergometers, air dynes, treadmill and rower). During ITP reassessments, we are monitoring how much higher their MET level has increased since 30 days prior, and making changes to either educate or show patients directly how to monitor their intensity increases themselves using RPE as a gauge. During graduations, we encourage patients to continue using RPE as a gauge to continue making intensity increases during their home exercise.

*Question From V. Yandle (New Plans Functional Capacity PM)

Reviewer Question (New Plans – Adherence PM)

Q: Does the Adherence plan appear to be new?

A: Deny. Program continues to say within the last year. No new plan provided.

2026 Pulmonary Page 10 Adherence Performance Measure: Review Page

Answer:
Overall, new for this past year, we worked to make exercise class times more amenable to patient schedules. We added an extra am class on MWF (730am) to meet the needs of our patients, and though we have delineated cardiac classes at MWF and pulmonary as TTh, we opened up all our classes to both so patients can have ease of access between all their appointments and busy lives. Our pulmonary patients are for the most part inconsistent attenders secondary to illness, weather changes, ride availability, etc, and so we removed any impediment by allowing them to attend anytime of the week if they are unable to make their designated clinic time. Another new thing we implemented is to ensure we repeat 6MWT/CAT and SOB at the 10th session and then directly communicate any positive increases by the end of their 10th session since their first session, contributing to both their confidence and pulmonary rehab experience and overall adherence to continue the program. In essence, they looked forward to more improvements in QOL/SOB and 6MWT by the time they reached a 36th session. We also continue to see greater retention with focused time spent during 30-day reassessments, and we made it a point to take time to talk with those patients who have questions and concerns. If co-payments are too high for patients and they are considering ending PR after session one, we encourage them with understanding, letting them know that, "Even if you are able to attend at least 10 sessions (and not the full 36 available), we can give you tools to be successful, and you will derive great benefit." Every pulmonary rehab staff member has been here for 10 plus years and patients who graduate repeatedly comment on how much they appreciated the time we took with them to develop a kind rapport and how well our staff work together.

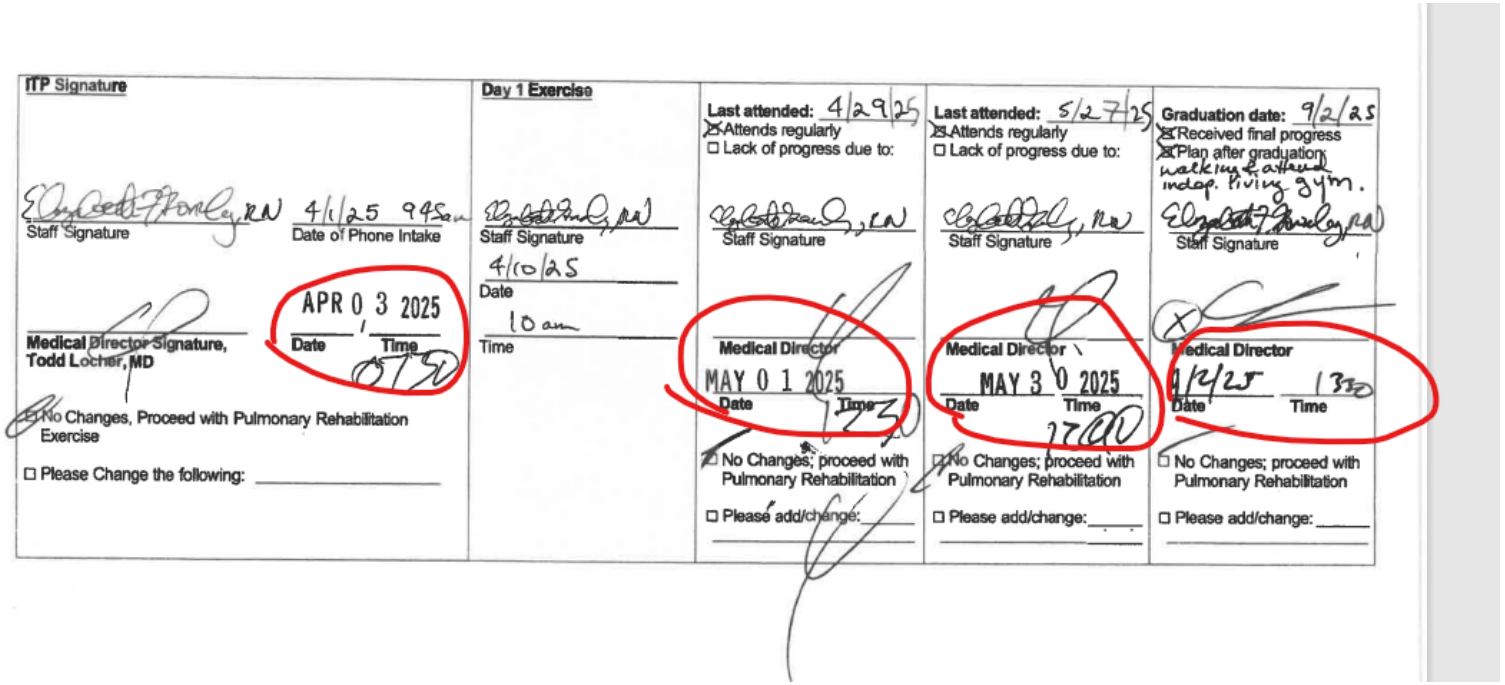
*Question From V. Yandle (New Plans Adherence PM)

AACVPR

Reviewer Question (ITP)

Q: Per the reviewer: Not all physician signatures are present on the ITP. It goes from 4/3/25; 5/1/25; 5/30/25 then 9/2/25, No signatures from 5/30/25 to 9/2/2025. I understand that they only included One Assessment, but I thought they were supposed to show all physician signatures from start until end of ITP. **This would be a denial.**

A: Deny. Program does have all the MD signatures listed on the last page of the ITP, but the date for July is not clearly visible. No way to determine if July signature is within the 30-day window.

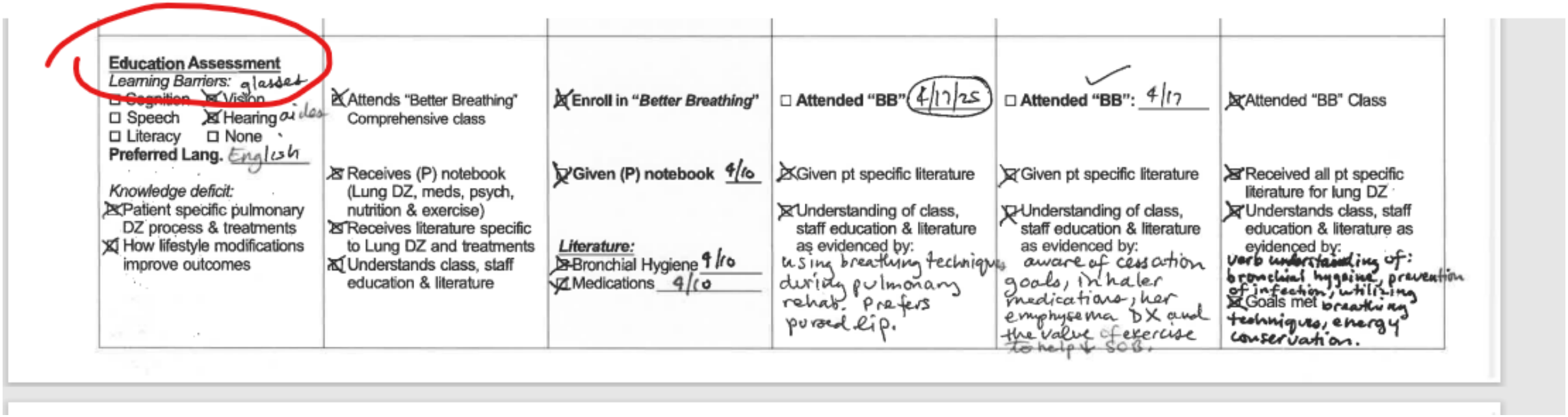


*Question From V. Yandle (ITP)

Reviewer Question (ITP cont.)

Q: Per the reviewer: **EDUCATION** is listed as a header. **Would this would be a denial?**

A: Approve. As long as education is within each domain area it meets the requirement. Even if education has it's own header.



Education Assessment					
Learning Barriers: glasses ☐ Cognition ☒ Vision ☐ Speech ☒ Hearing aides ☐ Literacy ☐ None **Preferred Lang.** English *Knowledge deficit:* ☒ Patient specific pulmonary DZ process & treatments ☒ How lifestyle modifications improve outcomes	☒ Attends "Better Breathing" Comprehensive class ☒ Receives (P) notebook (Lung DZ, meds, psych, nutrition & exercise) ☒ Receives literature specific to Lung DZ and treatments ☒ Understands class, staff education & literature	☒ **Enroll in "*Better Breathing*"** ☒ **Given (P) notebook** 4/10 ***Literature:*** ☒ Bronchial Hygiene 4/10 ☒ Medications 4/10	☐ **Attended "BB"** 4/17/25 ☒ Given pt specific literature ☒ Understanding of class, staff education & literature as evidenced by: using breathing techniques during pulmonary rehab. Prefers pursed lip.	☐ **Attended "BB":** 4/17 ☒ Given pt specific literature ☒ Understanding of class, staff education & literature as evidenced by: aware of cessation goals, inhaler medications, her emphysema DX and the value of exercise ~~to help~~ ↓ SOB.	☒ Attended "BB" Class ☒ Received all pt specific literature for lung DZ ☒ Understands class, staff education & literature as evidenced by: verb understanding of: bronchial hygiene, prevention of infection, utilizing ☒ Goals met breathing techniques, energy conservation.

*Question From V. Yandle (ITP)

AACVPR

Reviewer Question (Staff Competencies)

Q: Per the reviewer: While each of the objectives aligned with the knowledge and skills for pulmonary rehab staff, there was no formal test score that was considered passing. I believe they have met the absolute minimum requirements, but my recommendation would be to have a test with a passing score of 80% demonstrated competency.

A: Approve. Since it says that the staff successfully completed, and that there is a reference for review by leadership. Meets criteria.

Patient Assessment and Management

Competency was assessed using the AACVPR Pulmonary Rehabilitation competency-based educational module and associated knowledge assessment. Staff successfully completed the AACVPR competency content and post-assessment to demonstrate understanding of pulmonary patient assessment principles. Competency was further reinforced through application of this knowledge in clinical practice, including accurate documentation and participation in pulmonary rehabilitation patient evaluations under the oversight of program leadership. Completion of the AACVPR competency assessment and satisfactory clinical application were used to determine competency.

Dyspnea Assessment and Management

Competency was assessed through completion of the AACVPR Pulmonary Rehabilitation dyspnea management competency module and associated knowledge assessment. Staff demonstrated competency by successfully completing the educational content and post-assessment and by applying dyspnea assessment and management strategies during supervised pulmonary rehabilitation sessions. Program leadership reviewed clinical performance and documentation to confirm appropriate application of dyspnea management principles

Oxygen Assessment / Management / Titration

Competency was assessed through completion of the AACVPR Pulmonary Rehabilitation oxygen assessment and management competency module and corresponding knowledge assessment. Staff demonstrated competency by successfully completing the AACVPR assessment and by applying oxygen monitoring and management principles during patient care activities. Clinical practice was reviewed by program leadership to ensure safe and appropriate application of oxygen management consistent with program standards.

Psychosocial Management

Competency was assessed through completion of the AACVPR Pulmonary Rehabilitation psychosocial management competency module and associated knowledge assessment. Staff demonstrated competency by successfully completing the educational content and post-assessment and by appropriately addressing psychosocial considerations during pulmonary rehabilitation sessions. Program leadership evaluated clinical interactions and documentation to confirm competency.

