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3 **2018 ACC/AHA Clinical Performance and Quality Measures for Cardiac Rehabilitation**  
4  
5 **A Report of the American College of Cardiology/American Heart Association Task Force on**  
6 **Performance Measures**  
7 *Developed in Collaboration with the American Association of Cardiovascular and Pulmonary*  
8 *Rehabilitation*  
9 *Endorsed by the*  
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## 27 Preamble

28 The American College of Cardiology (ACC)/American Heart Association (AHA) performance measure  
 29 sets serve as vehicles to accelerate translation of scientific evidence into clinical practice. Measure sets  
 30 developed by the ACC/AHA are intended to provide practitioners and institutions that deliver  
 31 cardiovascular services with tools to measure the quality of care provided and identify opportunities for  
 32 improvement.

1 Writing committees are instructed to consider the methodology of performance measure  
2 development (1) and to ensure that the measures developed are aligned with ACC/AHA clinical  
3 guidelines. The writing committees also are charged with constructing measures that maximally capture  
4 important aspects of care quality, including timeliness, safety, effectiveness, efficiency, equity, and  
5 patient-centeredness, while minimizing, when possible, the reporting burden imposed on hospitals,  
6 practices, and/or practitioners.

7 Potential challenges from measure implementation may lead to unintended consequences. The  
8 manner in which challenges are addressed is dependent on several factors, including the measure design,  
9 data collection method, performance attribution, baseline performance rates, reporting methods, and  
10 incentives linked to these reports.

11 The ACC/AHA Task Force on Performance Measures (Task Force) distinguishes quality  
12 measures from performance measures. Quality measures are those metrics that *may* be useful for local  
13 quality improvement but are not yet appropriate for public reporting or pay for performance programs  
14 (uses of performance measures). New measures are initially evaluated for potential inclusion as  
15 performance measures. In some cases, a measure is insufficiently supported by the guidelines. In other  
16 instances, when the guidelines support a measure, the writing committee may feel it is necessary to have  
17 the measure tested to identify the consequences of measure implementation. Quality measures may then  
18 be promoted to the status of performance measures as supporting evidence becomes available.

19  
20 Gregg C. Fonarow, MD, FACC, FAHA  
21 Chair, ACC/AHA Task Force on Performance Measures  
22  
23

## 24 **1. Introduction**

25 In 2016, the ACC/AHA Task Force convened the writing committee to begin the process of  
26 revising the existing Cardiac Rehabilitation (CR) set that was released in 2007 (2) and for which a  
27 focused update was issued in 2010 (3). The writing committee also was charged with the task of  
28 developing new measures to benchmark and improve the quality of care for patients eligible for CR.

1 All the measures included in the measure set are briefly summarized in [Table 1](#) which provides  
 2 information on the measure number, measure title, and care setting. The detailed measure specifications  
 3 (available in [Appendix A](#)) provide not only the information included in [Table 1](#) but also provide more  
 4 detailed information including the measure description, numerator, denominator (including denominator  
 5 exclusions and exceptions), rationale for the measure, guideline that support the measure, measurement  
 6 period, source of data, attribution.

7 The writing committee has developed a comprehensive CR measure set that includes 9 total  
 8 measures, including 6 performance measures, and 3 quality measures as reflected in [Table 1](#) and  
 9 [Appendix A](#). The writing committee believes that implementation of this measure set by health care  
 10 systems, health care providers, health insurance carriers, chronic disease management organizations, CR  
 11 programs and other groups that have responsibility for the delivery of care to persons with cardiovascular  
 12 disease will help to enhance the structure, process, and outcomes of care provided to patients who are  
 13 eligible for CR services.

14  
 15

16 **Table 1. ACC/AHA 2018 Cardiac Rehabilitation Clinical Performance and Quality Measures**

17

o.	MEASURE TITLE	CARE SETTING	ATTRIBUTION	MEASURE DOMAIN
<b>PERFORMANCE MEASURES</b>				
PM-1	CR Patient Referral From an Inpatient Setting	Inpatient	Facility Level	Communication and Care Coordination
PM-2	Exercise Training Referral for HF from Inpatient Setting	Inpatient	Facility Level	Communication and Care Coordination
PM-3	CR Patient Referral From an Outpatient Setting	Outpatient	Facility or Provider Level	Communication and Care Coordination
PM-4	Exercise Training Referral for HF from Outpatient Setting	Outpatient	Facility or Provider Level	Communication and Care Coordination
PM-5a	CR Enrollment–Claims Based	Outpatient	Provider Level	Effective Clinical Care
PM-5b	CR Enrollment–Registry/Electronic Health Records Based	Inpatient	Provider Level	Effective Clinical Care
<b>QUALITY MEASURES</b>				
QM-1	CR Time to Enrollment	Outpatient	Facility or Provider Level	Effective Clinical Care
QM-2	CR Adherence (≥25 sessions)	Outpatient	Facility or Provider Level	Effective Clinical Care

o.	MEASURE TITLE	CARE SETTING	ATTRIBUTION	MEASURE DOMAIN
QM-3	CR Communication: Patient Enrollment, Adherence, and Clinical Outcomes	Outpatient	Facility or Provider Level	Communication and Care Coordination

1 ACCF indicates American College of Cardiology Foundation; AHA, American Heart Association; CR, cardiac rehabilitation;  
2 HF, heart failure; PM, performance measure; and QM, quality measure.

3

## 4 **1.1. Scope of the Problem**

5 The recently published AHA Heart and Stroke Statistical report highlights the large number of  
6 patients who are in need of CR each year, including 625,000 patients discharged from U.S. hospitals  
7 following an acute coronary syndrome, 954,000 patients who underwent percutaneous coronary  
8 interventions, 500,000 patients discharged with a new diagnosis of heart failure, and 397,000 who  
9 underwent coronary artery bypass graft surgery (CABG) (4). Furthermore, data from the national  
10 Healthcare Cost and Utilization Project statistics show that over 608,000 patients were discharged with a  
11 primary diagnosis of acute myocardial infarction (AMI) in 2012 with a length of stay (mean) of 4.6 days,  
12 charges (mean) of more than \$72,000 per patient stay and an in-hospital death rate of 5.16% (5). More  
13 than half a million patients with coronary atherosclerosis and other heart diseases were treated in hospitals  
14 in 2012 with a length of stay of 3.7 days and associated charges of almost \$69,000 (5).

15 CR is a multidisciplinary, systematic approach to applying secondary prevention therapies of  
16 known benefit. Following a myocardial infarction (MI), CR decreases recurrent MI and mortality rates  
17 based on a meta-analysis of 34 randomized trials (6). Participation in CR programs can also improve a  
18 patient's quality of life and ability to return to work more quickly (7,8). One study within a community  
19 demonstrated a 10-year absolute risk reduction in all-cause mortality of more than 12% in CABG patients  
20 who participate in a CR program (9). Studies have also found that CR participation is associated with a  
21 20-30% reduction in hospital readmission during the year after a cardiac event (8,10,11).

22 Even with the underlying evidence demonstrating the benefits of CR, the majority of eligible  
23 patients are still not receiving this therapy.

24 Analyses show that:

- 25 • Just over 13% of Medicare patients who had an AMI and 30% after a CABG received CR (12).

- Certain sub-populations including ethnic minorities, women and those with caregiver-related responsibilities, multiple comorbidities, limited program access, and inadequate health insurance coverage are less like to receive rehabilitation (12,13).

Data from the ACTION-Get With The Guidelines registry (2014) (4) on the current ST-elevation myocardial infarction/non-ST—elevation myocardial infarction measures related to CR continue to demonstrate an opportunity for improvement with 75.9% of patients with non-ST—elevation myocardial infarction receiving this referral and 84.5% for those with STEMI. Rates of CR referral are even lower (approximately 60%) for patients who undergo PCI (14). Similarly, data from the Get With The Guidelines-Heart Failure registry showed that in patients hospitalized for heart failure (HF), only 10.4% (12.2% with HFrEF and 8.8% with HFpEF) received CR referral at discharge (15).

Furthermore, in addition to a “referral gap,” an “enrollment gap” also exists in CR—with only about 50% of patients referred to CR actually enrolling and participating in CR (16-18). In addition, completion rates of CR are suboptimal (12,18). If CR participation rates were improved to at least 70%, it is estimated that approximately 25,000 deaths and 180,000 hospitalizations could be prevented each year (19). For all of the above-mentioned reasons, updating the existing CR measure set has been recognized as a high priority for the ACC and AHA. Particular attention has been given to the infrastructure and processes that are most likely to improve CR participation by eligible patients and ultimately improve patient outcomes. This document serves to reflect those measures that were developed by the writing committee after comprehensive internal discussion, peer review, and public comment.

## 1.2. Disclosure of Relationships With Industry and Other Entities

The ACC/AHA Task Force makes every effort to avoid actual, potential, or perceived conflicts of interest that could arise as a result of relationships with industry or other entities (RWI). Detailed information on the ACC/AHA policy on RWI can be found at <http://www.acc.org/guidelines/about-guidelines-and-clinical-documents/relationships-with-industry-policy>. All members of the writing committee, as well as those selected to serve as peer reviewers of this document, were required to disclose all current relationships and those existing within the 12 months before the initiation of this writing effort. ACC/AHA policy also requires that the writing committee chair and at least 50% of the writing committee have no relevant RWI.

1 Any writing committee member who develops new RWI during his or her tenure on the writing  
 2 committee is required to notify staff in writing. These statements are reviewed periodically by the Task  
 3 Force and by members of the writing committee. Author and peer reviewers RWI which are relevant to  
 4 the document are included in the appendices: Please see [Appendix B](#) for relevant writing committee RWI  
 5 and [Appendix C](#) for relevant peer reviewer RWI. Additionally, to ensure complete transparency, the  
 6 writing committee members' comprehensive disclosure information, including RWI not relevant to the  
 7 present document, is available online at [insert link to Comprehensive RWI here once paper finalized]  
 8 Disclosure information for the Task Force is also available online at [http://www.acc.org/guidelines/about-](http://www.acc.org/guidelines/about-guidelines-and-clinical-documents/guidelines-and-documents-task-forces)  
 9 [guidelines-and-clinical-documents/guidelines-and-documents-task-forces](http://www.acc.org/guidelines/about-guidelines-and-clinical-documents/guidelines-and-documents-task-forces).

10 The work of the writing committee was supported exclusively by the ACC and the AHA without  
 11 commercial support. Members of the writing committee volunteered their time for this effort. Meetings of  
 12 the writing committee were confidential and attended only by writing committee members and staff from  
 13 the ACC, AHA, and the American Association of Cardiovascular and Pulmonary Rehabilitation  
 14 (AACVPR) who served as a collaborator on this project.

