International Council of Cardiovascular Prevention and Rehabilitation (ICCPR)

# INTERNATIONAL CARDIAC REHABILITATION REGISTRY (ICRR)
# PROGRAM QUESTIONNAIRE & ON-BOARDING INTEREST

Instructions: Please answer the series of questions by: (1) clicking the appropriate radio button (sometimes one, and other times you will be asked to select as many buttons 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.

There are approximately 35 questions (depending on your responses based on your program offerings). At the bottom of each page you can find a button to save your answers submitted, and get a link to continue the survey later.

Contact iccpr.icrr@gmail.com with any questions.

Be sure to click the "Submit" button when you reach the end of the survey, so ICRR is alerted and receives your responses. The ICRR will then be in touch with you for next steps.

## SECTION A: DATA STEWARDS AND YOUR PROGRAM'S USE OF THE REGISTRY

1. What is the Title/Position of proposed ICRR data steward (ie., the person responsible for entering daa into the ICRR) at your cardiac rehabilitation program? (check ✓all that apply):
   - ☐ Allied healthcare provider (specify: _____)
   - ☐ Coordinator / Manager / Supervisor
   - ☐ *Other*
     Please specify: _____

2. Please provide the primary data steward's full first and last name: _____

3. Provide the primary data steward's contact email address: _____

4. In what country is your cardiac rehabilitation program? _____

5. City / Region: _____

6. Name of institution / site (note this will be denoted in the registry for you to identify yourself, but your data will not be identifiable to other sites): _____

7. Does your program meet the following: you offer (a) initial assessment, (b) structured exercise (can be supervised or unsupervised) and (c) at least one other strategy to control risk factors (e.g., dietary counselling)
   - ☐ Yes
   - ☐ No

     If no: please describe: _____

8. Do you agree to all the terms laid out in the "information for sites interested in joining the registry" on our website https://globalcardiacrehab.com/ICRR_sites?
   - ☐ Yes, all
   - ☐ Most (please specify: _____)
   - ☐ No

9. DATA STEWARDS: it is preferred each site has 1, at maximum 2 data stewards responsible for data entry, for reasons of data consistency / quality. It is preferable that the data enterer(s) is involved in patient care, but not necessary (e.g., administrative staff and/or trainees may enter data as long as they have approvals to access patient data and they undergo ICRR training processes). Will your site have another data steward than you?
   - ☐ *Yes, and I know who it is*
   - ☐ Maybe, I will let you know, or yes but I will get you their contact information later
   - ☐ No

   If *yes and I know who*:

   9.a. Please provide their full first and last name(s): _____

   9.b. Provide their contact email address(es): _____

   9.c. What is their title/role at your cardiac rehabilitation program? (check all that apply):
   - ☐ Allied healthcare provider (specify: _____)
   - ☐ Coordinator / Manager / Supervisor
   - ☐ *Other*

     Please specify _____

10. Does your site have a medical lead? And if yes, is the medical lead supportive of your program's participation in the ICRR?
    - ☐ Yes, we have a medical lead, and they are willing to champion our participation in the registry.
      - If selected – specify first and last name: _____ _____
      - email address: _____
    - ☐ Yes, and I am the medical lead
    - ☐ Yes we have a medical lead, but this person is too busy to champion our efforts
    - ☐ No, we do not have a medical lead

11. Will your site be collecting patient-reported data as well as program-reported (see https://globalcardiacrehab.com/International-CR-Registry-(ICRR) for list of variables)?
    - ☐ *Yes,* we will be applying to ethics to collect patient-reported data where possible (ICRR will be in touch with the protocol etc to support you)
    - ☐ No
    - ☐ We need to figure that out yet. Will discuss with you

    11.a. if Yes (check all that apply),
    - ☐ We hope to collect this electronically in willing patients with sufficient English-language ability and who have the technology

- ☐ We will print out the questions and ask the patients to fill it out if they are willing (and if they don't have the technology; note: ICRR will provide the forms) and will call them each year
- ☐ We will administer this via interview by staff if necessary, to the patient pre and post-program as well as each year (please have staff call patients who dropout to ask them the questions at follow-up) and enter responses into the registry manually (note: ICRR will provide the forms)

12. Would your site like to explore electronic automatic upload of some of your program-reported variables to the registry? (ICRR has covered the cost of this centrally)

