CARDIAC REHABILITATION PROGRAM QUESTIONNAIRE

Instructions: This survey pertains to post-acute cardiac care rehabilitation (eg., outpatient, Phase II or III depending on your country).

Please answer the series of questions by: (1) checking (🗸) the appropriate box (sometimes one box and other times you will be asked to check as many boxes as apply), (2) typing in an answer, or (3) entering a number, as indicated. The survey items for which you enter numbers are constrained to one value (i.e., you cannot enter a range. If you would like to enter a range, instead enter the midpoint) and will not accept text. You can report a number to up to 1 decimal place if desired. Enter zero (0) only if the answer is none.

Be sure to click the “Submit” button when you reach the end of the survey.

**Section A: About You**

1. What is your Title/Position at the cardiac rehabilitation program? (check 🗸one):

* Medical Director
* Coordinator / Manager / Supervisor
* Front-line staff
* Admin staff
* *Other*

Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you familiar with the International Council of Cardiovascular Prevention and Rehabilitation (ICCPR)’s Cardiac Rehabilitation Foundations Certification?
   * Yes
   * No

**Section B: Cardiac Rehab Location**

1. In what country is your cardiac rehabilitation program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. City / Region: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(optional)
3. Your cardiac rehabilitation program is located in an/a:
   * Urban area (e.g., larger cities, towns)
   * Suburban (a residential district located on the outskirts of a city)
   * Rural area or countryside (a geographic area that is located outside towns and cities).
4. Is your cardiac rehabilitation program part of a hospital?
   * *Yes* – it is in a referral center/ quarternary / tertiary facility and / or academic center
   * *Yes* – it is in a community hospital
   * *Yes -*  it is in a rehabilitation hospital/ residential facility
   * *Kind of* – we are on the larger campus or a satellite center from the main hospital
   * No *(skip to question 9)*

-- Please specify where your cardiac rehabilitation is located: \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8b. If Q8 was marked *yes or kind of*, does the hospital have an inpatient cardiology service? (Check one box):

* *Yes*
* No

8c. If Q8 and Q8a were marked yes, do they offer? (check all that apply)

* Revascularization via percutaneous coronary intervention (PCI)
* Coronary artery bypass graft surgery (CABG)
* Cardiac transplant
* None of the above

8d. If *yes*, are these patients referred to your cardiac rehab program? (Check all that apply):

* *Yes*, these patients are referred to our cardiac rehabilitation program **regularly**
* *Yes*, but **rarely**
* No

8e. If *yes*, how are these inpatients referred to your cardiac rehab program? (Check all that apply):

* These patients are referred to our cardiac rehabilitation program **systematically** (e.g., electronic; does not require human memory)
* These patients are referred to our cardiac rehabilitation program **before discharge**
* These patients are referred to our cardiac rehabilitation program **from inpatient rehab**
* Patients get an initial outpatient cardiac rehab **appointment** scheduled before discharge
* Someone from **outpatient cardiac rehab** speaks to the patients at the bedside about the program
* A **non-physician provider from the inpatient unit** speaks to the patients at the bedside about the program
* A **physician** speaks to the patients at the bedside about the program
* A **peer or volunteer** speaks to the patients at the bedside about the program
* Patients receive written materials about the referral and cardiac rehab and / or are provided a website to find out more information (e.g., contact information, directions).
* I am unsure
* Other (please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
* None of the above

8f. If yes, does your program track referrals of all indicated inpatients?

* + Yes, and we do a fairly **good** job at referring all of them
  + Yes, and we do a **poor** job at reaching all patients in need
  + No

9. Approximately what proportion of your program’s annual patients are referred directly from an inpatient hospital setting?