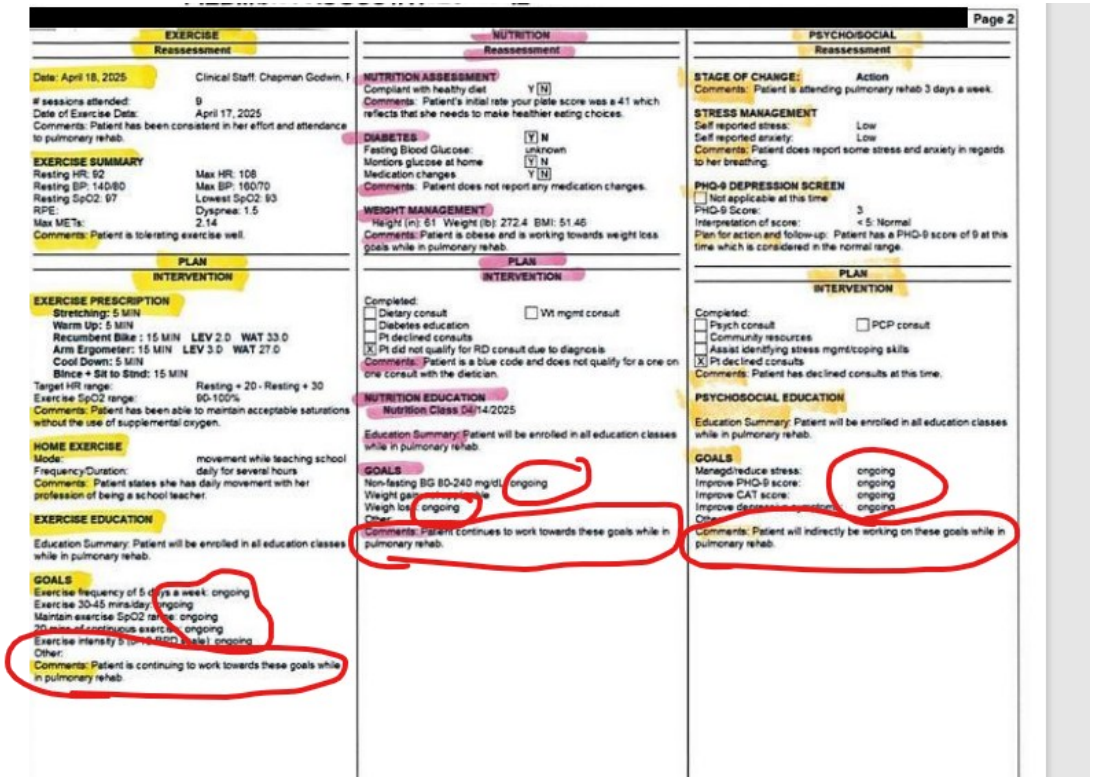
*Question From V. Yandle (Staff Competencies)

AACVPR

Reviewer Question (ITP)

Q: Per the reviewer: On their ITP, for PROGRESS TO GOAL, it has ONGOING AND PATIENT WILL CONTINE TO WORK TOWARDS THESE GOALS WHILE IN PULMONARY REHAB. I would not pass this, am I correct in my thinking?

A: Deny. Not telling the story of the patient's progression.



Page 2

EXERCISE
Reassessment

Date: April 18, 2025 Clinical Staff: Chapman Godwin, I

sessions attended: 9
Date of Exercise Data: April 17, 2025
Comments: Patient has been consistent in her effort and attendance to pulmonary rehab.

EXERCISE SUMMARY
Resting HR: 92 Max HR: 108
Resting BP: 140/80 Max BP: 160/70
Resting SpO2: 97 Lowest SpO2: 93
RPE: Dyspnea: 1.5
Max METs: 2.14
Comments: Patient is tolerating exercise well.

PLAN
INTERVENTION

EXERCISE PRESCRIPTION
Stretching: 5 MIN
Warm Up: 5 MIN
Recumbent Bike : 15 MIN **LEV** 2.0 **WAT** 33.0
Arm Ergometer: 15 MIN **LEV** 3.0 **WAT** 27.0
Cool Down: 5 MIN
Bince + Sit to Stnd: 15 MIN
Target HR range: Resting + 20 - Resting + 30
Exercise SpO2 range: 90-100%
Comments: Patient has been able to maintain acceptable saturations without the use of supplemental oxygen.

HOME EXERCISE
Mode: movement while teaching school
Frequency/Duration: daily for several hours
Comments: Patient states she has daily movement with her profession of being a school teacher.

EXERCISE EDUCATION
Education Summary: Patient will be enrolled in all education classes while in pulmonary rehab.

GOALS
Exercise frequency of 5 days a week: ongoing
Exercise 30-45 mins/day: ongoing
Maintain exercise SpO2 range: ongoing
20 min of continuous exercise: ongoing
Exercise intensity 5 (on 0-10 RPD scale): ongoing
Other:
Comments: Patient is continuing to work towards these goals while in pulmonary rehab.

NUTRITION
Reassessment

NUTRITION ASSESSMENT
Compliant with healthy diet Y N
Comments: Patient's initial rate your plate score was a 41 which reflects that she needs to make healthier eating choices.

DIABETES Y N
Fasting Blood Glucose: unknown
Monitors glucose at home Y N
Medication changes Y N
Comments: Patient does not report any medication changes.

WEIGHT MANAGEMENT
Height (in): 61 Weight (lb): 272.4 BMI: 51.46
Comments: Patient is obese and is working towards weight loss goals while in pulmonary rehab.

PLAN
INTERVENTION

Completed:
☐ Dietary consult ☐ Wt mgmt consult
☐ Diabetes education
☐ Pt declined consults
☒ Pt did not qualify for RD consult due to diagnosis
Comments: Patient is a blue code and does not qualify for a one on one consult with the dietician.

NUTRITION EDUCATION
Nutrition Class 04/14/2025

Education Summary: Patient will be enrolled in all education classes while in pulmonary rehab.

GOALS
Non-fasting BG 80-240 mg/dL: ongoing
Weight gain/maintenance: ongoing
Weigh loss: ongoing
Other:
Comments: Patient continues to work towards these goals while in pulmonary rehab.

PSYCHO/SOCIAL
Reassessment

STAGE OF CHANGE: Action
Comments: Patient is attending pulmonary rehab 3 days a week.

STRESS MANAGEMENT
Self reported stress: Low
Self reported anxiety: Low
Comments: Patient does report some stress and anxiety in regards to her breathing.

PHQ-9 DEPRESSION SCREEN
☐ Not applicable at this time
PHQ-9 Score: 3
Interpretation of score: < 5: Normal
Plan for action and follow-up: Patient has a PHQ-9 score of 9 at this time which is considered in the normal range.

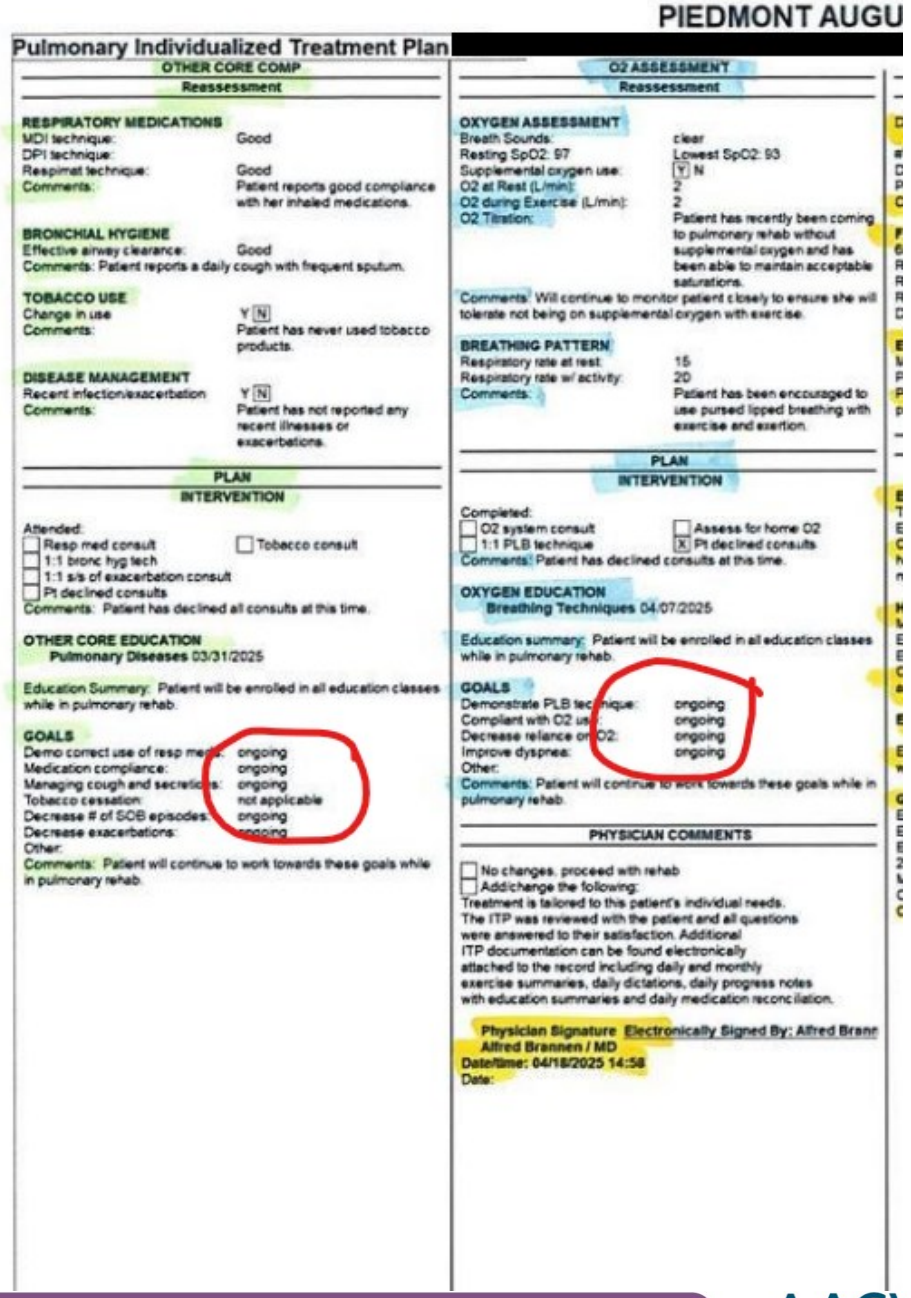
PLAN
INTERVENTION

Completed:
☐ Psych consult ☐ PCP consult
☐ Community resources
☐ Assist identifying stress mgmt/coping skills
☒ Pt declined consults
Comments: Patient has declined consults at this time.

PSYCHOSOCIAL EDUCATION

Education Summary: Patient will be enrolled in all education classes while in pulmonary rehab.

GOALS
Manage/reduce stress: ongoing
Improve PHQ-9 score: ongoing
Improve CAT score: ongoing
Improve depression symptoms: ongoing
Other:
Comments: Patient will indirectly be working on these goals while in pulmonary rehab.



PIEDMONT AUGU

Pulmonary Individualized Treatment Plan

OTHER CORE COMP
Reassessment

RESPIRATORY MEDICATIONS
MDI technique: Good
DPI technique:
Respimat technique: Good
Comments: Patient reports good compliance with her inhaled medications.

BRONCHIAL HYGIENE
Effective airway clearance: Good
Comments: Patient reports a daily cough with frequent sputum.

TOBACCO USE
Change in use Y N
Comments: Patient has never used tobacco products.

DISEASE MANAGEMENT
Recent infection/exacerbation Y N
Comments: Patient has not reported any recent illnesses or exacerbations.