☐ Yes
☐ No

13.The registry has in-built feedback functionality for programs (dashboards) and patients. Is your site interested in applying for ethics approval to also share with patients a lay summary (currently only available in English) of their progress post-program, based on their contributed data? You can find the template here: https://globalcardiacrehab.com/ICRR-for-Patients

☐ Yes, we will explore this (if yes, we will be in touch to ask if you would like to include your institutional logo and program email in the proforma).
☐ No

**SECTION B: GENERAL PROGRAM INFORMATION**

14 In what type of institution is your program delivered? (i.e., where are the staff offices and where do patients receive care; check all that apply)

- ☐ It is in a referral centre/ quarternary / tertiary facility and / or academic centre
- ☐ It is in a private hospital
- ☐ It is in a community hospital
- ☐ It is in a clinical setting outside a hospital
- ☐ It is in a community centre
- ☐ Remote / virtual sessions (i.e., patients are not only exercising at home between sessions, but also contact with program staff for sessions happens remotely)
- ☐ *Other*
  Please specify where your cardiac rehabilitation is located _____

14.a. *If one of the first 3 options above is checked*: Does your program track referrals of all indicated inpatients?

- ☐ Yes
- ☐ No
- ☐ Not applicable (no inpatients at our institution)

15. 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)(Please enter a numeric value in the field)

_____ **weeks for surgical patients (a.)**
_____ **weeks for other patients (b.)**
Or ☐ I do not know

16. Does your program have a waiting list for patients to start the program due to lack of capacity to intake new patients? (please check one box)

- ☐ *yes*
- ☐ no
- ☐ actually we have excess capacity, but not enough patients are referred

17. How many unique patients do you treat per month? (this will help us estimate the number of patients you may be entering into the registry)

_____ patients/month

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

- ☐ Social security / government
- ☐ Hospital or clinical center where the cardiac rehab service is based
- ☐ *Patient*
- ☐ Private health insurance
- ☐ *Other (e.g., donations, Foundation, grants)*

Please specify _____

18.a. *If patients pay*: What is the average **percent** of the total program cost that patients pay, if they complete the program? (Please enter a numeric value only in the field)

_____ %

18.b. What is the out-of-pocket cost to patients to participate in the sessions, if they complete the program? (Note: Please enter a numeric value in the currency of your country; do not consider transportation or parking)

_____
Amount

## SECTION C: STAFFING & COMPONENTS OF YOUR CARDIAC REHABILITATION PROGRAM

19. Is each patient stratified according to their level of risk?

- ☐ Yes
- ☐ No

20. 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) or sports medicine
- ☐ Generalist physician
- ☐ *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 ____

  _____

21. 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) or Sports Medicine Physician | ☐ | ☐ | ☐ |
| Internal Medicine | ☐ | ☐ | ☐ |
| *Other Physician (other than psychiatrist)* | ☐ | ☐ | ☐ |
| Physiotherapist | ☐ | ☐ | ☐ |
| Nurse / Nurse-Practitioner | ☐ | ☐ | ☐ |
| Psychiatrist or Psychologist | ☐ | ☐ | ☐ |
| Social worker | ☐ | ☐ | ☐ |
| Dietitian | ☐ | ☐ | ☐ |
| Kinesiologist/Exercise Specialist/Biokineticist/Exercise Physiologist | ☐ | ☐ | ☐ |
| Pharmacist | ☐ | ☐ | ☐ |
| Occupational Therapist | ☐ | ☐ | ☐ |
| Community Health worker | ☐ | ☐ | ☐ |

| | | | |
|---|---|---|---|
| Administrative assistant/ Secretary | ☐ | ☐ | ☐ |
| *Other* | ☐ | ☐ | ☐ |

Please specify what kind of other physician _____
Please specify which other type of personnel are part of your team _____

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

- ☐ Yes
- ☐ Mostly
- ☐ No

23. Does your program have a policy in place for cardiac emergencies and mock code blues?

- ☐ Yes
- ☐ No

24. In the registry you will be providing METs for patients pre and post-program. What is the most common means by which you assess functional capacity at your program?