## 15 2. Methodology

### 16 2.1. Literature Review

17 In developing the updated CR measure set, the writing committee reviewed evidence-based guidelines  
 18 and statements that would potentially impact the construct of the measures. The practice guidelines and  
 19 statements that most directly contributed to the development of these measures are shown in [Table 2](#).

20 **Table 2: Associated Guidelines and Other Clinical Guidance Documents**

CLINICAL PRACTICE GUIDELINES	
1.	2014 AHA/ACC Guideline for the Management of Patients With Non-ST-Elevation Acute Coronary Syndromes: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (20)
2.	2013 ACCF/AHA guideline for the management of ST-elevation myocardial infarction: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines (21)
3.	2015 ACC/AHA/SCAI Focused Update on Primary Percutaneous Coronary Intervention for Patients With ST-Elevation Myocardial Infarction: An Update of the 2011 ACCF/AHA/SCAI Guideline for Percutaneous Coronary Intervention and the 2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infarction (22)
4.	2013 ACCF/AHA Guideline for the Management of Heart Failure (23)
5.	2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk (24)



6.	2012 ACCF/AHA/ACP/AATS/PCNA/SCAI/STS Guideline for the Diagnosis and Management of Patients With Stable Ischemic Heart Disease (25)
7.	Effectiveness-based guidelines for the prevention of cardiovascular disease in women—2011 update: a guideline from the American Heart Association (26)
8.	AHA/ACCF secondary prevention and risk reduction therapy for patients with coronary artery and other atherosclerotic vascular disease: 2011 update (27)
9.	2011 ACCF/AHA Guideline for Coronary Artery Bypass Graft Surgery (28)
<b>PERFORMANCE MEASURES AND STATEMENTS</b>	
1.	ACCF/AHA/AMA-PCPI 2011 Performance Measures for Adults With Coronary Artery Disease and Hypertension (29)
2.	ACC/AHA 2008 performance measures for adults with ST-elevation and non-ST-elevation myocardial infarction (30)
3.	Acute Myocardial Infarction in Women: A Scientific Statement from the American Heart Association (31)
4.	Preventing and Experiencing Ischemic Heart Disease as a Woman: State of the Science: A Scientific Statement From the American Heart Association (32)
5.	ACCF/AHA/AMA-PCPI 2011 Performance Measures for Adults With Heart Failure (33)
6.	2012 ACCF/AATS/SCAI/STS Expert Consensus Document on Transcatheter Aortic Valve Replacement (34)

1 AATS indicates American Association for Thoracic Surgery; ACC, American College of Cardiology; ACCF, American College  
2 of Cardiology Foundation; ACP, American College of Physicians; AHA, American Heart Association; AMA, American Medical  
3 Association; PCPI, Physician Consortium for Performance Improvement; PCNA, Preventive Cardiovascular Nurses Association;  
4 SCAI, Society for Cardiovascular Angiography and Interventions; and STS, the Society of Thoracic Surgeons.

## 5 2.2. Definition and Selection of Measures

6 The writing committee reviewed both recent clinical practice guidelines and other clinical  
7 guidance documents in [Table 2](#). The writing committee also examined available information on gaps in  
8 care to address which new measures might be appropriate as performance measures or quality measures  
9 for this measure set update.

10 The writing committee took into consideration a number of additional factors, including the  
11 following:

- 12 • Previous feedback from the National Quality Forum endorsement process and from the  
13 Centers for Medicare and Medicaid Services (CMS) has included suggestions to  
14 incorporate “enrollment” in the next version of the CR performance measures.
- 15 • CMS approved heart failure with reduced ejection fraction as a covered indication for  
16 CR, beginning in February 2014. In addition, the 2013 ACC/AHA Guideline for the  
17 Management of Heart Failure included a Class I recommendation for exercise training for  
18 patients with heart failure (23). These factors highlighted the need to incorporate such  
19 patients in the updated version of the CR measures.

- 1           • As ACC and AHA have recently worked with CMS to establish a consensus core set of  
2 cardiovascular performance measures, the group decided to not include the CR referral  
3 performance measure as a separate measure due to concerns about the difficulty for some  
4 centers to collect the measure. However, the group did include the CR referral measure as  
5 a component of the composite “defect free care” measure for MI (35). This suggests that  
6 a goal of the updated version of the CR performance measures should be to improve the  
7 ease of collection, while maintaining high quality standards for data that are collected.
- 8           • Input from CMS has also requested the e-specification of the performance measures, a  
9 process that is difficult given that electronic health records generally do not include CR  
10 referral as a discrete data field, making it necessary to use manual chart abstraction or  
11 local electronic health record systems to collect data on CR referral. The CR referral  
12 measure is currently included in ACC and AHA registries, an important step that may  
13 serve as an example for ways in which vendors of electronic health records can include  
14 the CR referral measure, as well as other measures included in the updated CR measures  
15 set.
- 16           • Growing evidence suggests that alternative models of CR delivery (home-based,  
17 electronic/mobile technology-based, etc.) are both feasible and potentially helpful for  
18 increasing the reach of CR services, suggesting that the updated CR measures set should  
19 be broad enough in scope to allow for the inclusion of alternative models of CR delivery  
20 that are supported by published evidence.
- 21           • In January 2018, CMS will initiate a pilot program that includes the use of bundled  
22 payments and/or CR financial incentives for a select number of geographical regions,  
23 involving patients with AMI and/or those undergoing CABG surgery. Although it is  
24 unclear if these models program will be implemented for the longer-term use, it still has  
25 relevance to the updated CR measures, especially those aimed at promoting early  
26 enrollment and treatment adherence, given that the CMS CR financial incentives are tied  
27 to a patient’s adherence to CR sessions in the 90 days following the qualifying event.

28  
29           CR measures were designed to cover two specific aspects of CR services: 1) referral of eligible  
30 patients to a CR program and 2) delivery of CR services through multidisciplinary CR programs. The

1 measures also were designed to include all patients without a valid reason for exclusion from the measure.  
2 Measure exclusions are those reasons that remove a patient automatically from the denominator. For  
3 example, all measures excluded patients who were under 18 years of age. In contrast to exclusions,  
4 denominator exceptions are those conditions that remove a patient from the denominator only if the  
5 numerator criteria are not met. Denominator exceptions are used in select cases to allow for a fairer  
6 measurement of quality for those providers with higher risk populations. Exceptions are also used to defer  
7 to the clinical judgment of the provider. Several of the measures include exceptions. For example, in the  
8 case of the CR referral from an inpatient setting, a physician may recommend CR even if the patient says  
9 that he/she will not enroll in a CR program due to one or more reasons (e.g., lack of transportation, patient  
10 preference, etc.). In such a case, the physician would receive credit for the measure. If the patient has told  
11 the physician that he/she does not wish to enroll in a CR program, the physician can choose not to write  
12 the referral, and document in the medical record that the patient refused CR. In this scenario, the provider  
13 would not be penalized for the lack of a completed CR program referral as long as the patient reason is  
14 documented. The writing committee closely examined which exceptions should be included for each  
15 measure.

16 For the purposes of this document, a CR program is defined as a systematic, medically supervised  
17 program that helps patients recuperate from their cardiac event; adopt and adhere to healthy lifestyle  
18 habits; address co-morbid conditions (e.g., depression, diabetes, sleep apnea); monitor for safety issues;  
19 including new or recurrent signs or symptoms; and adhere to evidence-based medical therapies. A CR  
20 program may include a traditional center-based CR program that incorporates face-to-face interactions  
21 and supervised exercise training sessions or may include other delivery models that meet all criteria for a  
22 safe and effective CR program, as specified by AACVPR CR practice guidelines. In addition, an  
23 alternative CR program is defined as a hospital outpatient-based program that may include hybrid  
24 delivery options (e.g., remote monitoring, combined center- and home-based) as part of the program, and  
25 incorporates the core clinical and operational components of an industry-standard service that provides,  
26 tracks and reports on safe and effective exercise, and patient-centered disease management education  
27 aimed to progress patients toward improved outcomes in the clinical, functional and behavioral domains.

28 During the course of developing the measure set, the writing committee evaluated the potential  
29 measures against the ACC/AHA attributes of performance measures ([Table 3](#)) to reach consensus on  
30 which measures should be advanced for inclusion in the final measure set. After the peer review and

1 public comment period, the writing committee reviewed and discussed the comments received, and  
2 further refined the measure set. The writing committee acknowledges that the new measures created in  
3 this set will need to be tested and validated over time. By publishing this measure set, the writing  
4 committee hopes to encourage adoption of these performance measures which will help to facilitate the  
5 collection and analysis of data that are needed to assess the validity of these measures. In the future, the  
6 writing committee anticipates having data that will allow them to re-assess whether any of the measures  
7 included in this set should be modified, or potentially promoted from a quality measure to a performance  
8 measure.

1 **Table 3. ACC/AHA Task Force on Performance Measures: Attributes for Performance Measures (36)**

2

**1. Evidence Based**

High-impact area that is useful in improving patient outcomes

- a) For structural measures, the structure should be closely linked to a meaningful process of care that in turn is linked to a meaningful patient outcome.
- b) For process measures, the scientific basis for the measure should be well established, and the process should be closely linked to a meaningful patient outcome.
- c) For outcome measures, the outcome should be clinically meaningful. If appropriate, performance measures based on outcomes should adjust for relevant clinical characteristics through the use of appropriate methodology and high-quality data sources.

**2. Measure Selection**

Measure definition

- a) The patient group to whom the measure applies (denominator) and the patient group for whom conformance is achieved (numerator) are clearly defined and clinically meaningful.

Measure exceptions and exclusions

- b) Exceptions and exclusions are supported by evidence.

Reliability

- c) The measure is reproducible across organizations and delivery settings.

Face validity

- d) The measure appears to assess what it is intended to.

Content validity

- e) The measure captures most meaningful aspects of care.

Construct validity

- f) The measure correlates well with other measures of the same aspect of care.

**3. Measure Feasibility**

Reasonable effort and cost\*

- a) The data required for the measure can be obtained with reasonable effort and cost.

Reasonable time period

- b) The data required for the measure can be obtained within the period allowed for data collection.

**4. Accountability**

Actionable\*

- a) Those held accountable can affect the care process or outcome.

Unintended consequences avoided

- b) The likelihood of negative unintended consequences with the measure is low.

3 ACC indicates American College of Cardiology and AHA, American Heart Association.

4

5

6

### 3. ACC/AHA Cardiac Rehabilitation Measure Set Performance Measures

#### 3.1 Discussion of Changes to 2008 and 2010 Cardiac Rehabilitation Measure Set

After reviewing the existing guidelines, the 2007 measure set (2) and the 2010 focused update (3), the writing committee discussed which measures required revision to reflect updated science in the field of CR, and identified which guideline recommendations could serve as the basis for new performance or quality measures. The writing committee also reviewed existing publically available measure sets.

The following subsections serve as a synopsis of the revisions that were made to previous measures, and a description of why the new measures were created for both the inpatient and outpatient setting.