PLAN
INTERVENTION

Attended:
☐ Resp med consult ☐ Tobacco consult
☐ 1:1 bronc hyg tech
☐ 1:1 s/s of exacerbation consult
☐ Pt declined consults
Comments: Patient has declined all consults at this time.

OTHER CORE EDUCATION
Pulmonary Diseases 03/31/2025

Education Summary: Patient will be enrolled in all education classes while in pulmonary rehab.

GOALS
Demo correct use of resp meds: ongoing
Medication compliance: ongoing
Managing cough and secretions: ongoing
Tobacco cessation: not applicable
Decrease # of SOB episodes: ongoing
Decrease exacerbations: ongoing
Other:
Comments: Patient will continue to work towards these goals while in pulmonary rehab.

O2 ASSESSMENT
Reassessment

OXYGEN ASSESSMENT
Breath Sounds: clear
Resting SpO2: 97 Lowest SpO2: 93
Supplemental oxygen use: Y N
O2 at Rest (L/min): 2
O2 during Exercise (L/min): 2
O2 Titration: Patient has recently been coming to pulmonary rehab without supplemental oxygen and has been able to maintain acceptable saturations.
Comments: Will continue to monitor patient closely to ensure she will tolerate not being on supplemental oxygen with exercise.

BREATHING PATTERN
Respiratory rate at rest: 15
Respiratory rate w/ activity: 20
Comments: Patient has been encouraged to use pursed lipped breathing with exercise and exertion.

PLAN
INTERVENTION

Completed:
☐ O2 system consult ☐ Assess for home O2
☐ 1:1 PLB technique ☒ Pt declined consults
Comments: Patient has declined consults at this time.

OXYGEN EDUCATION
Breathing Techniques 04/07/2025

Education summary: Patient will be enrolled in all education classes while in pulmonary rehab.

GOALS
Demonstrate PLB technique: ongoing
Compliant with O2 use: ongoing
Decrease reliance on O2: ongoing
Improve dyspnea: ongoing
Other:
Comments: Patient will continue to work towards these goals while in pulmonary rehab.

PHYSICIAN COMMENTS

☐ No changes, proceed with rehab
☐ Add/change the following:
Treatment is tailored to this patient's individual needs.
The ITP was reviewed with the patient and all questions were answered to their satisfaction. Additional ITP documentation can be found electronically attached to the record including daily and monthly exercise summaries, daily dictations, daily progress notes with education summaries and daily medication reconciliation.

Physician Signature Electronically Signed By: Alfred Brann
Alfred Brannen / MD
Date/time: 04/18/2025 14:58
Date:

*Question From V. Yandle (ITP)

AACVPR

Reviewer Question (Enrollment PM)

Q: Could you take a look at the enrollment measure on this one? These do not seem like new interventions. They all seem to already be implemented. There doesn't seem to be a NEW plan. Thoughts?

A: Deny. Program only reviewing what they are already doing, not providing a new plan.

Answer	To improve our patient enrollment, we have implemented a new referral system which decreases the time between hospital stay and first contact with patient. We are visiting patients who are still inpatient, explaining what cardiac rehab is, addressing any common concerns. We have also implemented a new script on their hospital discharge packet to provide more information about cardiac rehab. Once they are discharged, we are calling them the next day to again discuss cardiac rehab, why they were referred and answer and common concerns or questions. This early direct contact has reduced confusion and anxiety that often prevents patients from enrolling.

*Question From S. Dunn (Enrollment PM)

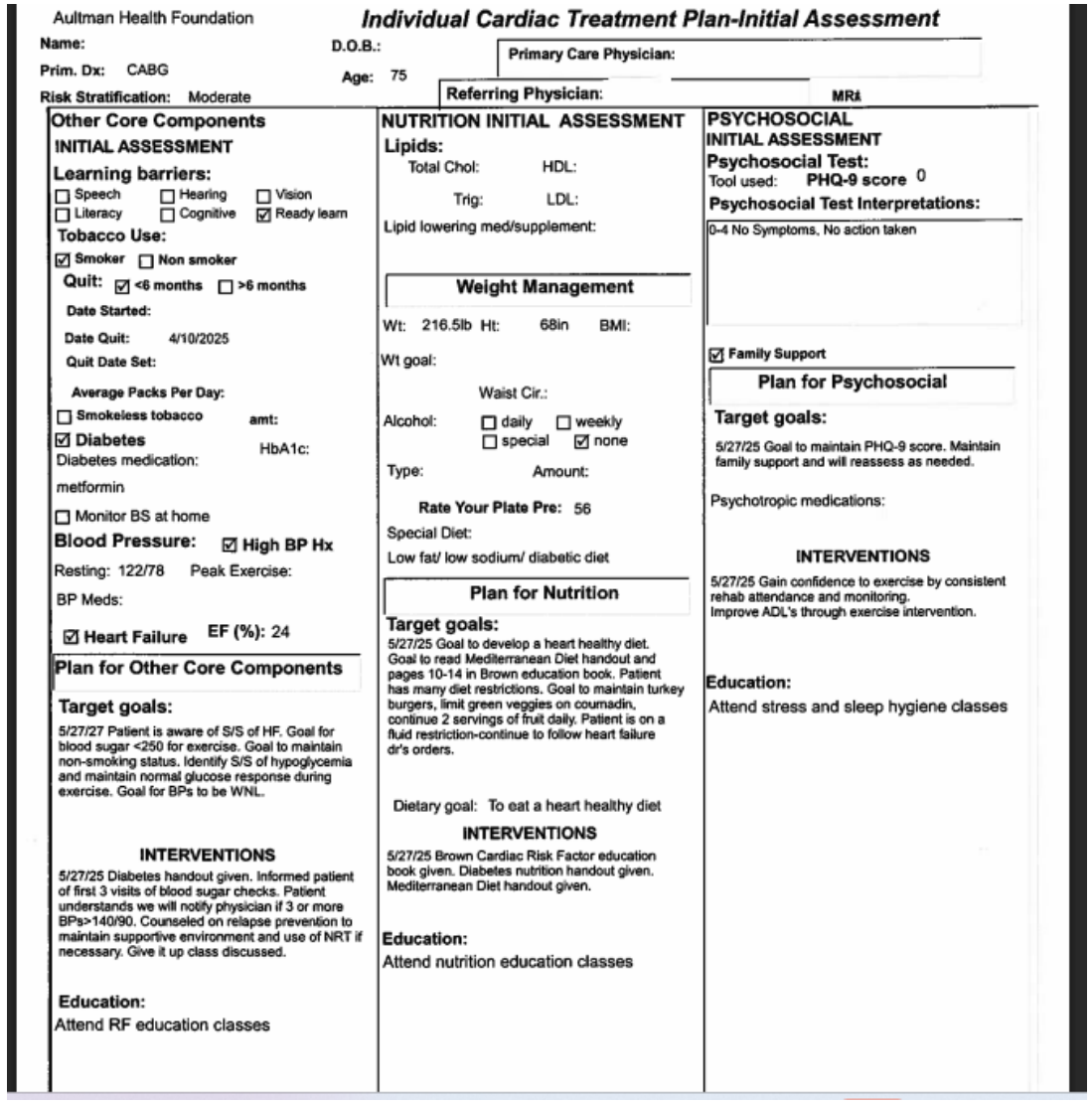
Reviewer Question (ITP)

Q: I'm not sure the ITP on this one meets for OCC. They chose diabetes management. I don't see a very good assessment/reassessment. The box is checked that they have it and Metformin is listed as a medication on the initial ITP but nothing additional (no FSBS or HgbA1c). It is mentioned that it is "normal" on one reassessment and at discharge it says there is "appropriate blood sugar response". Is that enough to meet minimum? Blood pressure seems a little better but they chose diabetes.

Also, with sister programs should their performance measure numbers be exactly the same?

A: Deny. No assessment at all for diabetes throughout the whole ITP and since that was OCC selected it must be denied. Also, it is unlikely for sister programs to have the exact same performance measures, but it is not a reason for denial.

*Question From S. Dunn (ITP)



Aultman Health Foundation

Individual Cardiac Treatment Plan-Initial Assessment

Name: D.O.B.: Primary Care Physician:

Prim. Dx: CABG Age: 75 Referring Physician: MR#

Risk Stratification: Moderate

Other Core Components

INITIAL ASSESSMENT

Learning barriers:

☐ Speech ☐ Hearing ☐ Vision
☐ Literacy ☐ Cognitive ☑ Ready learn

Tobacco Use:

☑ Smoker ☐ Non smoker

Quit: ☑ <6 months ☐ >6 months

Date Started:

Date Quit: 4/10/2025

Quit Date Set:

Average Packs Per Day:

☐ Smokeless tobacco **amt:**

☑ **Diabetes** HbA1c:

Diabetes medication:

metformin

☐ Monitor BS at home

Blood Pressure: ☑ **High BP Hx**

Resting: 122/78 Peak Exercise:

BP Meds:

☑ **Heart Failure** **EF (%):** 24

Plan for Other Core Components

Target goals:

5/27/27 Patient is aware of S/S of HF. Goal for blood sugar <250 for exercise. Goal to maintain non-smoking status. Identify S/S of hypoglycemia and maintain normal glucose response during exercise. Goal for BPs to be WNL.

INTERVENTIONS

5/27/25 Diabetes handout given. Informed patient of first 3 visits of blood sugar checks. Patient understands we will notify physician if 3 or more BPs>140/90. Counseled on relapse prevention to maintain supportive environment and use of NRT if necessary. Give it up class discussed.

Education:

Attend RF education classes

NUTRITION INITIAL ASSESSMENT

Lipids:

Total Chol: HDL:

Trig: LDL:

Lipid lowering med/supplement:

Weight Management

Wt: 216.5lb Ht: 68in BMI:

Wt goal:

Waist Cir.:

Alcohol: ☐ daily ☐ weekly ☐ special ☑ none

Type: Amount:

Rate Your Plate Pre: 56

Special Diet:

Low fat/ low sodium/ diabetic diet

Plan for Nutrition

Target goals:

5/27/25 Goal to develop a heart healthy diet. Goal to read Mediterranean Diet handout and pages 10-14 in Brown education book. Patient has many diet restrictions. Goal to maintain turkey burgers, limit green veggies on coumadin, continue 2 servings of fruit daily. Patient is on a fluid restriction-continue to follow heart failure dr's orders.

Dietary goal: To eat a heart healthy diet

INTERVENTIONS

5/27/25 Brown Cardiac Risk Factor education book given. Diabetes nutrition handout given. Mediterranean Diet handout given.

Education:

Attend nutrition education classes

PSYCHOSOCIAL INITIAL ASSESSMENT

Psychosocial Test:

Tool used: **PHQ-9 score** 0

Psychosocial Test Interpretations:

0-4 No Symptoms, No action taken

☑ **Family Support**

Plan for Psychosocial

Target goals:

5/27/25 Goal to maintain PHQ-9 score. Maintain family support and will reassess as needed.

Psychotropic medications:

INTERVENTIONS

5/27/25 Gain confidence to exercise by consistent rehab attendance and monitoring. Improve ADL's through exercise intervention.