­­\_\_\_\_\_\_\_\_ %

**Section C: Cardiac Rehab Access, Capacity & Costs**

1. In what year was your cardiac rehabilitation program initiated? (Please enter a valid four digit start year)

\_\_\_\_\_\_\_ (year)

1. Who can refer a patient to your program? (Check all that apply)
   * Patients can self-refer
   * Physicians
   * Allied healthcare providers and / or nurses
   * Community health care workers
   * *Other*  
     Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. When scheduling initial visits with referred patients and you experience challenges, what does your program do? (check all that apply)

* + We call the patient a couple of times and then stop contact
  + We work with patients to overcome any barriers (e.g., offer home-based, offer start post-vacation or scheduled clinical procedures)
  + We notify the referring provider
  + We mail information to the patient
  + *Other*  
    Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + None of the above

13. How do your intakes work? (check all that apply)

* + Group
  + Individual
  + There are some group and some individual patient elements
  + Patients complete some paperwork independently
  + Family member or loved ones are open to accompany the patient
  + Interpretation / translation is available for patients’ whose first language is not English

14. How do your programs start?

* + We have rolling starts for classes, so when it is time patients start the next available session
  + Patients start a new class as a cohort
  + *Other*  
    Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How many new **patients** do you have capacity to serve **each year**, in terms of staff and space, if they all completed your program? (Please enter a numeric value; please report the number of new patients that could start your program each year, not the number of patients you treat each year or the number of sessions you offer)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **patients per year**

1. How many new cardiac rehabilitation **patients** do you provide service to **each year** in your program? (Please enter a numeric value; please report the number of new patients that start each year; i.e., volume)

\_\_\_\_\_\_\_\_\_ **patients per year**

1. For patients referred following a cardiac hospitalization, on average how many weeks after discharge does a patient start your program? (i.e., initial assessment appointment / first billable session)(Please enter a numeric value in the field; if less than one week you can enter a decimal place- e.g., .5)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **weeks**

18. Does your program have a waiting list for patients to start the program? (please check one box)

* + no
  + *yes,* due to lack of capacity to intake new patients
  + *Yes,* due to another reason (please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
  + actually we have excess capacity, as not enough patients are referred

18b. If yes, how many people are on the waiting list on average at one time?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **patients**

19. If patients do not show up for a few sessions, what do you do? (check all that apply)

* + We call the patient a couple of times and then stop contact if there is no response
  + We mail the patient to inform them they have been removed from the program
  + We work with patients to overcome any barriers (e.g., offer home-based, offer to re-start patient post-vacation or scheduled clinical procedures)
  + We notify the referring provider
  + We use the space to start new patients
  + *Other,* Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + None of the above

1. Who pays for cardiac rehabilitation? (Check all that apply)

* Social security / government
* Hospital or clinical center where the cardiac rehab service is based
* *Patient* (e.g., patient education materials)
* Private health insurance

*Other (e.g., donations, Foundation, grants)*Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

20b. *If patients pay*: What is the average **percent** of the total program cost that patients pay, if they complete the program? (i.e., co-pays; Please enter a numeric value only in the field)

\_\_\_\_\_ **%**

20c. What is the out-of-pocket cost to patients to participate in all prescribed sessions, if they complete the program?  (Note: Please enter a numeric value without currency symbol; do not consider transportation or parking which is assessed below, just the program cost)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** (in your country’s currency)

Amount

21. Do most patients travel by car, and have parking charges to attend each session? (check all that apply)

* Yes, most patients drive (or someone drives them)
* Patients can get a parking pass at a reduced rate
* Patients generally consider the parking costs to be prohibitive
* Parking is free
* Public transit is available, but it is not very convenient
* Public transit is readily available
* *Other* (please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

22. The following questions will help us estimate the cost to deliver your program. Please check all of the costs that you have at your program (left), and the estimated amount of each you select per year (even if these are donated, report the cost; we will assume you report in the currency of your country):