##### 3.1.1. Retired Measures

The writing committee decided to retire the “Set B” CR performance measures (CR program measures) included in the original 2007 CR measures set. This was done to avoid duplication of effort, since the “Set B” measures are currently being updated, tested, and implemented through a separate process by the AACVPR. The measures along with a brief rationale for retiring the measures are included in [Table 4](#).

**Table 4: Retired Cardiac Rehabilitation Measures from the 2007 Set**

#	Care Setting	Measure Title	Rationale for Retiring the Measures
B-1	N/A	Structure-Based Measurement Set	This measure will be considered for revision and/or maintenance by the AACVPR as elements of this measure are currently used within AACVPR Program Certification.
B-2	N/A	Assessment of Risk for Adverse Cardiovascular Events	This measure will be considered for revision and/or maintenance by the AACVPR because it is specific to CR programming and outcomes, and is used within the AACVPR CR Registry and Program Certification.
B-3	N/A	Individualized Assessment and Evaluation of Modifiable Cardiovascular Risk Factors, Development of Individualized Interventions, and Communication With Other Health Care Providers	This measure and all of its subset measures are being retired and are being replaced by AACVPR with patient-related outcomes measures, which currently include improvement in functional capacity, blood pressure control, and depression, as well as a process measures related to intervention for tobacco use. AACVPR will continue to evaluate and develop new measures related to CR programming and outcomes to use within the AACVPR CR Registry and

			Program Certification.
B-4	N/A	Monitor Response to Therapy and Document Program Effectiveness	This measure will be considered for revision and/or maintenance by AACVPR as elements are used within the AACVPR CR Registry and Program Certification.

1 AACVPR indicates American Association of Cardiovascular and Pulmonary Rehabilitation and CR, cardiac  
 2 rehabilitation.

3

4 **3.1.2. Revised Measures**

5 The writing committee reviewed and made changes to the inpatient and outpatient CR referral measures,  
 6 as summarized in [Table 5](#). Minimal changes were made, primarily those that improve ease of use of the  
 7 measures and strengthen the construct of the measures. [Table 5](#) provides information on the updated  
 8 measures including the care setting, title, and a brief rationale for revisions made to the measures.

1 **Table 5: Revised Cardiac Rehabilitation Measures**

#	Measure Title	Description	Rationale for Revisions
PM-1	CR referral from an Inpatient Setting	All patients hospitalized with a CR-eligible diagnosis or procedure should be referred to an outpatient CR program prior to hospital discharge	If patient refuses CR referral, referral order and patient materials should not be sent to the receiving CR program against the patient’s wishes. CR referral would still be met as long as other aspects of CR referral have been met (CR referral recommended and documented)
PM-3	CR Referral from an Outpatient Setting	All outpatients who are eligible for CR and have not yet participated in CR should be referred to an outpatient CR program.	If patient refuses CR referral, referral order and patient materials should not be sent to the receiving CR program against the patient’s wishes. CR referral would still be met as long as other aspects of CR referral have been met (CR referral recommended and documented)

2 CR indicates cardiac rehabilitation and PM, performance measures.

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1 **3.1.3. New Measures**

2 The writing committee has created a comprehensive list of measures that can be utilized for patients who  
3 are eligible to participate in CR. This set includes five new performance measures, and three new quality  
4 measures. [Table 6](#) includes a list of the measures with information on the care setting, and a brief  
5 rationale.

6 The measures are structured in a typical format in which the goal is to seek a higher performance  
7 score, ideally nearing 100%.

8 For more detailed information on the measure construct, please refer to the detailed measure  
9 specifications for each measure in [Appendix A](#).

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1 **Table 6: New Cardiac Rehabilitation Measures**

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#	Care Setting	Measure Title	Rationale for Creating New Measure	Rationale for Designating as a Quality Measure as Opposed to a Performance Measure (If Applicable)
PM-2	Inpatient	Exercise Training Referral for Heart Failure from Inpatient Setting	Exercise training is a Class 1 recommendation for patients with HFrEF and is typically provided through an outpatient CR program. Exercise training has been shown to help improve functional capacity for patients with HFrEF. In addition, CR has been shown to improve functional capacity, exercise duration, HRQOL, and mortality (Class IIa, Level of Evidence B).	Non applicable
PM-4	Outpatient	Exercise Training Referral for Heart Failure from Outpatient Setting	Exercise training is a Class 1 recommendation for patients with HFrEF and is typically provided through an outpatient CR program. Exercise training has been shown to help improve functional capacity for patients with HFrEF. In addition, CR has been shown to improve functional capacity, exercise duration, HRQOL, and mortality (Class IIa, Level of Evidence B).	Non applicable
PM-5a	Outpatient	CR Enrollment–Claims Based	While CR referral is a critically important first step in CR participation, CR enrollment is the goal of CR referral and is essential for patients to receive the benefits associated with CR participation. This option, to use claims-based data, is included to allow flexibility in the measure assessment for healthcare organizations that may wish to use claims-based data, with or without the use of registry/electronic health record data.	Non applicable

PM-5b	Outpatient	CR Enrollment-Registry/Electronic Health Records Based	While CR referral is a critically important first step in CR participation, CR enrollment is the goal of CR referral and is essential for patients to receive the benefits associated with CR participation. This option, to use registry/electronic health record data, is included to allow flexibility in the measure assessment for healthcare organizations that may wish to use registry/electronic health record data with or without the use of claims-based data.	Non applicable
QM-1	Inpatient	CR Time to Enrollment	Research indicates that earlier enrollment into CR improves overall enrollment, thus it may also be associated with better patient outcomes. Specifically, for every day that passes after hospital discharge there is a ~1% decrease in participation (37). This measure may involve process improvement strategies at the patient, hospital, and program levels.	Early enrollment in CR is a safe and important goal to help optimize enrollment, participation and eventual patient outcomes of CR. However, since time to enrollment is not part of the Class I, Level of Evidence A, clinical practice guidelines, this measure is being introduced as a QM.
QM-2	Outpatient	CR Adherence ( $\geq 25$ sessions)	Research demonstrates that attending $\geq 25$ sessions is associated with lower risks of death and MI at four years, compared with attending fewer sessions (38).	While observational data show an association between “dose” of CR and patient outcomes, achievement of a “high dose” (i.e., $\geq 25$ sessions) of CR is a very high level of performance, considering that only a minority of patients participate in any CR sessions at present. The writing group has proposed that this “high dose” measure be introduced as a QM, which CR programs and patients are encouraged to ideally achieve.

QM-3	Outpatient	CR Communication: Patient Enrollment Adherence and Clinical Outcomes	Research demonstrates that care coordination and communication between healthcare providers helps to improve quality of care, patient satisfaction, and patient outcomes.	While extremely important, CR communications to referring/primary healthcare providers is not part of Class I clinical practice recommendations. However, such care coordination is considered a standard of care and is included as a QM that CR programs are encouraged to ideally achieve.
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- 1 CR indicates cardiac rehabilitation; HFrEF, heart failure with reduced ejection fraction; HRQOL; health-related quality of life; MI, myocardial
- 2 infarction; PM, performance measures; and QM, quality measure.
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## 4. Areas for Further Research

Additional areas for further research that will potentially have an impact on CR performance and quality measures include the following:

- Impact of CR performance and quality measures on CR participation, adherence and related clinical outcomes.
- Impact of CR performance and quality measures on healthcare expenditures.
- Comparative effectiveness of center-based vs novel CR delivery models on CR participation, adherence, and related clinical outcomes.
- Comparative effectiveness of center-based vs novel CR delivery models in implementing CR performance and quality measures to improve CR participation and adherence rates.
- Impact of the inclusion of CR performance measures in “pay for performance” strategies, on CR participation, adherence, and outcomes.
- Novel performance and quality measures to stimulate higher CR participation and adherence rates
- Performance and quality measures to promote longer-term adherence to secondary prevention therapies, after “completion” of early outpatient (Phase 2) CR

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 4  
 5 **Key Words**

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 7 ACC/AHA Performance Measures ■ cardiac rehabilitation ■ performance measures ■ quality  
 8 measures ■ quality indicators

9 **Appendix A. Cardiac Rehabilitation Measure Set**

10 **Performance Measures for Cardiac Rehabilitation**

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<b>Short Title: PM-1: Referral From Inpatient Setting</b>	
<b>PM-1: Cardiac Rehabilitation Patient Referral From an Inpatient Setting</b>	
<b>Measure Description:</b> Percentage of patients, age ≥18 y, hospitalized with a qualifying event/ diagnosis for CR in the previous 12 m including: an MI, CSA or who during hospitalization have undergone CABG surgery, PCI, cardiac valve repair/replacement, or heart transplantation, are to be referred to an outpatient CR program.	
<b>Numerator</b>	<p>Patients with a qualifying event/diagnosis who have been referred to an outpatient CR program prior to hospital discharge</p> <p>A referral is defined as all of the below:                      (1) an official communication* between the health care provider and the patient to recommend and carry out a referral order to an outpatient CR program                      (2) an official referral order to an outpatient CR program, and                      (3) a communication between the health care provider or health care system and the receiving CR program that includes the patient’s referral information† for the program.</p> <p>While all steps should be met, patients who refuse a CR referral should not have their data transmitted to the receiving CR program against their will. In that case, performance is considered to be met if the first two steps of the referral process and a patient refusal are documented in the patient’s medical record.</p> <p>*All communications must maintain appropriate confidentiality as outlined by the 1996 Health Insurance Portability and Accountability Act [HIPAA].</p> <p>†Necessary patient information may be found in the hospital discharge summary.</p>

<b>Denominator</b>	All patients with a qualifying event/diagnosis in the previous 12 m including: MI, PCI, CABG, CSA, valve repair/replacement, or heart transplantation, who discharged from the hospital during the reporting period
<b>Denominator Exclusions</b>	<ul style="list-style-type: none"> <li>• Patients age &lt;18 y</li> <li>• Patients who leave during the hospitalization against medical advice</li> <li>• Patients who die during the hospitalization period</li> <li>• Patients who are transferred to another hospital for inpatient care</li> <li>• Patient is already participating in a CR program prior to hospitalization</li> </ul>
<b>Denominator Exceptions</b>	<ul style="list-style-type: none"> <li>• Documentation of a patient-oriented reason that precludes referral to CR (e.g., no traditional CR program available to the patient, within 60 min of travel time from the patient's home, or patient has access to an alternative model of CR delivery that meets all criteria for a CR program)</li> <li>• Documentation of a medical reason that precludes referral to CR (e.g., patient deemed by a medical provider to have a medically unstable, life-threatening condition or has other cognitive or physical impairments that preclude CR participation)</li> <li>• Documentation of a healthcare system reason that preclude referral to CR (e.g., patient is discharged to a nursing care or long-term care facility, or patients lack medical coverage for CR)</li> </ul>
<b>Measurement Period</b>	Encounter
<b>Sources of Data</b>	Medical record or other database (e.g., administrative, clinical, registry)
<b>Attribution</b>	Measure reportable at facility level
<b>Care Setting</b>	Inpatient
<b>Rationale</b>	
<p>CR services have been shown to help reduce morbidity and mortality in persons who have experienced a recent coronary artery disease event, but these services are used in less than 30% of eligible patients (39).</p> <p>A key component to outpatient CR program utilization is the appropriate and timely referral of patients. Generally, the most important time for this referral to take place is while the patient is hospitalized for a qualifying event/diagnosis (MI, CSA, CABG, PCI, and cardiac valve repair/replacement.).</p> <p>This performance measure has been developed to help healthcare systems implement effective steps in their systems of care that will optimize the appropriate referral of a patient to an outpatient CR program.</p> <p>This measure is designed to serve as a stand-alone measure or, preferably, to be included within other performance measurement sets that involve disease states or other conditions for which CR services have been found to be appropriate and beneficial (e.g., following MI, CABG surgery). This performance measure is provided in a format that is meant to allow easy and flexible inclusion into such performance measurement sets.</p>	

Effective referral of appropriate inpatients to an outpatient CR program is the responsibility of the healthcare team within a healthcare system that is primarily responsible for providing cardiovascular care to the patient during the hospitalization.