Education:

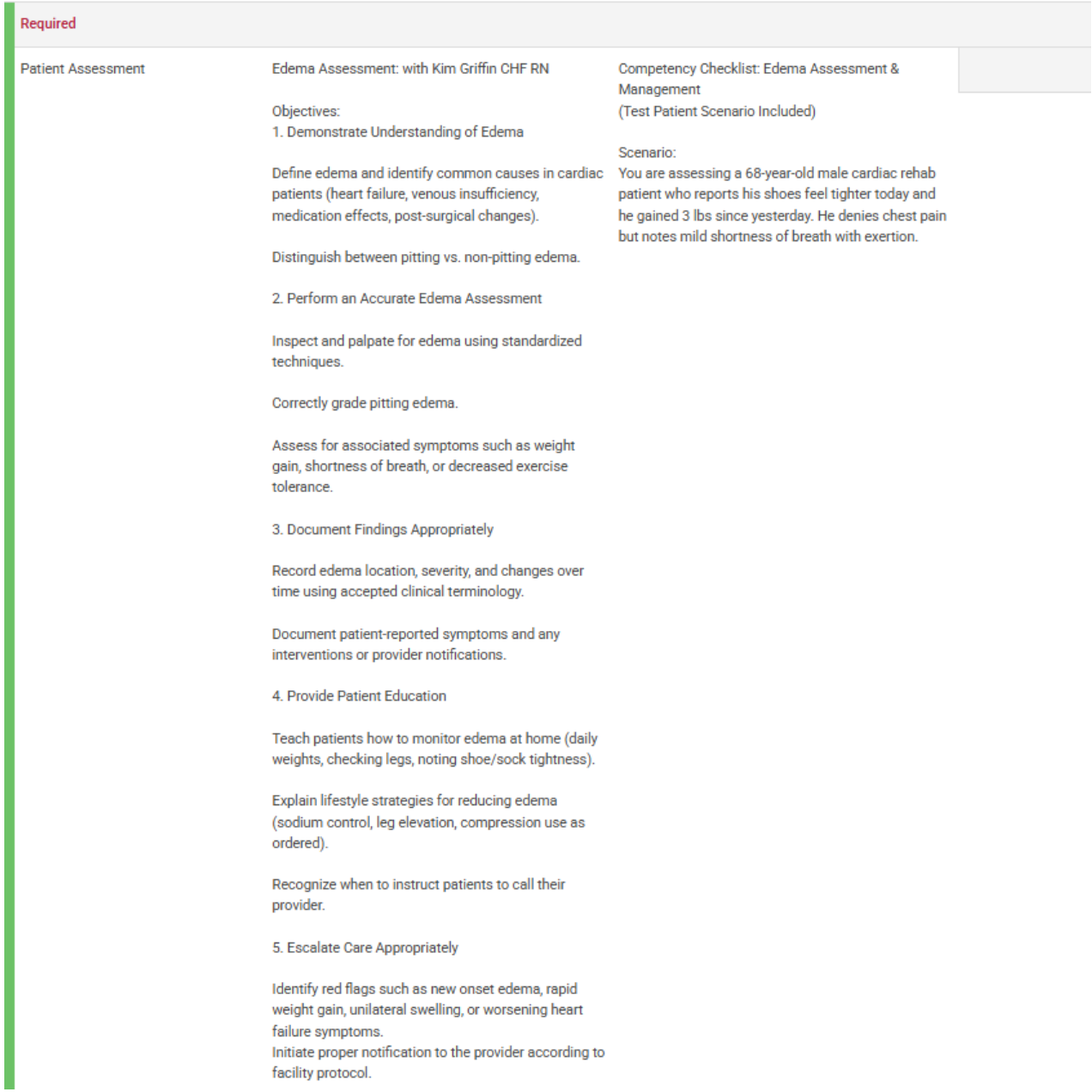
Attend stress and sleep hygiene classes

Reviewer Question (Staff Competencies)

Q: The submitted competency does not demonstrate how competent. They met all the criteria for the other three, but not for Patient Assessment. Would you deny this competency or does it meet the minimum requirements?

A: Deny. None of the competencies provided show how the team met the competencies. No measures given to show a staff member is competent.

*Question From V. Yandle (Staff Comp)



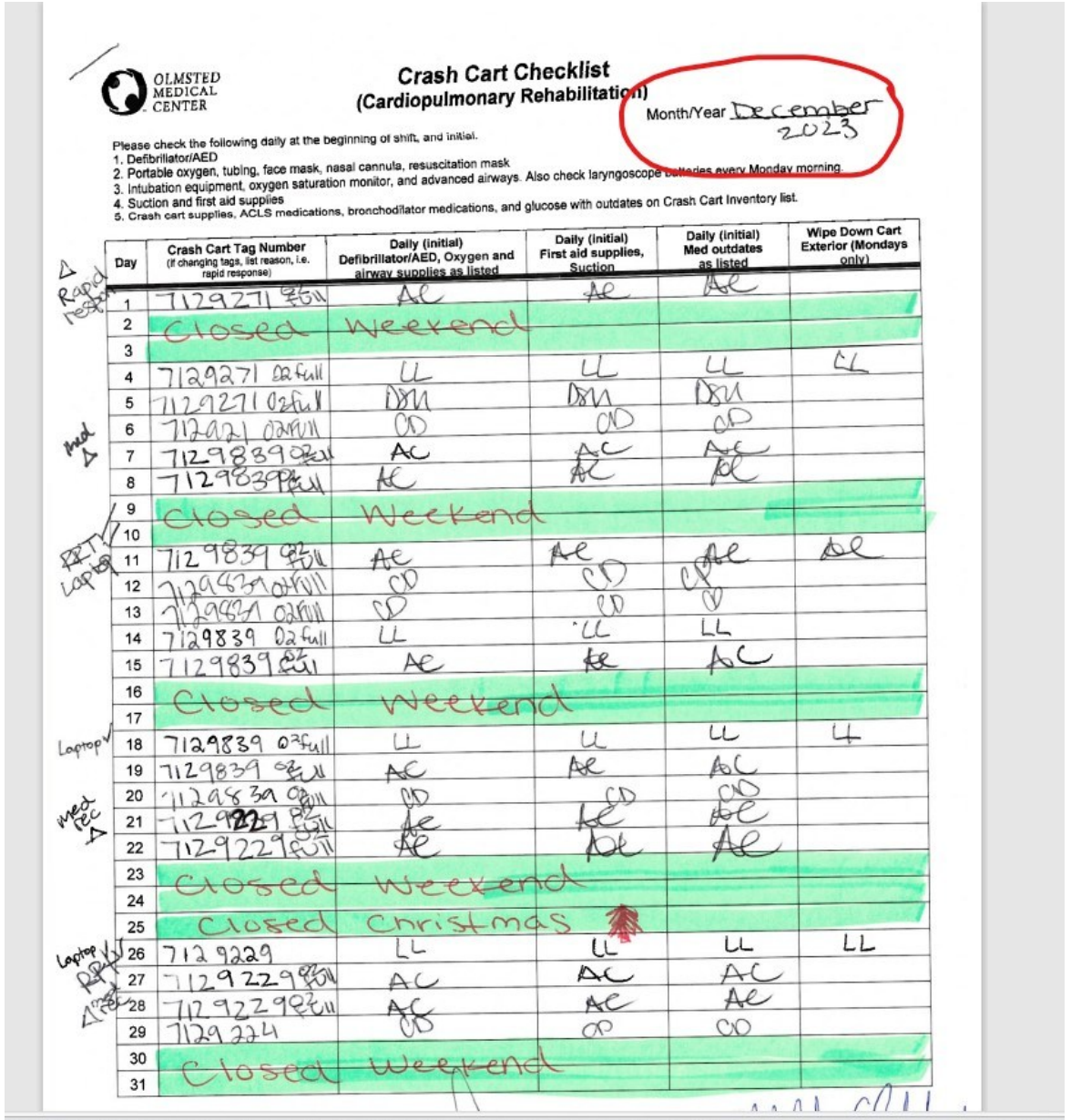
Required		
Patient Assessment	Edema Assessment: with Kim Griffin CHF RN Objectives: 1. Demonstrate Understanding of Edema Define edema and identify common causes in cardiac patients (heart failure, venous insufficiency, medication effects, post-surgical changes). Distinguish between pitting vs. non-pitting edema. 2. Perform an Accurate Edema Assessment Inspect and palpate for edema using standardized techniques. Correctly grade pitting edema. Assess for associated symptoms such as weight gain, shortness of breath, or decreased exercise tolerance. 3. Document Findings Appropriately Record edema location, severity, and changes over time using accepted clinical terminology. Document patient-reported symptoms and any interventions or provider notifications. 4. Provide Patient Education Teach patients how to monitor edema at home (daily weights, checking legs, noting shoe/sock tightness). Explain lifestyle strategies for reducing edema (sodium control, leg elevation, compression use as ordered). Recognize when to instruct patients to call their provider. 5. Escalate Care Appropriately Identify red flags such as new onset edema, rapid weight gain, unilateral swelling, or worsening heart failure symptoms. Initiate proper notification to the provider according to facility protocol.	Competency Checklist: Edema Assessment & Management (Test Patient Scenario Included) Scenario: You are assessing a 68-year-old male cardiac rehab patient who reports his shoes feel tighter today and he gained 3 lbs since yesterday. He denies chest pain but notes mild shortness of breath with exertion.

Reviewer Question (Emergency Preparedness)

Q: The calendar month shows DECEMBER 2023 NOT DECEMBER 2025. They do meet approval for the four medical emergencies.

A: Deny. Program uploaded the wrong year for their emergency preparedness.

*Question From V. Yandle (Emerg Prep)



OLMSTED MEDICAL CENTER

Crash Cart Checklist
(Cardiopulmonary Rehabilitation)

Month/Year December 2023

Please check the following daily at the beginning of shift, and initial.
1. Defibrillator/AED
2. Portable oxygen, tubing, face mask, nasal cannula, resuscitation mask
3. Intubation equipment, oxygen saturation monitor, and advanced airways. Also check laryngoscope blades every Monday morning.
4. Suction and first aid supplies
5. Crash cart supplies, ACLS medications, bronchodilator medications, and glucose with outdates on Crash Cart Inventory list.

Day	Crash Cart Tag Number (If changing tags, list reason, i.e. rapid response)	Daily (initial) Defibrillator/AED, Oxygen and airway supplies as listed	Daily (initial) First aid supplies, Suction	Daily (initial) Med outdates as listed	Wipe Down Cart Exterior (Mondays only)
1	7129271 02 full	AC	AC	AC	
2	Closed	Weekend			
3					
4	7129271 02 full	LL	LL	LL	LL
5	7129271 02 full	DSM	DSM	DSM	
6	7129271 02 full	CD	CD	CD	
7	7129839 02 full	AC	AC	AC	
8	7129839 02 full	AC	AC	AC	
9	Closed	Weekend			
10					
11	7129839 02 full	AC	AC	AC	AC
12	7129839 02 full	CD	CD	CD	
13	7129839 02 full	CD	CD	CD	
14	7129839 02 full	LL	LL	LL	
15	7129839 02 full	AC	AC	AC	
16	Closed	Weekend			
17					
18	7129839 02 full	LL	LL	LL	LL
19	7129839 02 full	AC	AC	AC	
20	7129839 02 full	CD	CD	CD	
21	7129839 02 full	AC	AC	AC	
22	7129229 02 full	AC	AC	AC	
23	Closed	Weekend			
24					
25	Closed	Christmas			
26	7129229	LL	LL	LL	LL
27	7129229 02 full	AC	AC	AC	
28	7129229 02 full	AC	AC	AC	
29	7129224	AC	CD	CD	
30	Closed	Weekend			
31					

Reviewer Question (Staff Competencies)

Q: I have a question about the staff competencies submitted for a CR program. The Tobacco Cessation competency is about “Pulmonary Disease, COPD, Smoking Cessation.” The article and objectives were
COPD and pulmonary related. I am thinking this should be denied as it is pulmonary rehab related. The Exercise training was specific to heart transplant, and the Patient Assessment was specific to CHF. Would these be ok?

This effects 3 applications as all of the sister program cardiac rehabs were the same.

A: Approve. Objectives 3 and 4 can be attributed to any patient. Not just PR.