|  |  |  |
| --- | --- | --- |
|  |  | **Amount per year** |
| **□** | Physicians |  |
| **□** | Front-line staff (including mandatory deductions and benefits) |  |
| **□** | Management staff |  |
| **□** | Administrative support staff |  |
| **□** | Staff training / continuing education |  |
| **□** | Computers / technology for staff and for delivery of alternative models |  |
| **□** | Space / facility |  |
| **□** | Rental costs |  |
| **□** | Capital costs (i.e., you are paying off a fixed one-time expense incurred to purchase your center; specify the amount you pay towards this per year) |  |
| **□** | Exercise equipment & its’ maintenance |  |
| **□** | Equipment / supplies for cardiovascular risk assessment (not including exercise stress tests; e.g., blood pressure, lipids, blood glucose) |  |
| **□** | Functional capacity assessment (and related technicians, space, equipment and its’ maintenance; if there are one-time costs please average over life of the cost for an annual estimate) |  |
| **□** | Free weights etc. for resistance training |  |
| **□** | Patient education materials |  |
| **□** | Other (please specify) |  |

23. What do you estimate is the cost to your program to serve one (1) patient, if they complete the program? (Note: Please enter a numeric value in the field. If some patients are funded to participate in your program via private funding and some via public, please consider the costs to serve patients by both means and then roughly estimate the proportion of patients funded by each source and then take an average. We will take into consideration the funding sources for your program which you reported above)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (**in your country’s currency)

Amount

24. Do the costs to provide services to patients vary greatly depending on funding source?

* Yes
* No
* Not applicable as all patient’s care is covered by the same source.

1. How expensive are the following aspects of delivering your cardiac rehab program? (check one box per row)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Free | Only a minor cost | | Costs a bit | Costs quite a bit | Very expensive | Not applicable as we do not have this | |
| Front-line personnel |  | |  |  |  |  | |  |
| Space |  | |  |  |  |  | |  |
| Aerobic exercise equipment |  | |  |  |  |  | |  |
| Equipment / supplies for cardiovascular risk assessment (not including exercise stress tests; e.g., blood pressure, lipids) |  | |  |  |  |  | |  |
| Exercise stress testing on a treadmill or cycle ergometer |  | |  |  |  |  | |  |
| Patient education materials |  | |  |  |  |  | |  |
| Resistance training equipment |  | |  |  |  |  | |  |

1. Please rate the degree to which each of the following are barriers to greater patient participation in your cardiac rehab program, from “this is definitely not an issue” to “this is a major issue”: Check one per row.

| This is definitely not an issue | This is not an issue | Neutral | This is a minor issue | This is a major issue |
| --- | --- | --- | --- | --- |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Lack of patient referral / physician awareness of CR | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif |
| *Lack of equipment* | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif |
| Lack of space | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif |
| Lack of human resources/ staff | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif |
| Lack of financial resources/ budget within program | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif |
| Lack of service reimbursement from government or private healthcare insurance | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif |
| Patient transportation barriers / distance / cost |  |  |  |  |  |
| *Other barrier* | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif |  | http://www.surveymonkey.com/i/t.gif | http://www.surveymonkey.com/i/t.gif |

Please specify the equipment you lack, if applicable \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please specify the other barrier, if applicable \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION D: Program quality assessment**

1.Does your program track the proportion of referred patients who enroll?

* Yes
* No

1. Does your program use strategies to augment patient enrollment?

* *Yes*
* No

2b. If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does your program track patient program adherence and / or completion?

* Yes
* No

1. Does your program use strategies to augment patient program adherence and /or completion?

* *Yes*
* No

4b. If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does your program audit patient outcomes? (eg., blood pressure control, functional capacity increases; check all that apply)

* *Yes,* and we discuss the information as a team and work to address any areas of poor performance
* *Yes,* but we don’t really systematically review the information or act on it these days
* No

1. At what points does your program communicate with referring and / or primary care providers? (check all that apply)

* Upon referral receipt
* With intake assessment results
* Mid-program progress
* If a patient’s condition changes
* If medications need to change
* If a patient drops out
* At the end of the program
* Other (please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
* We do not communicate if the patient drops out
* We do not need to send information as referring / primary care providers can acces our electronic medical records (shared)
* No communication is sent at any time