Published evidence suggests that automatic referral systems accompanied by strong and supportive advice and guidance from a healthcare professional can significantly help improve CR referral and enrollment.

#### Clinical Recommendation(s)

##### **2014 AHA/ACC Guideline for the Management of Patients With Non–ST-elevation Acute Coronary Syndromes** (20)

1. All eligible patients with NSTEMI-ACS should be referred to a comprehensive cardiovascular rehabilitation program either before hospital discharge or during the first outpatient visit (40-43) . (*Class I, Level of Evidence: B*)

##### **2013 ACCF/AHA Guideline for the Management of Patients With ST-Elevation Myocardial Infarction** (21)

1. Exercise-based cardiac rehabilitation/secondary prevention programs are recommended for patients with STEMI (42,44-46) . (*Class I, Level of Evidence: B*)

##### **AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients With Coronary Artery and Other Atherosclerotic Vascular Disease: 2011 Update** (27)

1. All eligible patients with ACS or whose status is immediately post coronary artery bypass surgery or post-PCI should be referred to a comprehensive outpatient cardiovascular rehabilitation program either prior to hospital discharge or during the first follow-up office visit (2,42,47,48). (*Class I, Level of Evidence: A*)

##### **AHA Effectiveness-Based Guidelines for the Prevention of Cardiovascular Disease in Women–2011 Update** (26)

1. A comprehensive CVD risk-reduction regimen such as cardiovascular or stroke rehabilitation or a physician-guided home- or community-based exercise training program should be recommended to women with a recent acute coronary syndrome or coronary revascularization, new-onset or chronic angina, recent cerebrovascular event, peripheral arterial disease (*Class I; Level of Evidence A*) or current/prior symptoms of heart failure and an LVEF  $\leq$  35%. (*Class I; Level of Evidence B*)

##### **2011 ACCF/AHA Guideline for Coronary Artery Bypass Graft Surgery** (28)

1. Cardiac rehabilitation is recommended for all eligible patients after CABG (2,42,47-50). (*Class I, Level of Evidence: A*)

- 1 ACC indicates American College of Cardiology; ACCF, American College of Cardiology Foundation; ACS, acute
- 2 coronary syndrome; AHA, American Heart Association; CABG, coronary artery bypass graft; CR, cardiac
- 3 rehabilitation; CSA chronic stable angina; CVD, cardiovascular disease; LVEF, left ventricular ejection fraction;
- 4 MI, myocardial infarction; NSTEMI-ACS, non–ST-elevation myocardial infarction- acute coronary syndromes; and
- 5 PCI, percutaneous coronary intervention.

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<b>Short Title: PM-2: Exercise Training Referral for HF rEF from Inpatient Setting</b>	
<b>PM-2: Exercise Training Referral for HF from an Inpatient Setting</b>	
<b>Measure Description:</b> Percentage of patients, age ≥18 y, hospitalized with a primary diagnosis of HF rEF in the previous 12 m, who are referred for outpatient exercise training (or regular physical activity), typically delivered in the setting of an outpatient CR program.	
<b>Numerator</b>	<p>Patients with HF rEF who have been referred to an outpatient CR program prior to hospital discharge</p> <p>A referral is defined as all of the below:                      (1) an official communication* between the health care provider and the patient to recommend and carry out a referral order to an outpatient CR program,                      (2) an official referral order to an outpatient CR program, and                      (3) a communication between the health care provider or health care system and the receiving CR program that includes the patient’s referral information† for the program.</p> <p>While all steps should be met ideally, patients who refuse a CR referral should not have their data transmitted to the receiving CR program against their will. In that case, performance is considered to be met if the first two steps of the referral process and a patient refusal are documented in the patient’s medical record.</p> <p>*All communications must maintain appropriate confidentiality as outlined by the 1996 Health Insurance Portability and Accountability Act [HIPAA].</p> <p>†Necessary patient information may be found in the hospital discharge summary</p>
<b>Denominator</b>	All patients who have had HF rEF during the previous 12 m, who are discharged from the hospital during the reporting period
<b>Denominator Exclusions</b>	<ul style="list-style-type: none"> <li>• Patients age &lt;18 y</li> <li>• Patients who leave during the hospitalization against medical advice</li> <li>• Patients who die during the hospitalization period</li> <li>• Patients who are transferred to another hospital for inpatient care</li> <li>• Patient is already participating in a CR program prior to hospitalization</li> </ul>
<b>Denominator Exceptions</b>	<ul style="list-style-type: none"> <li>• Documentation of a patient-oriented reason that precludes referral to CR (e.g., no traditional CR program available to the patient, within 60</li> </ul>

	<p>min of travel time from the patient’s home, or patient has access to an alternative model of CR delivery that meets all criteria for a CR program)</p> <ul style="list-style-type: none"> <li>• Documentation of a medical reason that precludes referral to CR (e.g., patient deemed by a medical provider to have a medically unstable, life-threatening condition or has other cognitive or physical impairments that preclude CR participation)</li> <li>• Documentation of a healthcare system reason that preclude referral to CR (e.g., patient is discharged to a nursing care or long-term care facility, or patients lack medical coverage for CR)</li> </ul>
<b>Measurement Period</b>	Encounter
<b>Sources of Data</b>	Medical record or other database (e.g., administrative, clinical, registry)
<b>Attribution</b>	Measure reportable at facility level
<b>Care Setting</b>	Inpatient
<b>Rationale</b>	
<p>CR services have been shown to help improve functional status, and may help reduce morbidity and mortality in persons with stable chronic heart failure with reduced HFrEF, but these services are used in a minority of eligible patients (39,51)</p> <p>A key component to outpatient CR program utilization is the appropriate and timely referral of patients. Generally, the most important time for this referral to take place is while the patient is hospitalized for a HFrEF.</p> <p>This performance measure has been developed to help healthcare systems implement effective steps in their systems of care that will optimize the appropriate referral of a patient to an outpatient CR program.</p> <p>This measure is designed to serve as a stand-alone measure or, preferably, to be included within other performance measurement sets that involve patients with HFrEF. This performance measure is provided in a format that is meant to allow easy and flexible inclusion into such performance measurement sets.</p> <p>Effective referral of appropriate inpatients to an outpatient CR program is the responsibility of the healthcare team within a healthcare system that is primarily responsible for providing cardiovascular care to the patient with HFrEF during the hospitalization.</p> <p>Published evidence suggests that automatic referral systems accompanied by strong and supportive advice and guidance from a healthcare professional can significantly help improve CR referral and enrollment.</p>	
<b>Clinical Recommendation(s)</b>	
<p><b>2013 ACCF/AHA Guideline for the Management of Heart Failure (23)</b></p> <ol style="list-style-type: none"> <li>1. Exercise training (or regular physical activity) is recommended as safe and effective for patients with HF who are able to participate to improve functional status (52-58). (<i>Class I, Level of Evidence: A</i>)</li> </ol>	

**AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients with Coronary Artery and Other Atherosclerotic Vascular Disease: 2011 Update (27)**

- 1. All eligible patients with ACS or whose status is immediately post coronary artery bypass surgery or post-PCI should be referred to a comprehensive outpatient cardiovascular rehabilitation program either prior to hospital discharge or during the first follow-up office visit (2,42,47,48). (*Class I, Level of Evidence: A*)
- 2. All eligible outpatients with the diagnosis of ACS, coronary artery bypass surgery or PCI (*Class I, Level of Evidence: A*) (2,42,47,59), chronic angina (*Class I, Level of Evidence: B*) (2,48), and/or peripheral artery disease (*Class I, Level of Evidence: A*) (60,61) within the past year should be referred to a comprehensive outpatient cardiovascular rehabilitation program.

**AHA Effectiveness-Based Guidelines for the Prevention of Cardiovascular Disease in Women – 2011 Update (26)**

- 1. A comprehensive CVD risk-reduction regimen such as cardiovascular or stroke rehabilitation or a physician-guided home- or community-based exercise training program should be recommended to women with a recent acute coronary syndrome or coronary revascularization, new-onset or chronic angina, recent cerebrovascular event, peripheral arterial disease (*Class I; Level of Evidence A*) or current/prior symptoms of heart failure and an LVEF 35%. (*Class I; Level of Evidence B*)

1 ACC, indicates American College of Cardiology; ACCF, American College of Cardiology Foundation; ACS, acute  
 2 coronary syndrome; AHA, American Heart Association; CR, cardiac rehabilitation; CVD, cardiovascular disease;  
 3 HF, heart failure; HFrEF, heart failure with reduced ejection fraction; LVEF, left ventricular ejection fraction; MI,  
 4 myocardial infarction; NSTEMI-ACS, non-ST-elevation myocardial infarction- acute coronary syndromes; and PCI,  
 5 percutaneous coronary intervention.  
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<b>Short Title: PM-3: Referral From Outpatient Setting</b>	
<b>PM-3: Cardiac Rehabilitation Patient Referral From an Outpatient Setting</b>	
<b>Measure Description:</b> Percentage of patients, age ≥18 y, evaluated in an outpatient setting, who within the previous 12 m have had a qualifying event/diagnosis for CR including: MI, CABG surgery, a PCI, cardiac valve surgery, or heart transplantation, or who have CSA and have not already participated in a CR program for the qualifying event/diagnosis are to be referred to such a program.	
<b>Numerator</b>	<p>Patients in an outpatient clinical practice who have had a qualifying event/diagnosis during the previous 12 m, who have been referred to an outpatient CR program</p> <p>A referral is defined as all of the below:                      (1) an official communication* between the health care provider and the patient to recommend and carry out a referral order to an outpatient CR program                      (2) an official referral order to an outpatient CR program, and                      (3) a communication between the health care provider or health care system and the receiving CR program that includes the patient’s referral information† for the program</p> <p>While all steps should be met, patients who refuse a CR referral should not have their data transmitted to the receiving CR program against their will. In that case, performance is considered to be met if the first two steps of the referral process and a patient refusal are documented in the patient’s medical record.</p> <p>* All communications must maintain appropriate confidentiality as outlined by the 1996 Health Insurance Portability and Accountability Act [HIPAA].</p> <p>†Necessary patient information may be found in the outpatient office note</p>
<b>Denominator</b>	All patients in an outpatient clinical practice who have had a qualifying event/diagnosis during the previous 12 m including: MI, PCI, CABG, CSA, valve repair/replacement, or heart transplantation
<b>Denominator Exclusions</b>	<ul style="list-style-type: none"> <li>• Patients age &lt;18 y</li> <li>• Patients who leaves clinic visit against medical advice</li> <li>• Patient has already participated in or has already completed CR program prior to clinical visit</li> </ul>