Tobacco Cessation	Tobacco Cessation HealthStream course: COPD & Smoking Cessation Learning Objectives: At the conclusion of this course, participants should be able to: 1. Define COPD and describe its epidemiology; 2. Describe the role that smoking cessation plays in the treatment for COPD in patients who smoke; 3. List the benefits and risks associated with pharmacotherapy that is prescribed to treat tobacco dependence; and 4. Describe intervention strategies to treat tobacco dependence. Team members completed the education module “Pulmonary Disease, Chronic Obstructive (COPD): Smoking Cessation” by Obiamaka Oji, DNP, APRN, FNP-BC, in the HealthStream Learning Center. This HealthStream module provided education for clinicians regarding current information about chronic obstructive pulmonary disease (COPD) and smoking cessation for the healthcare provider, including evidence-based information on strategies for treating tobacco dependence in patients with COPD. Information for patient education was included.	Assessment of each team member’s competency included reading the entire article “Pulmonary Disease, Chronic Obstructive (COPD): Smoking Cessation”. Team members completed the entire education/professional development activity with the required score of 80% or higher on the post-test. A certificate of completion was obtained and is on file in each team member’s employee file.

*Question From D. Anderson (Staff Comp)

Reviewer Question (Medical Emergencies)

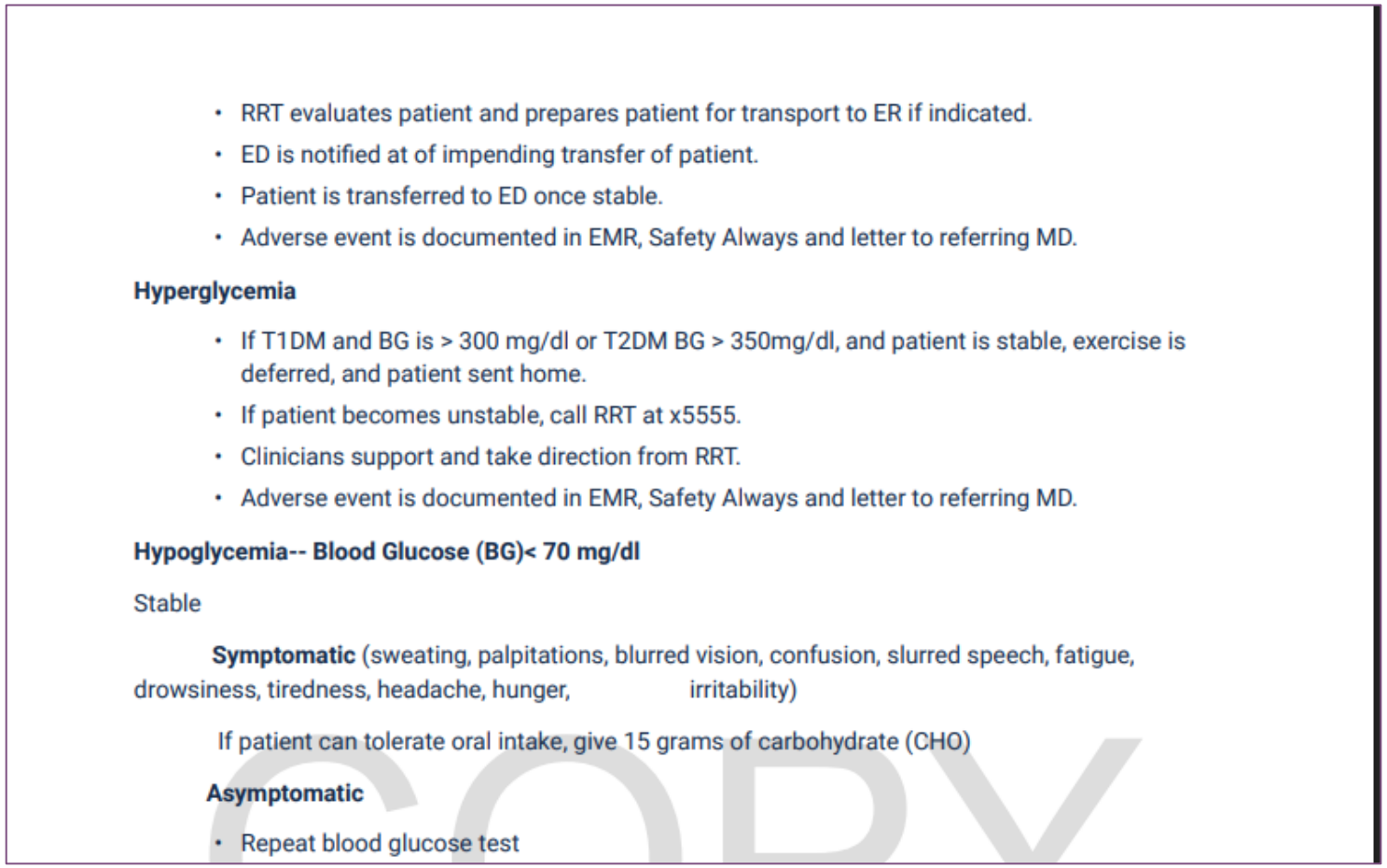
Q: The Medical Emergency has a very minimal Hyperglycemia section.

Hyperglycemia
• If T1DM and BG is > 300 mg/dl or T2DM BG > 350mg/dl, and patient is stable, exercise is deferred, and patient sent home.
• If patient becomes unstable, call RRT at x5555.
• Clinicians support and take direction from RRT.
• Adverse event is documented in EMR, Safety Always and letter to referring MD.

Would you approve this? It is very minimal!

Note: The decision on the hyperglycemia could effect 7 applications as I think all system sister programs have the same policy.

A: Approve. Talks about not letting patient exercise, what to do if the patient becomes unstable. Meets the minimum criteria.



- RRT evaluates patient and prepares patient for transport to ER if indicated.
- ED is notified at of impending transfer of patient.
- Patient is transferred to ED once stable.
- Adverse event is documented in EMR, Safety Always and letter to referring MD.

Hyperglycemia

- If T1DM and BG is > 300 mg/dl or T2DM BG > 350mg/dl, and patient is stable, exercise is deferred, and patient sent home.
- If patient becomes unstable, call RRT at x5555.
- Clinicians support and take direction from RRT.
- Adverse event is documented in EMR, Safety Always and letter to referring MD.

Hypoglycemia-- Blood Glucose (BG)< 70 mg/dl

Stable

Symptomatic (sweating, palpitations, blurred vision, confusion, slurred speech, fatigue, drowsiness, tiredness, headache, hunger, irritability)

If patient can tolerate oral intake, give 15 grams of carbohydrate (CHO)

Asymptomatic

- Repeat blood glucose test

*Question From D. Anderson (Med Emerg)

Reviewer Question (Staff Competencies)

Q: Vague tools on staff competencies. They just say, online tutorial, post test, discussion, return demonstration, handout, discussion.

A: Deny. Not enough details to determine how the staff meet the competencies. All 4 competencies should be denied.

*Question From L. Hahne (Staff Competencies)

Blood Pressure Management	Define normal, elevated, and hypertensive BP ranges according to current guidelines. Correctly identify when BP readings require immediate follow up. Verbalize risk factors and complications associated with uncontrolled hypertension. Identify medications commonly used for BP management, including indications and common side effects.	online tutorial, Post test	
Required			
Diabetes Management	Knowledge on signs and symptoms of hypo and hyperglycemia. Demonstrates knowledge on how to order an accu-check on a patient and correctly obtain blood sugar. Able to document results Able to state critical values and how to properly manage care. Knowledge on properly cleaning the meter, including isolation patients. Demonstrates how to review results. Demonstrates the proper procedure for running QC test and states what to do if meter fails.	Instruction, return demonstration, and post test	
Required			
Exercise Training Evaluation	Provide practical guidelines for the 6-minute walk test. Review indications. Detail factors that influence results. Provide a step by step protocol. Outlines safety measures. Describes proper patient preparation and procedure. Offers guidelines for clinical interpretation of results.	Hand out, discussion and post test	
Required			
Tobacco Cessation	Knowledge on what is involved with assisting patients with smoking cessation. What to expect after assisting a patient with smoking cessation. Importance of family support during smoking cessation. Establishing a quit date Knowledge of the 5 R's of motivational intervention in patients not willing to quit. Knowledge of effective smoking cessation	Tutorial, discussion, and post test	

AACVPR

Reviewer Question (Functional Capacity PM)

Q: Improvement in Functional Capacity: I'm not sure if this is something that will help the patients improve the percentages.

A: Deny. Not enough information to show how the staff understand the competency.

Answer	Each staff member will complete an annual competency to ensure the expected standard is met and maintained. Staff will follow a script when giving the patient instructions to ensure continuity in the test between staff members.

*Question From L. Hahne (Functional Capacity PM)

Reviewer Question (Staff Competencies)

Q: Under staff competencies: The tools for Patient Assessment and Management are the exact ones used under Psychosocial Management. Could the same ones be used for both?

A: Approve. Objectives for both meet the requirements.

Patient Assessment and Management	Demonstrate knowledge of pulmonary anatomy, physiology and pathophysiology; pulmonary disease risk factors; pulmonary assessment, diagnostic tests and procedures including PFT; COPD grade and group; common comorbidities; exacerbation risks; individual patient needs, patient readiness to initiate behavior change; appropriate pulmonary rehab recommendations; contraindications for pulmonary rehab; exercise and treatment protocols; tailoring rehab interventions to meet specific needs with regard to underlying respiratory disease, physical limitations and comorbidities; common comorbidities that limit or influence physical activity, symptom management and quality of life (metabolic disorders, musculoskeletal conditions, cardiovascular conditions, neuromuscular conditions, psychiatric and mood disorders), smoking cessation assessment; nutrition assessment	Skills/Ability to be verbalized/demonstrated by the employee: • Screen for psychological symptom burden (especially anxiety and depression), substance abuse, and poor quality of life • Verbalized understanding of PHQ-9 score and appropriate referral / actions to implement • Assessment of cognitive capacity for adequate pulmonary rehab program participation and adherence to medical recommendation • Referral to resources • Measure and report outcomes of psycho-social functioning at the conclusion of the program Once employee has met expectation of these requirements through verbalized/demonstrated, the employee is deemed competent

Psychosocial Management	Demonstrate understanding of the influence of pulmonary disease process on emotional functioning, especially anxiety and depression; relationships and quality of life; cognitive function, memory and problem-solving skills; influence of socioeconomic factors (i.e., work status, income level, education level, access to health care) on patient functioning; influence of psycho-social factors on adherence to health behaviors; medications commonly used to treat psychological distress; available resources to address psycho-social needs; long-term planning needs (advanced directives, palliative care, hospice information).	Skills/Ability to be verbalized/demonstrated: • Screen for psychological symptom burden (especially anxiety and depression), substance abuse, and poor quality of life • Verbalized understanding of PHQ-9 score and appropriate referral / actions to implement • Assessment of cognitive capacity for adequate pulmonary rehab program participation and adherence to medical recommendation • Referral to resources • Measure and report outcomes of psycho-social functioning at the conclusion of the program Once employee has met expectation of these requirements through verbalized/demonstrated, the employee is deemed competent