1. What information is included in communication to referring and / or primary care providers? (check all that apply)

* Blood pressure
* Lipids
* Blood glucose
* Anthropometrics
* Tobacco use
* Exercise prescription
* Risk stratification / clinical status
* Diet
* Psychosocial well-being (incl. quality of life)
* Medications
* Patient care plan
* Degree of program participation
* Functional capacity
* *Other*

(please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

1. Does your program regularly assess patient satisfaction with your program? (check one box)

* Yes, using a psychometrically-validated tool
* Yes
* No

**Section E: Team Composition**

1. Who has overall responsibility for cardiac rehabilitation at your program? (Please check one box)

* Cardiologist
* Physician specialist in internal medicine
* Physical medicine and rehabilitation (physiatrist)
* *Physician, other specialty*   
   If you selected "Physician, other specialty", please specify the specialty here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Nurse
* Exercise physiologist
* Physiotherapist
* *Other*   
   If you checked "other", please specify the heath profession here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9b. If you checked “physician”, for what proportion of the time your exercise sessions are occurring is your medical director physically present or very near/on hospital grounds?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **% of the time**

1. Which types of personnel are part of your cardiovascular rehabilitation (CR) team? If they are part of your team, do they work in Cardiac Rehabilitation only, or do they have other department obligations? (Check one box in each row):

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes-Only CR** | **Yes-Partial** | **No** |
| Cardiologist |  |  |  |
| Physiatrist (Physical Medicine and Rehabilitation) |  |  |  |
| Sports Medicine Physician |  |  |  |
| *Other Physician (other than psychiatrist)* |  |  |  |
| Physiotherapist |  |  |  |
| Nurse / Nurse-Practitioner |  |  |  |
| Psychiatrist |  |  |  |
| Psychologist |  |  |  |
| Social worker |  |  |  |
| Dietitian |  |  |  |
| Kinesiologist/Exercise Specialist/Biokineticist/Exercise Physiologist |  |  |  |
| Pharmacist |  |  |  |
| Occupational Therapist |  |  |  |
| Community Health worker |  |  |  |
| Administrative assistant/ Secretary |  |  |  |
| Health educator |  |  |  |
| *Other* |  |  |  |

 Please specify what kind of other physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please specify which other type of personnel are part of your team \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do all your clinical staff supervising patients during exercise sessions have cardiopulmonary resuscitation (CPR) training / certification?

* *Yes*
* Most
* No (skip next question)

11b. If *yes*, are they required to renew their CPR training regularly?

* Yes
* No

**Section F: Components**

1. Which of the following elements of cardiac rehabilitation are provided in your program?

Please check one box per row.

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Initial assessment |  |  |
| Individual consultation with a nurse |  |  |
| Exercise stress test |  |  |
| *Other functional capacity test* |  |  |
| Assessment of strength (e.g., handgrip) |  |  |
| Assessment for comorbities / issues that could impact exercise (e.g., cognition, vision, musculoskeletal / mobility issues, frailty, and / or balance / falls risk) |  |  |
| Symptom management education (e.g., chest pain, dyspnea) |  |  |
| Exercise prescription |  |  |
| Structured exercise training |  |  |
| Resistance training |  |  |
| Patient education |  |  |
| Management of cardiovascular risk factors |  |  |
| Prescription and/or titration of secondary prevention medications |  |  |
| Nutrition counseling |  |  |
| Psychosocial counseling (e.g., depression, anxiety, hostility) |  |  |
| Tobacco cessation interventions |  |  |
| Vocational counseling / support for return-to-work |  |  |
| Sexual / relationship counselling |  |  |
| Stress management / Relaxation techniques |  |  |
| *Alternative forms of exercise, such as yoga, dance, or tai chi* |  |  |
| Women-only classes |  |  |
| Inclusion of family / informal caregivers |  |  |
| End of program re-assessment |  |  |
| Follow-up after outpatient program |  |  |
| Maintenance program |  |  |
| *Other* |  |  |