<b>Denominator Exceptions</b>	<ul style="list-style-type: none"> <li>• Documentation of a patient-oriented reason that precludes referral to CR (e.g., no traditional CR program available to the patient, within 60 min of travel time from the patient’s home, or patient has access to an alternative model of CR delivery that meets all criteria for a CR program)</li> <li>• Documentation of a medical reason that precludes referral to CR (e.g., patient deemed by a medical provider to have a medically unstable, life-threatening condition or has other cognitive or physical impairments that preclude CR participation)</li> <li>• Documentation of a healthcare system reason that preclude referral to CR (e.g., patient resides in a nursing care or long-term care facility, or patients lack medical coverage for CR)</li> </ul>
<b>Measurement Period</b>	Encounter
<b>Sources of Data</b>	Medical record or other database (e.g., administrative, clinical, registry)
<b>Attribution</b>	Measure reportable at provider and facility level
<b>Care Setting</b>	Outpatient
<b>Rationale</b>	
<p>CR services have been shown to help reduce morbidity and mortality in persons who have experienced a recent coronary artery disease event, but these services are used in less than 30% of eligible patients (39). A key component to CR utilization is the appropriate and timely referral of patients to an outpatient CR program. While referral takes place generally while the patient is hospitalized for a qualifying event (MI, CSA, CABG, PCI, or cardiac valve repair/replacement,), there are many instances in which a patient can and should be referred from an outpatient clinical practice setting (e.g., when a patient does not receive such a referral while in the hospital, or when the patient fails to follow through with the referral for whatever reason).</p> <p>This performance measure has been developed to help healthcare systems implement effective steps in their systems of care that will optimize the appropriate referral of a patient to an outpatient CR program.</p> <p>This measure is designed to serve as a stand-alone measure or, preferably, to be included within other performance measurement sets that involve disease states or other conditions for which CR services have been found to be appropriate and beneficial (e.g., following MI, CABG surgery). This performance measure is provided in a format that is meant to allow easy and flexible inclusion into such performance measurement sets.</p> <p>Referral of appropriate outpatients to a CR program is the responsibility of the healthcare provider within a healthcare system that is providing the primary cardiovascular care to the patient in the outpatient setting.</p> <p>Published evidence suggests that automatic referral systems accompanied by strong and supportive advice and guidance from a healthcare professional can significantly help improve CR referral and enrollment.</p>	
<b>Clinical Recommendation(s)</b>	
<p><b><u>2014 AHA/ACC Guideline for the Management of Patients With Non–ST-Elevation Acute Coronary Syndromes</u></b> (20)</p>	

1. All eligible patients with NSTEMI-ACS should be referred to a comprehensive cardiovascular rehabilitation program either before hospital discharge or during the first outpatient visit (40-43). (*Class I, Level of Evidence: B*)

**2013 ACCF/AHA Guideline for the Management of Patients With ST-Elevation Myocardial Infarction** (21)

1. Exercise-based cardiac rehabilitation/secondary prevention programs are recommended for patients with STEMI (42,44-46). (*Class I, Level of Evidence: B*)

**AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients with Coronary Artery and Other Atherosclerotic Vascular Disease: 2011 Update** (27)

1. All eligible patients with ACS or whose status is immediately post coronary artery bypass surgery or post-PCI should be referred to a comprehensive outpatient cardiovascular rehabilitation program either prior to hospital discharge or during the first follow-up office visit (2,42,47,48). (*Class I, Level of Evidence: A*)
2. All eligible outpatients with the diagnosis of ACS, coronary artery bypass surgery or PCI (*Class I, Level of Evidence: A*) (2,42,47,59), chronic angina (*Class I, Level of Evidence: B*) (2,48), and/or peripheral artery disease (*Class I, Level of Evidence: A*) (60,61) within the past year should be referred to a comprehensive outpatient cardiovascular rehabilitation program.

**AHA Effectiveness-Based Guidelines for the Prevention of Cardiovascular Disease in Women – 2011 Update** (26)

1. A comprehensive CVD risk-reduction regimen such as cardiovascular or stroke rehabilitation or a physician-guided home- or community-based exercise training program should be recommended to women with a recent acute coronary syndrome or coronary revascularization, new-onset or chronic angina, recent cerebrovascular event, peripheral arterial disease (*Class I; Level of Evidence A*) or current/prior symptoms of heart failure and an LVEF 35%. (*Class I; Level of Evidence B*)

**2011 ACCF/AHA Guideline for Coronary Artery Bypass Graft Surgery** (28)

1. Cardiac rehabilitation is recommended for all eligible patients after CABG (2,42,47-50). (*Class I, Level of Evidence: A*)

1 ACC indicates American College of Cardiology; ACCF, American College of Cardiology Foundation; ACS, acute  
 2 coronary syndrome; AHA, American Heart Association; CABG, coronary artery bypass graft; CSA chronic stable  
 3 angina; CR, cardiac rehabilitation; CVD, cardiovascular disease; LVEF, left ventricular ejection fraction; MI,  
 4 myocardial infarction; NSTEMI-ACS, non-ST-elevation myocardial infarction- acute coronary syndromes; and PCI,  
 5 percutaneous coronary intervention.

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<b>Short Title: PM-4: Exercise Training Referral for HFrEF from Outpatient Setting</b>	
<b>PM-4: Exercise Training Referral for HF from an Outpatient Setting</b>	
<b>Measure Description:</b> Percentage of patients, age $\geq 18$ y, evaluated in an outpatient setting who within the previous 12 m, have had HFrEF and have not participated in an exercise training program, such as provided in CR programs, for the qualifying event/diagnosis, are to be referred for exercise training.	
<b>Numerator</b>	<p>Patients in an outpatient clinical practice who have had HFrEF during the previous 12 m, who have been referred to an outpatient CR program</p> <p>A referral is defined as all of the below:</p> <ul style="list-style-type: none"> <li>(1) an official communication* between the health care provider and the patient to recommend and carry out a referral order to an outpatient CR program</li> <li>(2) an official referral order to an outpatient CR program, and</li> <li>(3) a communication between the health care provider or health care system and the receiving CR program that includes the patient’s referral information† for the program.</li> </ul> <p>While all steps should be met ideally, patients who refuse a CR referral should not have their data transmitted to the receiving CR program against their will. In that case, performance is considered to be met if the first two steps of the referral process and a patient refusal are documented in the patient’s medical record.</p> <p>*All communications must maintain appropriate confidentiality as outlined by the 1996 Health Insurance Portability and Accountability Act [HIPAA].)</p> <p>† Necessary patient information may be found in the outpatient office notes</p>
<b>Denominator</b>	All patients in an outpatient clinical practice who have had HFrEF during the previous 12 m
<b>Denominator Exclusions</b>	<ul style="list-style-type: none"> <li>• Patients age &lt;18 y</li> <li>• Patients who leaves clinic visit against medical advice</li> <li>• Patient has already participated in or had already completed a CR program prior to clinic visit</li> </ul>

<b>Denominator Exceptions</b>	<ul style="list-style-type: none"> <li>• Documentation of a patient-oriented reason that precludes referral to CR (e.g., no traditional CR program available to the patient, within 60 min of travel time from the patient’s home, or patient has access to an alternative model of CR delivery that meets all criteria for a CR program)</li> <li>• Documentation of a medical reason that precludes referral to CR (e.g., patient deemed by a medical provider to have a medically unstable, life-threatening condition or has other cognitive or physical impairments that preclude CR participation)</li> <li>• Documentation of a healthcare system reason that preclude referral to CR (e.g., patient resides in a nursing care or long-term care facility, or patients lack medical coverage for CR)</li> </ul>
<b>Measurement Period</b>	Encounter
<b>Sources of Data</b>	Medical record or other database (e.g., administrative, clinical, registry)
<b>Attribution</b>	Measure reportable at provider and facility level
<b>Care Setting</b>	Outpatient
<b>Rationale</b>	
<p>CR services have been shown to help improve functional status, and may help reduce morbidity and mortality in persons with stable chronic heart failure with reduced HFrEF, but these services are used in a minority of eligible patients (39,51).</p> <p>A key component to outpatient CR program utilization is the appropriate and timely referral of patients. Generally, the most important time for this referral to take place is while the patient is hospitalized for a HFrEF.</p> <p>This performance measure has been developed to help healthcare systems implement effective steps in their systems of care that will optimize the appropriate referral of a patient to an outpatient CR program.</p> <p>This measure is designed to serve as a stand-alone measure or, preferably, to be included within other performance measurement sets that involve patients with HFrEF. This performance measure is provided in a format that is meant to allow easy and flexible inclusion into such performance measurement sets.</p> <p>Effective referral of appropriate inpatients to an outpatient CR program is the responsibility of the healthcare team within a healthcare system that is primarily responsible for providing cardiovascular care to the patient with HFrEF during the hospitalization.</p> <p>Published evidence suggests that automatic referral systems accompanied by strong and supportive advice and guidance from a healthcare professional can significantly help improve CR referral and enrollment.</p>	
<b>Clinical Recommendation(s)</b>	
<b><u>2013 ACCF/AHA Guideline for the Management of Heart Failure</u> (23)</b>	



1. Exercise training (or regular physical activity) is recommended as safe and effective for patients with HF who are able to participate to improve functional status (52-58). (*Class I, Level of Evidence: A*)

**AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients with Coronary Artery and Other Atherosclerotic Vascular Disease: 2011 Update** (27)

1. All eligible patients with ACS or whose status is immediately post coronary artery bypass surgery or post-PCI should be referred to a comprehensive outpatient cardiovascular rehabilitation program either prior to hospital discharge or during the first follow-up office visit (2,42,47,48). (*Class I, Level of Evidence: A*)
2. All eligible outpatients with the diagnosis of ACS, coronary artery bypass surgery or PCI (*Class I, Level of Evidence: A*) (2,42,47,59), chronic angina (*Class I, Level of Evidence: B*) (2,48), and/or peripheral artery disease (*Class I, Level of Evidence: A*) (60,61) within the past year should be referred to a comprehensive outpatient cardiovascular rehabilitation program.