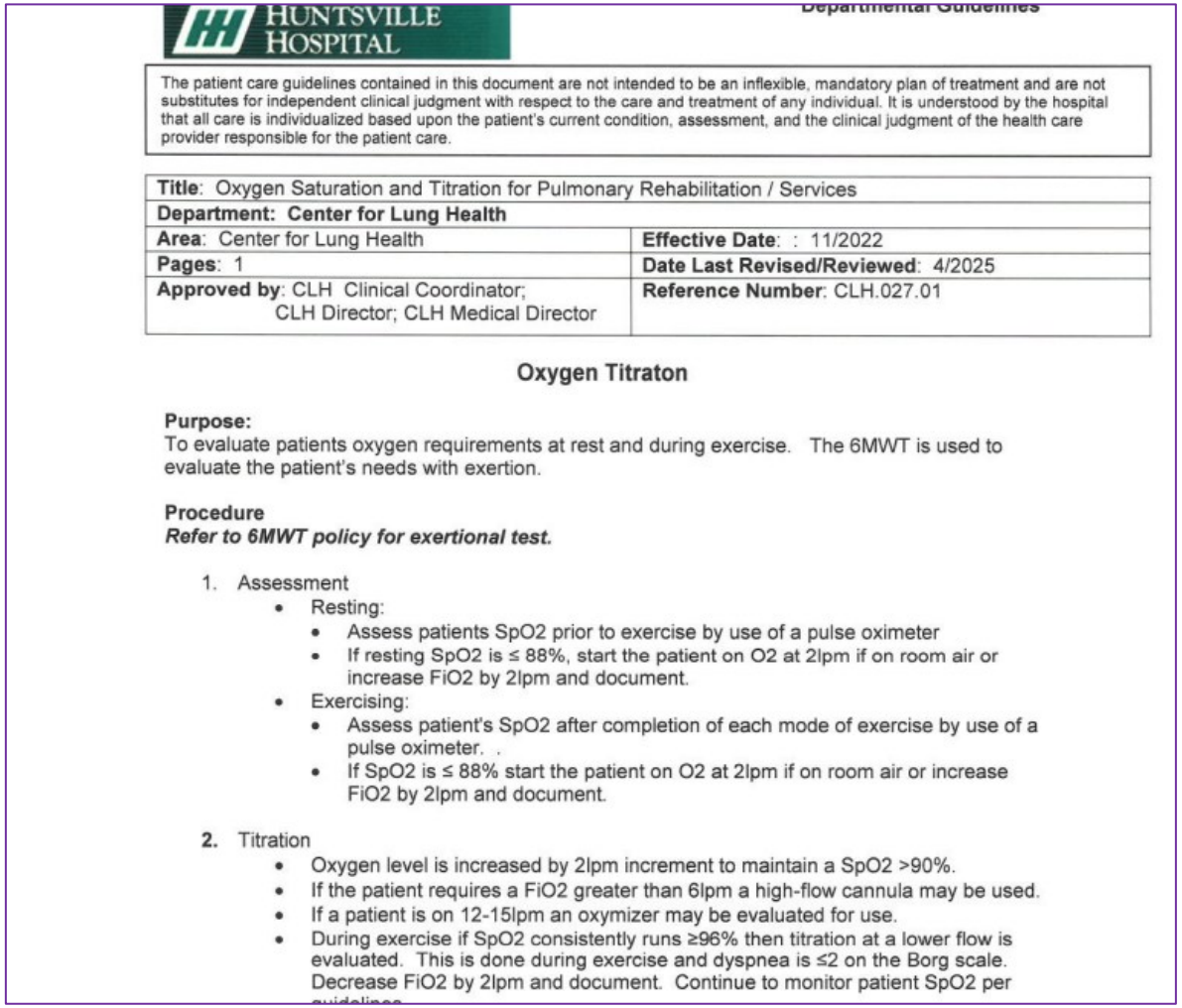
*Question From L. Hahne (Staff Competencies)

AACVPR

Reviewer Question (Exercise Prescription/ Oxygen Titration)

Q: O2 titration policy mentions "Refer to 6mwt policy exertional test" but I can't find a 6mwt policy. Do referenced policies need to also be uploaded? I couldn't find that as a denial reason so I wasn't sure.

A: Deny. Policy reference another policy that is not attached.



HUNTSVILLE HOSPITAL

Departmental Guidelines

The patient care guidelines contained in this document are not intended to be an inflexible, mandatory plan of treatment and are not substitutes for independent clinical judgment with respect to the care and treatment of any individual. It is understood by the hospital that all care is individualized based upon the patient's current condition, assessment, and the clinical judgment of the health care provider responsible for the patient care.

Title: Oxygen Saturation and Titration for Pulmonary Rehabilitation / Services	
Department: Center for Lung Health	
Area: Center for Lung Health	**Effective Date**: : 11/2022
Pages: 1	**Date Last Revised/Reviewed**: 4/2025
Approved by: CLH Clinical Coordinator; CLH Director; CLH Medical Director	**Reference Number**: CLH.027.01

Oxygen Titraton

Purpose:
To evaluate patients oxygen requirements at rest and during exercise. The 6MWT is used to evaluate the patient's needs with exertion.

Procedure
Refer to 6MWT policy for exertional test.

1. Assessment
   - Resting:
     - Assess patients SpO2 prior to exercise by use of a pulse oximeter
     - If resting SpO2 is ≤ 88%, start the patient on O2 at 2lpm if on room air or increase FiO2 by 2lpm and document.
   - Exercising:
     - Assess patient's SpO2 after completion of each mode of exercise by use of a pulse oximeter. .
     - If SpO2 is ≤ 88% start the patient on O2 at 2lpm if on room air or increase FiO2 by 2lpm and document.

2. Titration
   - Oxygen level is increased by 2lpm increment to maintain a SpO2 >90%.
   - If the patient requires a FiO2 greater than 6lpm a high-flow cannula may be used.
   - If a patient is on 12-15lpm an oxymizer may be evaluated for use.
   - During exercise if SpO2 consistently runs ≥96% then titration at a lower flow is evaluated. This is done during exercise and dyspnea is ≤2 on the Borg scale. Decrease FiO2 by 2lpm and document. Continue to monitor patient SpO2 per

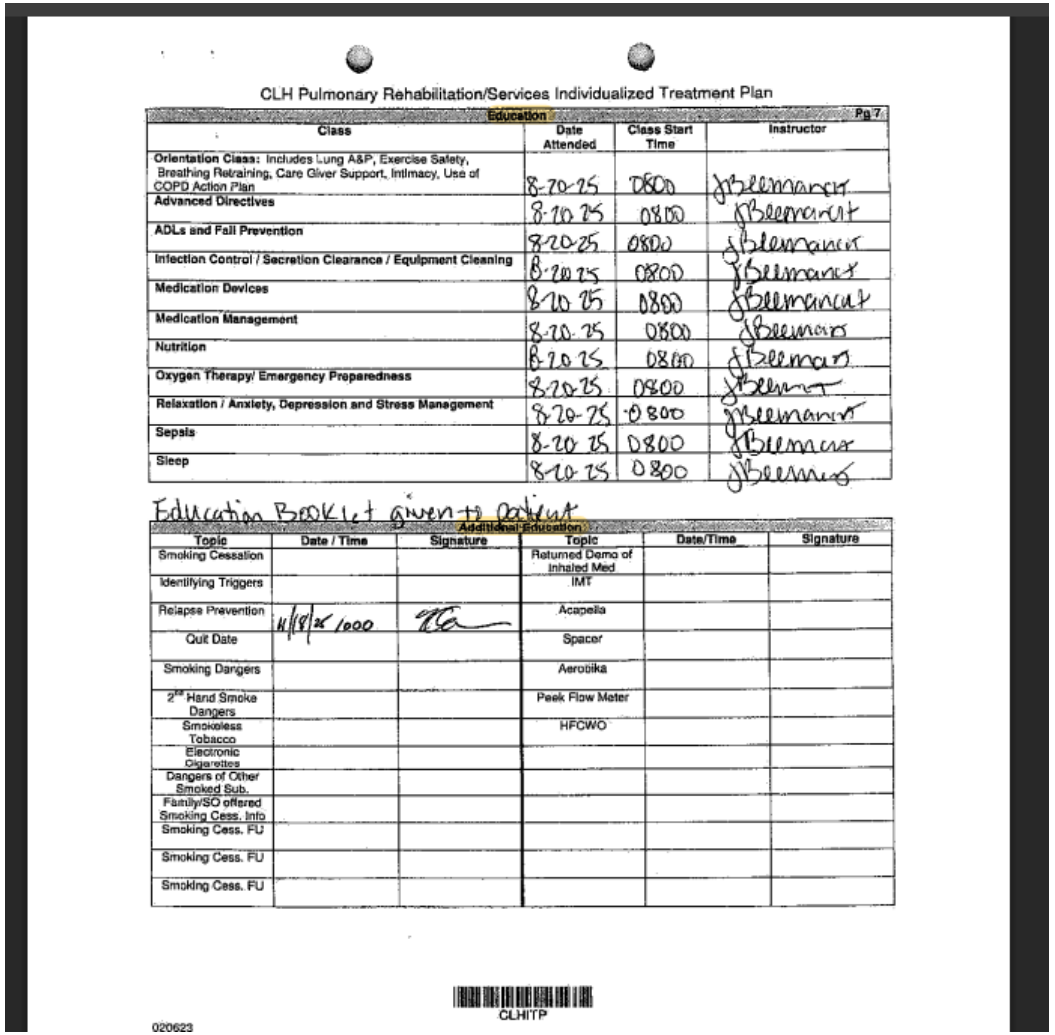
*Question From L. Hahne (Exercise Prescription/Oxygen Titration)

AACVPR

Reviewer Question (ITP)

Q: ITP: Education is on its own page and seems to have a lot of check boxes without a lot of details written.

A: Deny. Education is only listed on one page instead of under each domain.



CLH Pulmonary Rehabilitation/Services Individualized Treatment Plan

Education Pg 7

Class	Date Attended	Class Start Time	Instructor
Orientation Class: Includes Lung A&P, Exercise Safety, Breathing Retraining, Care Giver Support, Intimacy, Use of COPD Action Plan	8-20-25	0800	JBellmancat
Advanced Directives	8-20-25	0800	JBellmancat
ADLs and Fall Prevention	8-20-25	0800	JBellmancat
Infection Control / Secretion Clearance / Equipment Cleaning	8-20-25	0800	JBellmancat
Medication Devices	8-20-25	0800	JBellmancat
Medication Management	8-20-25	0800	JBellmancat
Nutrition	8-20-25	0800	JBellmancat
Oxygen Therapy/ Emergency Preparedness	8-20-25	0800	JBellmancat
Relaxation / Anxiety, Depression and Stress Management	8-20-25	0800	JBellmancat
Sepsis	8-20-25	0800	JBellmancat
Sleep	8-20-25	0800	JBellmancat

Education Booklet given to patient

Additional Education

Topic	Date / Time	Signature	Topic	Date/Time	Signature
Smoking Cessation			Returned Demo of Inhaled Med		
Identifying Triggers			IMT		
Relapse Prevention	11/18/25 1000		Acapella		
Quit Date			Spacer		
Smoking Dangers			Aerobika		
2nd Hand Smoke Dangers			Peek Flow Meter		
Smokeless Tobacco			HFCWO		
Electronic Cigarettes					
Dangers of Other Smoked Sub.					
Family/SO offered Smoking Cess. Info					
Smoking Cess. FU					
Smoking Cess. FU					
Smoking Cess. FU					

CLHITP

020623

*Question From L. Hahne (ITP)