12b.If applicable, please specify what other functional capacity test is used in your program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12c. If applicable, please specify what other alternative forms of exercise are offered in your program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12d. If applicable, please specify what other elements of cardiac rehabilitation are provided in your program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How many education sessions are provided to each patient in your program? (Please enter a numeric value; enter zero if you do not provide education)

\_\_\_\_\_\_\_\_ **sessions**

1. How many minutes on average is each education session? (Please enter a numeric value; enter zero if you do not provide education)

\_\_\_\_\_\_ **minutes**

1. In your program, do you assess the following risk factors? (Please check one box per row)

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Time spent being sedentary |  |  |
| Tobacco use |  |  |
| Harmful use of alcohol |  |  |
| Blood pressure |  |  |
| Body mass index |  |  |
| Waist circumference |  |  |
| Body composition |  |  |
| Lipids |  |  |
| HbA1c or blood glucose |  |  |
| Sleep apnea |  |  |
| Depression / Anxiety |  |  |
| Other psychosocial factors (e.g., stress, support) |  |  |
| Physical inactivity |  |  |
| Erectile dysfunction |  |  |
| Poor diet |  |  |
| *Other factor(s)* |  |  |

Please specify which other factor(s) you assess in your program\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does your program have each of the following ítems, and if yes, is its’ use dedicated to your program or shared with another group (check one option in each row)?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Dedicated | Shared | Not available |
| Bicycle ergometer |  |  |  |
| Treadmill ergometer |  |  |  |
| Arm cycloergomenter |  |  |  |
| Doppler Echocardiography |  |  |  |
| Stress test (no O2) |  |  |  |
| Stress test with O2 |  |  |  |
| Telemetry |  |  |  |
| Group education room |  |  |  |
| Gym space |  |  |  |
| Individual assessment/ Counselling room |  |  |  |
| Patient change room |  |  |  |
| Shower |  |  |  |
| Kitchen |  |  |  |
| Administrative office |  |  |  |
| Electronic patient charts |  |  |  |
| Resistance training equipment |  |  |  |
| Body composition analyzer |  |  |  |
| Staff meeting room |  |  |  |
| Staff office space |  |  |  |
| Shuttle bus |  |  |  |
|  |  |  |  |
| Track |  |  |  |
|  |  |  |  |

* + 1. Please specify any other items your program has: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does your site offer a supervised Cardiac Rehabilitation program?

* *Yes (section G)*
* No

**SECTION G: CARDIAC REHABILITATION – Supervised Program**

1. Which of the following cardiac diagnoses or indications do you accept for your supervised program? (Check all that apply)

* Post-Myocardial Infarction / acute coronary syndrome
* Stable coronary artery disease, without a recent event or procedure
* Post-percutaneous coronary intervention (PCI)
* Post-coronary artery bypass graft surgery (CABG)
* Heart failure
* Patients who have had valve surgery/repair or transcatheter aortic valve implantation (TAVI)
* Heart transplant
* Patients with ventricular assist devices
* Arrhythmias (hemodynamically-stable)
* Patients with implanted devices for rhythm control (i.e., ICD / CRT, pacemaker)
* Congenital heart disease
* Cardiomyopathy
* Abdominal Aortic aneurysm / repair
* Microvascular disease
* Patients at high-risk of cardiovascular disease (primary prevention)
* *Other*  
  Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Which of the following non-cardiac diagnoses or indications do you accept for your on-site program? (Check all that apply)

* Stroke / transient ischemic attack
* Intermittent claudication / peripheral vascular disease
* Cancer
* Diabetes
* Lung disease
* Liver disease
* Kidney disease
* HIV/AIDs
* Dementia / cognitive impairment
* Morbid obesity / bariatric surgery
* None
* *Other*

Please, specify which other non-cardiac diagnosis is accepted in your program\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Which of the following patient levels of cardiac risk do you accept for your supervised program? (Check all that apply)

* Low
* Moderate
* High
* Not applicable because we do not risk stratify at our program

1. Do patients have an individual consult with a physician during the program?
   * *Yes*
   * No

54b. If *yes*, Please specify the average number of times in a full program an average patient has an individual consult with a physician (Please enter a numeric value)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **times**

1. What is the standard duration of the on-site cardiac rehabilitation program that you provide to patients? (Please enter a numeric value.)