**AHA Effectiveness-Based Guidelines for the Prevention of Cardiovascular Disease in Women – 2011 Update** (26)

1. A comprehensive CVD risk-reduction regimen such as cardiovascular or stroke rehabilitation or a physician-guided home- or community-based exercise training program should be recommended to women with a recent acute coronary syndrome or coronary revascularization, new-onset or chronic angina, recent cerebrovascular event, peripheral arterial disease (*Class I; Level of Evidence A*) or current/prior symptoms of heart failure and an LVEF 35%. (*Class I; Level of Evidence B*)

1 ACC indicates American College of Cardiology; ACCF, American College of Cardiology Foundation; ACS, acute  
 2 coronary syndrome; AHA, American Heart Association; CABG, coronary artery bypass graft; CSA chronic stable  
 3 angina; CR, cardiac rehabilitation; CVD, cardiovascular disease; HF, heart failure; HFrEF, heart failure with  
 4 reduced ejection fraction; LVEF, left ventricular ejection fraction; MI, myocardial infarction; and PCI, percutaneous  
 5 coronary intervention.

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<b>Short Title: PM-5A: Enrollment (Claims-Based)</b>	
<b>PM-5A: Cardiac Rehabilitation Enrollment (Claims-Based)</b>	
<b>Measure Description:</b> Percentage of patients, age ≥18 y, with a qualifying event/diagnosis for CR including: MI, PCI, CABG, CSA, valve repair/replacement, or heart transplantation, who attend at least one session in a CR program.	
<b>Numerator</b>	Patients with a qualifying event/diagnosis for CR who attend at least one CR session within 90 calendar d of hospital discharge following a qualifying event, or within 90 calendar d of the date of a qualifying outpatient procedure or office visit
<b>Denominator</b>	All patients with a qualifying event/diagnosis in the previous 12 m including: MI, PCI, CABG, CSA, valve repair/replacement, or heart transplantation
<b>Denominator Exclusions</b>	<ul style="list-style-type: none"> <li>• Patients age &lt;18 y</li> <li>• Patient is already participating in a CR program prior to hospitalization</li> <li>• Patients who leave against medical advice</li> </ul>
<b>Denominator Exceptions</b>	None
<b>Measurement Period</b>	Encounter
<b>Sources of Data</b>	Medical record or other database (e.g., administrative or clinical)
<b>Attribution</b>	Measure reportable at facility level* *Healthcare system or where diagnosis occurred.
<b>Care Setting</b>	Inpatient or Outpatient
<b>Rationale</b>	
<p>Participation in CR significantly improves meaningful patient outcomes, including mortality, readmissions to acute care, functional capacity, psychosocial well-being, and health-related quality of life. There are geographic and demographic disparities related to CR, which can be influenced by changes in systems and processes that address barriers to participation (19).</p> <p>While referral to CR is the first, critical step to involve patients in a CR program, actual enrollment in the CR program is essential to CR participation. Measuring CR enrollment will encourage both referring practitioners/facilities and CR programs to develop performance improvement activities that increase participation.</p>	

**Clinical Recommendation(s)**

**2014 AHA/ACC Guideline for the Management of Patients With Non–ST-Elevation Acute Coronary Syndromes (20)**

1. All eligible patients with NSTEMI-ACS should be referred to a comprehensive cardiovascular rehabilitation program either before hospital discharge or during the first outpatient visit (40-43). (*Class I, Level of Evidence: B*)

**2013 ACCF/AHA Guideline for the Management of Patients With ST-Elevation Myocardial Infarction (21)**

1. Exercise-based cardiac rehabilitation/secondary prevention programs are recommended for patients with STEMI (42,44-46). (*Class I, Level of Evidence: B*)

**AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients with Coronary Artery and Other Atherosclerotic Vascular Disease: 2011 Update (27)**

1. All eligible patients with ACS or whose status is immediately post coronary artery bypass surgery or post-PCI should be referred to a comprehensive outpatient cardiovascular rehabilitation program either prior to hospital discharge or during the first follow-up office visit (2,42,47,48). (*Class I, Level of Evidence: A*)
2. All eligible outpatients with the diagnosis of ACS, coronary artery bypass surgery or PCI (*Class I, Level of Evidence: A*) (2,42,47,59), chronic angina (*Class I, Level of Evidence: B*) (2,48), and/or peripheral artery disease (*Class I, Level of Evidence: A*) (60,61) within the past year should be referred to a comprehensive outpatient cardiovascular rehabilitation program.

**AHA Effectiveness-Based Guidelines for the Prevention of Cardiovascular Disease in Women–2011 Update (26)**

1. A comprehensive CVD risk-reduction regimen such as cardiovascular or stroke rehabilitation or a physician-guided home- or community-based exercise training program should be recommended to women with a recent acute coronary syndrome or coronary revascularization, new-onset or chronic angina, recent cerebrovascular event, peripheral arterial disease (*Class I; Level of Evidence A*) or current/prior symptoms of heart failure and an LVEF  $\leq$  35%. (*Class I; Level of Evidence B*)

**2011 ACCF/AHA Guideline for Coronary Artery Bypass Graft Surgery (28)**

1. Cardiac rehabilitation is recommended for all eligible patients after CABG (2,42,47-50). (*Class I, Level of Evidence: A*)

1 ACC, indicates American College of Cardiology; ACCF, American College of Cardiology Foundation; ACS, acute  
 2 coronary syndrome; AHA, American Heart Association; CABG, coronary artery bypass graft; CSA chronic stable  
 3 angina; CR, cardiac rehabilitation; CVD, cardiovascular disease; LVEF, left ventricular ejection fraction; MI,  
 4 myocardial infarction; NSTEMI-ACS, non–ST-elevation myocardial infarction- acute coronary syndromes; and PCI,  
 5 percutaneous coronary intervention.

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<b>Short Title: PM-5B: Enrollment (Medical Records and/or Databases/Registries)</b>	
<b>PM-5B: Cardiac Rehabilitation Enrollment (Medical Records and/or Databases/Registries)</b>	
<b>Measure Description:</b> Percentage of patients, age $\geq 18$ y, with a qualifying event/diagnosis for CR including: MI, PCI, CABG, CSA, valve repair/replacement, or heart transplantation, who attend at least one session in a CR program.	
<b>Numerator</b>	Patients with a qualifying event/diagnosis for CR who attend at least one CR session within 90 calendar d of hospital discharge following a qualifying event, or within 90 calendar d of the date of a qualifying outpatient procedure or office visit
<b>Denominator</b>	All patients who have been hospitalized for a qualifying event/diagnosis in the previous 12 m including: MI, PCI, CABG, CSA, valve repair/replacement, or heart transplantation
<b>Denominator Exclusions</b>	<ul style="list-style-type: none"> <li>• Patients age <math>&lt; 18</math> y</li> <li>• Patients who die during hospitalization period</li> <li>• Patient is already participating in a CR program prior to hospitalization</li> <li>• Patients who leave against medical advice</li> </ul>
<b>Denominator Exceptions</b>	<ul style="list-style-type: none"> <li>• Documentation of a patient-oriented reason that precludes enrollment in CR (e.g., no traditional CR program available to the patient, within 60 minutes of travel time from the patient's home, or patient has access to an alternative model of CR delivery that meets all criteria for a CR program)</li> <li>• Documentation of a medical reason that precludes enrollment in CR (e.g., patient deemed by a medical provider to have a medically unstable, life-threatening condition or has other cognitive or physical impairments that preclude CR participation)</li> <li>• Documentation of a healthcare system reason that precludes enrolment in CR (e.g., patient is discharged to a nursing care or long-term care facility, or patients lack medical coverage for CR)</li> </ul>
<b>Measurement Period</b>	Encounter
<b>Sources of Data</b>	Medical record or other database (e.g., clinical or registry)
<b>Attribution</b>	Measure reportable at provider level
<b>Care Setting</b>	Inpatient or Outpatient
<b>Rationale</b>	

Participation in CR significantly improves meaningful patient outcomes, including mortality, readmissions to acute care, functional capacity, psychosocial well-being, and health related quality of life. There are geographic and demographic disparities related to CR, which can be influenced by changes in systems and processes that address barriers to participation (19).

While referral to CR is the first, critical step to involve patients in a CR program, actual enrollment in the CR program is essential to CR participation. Measuring CR enrollment will encourage both referring practitioners/facilities and cardiac rehabilitation programs to develop performance improvement activities that increase participation.

#### Clinical Recommendation(s)

##### **2014 AHA/ACC Guideline for the Management of Patients With Non–ST-elevation Acute Coronary Syndromes (20)**

1. All eligible patients with NSTEMI-ACS should be referred to a comprehensive cardiovascular rehabilitation program either before hospital discharge or during the first outpatient visit (40-43). (*Class I, Level of Evidence: B*)

##### **2013 ACCF/AHA Guideline for the Management of Patients With ST-Elevation Myocardial Infarction (21)**

1. Exercise-based cardiac rehabilitation/secondary prevention programs are recommended for patients with STEMI (42,44-46). (*Class I, Level of Evidence: B*)

##### **AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients with Coronary Artery and Other Atherosclerotic Vascular Disease: 2011 Update (27)**

1. All eligible patients with ACS or whose status is immediately post coronary artery bypass surgery or post-PCI should be referred to a comprehensive outpatient cardiovascular rehabilitation program either prior to hospital discharge or during the first follow-up office visit (2,42,47,48). (*Class I, Level of Evidence: A*)
2. All eligible outpatients with the diagnosis of ACS, coronary artery bypass surgery or PCI (*Class I, Level of Evidence: A*) (2,42,47,59), chronic angina (*Class I, Level of Evidence: B*) (2,48), and/or peripheral artery disease (*Class I, Level of Evidence: A*) (60,61) within the past year should be referred to a comprehensive outpatient cardiovascular rehabilitation program.

##### **AHA Effectiveness-Based Guidelines for the Prevention of Cardiovascular Disease in Women—2011 Update (26)**

1. A comprehensive CVD risk-reduction regimen such as cardiovascular or stroke rehabilitation or a physician-guided home- or community-based exercise training program should be recommended to women with a recent acute coronary syndrome or coronary revascularization, new-onset or chronic angina, recent cerebrovascular event, peripheral arterial disease (*Class I; Level of Evidence A*) or current/prior symptoms of heart failure and an LVEF  $\leq 35\%$ . (*Class I; Level of Evidence B*)

##### **2011 ACCF/AHA Guideline for Coronary Artery Bypass Graft Surgery (28)**

1. Cardiac rehabilitation is recommended for all eligible patients after CABG (2,42,47-50). (*Class I, Level of Evidence: A*)

1 ACC indicates American College of Cardiology; ACCF, American College of Cardiology Foundation; ACS, acute  
 2 coronary syndrome; AHA, American Heart Association; CABG, coronary artery bypass graft; CSA chronic stable  
 3 angina; CR, cardiac rehabilitation; CVD, cardiovascular disease; LVEF, left ventricular ejection fraction; MI,  
 4 myocardial infarction; NSTEMI-ACS, non-ST-elevation myocardial infarction- acute coronary syndromes; and PCI,  
 5 percutaneous coronary intervention.