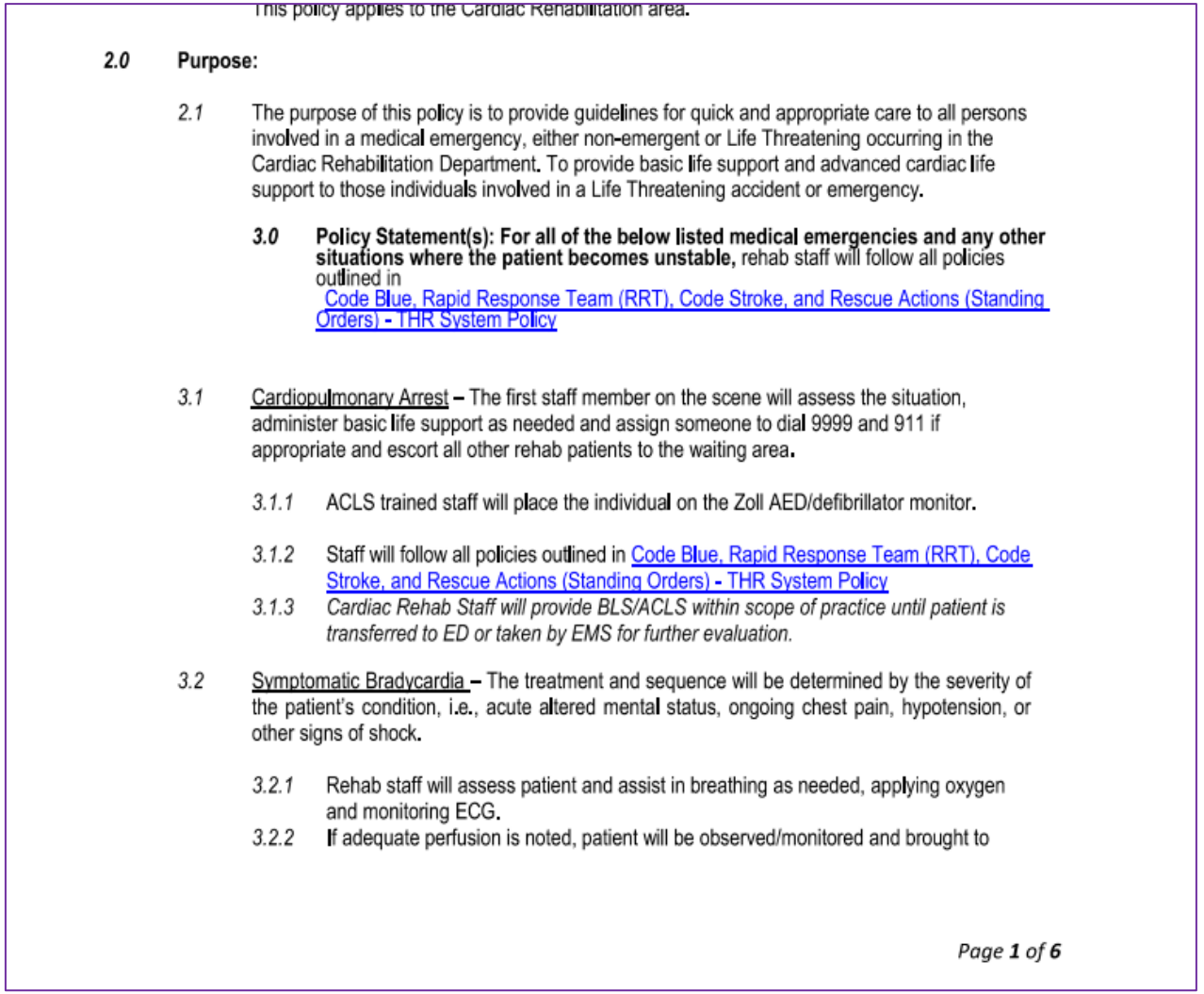
Reviewer Question (Medical Emergencies)

Q: Cardiac Arrest: References another policy not included. Do I have enough info to pass this one?

Hypertension: Does not follow through to the ER at rest, but they do follow through to the ER during exercise. Would this pass?

"j.sleepiness" should be under hypoglycemia

A: Deny. Referenced a policy under cardiac arrest that was not included in the policy. Also deny for hypertension for not having the resting part not going all the way to resolution.



This policy applies to the Cardiac Rehabilitation area.

2.0 Purpose:

2.1 The purpose of this policy is to provide guidelines for quick and appropriate care to all persons involved in a medical emergency, either non-emergent or Life Threatening occurring in the Cardiac Rehabilitation Department. To provide basic life support and advanced cardiac life support to those individuals involved in a Life Threatening accident or emergency.

3.0 Policy Statement(s): For all of the below listed medical emergencies and any other situations where the patient becomes unstable, rehab staff will follow all policies outlined in Code Blue, Rapid Response Team (RRT), Code Stroke, and Rescue Actions (Standing Orders) - THR System Policy

3.1 Cardiopulmonary Arrest – The first staff member on the scene will assess the situation, administer basic life support as needed and assign someone to dial 9999 and 911 if appropriate and escort all other rehab patients to the waiting area.

3.1.1 ACLS trained staff will place the individual on the Zoll AED/defibrillator monitor.

3.1.2 Staff will follow all policies outlined in Code Blue, Rapid Response Team (RRT), Code Stroke, and Rescue Actions (Standing Orders) - THR System Policy

3.1.3 *Cardiac Rehab Staff will provide BLS/ACLS within scope of practice until patient is transferred to ED or taken by EMS for further evaluation.*

3.2 Symptomatic Bradycardia – The treatment and sequence will be determined by the severity of the patient's condition, i.e., acute altered mental status, ongoing chest pain, hypotension, or other signs of shock.

3.2.1 Rehab staff will assess patient and assist in breathing as needed, applying oxygen and monitoring ECG.

3.2.2 If adequate perfusion is noted, patient will be observed/monitored and brought to

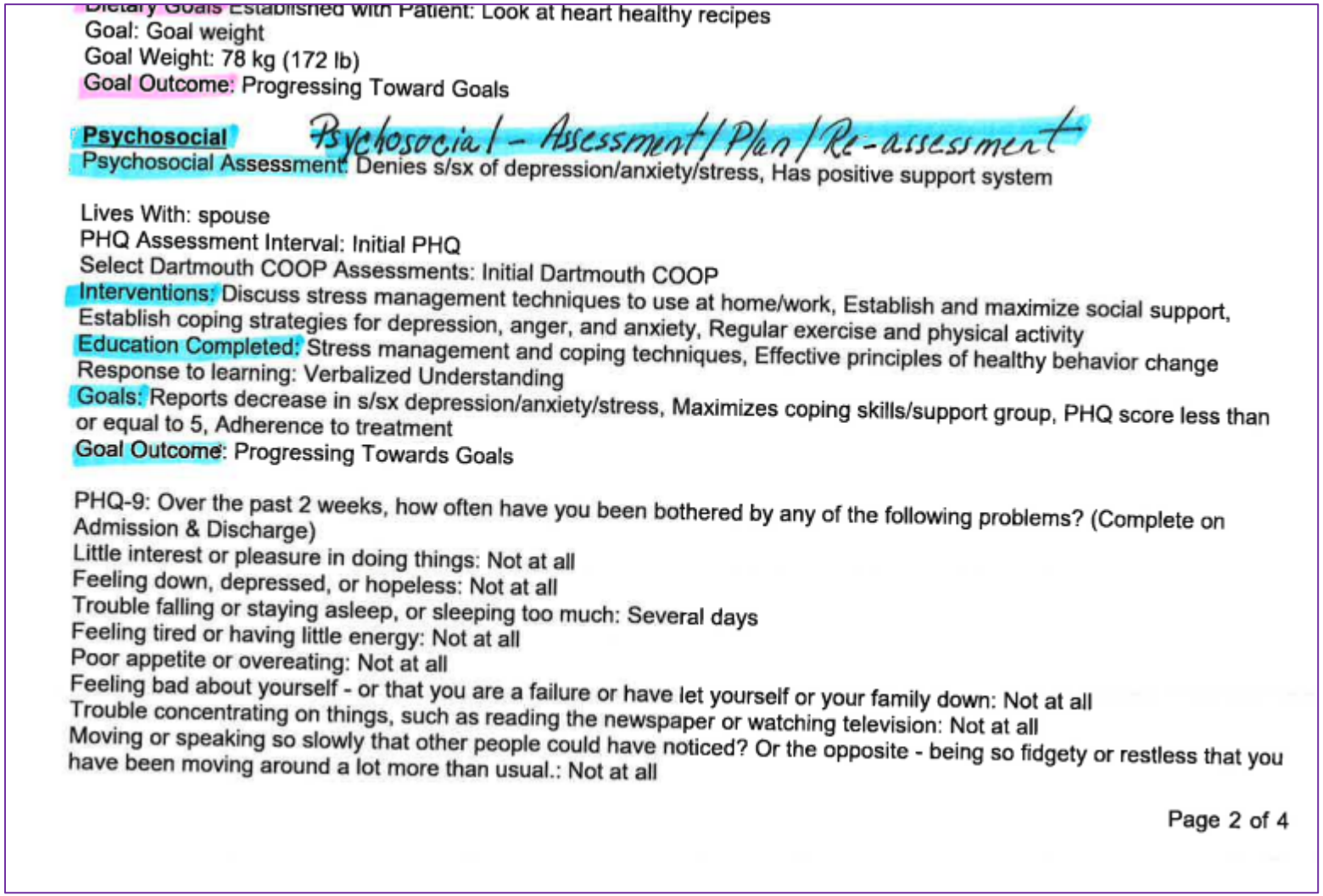
*Page **1** of **6***

*Question From M. Chang (Medical Emergencies)

Reviewer Question (ITP)

Q: Psychosocial Assessment/Plan/Reassessment is handwritten. Should I deny this?

A: Approve. Handwritten information is only a label.



Dietary Goals Established with Patient: Look at heart healthy recipes
Goal: Goal weight
Goal Weight: 78 kg (172 lb)
Goal Outcome: Progressing Toward Goals

Psychosocial Psychosocial - Assessment/Plan/Re-assessment
Psychosocial Assessment: Denies s/sx of depression/anxiety/stress, Has positive support system

Lives With: spouse
PHQ Assessment Interval: Initial PHQ
Select Dartmouth COOP Assessments: Initial Dartmouth COOP
Interventions: Discuss stress management techniques to use at home/work, Establish and maximize social support, Establish coping strategies for depression, anger, and anxiety, Regular exercise and physical activity
Education Completed: Stress management and coping techniques, Effective principles of healthy behavior change
Response to learning: Verbalized Understanding
Goals: Reports decrease in s/sx depression/anxiety/stress, Maximizes coping skills/support group, PHQ score less than or equal to 5, Adherence to treatment
Goal Outcome: Progressing Towards Goals

PHQ-9: Over the past 2 weeks, how often have you been bothered by any of the following problems? (Complete on Admission & Discharge)
Little interest or pleasure in doing things: Not at all
Feeling down, depressed, or hopeless: Not at all
Trouble falling or staying asleep, or sleeping too much: Several days
Feeling tired or having little energy: Not at all
Poor appetite or overeating: Not at all
Feeling bad about yourself - or that you are a failure or have let yourself or your family down: Not at all
Trouble concentrating on things, such as reading the newspaper or watching television: Not at all
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual.: Not at all

Page 2 of 4

*Question From M. Chang (ITP)

AACVPR

Reviewer Question (Staff Competencies)

Q: Are the tools too generic? All have the same one.

A: Approve. Details provided explaining how staff is scored after completing competency.

Blood Pressure Management	Verbalizes knowledge of normal ranges of blood pressure at rest and during exercise, Performs Best practice BP administration--both manual and automatic, understands common side effects of BP medications, postural and post-exercise hypotension. BP's are checked before, during and after exercise and compared with previous recordings. Complies with P&Ps for symptom management.	Annual competency assessment document performed and completed by Manager and peer reviewed through one or more of the following methods: Observation, Verbal test, written test, return demonstration, or completion of skills lab. Validation is scored 0-4. 0 =does not meet expectation, 1 = no opportunity to assess, 2 = Needs improvement/reassessment, 3 = performs with assistance/supervision, 4 = performs independently/competent. There is a comment/action plan section for each objective.
Required		
Psychosocial Management	Demonstrates an understanding of psychosocial factors of cardiovascular disease and adherence to treatment, and other psychological indicators that may affect treatment response, such as anxiety, anger or hostility, and social isolation. Makes referrals to psych or PCP as indicated beyond the scope of usual care. Measure and report outcomes of psychosocial management at the conclusion of program. Demonstrates knowledge and skill in addressing lifestyle management, principles of learning for behavior change, adherence, coping, and disease management for influencing function and treatment strategies. Recognizes barriers and makes recommendations for referrals.	Annual competency assessment document performed and completed by Manager and peer reviewed through one or more of the following methods: Observation, Verbal test, written test, return demonstration, or completion of skills lab. Validation is scored 0-4. 0 =does not meet expectation, 1 = no opportunity to assess, 2 = Needs improvement/reassessment, 3 = performs with assistance/supervision, 4 = performs independently/competent. There is a comment/action plan section for each objective.