\_\_\_\_\_\_\_\_\_\_ **weeks**

1. On average, for how many sessions does each patient come on-site each week? (i.e., frequency; do not report how many sessions your program runs in a week)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_**sessions per week**

1. On average, how long is each exercise session (including warm up, aerobic exercise, strength training and/ or cool down as applicable)? (Please enter a numeric value) \_\_\_ **minutes / session**
2. On average, how many patients are in each exercise session? (Please enter a numeric value)

**\_\_\_\_\_\_\_\_\_\_\_ patients / session**

1. What is the maximum number of patients that your program allows in the same exercise session? (Please enter a numeric value in the field.)

\_\_\_\_\_\_\_\_\_\_\_\_ **patients / session**

1. What is the staff-to-patient ratio during supervised exercise at your program? (Note: if there are 6 staff persons per 14 patients, enter 2.3) (Please enter a numeric value in the field.)

Insert here the number of staff per one patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. During what hours do you offer supervised sessions? (check all that apply)

* Before 9am
* Regular business hours
* Evenings
* Weekends
* Patients can also access program information on the web at any time

1. Does the supervised program offer telemetry or another method of monitoring patients’ clinical status while exercising? (check all that apply)

* Yes, telemetry on all patients all the time
* Yes, telemetry as needed
* *Yes, other method of monitoring*
* None

b. If other method of monitoring please specify:

* Borg scale (perceived exertion)
* Heart rate
* Other

If applicable, please specify what other method of monitoring is used in your program\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section H- alternative models of Cardiac rehabilitation delivery**

1. Are alternative cardiac rehabilitation models such as home-based, reimbursable by government or insurance companies in your region?
   * *Yes*  
      Please specify which model are reimbursable by government or insurance companies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * No
2. Does your cardiac rehabilitation program offer alternative models of program delivery than an on-site program?

* *Yes*
* No *(end of survey)*

b. **If Q was marked: yes**, please specify (check all that apply):

* Home-based (includes web or Smartphone-based)
* Community-based
* *Hybrid of supervised with home or community-based*   
   Please describe the nature of your hybrid model\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* *Other*

 Please, specify what other alternative model is offered\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If Qb was marked: home–based program, please answer the following questions**:

1. When did the home-based program start? (Please enter a 4-digit numeric value)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **year**

1. What percentage of your patients are served in a home-based program? (Enter ‘unknown’ if you do not know)(Please enter a numeric value)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **%**

1. Do you perceive your program has sufficient capacity to meet need/demand in the home-based model?
   * Yes
   * *No*

b. **If NO,** please specify why your program doesn't have sufficient capacity to meet/demand in the home-based model (check all that apply):

* Not enough funding
* Not enough staff
* Patients’ risk too high for unsupervised exercise
* *Other*

c. Please specify the other reason your program doesn't have sufficient capacity in the home-based program\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What is the standard duration of the home-based cardiac rehabilitation program that you provide to patients? (specify in weeks) (Please enter a numeric value in the field)

\_\_\_\_\_\_\_\_\_\_ **weeks**

1. On average, how many sessions (i.e., formal contact with the Cardiac Rehabilitation staff) does each patient complete in the home-based program each month? (frequency; do not report how many sessions your program runs in a month for all home-based patients)

\_\_\_\_\_\_\_\_\_\_ **sessions / month**

1. On what basis are patients offered a home-based program? (check all that apply)
   * Risk stratification
   * Patient indication
   * Distance to center
   * Time or work constraints during the Cardiac Rehabilitation center hours
   * Transportation barriers
   * Patient choice
   * Cost
   * *Other*

Please, specify on what other basis are patients offered a home-based program\_\_\_\_\_\_\_\_\_

1. Do participants in your home-based program receive any materials to support them in the program? (check all that apply)