- ☐ Graded exercise stress test (check one of the two top boxes, and one of the 2 bottom boxes)
  - o (if yes) mostly on a treadmill
  - o Mostly on a cycle ergometer
  - o AND (if yes) oxygen consumption is directly measured
  - o No gas analysis
- ☐ 6-minute walk test
- ☐ Incremental shuttle walk test
- ☐ Duke Activity Status Index
- ☐ Other (please specify: _____)

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

| | **Yes** | **No** |
|---|---|---|
| Time spent being sedentary | ☐ | ☐ |
| Physical activity | ☐ | ☐ |
| Poor diet | ☐ | ☐ |
| Tobacco use | ☐ | ☐ |
| Harmful use of alcohol | ☐ | ☐ |
| Blood pressure | ☐ | ☐ |
| Body composition (e.g., BMI, waist) | ☐ | ☐ |
| Lipids | ☐ | ☐ |
| HbA1c or blood glucose | ☐ | ☐ |
| Sleep apnea | ☐ | ☐ |
| Depression | ☐ | ☐ |
| Other psychosocial (e.g., anxiety, stress, hostility, support, sleep quality…) | ☐ | ☐ |
| Erectile dysfunction / sexual function | ☐ | ☐ |

*Other factor(s)* ☐ ☐

Please specify which other factor(s) you assess in your program_____

26. Are the following elements of cardiac rehabilitation are provided in your program? (check one box per row)

| | Yes | No | We have a relationship with an external party to deliver this element |
|---|---|---|---|
| Initial assessment | ☐ | ☐ | ☐ |
| Risk stratification | ☐ | ☐ | ☐ |
| Exercise prescription | ☐ | ☐ | ☐ |
| Supervised exercise training | ☐ | ☐ | ☐ |
| Resistance training | ☐ | ☐ | ☐ |
| Patient education | ☐ | ☐ | ☐ |
| Prescription and/or titration of secondary prevention medications | ☐ | ☐ | ☐ |
| Nutrition counseling | ☐ | ☐ | ☐ |
| Stress management / Relaxation techniques | ☐ | ☐ | ☐ |
| Psychological counseling (where applicable) | ☐ | ☐ | ☐ |
| Tobacco cessation sessions/classes | ☐ | ☐ | ☐ |
| Sexual counselling | ☐ | ☐ | ☐ |
| Vocational counseling / support for return-to-work | ☐ | ☐ | ☐ |
| *Alternative forms of exercise* (eg., yoga, dance, tai chi, virtual reality/exergames) | ☐ | ☐ | ☐ |
| Women-only or focused classes | ☐ | ☐ | ☐ |
| Inclusion of family / informal caregivers | ☐ | ☐ | ☐ |
| End of program re-assessment | ☐ | ☐ | ☐ |
| Communication of patient assessment results with their primary care provider | ☐ | ☐ | ☐ |
| Maintenance program | ☐ | ☐ | ☐ |
| *Other* | ☐ | ☐ | ☐ |

If applicable, please specify what other alternative forms of exercise are offered in your program

_____

If applicable, please specify what other components of cardiac rehabilitation are provided in your program

_____

27. 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**

28. Does your site offer a supervised on-site (clinical setting) Cardiac Rehabilitation program?

☐ *Yes*
☐ No *(if selected, skips to Section E)*

## SECTION D: About Your Supervised On-Site Program

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

_____ **weeks**

30. 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. Note: if you run a residential program, leave this question blank)

_____ **sessions per week**

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

☐ Yes, telemetry
☐ *Yes, other method of monitoring*
☐ None

If applicable, please specify what other method of monitoring is used in your program:
_____

### SECTION E- ALTERNATIVE MODELS OF CARDIAC REHABILITATION DELIVERY

32. Does your cardiac rehabilitation program offer alternative models of program delivery than an on-site (clinical setting) program?

☐ *Yes*
☐ No *(if no, this ends survey)*

32.a. **If yes**, please specify (check all that apply):

☐ *Home-based* (includes web or smartphone-based)
☐ Community-based
☐ *Hybrid of supervised on-site with home or community-based*
Please describe the nature of your hybrid model: _____
☐ *Other*
Please, specify what other alternative model is offered:
_____

*If Q32a was marked: home–based program, please answer the following questions:*

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

_____ _ **%**

34. 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**

35. 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**

36. 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., accelerometer, log book / diary)
- ☐ 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:_____
- ☐ No

THANK YOU! WE WILL BE IN TOUCH TO GET YOU STARTED, INCLUDING SUPPORT FOR INSTITUTIONAL AND ETHICAL APPROVALS ETC. WE CAN BE REACHED AT ICCPR.ICRR@GMAIL.COM