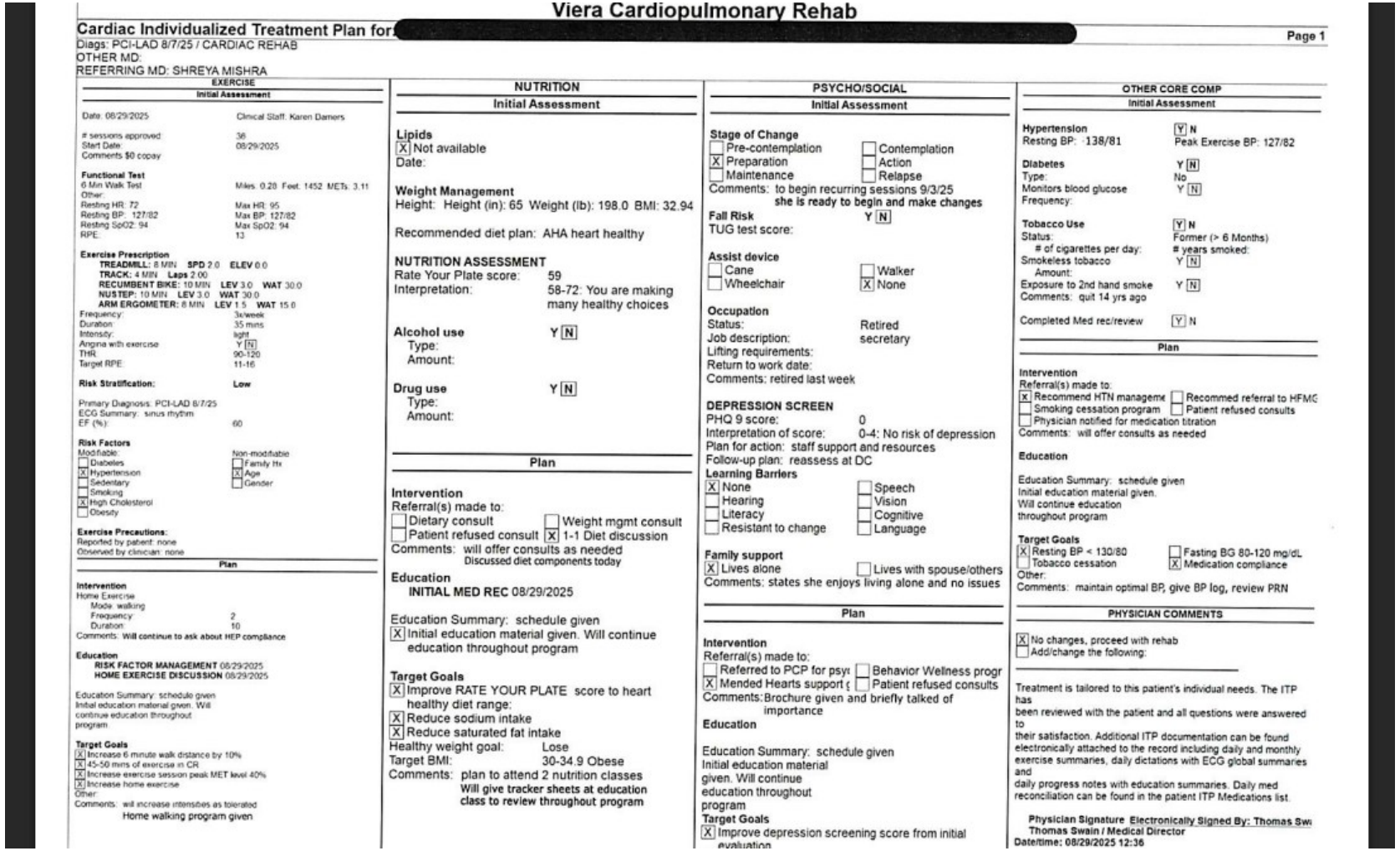
*Question From M. Chang (Staff Competencies)

AACVPR

Reviewer Question (ITP)

Q: Doesn't have the word "mode" under exercise. Modes are listed but not the actual word "mode". Should this be denied?

A: Approve. Mode is clearly listed.



Viera Cardiopulmonary Rehab

Cardiac Individualized Treatment Plan for: [redacted] Page 1

Diags: PCI-LAD 8/7/25 / CARDIAC REHAB
OTHER MD:
REFERRING MD: SHREYA MISHRA

EXERCISE
Initial Assessment

Date: 08/29/2025 Clinical Staff: Karen Damers

sessions approved: 36
Start Date: 08/29/2025
Comments $0 copay:

Functional Test
6 Min Walk Test Miles: 0.28 Feet: 1452 METs: 3.11
Other:
Resting HR: 72 Max HR: 95
Resting BP: 127/82 Max BP: 127/82
Resting SpO2: 94 Max SpO2: 94
RPE: 13

Exercise Prescription
TREADMILL: 8 MIN **SPD** 2.0 **ELEV** 0.0
TRACK: 4 MIN **Laps** 2.00
RECUMBENT BIKE: 10 MIN **LEV** 3.0 **WAT** 30.0
NUSTEP: 10 MIN **LEV** 3.0 **WAT** 30.0
ARM ERGOMETER: 8 MIN **LEV** 1.5 **WAT** 15.0
Frequency: 3x/week
Duration: 35 mins
Intensity: light
Angina with exercise: Y [N]
THR: 90-120
Target RPE: 11-16

Risk Stratification: Low

Primary Diagnosis: PCI-LAD 8/7/25
ECG Summary: sinus rhythm
EF (%): 60

Risk Factors
Modifiable: Non-modifiable
[ ] Diabetes [ ] Family Hx
[X] Hypertension [X] Age
[ ] Sedentary [ ] Gender
[ ] Smoking
[X] High Cholesterol
[ ] Obesity

Exercise Precautions:
Reported by patient: none
Observed by clinician: none

Plan

Intervention
Home Exercise
Mode: walking
Frequency: 2
Duration: 10
Comments: **Will continue to ask about HEP compliance**

Education
RISK FACTOR MANAGEMENT 08/29/2025
HOME EXERCISE DISCUSSION 08/29/2025

Education Summary: schedule given
Initial education material given. Will continue education throughout program

Target Goals
[X] Increase 6 minute walk distance by 10%
[X] 45-50 mins of exercise in CR
[X] Increase exercise session peak MET level 40%
[X] Increase home exercise
Other:
Comments: will increase intensities as tolerated
Home walking program given

NUTRITION
Initial Assessment

Lipids
[X] Not available
Date:

Weight Management
Height: Height (in): 65 Weight (lb): 198.0 BMI: 32.94

Recommended diet plan: AHA heart healthy

NUTRITION ASSESSMENT
Rate Your Plate score: 59
Interpretation: 58-72: You are making many healthy choices

Alcohol use Y [N]
Type:
Amount:

Drug use Y [N]
Type:
Amount:

Plan

Intervention
Referral(s) made to:
[ ] Dietary consult [ ] Weight mgmt consult
[ ] Patient refused consult [X] 1-1 Diet discussion
Comments: will offer consults as needed
Discussed diet components today

Education
INITIAL MED REC 08/29/2025

Education Summary: schedule given
[X] Initial education material given. Will continue education throughout program

Target Goals
[X] Improve RATE YOUR PLATE score to heart healthy diet range:
[X] Reduce sodium intake
[X] Reduce saturated fat intake
Healthy weight goal: Lose
Target BMI: 30-34.9 Obese
Comments: plan to attend 2 nutrition classes
Will give tracker sheets at education class to review throughout program

PSYCHO/SOCIAL
Initial Assessment

Stage of Change
[ ] Pre-contemplation [ ] Contemplation
[X] Preparation [ ] Action
[ ] Maintenance [ ] Relapse
Comments: to begin recurring sessions 9/3/25
she is ready to begin and make changes

Fall Risk Y [N]
TUG test score:

Assist device
[ ] Cane [ ] Walker
[ ] Wheelchair [X] None

Occupation
Status: Retired
Job description: secretary
Lifting requirements:
Return to work date:
Comments: retired last week

DEPRESSION SCREEN
PHQ 9 score: 0
Interpretation of score: 0-4: No risk of depression
Plan for action: staff support and resources
Follow-up plan: reassess at DC

Learning Barriers
[X] None [ ] Speech
[ ] Hearing [ ] Vision
[ ] Literacy [ ] Cognitive
[ ] Resistant to change [ ] Language

Family support
[X] Lives alone [ ] Lives with spouse/others
Comments: states she enjoys living alone and no issues

Plan

Intervention
Referral(s) made to:
[ ] Referred to PCP for psyc [ ] Behavior Wellness progr
[X] Mended Hearts support g [ ] Patient refused consults
Comments: Brochure given and briefly talked of importance

Education

Education Summary: schedule given
Initial education material given. Will continue education throughout program

Target Goals
[X] Improve depression screening score from initial evaluation

OTHER CORE COMP
Initial Assessment

Hypertension Y [N]
Resting BP: 138/81 Peak Exercise BP: 127/82

Diabetes Y [N]
Type: No
Monitors blood glucose Y [N]
Frequency:

Tobacco Use Y [N]
Status: Former (> 6 Months)
# of cigarettes per day: # years smoked:
Smokeless tobacco Y [N]
Amount:
Exposure to 2nd hand smoke Y [N]
Comments: quit 14 yrs ago

Completed Med rec/review Y [N]

Plan

Intervention
Referral(s) made to:
[X] Recommend HTN manageme [ ] Recommed referral to HFMC
[ ] Smoking cessation program [ ] Patient refused consults
[ ] Physician notified for medication titration
Comments: will offer consults as needed

Education

Education Summary: schedule given
Initial education material given.
Will continue education throughout program

Target Goals
[X] Resting BP < 130/80 [ ] Fasting BG 80-120 mg/dL
[ ] Tobacco cessation [X] Medication compliance
Other:
Comments: maintain optimal BP, give BP log, review PRN

PHYSICIAN COMMENTS

[X] No changes, proceed with rehab
[ ] Add/change the following:

Treatment is tailored to this patient's individual needs. The ITP has been reviewed with the patient and all questions were answered to their satisfaction. Additional ITP documentation can be found electronically attached to the record including daily and monthly exercise summaries, daily dictations with ECG global summaries and daily progress notes with education summaries. Daily med reconciliation can be found in the patient ITP Medications list.

Physician Signature Electronically Signed By: Thomas Swa
Thomas Swain / Medical Director
Date/time: 08/29/2025 12:36

*Question From M. Chang (ITP)

Upcoming Reviewer Q&A Sessions

Monday, April 13, 2026, from 1:00pm to 2:00pm Central Time
Monday, April 20, 2026, from 12:00pm to 1:00pm Central Time
Monday, April 27, 2026, from 12:00pm to 1:00pm Central Time
*Tuesday, May 5, 2026, from 12:00pm to 1:00pm Central Time (Extra call if needed)

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Reminder – Timeline for Review

- ~~March 5 - Review begins~~
- **April 1 - 25% complete**
- April 15 - 50% complete
- April 29 75% complete
- May 15 - 100% complete

June – July 2026 – Chair reviews of denied apps & Board grants final decision for approved programs

August 1, 2026 – Initial review cycle closed and all programs are notified of their status

August – September 2026 – Remediation for denied application begins

AACVPR

Contact Information

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THANK YOU