* Yes they receive an activity tracker (e.g., pedometer, accelerometer, log book)
* Yes they receive resistance training materials (e.g., therabands, dumbbells)
* Yes they receive education materials (e.g., workbook)
* *Yes they receive other materials*

 Please specify what other materials they receive\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* *Sometimes*

 Please describe under what instances participants receive materials, and type of material(s) provided\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* No

1. Which of the following patient levels of cardiac risk do you accept for your home-based program? (Check all that apply)

* Low
* Moderate
* High
* Not applicable because we do not risk stratify at our program

1. What forms of communication are used with patients in your home-based program? (check one box per row, to report the frequency)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Never | Daily | Several Times/week | Weekly | Several times / month | Monthly | Just once |
| Internet webpage |  |  |  |  |  |  |  |
| Email |  |  |  |  |  |  |  |
| Webcam / videoconference |  |  |  |  |  |  |  |
| Smartphone app |  |  |  |  |  |  |  |
| Text messages |  |  |  |  |  |  |  |
| Log or diary (paper) |  |  |  |  |  |  |  |
| Phone (mobile or landline) |  |  |  |  |  |  |  |
| In-person / on-site visit |  |  |  |  |  |  |  |
| *Other* |  |  |  |  |  |  |  |

b. Please specify what other form of communication is used in your home-based program\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Did you perceive any barriers to using these communication tools?

* *Yes*
* No

b. If yes: Check all the barriers that apply:

* + - * Logistical problems: i.e., connection
      * Lack of patient access (i.e., patients do not have computer with email)
      * Difficulty for the clinical staff   
        Please specify the difficulties for the clinical staff\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
      * Difficulty for the patients

Please specify the difficulties for the patients\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* + - * *Other*

Please specify other perceived barriers to communicating with patients via technology\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What do you think you would need to be ready and able to significantly increase your program’s capacity to provide home-based cardiac rehabilitation services to patients? Why?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If Qb was marked: Community-based** **program, please answer the following**:

1. Where does the community-based program take place?

* Public center
* Private center
* Semi-private center
* *Other*

Please specify where the community-based program takes place\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. When did it start? (Please enter a 4-digit numeric value)

\_\_\_\_\_\_\_ **year**

1. What proportion of your patients are served in the community-based program? (Please, enter a percentage; only a number)

\_\_\_\_\_\_\_\_\_\_\_\_\_ **%**

1. On average, how many patients are in each exercise session? (Please enter a numeric value)

\_\_\_\_\_\_\_\_\_\_ **patients / session**

1. How many classes do you offer in a week? (for all patients)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **sessions per week**

1. Which of the following patient levels of cardiac risk do you accept for your community-based program? (Check all that apply)
   * + Low
     + Moderate
     + High
     + Not applicable because we do not risk stratify at our program
2. Which type of provider is most responsible to supervise the Community-based exercise sessions? Please check one box:

* *Physician*

83b. If yes, please specify the specialty \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Nurse
* Exercise physiologist
* Physiotherapist
* *Other*

83c. Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What is the standard duration of the community-based cardiac rehabilitation program that you provide to patients? (Please enter a numeric value)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **weeks**

1. On average, how many sessions does each patient complete in the community-based program each month? (i.e., frequency; do not report how many sessions your program runs in a month)

\_\_\_\_\_\_\_\_\_\_ **sessions per month**

1. On what basis are patients offered a community-based program? (check all that apply)
   * Risk stratification
   * Patient indication
   * Distance to main Cardiac Rehabilitation center
   * Time or work constraints during the Cardiac Rehabilitation center hours
   * Transportation barriers
   * Patient choice
   * Cost
   * We do not have a main center in a clinical setting
   * *Other*

Please specify on what other basis patients are offered a community-based program\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What do you think you would need to be ready and able to significantly increase your program’s capacity to provide community-based cardiac rehabilitation services to patients? Why?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Thank you most sincerely on behalf of the International Council of Cardiovascular Prevention and Rehabilitation for the time and expertise you have committed to complete this important questionnaire.**