## 6 Quality Measures for Cardiac Rehabilitation

<b>Short Title: QM-1: Time to Enrollment</b>	
<b>QM-1: Cardiac Rehabilitation Time to Enrollment (21 days)</b>	
Percentage of patients, age $\geq 18$ y, with a qualifying events/diagnosis including MI, PCI, CABG, heart valve surgery/repair, and/or heart transplantation, who enroll in CR within 21 d of hospital discharge.	
<b>Numerator</b>	Patients discharged from the hospital after qualifying event/diagnosis, who are referred to CR, and who begin CR participation $\leq 21$ d after hospital discharge
<b>Denominator</b>	All patients discharged from the hospital after qualifying event/diagnosis including: MI, PCI, CABG, heart valve surgery/repair and/or heart transplantation, who are referred to CR, and who begin CR participation (at least one billed CR session)
<b>Denominator Exclusions</b>	<ul style="list-style-type: none"> <li>• Patients age <math>&lt; 18</math> y</li> <li>• Patients who leave against medical advice</li> </ul>
<b>Denominator Exceptions</b>	<ul style="list-style-type: none"> <li>• Documentation of a patient-oriented reason that precludes CR participation after the patient has enrolled (e.g., patient moves to a new location that requires more than 60 minutes travel time to arrive at the enrolling CR program)</li> <li>• Documentation of a medical reason that precludes CR participation after the patient has enrolled (e.g., patient deemed by a medical provider to have a medically unstable, life-threatening condition or has other cognitive or physical impairments that preclude CR participation)</li> <li>• Documentation of a healthcare system reason that precludes CR participation after the patient has enrolled (e.g., patient is admitted to 38 nursing care or long-term care facility, or patients loses medical coverage for CR)</li> </ul>
<b>Measurement Period</b>	Encounter <del>Considered confidential and has been provided for comment purposes</del>
<b>Sources of Data</b>	<del>Not shared or distributed to other individuals</del> Medical record or other database (e.g., administrative, clinical, registry)
<b>Attribution</b>	Measure reportable at the facility or provider level

<b>Care Setting</b>	Shared responsibility between healthcare centers and CR program
<b>Rationale</b>	
<p>A variety of factors influence CR, including patient-, medical-, program- and system-related issues. Current literature (single-site randomized, systematic review and observational) suggests that targeting earlier enrollment in rehabilitation improves over-all enrollment, such that for every day that passes after hospital discharge there is a ~1% decrease in program participation rate. One randomized trial targeted &lt;10 d for time from qualifying event to enrollment and showed an 18% improvement in time to first visit in CR (62). A systematic review suggested 17d as the optimal duration of time (63).</p> <p>As with other CR performance measures, this performance measure addressing time from discharge to start in rehabilitation is important, in that it can influence potential processes or barriers at the patient (conflict with return to work), hospital, provider, and program (workflow and throughput) levels.</p>	
<b>Clinical Recommendation(s)</b>	
<p><b><u>2014 AHA/ACC Guideline for the Management of Patients With Non–ST-elevation Acute Coronary Syndromes (20)</u></b></p> <p>1. All eligible patients with NSTEMI-ACS should be referred to a comprehensive cardiovascular rehabilitation program either before hospital discharge or during the first outpatient visit (40-43). (<i>Class I, Level of Evidence: B</i>)</p> <p><b><u>2013 ACCF/AHA Guideline for the Management of Patients With ST-Elevation Myocardial Infarction (21)</u></b></p> <p>1. Exercise-based cardiac rehabilitation/secondary prevention programs are recommended for patients with STEMI (42,44-46). (<i>Class I, Level of Evidence: B</i>)</p> <p><b><u>AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients with Coronary Artery and Other Atherosclerotic Vascular Disease: 2011 Update (27)</u></b></p> <p>1. All eligible patients with ACS or whose status is immediately post coronary artery bypass surgery or post-PCI should be referred to a comprehensive outpatient cardiovascular rehabilitation program either prior to hospital discharge or during the first follow-up office visit (2,42,47,48). (<i>Class I, Level of Evidence: A</i>)</p> <p>2. All eligible outpatients with the diagnosis of ACS, coronary artery bypass surgery or PCI (<i>Class I, Level of Evidence: A</i>) (2,42,47,59), chronic angina (<i>Class I, Level of Evidence: B</i>)(2,48), and/or peripheral artery disease (<i>Class I, Level of Evidence: A</i>) (60,61) within the past year should be referred to a comprehensive outpatient cardiovascular rehabilitation program.</p> <p><b><u>AHA Effectiveness-Based Guidelines for the Prevention of Cardiovascular Disease in Women–2011 Update (26)</u></b></p> <p>1. A comprehensive CVD risk-reduction regimen such as cardiovascular or stroke rehabilitation or a physician-guided home- or community-based exercise training program should be recommended to women with a recent acute coronary syndrome or coronary revascularization, new-onset or chronic angina, recent cerebrovascular event, peripheral arterial disease (<i>Class I; Level of Evidence A</i>) or current/prior symptoms of</p>	

heart failure and an LVEF 35%. (Class I; Level of Evidence B)

**ACCF/AHA Guideline for Coronary Artery Bypass Graft Surgery (28)**

1. Cardiac rehabilitation is recommended for all eligible patients after CABG (2,42,47-50). (Class I, Level of Evidence: A)

1 ACC indicates American College of Cardiology; ACCF, American College of Cardiology Foundation; ACS, acute  
2 coronary syndrome; AHA, American Heart Association; CABG, coronary artery bypass graft; CR, cardiac  
3 rehabilitation; CVD, cardiovascular disease; LVEF, left ventricular ejection fraction; MI, myocardial infarction;  
4 NSTEMI-ACS, non-ST-elevation myocardial infarction- acute coronary syndromes; and PCI, percutaneous coronary  
5 intervention.

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<b>Short Title: QM-2: Cardiac Rehabilitation Adherence (<math>\geq 25</math> sessions)</b>	
<b>QM-2: Cardiac Rehabilitation Adherence (<math>\geq 25</math> sessions)</b>	
<b>Measure Description:</b> Percentage of patients, age $\geq 18$ y, with a qualifying event/diagnosis for CR including: MI, PCI, CABG, heart valve repair/replacement, heart transplantation, or HFrEF, who have enrolled in CR and have participated in $\geq 25$ sessions.	
<b>Numerator</b>	Patients with a qualifying event/diagnosis who have enrolled in CR and have participated in $\geq 25$ CR sessions
<b>Denominator</b>	All patients with a qualifying event/diagnosis in the: MI, PCI, CABG, CSA, valve repair/replacement, heart transplantation, or HFrEF and who were enrolled in CR during the 3 m prior to the start of the measurement period.  Note: Sites can only report this on a semi-annual basis.
<b>Denominator Exclusions</b>	<ul style="list-style-type: none"> <li>• Patients age <math>&lt; 18</math> y</li> <li>• Patients who leave against medical advice</li> </ul>
<b>Denominator Exceptions</b>	<ul style="list-style-type: none"> <li>• Documentation of a patient-oriented reason that precludes CR participation after the patient has enrolled (e.g., patient moves to a new location that requires more than 60 minutes travel time to arrive at the enrolling CR program)</li> <li>• Documentation of a medical reason that precludes CR participation after the patient has enrolled (e.g., patient deemed by a medical provider to have a medically unstable, life-threatening condition or has other cognitive or physical impairments that preclude CR participation)</li> <li>• Documentation of a healthcare system reason that precludes CR participation after the patient has enrolled (e.g., patient is admitted to a nursing care or long-term care facility, or patients loses medical coverage for CR)</li> </ul>
<b>Measurement Period</b>	Quarterly
<b>Sources of Data</b>	Claims databases, Medical record or other database (e.g. administrative, clinical, registry)
<b>Attribution</b>	Measure reportable at the facility or provider level
<b>Care Setting</b>	Outpatient, CR program
<b>Rationale</b>	
Participation in CR significantly improves meaningful patient outcomes, including mortality, readmissions to acute care, functional capacity, psychosocial well-being, and health-related quality of life. A dose-response relationship	

has been demonstrated between the number of CR sessions and long-term outcomes and has been estimated at 1% mortality reduction per session of CR attended (38,46,64,65). Attending  $\geq 36$  sessions is associated with lower risks of death and MI at 4 years compared to attending fewer sessions. Thus, the optimal dose of CR appears to be  $\geq 36$  CR sessions.

#### **Clinical Recommendation(s)**

#### **2014 AHA/ACC Guideline for the Management of Patients With Non–ST-Elevation Acute Coronary Syndromes (20)**

1. All eligible patients with NSTEMI-ACS should be referred to a comprehensive cardiovascular rehabilitation program either before hospital discharge or during the first outpatient visit (40-43). (*Class I, Level of Evidence: B*)

#### **2013 ACCF/AHA Guideline for the Management of Patients With ST-Elevation Myocardial Infarction (21)**

1. Exercise-based cardiac rehabilitation/secondary prevention programs are recommended for patients with STEMI (42,44-46). (*Class I, Level of Evidence: B*)

#### **AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients with Coronary Artery and Other Atherosclerotic Vascular Disease: 2011 Update (27)**

1. All eligible patients with ACS or whose status is immediately post coronary artery bypass surgery or post-PCI should be referred to a comprehensive outpatient cardiovascular rehabilitation program either prior to hospital discharge or during the first follow-up office visit(2,42,47,48). (*Class I, Level of Evidence: A*)
2. All eligible outpatients with the diagnosis of ACS, coronary artery bypass surgery or PCI (*Class I, Level of Evidence: A*) (2,42,47,59), chronic angina (*Class I, Level of Evidence: B*) (2,48), and/or peripheral artery disease (*Class I, Level of Evidence: A*) (60,61) within the past year should be referred to a comprehensive outpatient cardiovascular rehabilitation program.

#### **2012 ACCF/AHA Guideline for the Management of Heart Failure**

1. Exercise training (or regular physical activity) is recommended as safe and effective for patients with HF who are able to participate to improve functional status (52-58). (*Class I, Level of Evidence: A*)

#### **AHA Effectiveness-Based Guidelines for the Prevention of Cardiovascular Disease in Women–2011 Update (26)**

1. A comprehensive CVD risk-reduction regimen such as cardiovascular or stroke rehabilitation or a physician-guided home- or community-based exercise training program should be recommended to women with a recent acute coronary syndrome or coronary revascularization, new-onset or chronic angina, recent cerebrovascular event, peripheral arterial disease (*Class I; Level of Evidence A*) or current/prior symptoms of heart failure and an LVEF  $\leq 35\%$ . (*Class I; Level of Evidence B*)

#### **2011 ACCF/AHA Guideline for Coronary Artery Bypass Graft Surgery (28)**

1. Cardiac rehabilitation is recommended for all eligible patients after CABG (2,42,47-50). (*Class I, Level of Evidence: A*)

[Redacted]

1 ACC, indicates American College of Cardiology; ACCF, American College of Cardiology Foundation; ACS, acute  
2 coronary syndrome; AHA, American Heart Association; CABG, coronary artery bypass graft; CR, cardiac  
3 rehabilitation; CVD, cardiovascular disease; HF; heart failure; HFrEF, heart failure with reduced ejection fraction;  
4 LVEF, left ventricular ejection fraction; MI, myocardial infarction; NSTEMI, non-ST-elevation myocardial  
5 infarction- acute coronary syndromes; and PCI, percutaneous coronary intervention.

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<b>Short Title: QM-3: Cardiac Rehabilitation Outcomes Communication</b>	
<b>QM-3: Cardiac Rehabilitation Communication: Patient Enrollment, Adherence, and Clinical Outcomes</b>	
<b>Measure Description:</b> Percentage of patients, age $\geq 18$ y, for whom the receiving CR program has communicated to the referring provider and/or primary care provider regarding the patient's enrollment, attendance and key clinical outcomes (e.g., changes in functional capacity, quality of life) in the CR program.	
<b>Numerator</b>	<p>Patients referred by a healthcare provider to a receiving CR program, for whom the receiving CR program has provided written communication* to the referring provider and/or primary care provider regarding the patient's enrollment, attendance, and clinical outcomes in the CR program</p> <p>*While any communication regarding a patient's participation in CR will be accepted, ideal communication would include information on all three aspects: patient's enrollment, attendance, and clinical outcomes in the CR program.</p>
<b>Denominator</b>	All patients with a qualifying event/ diagnosis in the previous 12 m including: MI, PCI, CABG, CSA, heart valve repair/replacement, or heart transplantation, who are referred to CR
<b>Denominator Exclusions</b>	<ul style="list-style-type: none"> <li>• Patients &lt;18 y</li> <li>• Patients who leave against medical advice</li> <li>• Patient was already participating in a CR program</li> </ul>
<b>Denominator Exceptions</b>	<ul style="list-style-type: none"> <li>• Documentation of a patient-oriented reason that precludes CR participation after the patient has enrolled (e.g., patient moves to a new location that requires more than 60 min travel time to arrive at the enrolling CR program)</li> <li>• Documentation of a medical reason that precludes CR participation after the patient has enrolled (e.g., patient deemed by a medical provider to have a medically unstable, life-threatening condition or has other cognitive or physical impairments that preclude CR participation)</li> <li>• Documentation of a healthcare system reason that precludes CR participation after the patient has enrolled (e.g., patient is admitted to a nursing care or long-term care facility, or patients loses medical coverage for CR)</li> </ul>
<b>Measurement Period</b>	Encounter
<b>Sources of Data</b>	Medical record or other database (e.g., administrative, clinical, registry)
<b>Attribution</b>	Measure reportable at the facility or provider level

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*This draft document should be considered confidential and has been provided for comment purposes only. This document should not be cited or distributed to other individuals*

<b>Care Setting</b>	Outpatient, CR Program
<b>Rationale</b>	
A key function of CR is to help coordinate the care of patients, often with very complex cardiovascular conditions, who are referred to CR. Communication between the CR program and the referring provider helps provide greater coordination of care by providing information to the referring provider that will be of help in the management of the patient's cardiovascular disease.	
<b>Clinical Recommendation(s)</b>	
<p><b><u>2014 AHA/ACC Guideline for the Management of Patients With Non–ST-elevation Acute Coronary Syndromes (20)</u></b></p> <p>1. All eligible patients with NSTEMI-ACS should be referred to a comprehensive cardiovascular rehabilitation program either before hospital discharge or during the first outpatient visit (40-43) . (Class I, Level of Evidence: B)</p> <p><b><u>2013 ACCF/AHA Guideline for the Management of Patients With ST-Elevation Myocardial Infarction (21)</u></b></p> <p>1. Exercise-based cardiac rehabilitation/secondary prevention programs are recommended for patients with STEMI (42,44-46). (Class I, Level of Evidence: B)</p> <p><b><u>2012 ACCF/AHA Guideline for the Management of Heart Failure</u></b></p> <p>1. Exercise training (or regular physical activity) is recommended as safe and effective for patients with HF who are able to participate to improve functional status (52-58). (Class I, Level of Evidence: A)</p> <p><b><u>AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients with Coronary Artery and Other Atherosclerotic Vascular Disease: 2011 Update (27)</u></b></p> <p>1. All eligible patients with ACS or whose status is immediately post coronary artery bypass surgery or post-PCI should be referred to a comprehensive outpatient cardiovascular rehabilitation program either prior to hospital discharge or during the first follow-up office visit (2,42,47,48). (Class I, Level of Evidence: A)</p> <p>2. All eligible outpatients with the diagnosis of ACS, coronary artery bypass surgery or PCI (Class I, Level of Evidence: A)(2,42,47,59), chronic angina (Class I, Level of Evidence: B) (2,48), and/or peripheral artery disease (Class I, Level of Evidence: A) (60,61) within the past year should be referred to a comprehensive outpatient cardiovascular rehabilitation program.</p> <p><b><u>AHA Effectiveness-Based Guidelines for the Prevention of Cardiovascular Disease in Women–2011 Update (26)</u></b></p> <p>1. A comprehensive CVD risk-reduction regimen such as cardiovascular or stroke rehabilitation or a physician-guided home- or community-based exercise training program should be recommended to women with a recent acute coronary syndrome or coronary revascularization, new-onset or chronic angina, recent cerebrovascular event, peripheral arterial disease (Class I; Level of Evidence A) or current/prior symptoms of heart failure and an LVEF 35%. (Class I; Level of Evidence B)</p>	

**2011 ACCF/AHA Guideline for Coronary Artery Bypass Graft Surgery** (28)

1. Cardiac rehabilitation is recommended for all eligible patients after CABG (2,42,47-50). (*Class I, Level of Evidence: A*)

1 ACC, indicates American College of Cardiology; ACCF, American College of Cardiology Foundation; ACS, acute  
2 coronary syndrome; AHA, American Heart Association; CABG, coronary artery bypass graft; CR, cardiac  
3 rehabilitation; CVD, cardiovascular disease; HF, heart failure; LVEF, left ventricular ejection fraction; MI,  
4 myocardial infarction; NSTEMI-ACS, non-ST-elevation myocardial infarction- acute coronary syndromes; and PCI,  
5 percutaneous coronary intervention.

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1 **APPENDIX B. AUTHOR LISTING OF RELATIONSHIPS WITH**  
 2 **INDUSTRY AND OTHER ENTITIES (RELEVANT)—2018**  
 3 **ACCF/AHA CLINICAL PERFORMANCE AND QUALITY**  
 4 **MEASURES FOR CARDIAC REHABILITATION**

Committee Member	Employment	Consultant	Speaker	Ownership/Partnership/Principal	Research	Institutional, Organizational, or Other Financial Benefit	Expert Witness
Randal Thomas <i>Chair</i>	Mayo Clinic — Professor of Medicine	None	None	None	None	None	None
Gaurav Banka	University of California Los Angeles — Fellow	None	None	None	None	None	None
Gary Balady	Boston University — Professor of Medicine	None	None	None	None	None	None
Theresa Beckie	University of South Florida — Professor	None	None	None	None	None	None
Jensen Chiu	Senior Associate— IMPAQ International	None	None	None	None	• IMPAQ International, LLC†	None
Sana Gokak	American College of Cardiology; American Heart Association	None	None	None	None	None	None
P. Michael Ho	University of Colorado School of Medicine — Associate Professor of Medicine	None	None	None	• Janssen Pharmaceuticals, Inc*	None	None
Steven Keteyian	Program Director — Henry Ford Hospital	None	None	None	None	• Nimble Hearts, Inc†	None
Marjorie King	Chief Medical Officer — Helen Hayes Hospital	None	None	None	None	None	None
Karen Lui	Regulatory Analyst — GRQ, LLC	None	None	None	None	• GRQ, LLC†	None
Quinn Pack	Tufts University School of Medicine — Assistant Professor of Medicine	None	None	None	None	None	None
Bonnie Sanderson	Auburn University—	None	None	None	None	None	None

Committee Member	Employment	Consultant	Speaker	Ownership/Partnership/Principal	Research	Institutional, Organizational, or Other Financial Benefit	Expert Witness
Tracy Wang	Professor Duke University Medical Center — Assistant Professor of Medicine	<ul style="list-style-type: none"> <li>• Astra Zeneca†</li> <li>• Ely Lilly</li> <li>• Merk</li> <li>• Premier, Inc</li> </ul>	None	None	<ul style="list-style-type: none"> <li>• Astra Zeneca†</li> <li>• Boston Scientific†</li> <li>• Bristol-Myers Squibb Company</li> <li>• Eli Lilly/Daiichi Sankyo Alliance†</li> <li>• Gilead†</li> <li>• Regeneron†</li> </ul>	None	None

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2 This table represents the relationships of committee members with industry and other entities that were reported by authors to  
3 be relevant to this document. These relationships were reviewed and updated in conjunction with all meetings and/or  
4 conference calls of the writing committee during the document development process. The table does not necessarily reflect  
5 relationships with industry at the time of publication. A person is deemed to have a significant interest in a business if the  
6 interest represents ownership of 5% or more of the voting stock or share of the business entity, or ownership of \$5,000 or  
7 more of the fair market value of the business entity; or if funds received by the person from the business entity exceed 5% of  
8 the person’s gross income for the previous year. A relationship is considered to be modest if it is less than significant under  
9 the preceding definition. Relationships in this table are modest unless otherwise noted.

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11 \*No financial relationship †Significant (greater than \$5,000) relationship.

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15 ACC is American College of Cardiology; AHA is American Heart Association; GRQ is Governmental Representation with Quality.

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2 **APPENDIX C. PEER REVIEWER RELATIONSHIPS WITH**  
3 **INDUSTRY AND OTHER ENTITIES 2018 — 2018 ACC/AHA**  
4 **CLINICAL PERFORMANCE AND QUALITY MEASURES FOR**  
5 **CARDIAC REHABILITATION MEASURES**

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8 This section will be added upon completion of peer review.

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