AACVPR Outpatient Cardiac Rehabilitation Registry: Definitions and Comments for Selected Data Elements

To ensure consistency in the data entered, definitions of several of the data elements in the AACVPR Outpatient Cardiac Rehabilitation Registry have been standardized. All data entered must conform to these particular definitions.

The data elements are listed in the order they may be encountered while moving through the patient record.

Referral date	Enter the date the referral document was *signed by a physician*. For patients referred from an inpatient care team, this may be the date of the discharge orders.
Enrollment date	Enter the date of the patient's first *billable exercise session*. A billable session would use either the 93797 or 93798 code. An orientation session without exercise would not meet this criterion.
Diagnoses/ procedures	Enter the diagnoses or procedures that prompted the referral to CR. Enter all that apply and select a diagnosis/procedure as the primary diagnosis. For example, if the patient was admitted for a non-ST elevation MI and subsequently had angioplasty and coronary stenting, enter "NSTEMI" and "PCI" as the diagnosis/procedure. NSTEMI would be the primary event, followed by PCI. Also enter the date of the hospital admission. *For patients who are referred to CR with stable exertional angina or heart failure and who were NOT hospitalized, enter the date of the physician consult that prompted the referral.*
Justification for number of prescribed exercise sessions	Select the option that best describes how the number of prescribed exercise sessions was determined. For example, if the patient's health insurance limits the number of outpatient CR sessions to 12, select "Insurance." If your program's risk stratification protocol determines the patient should have 24 sessions, select the "Risk stratification" option. If it is your program's protocol to prescribe 36 sessions for all patients, select the "Protocol" option.
Pre/post lab values and dates (lipids, fasting blood glucose, hemoglobin A1C)	Use the values from the most recent date you can find in the medical record that is **no earlier than one (1) year prior to the assessment date**. For example, if the patient's enrollment date is in November and he/she had lipid results from three months earlier (in August), use these values. If there are no entry values within the one-year time limit, leave the fields blank. If the patient's discharge was subsequently in January but he/she did not have any repeat lipid tests done, DO NOT repeat the previous values. Instead, leave the discharge fields blank. If the patient is scheduled to have labs done *as part of his/her admission and/or discharge evaluation*, you can use those results in the corresponding sections. If the lipids, glucose, or A1C value was obtained by point-of-care methods such as a glucometer or Cholestech machine, check the POC box.

Blood pressure	Use the average of two (2) consecutive readings taken at least five (5) minutes apart for the admission and discharge values. Use AHA guidelines for proper BP measurement.
Medication prescribed	Has the medication (Aspirin, beta-antagonist, ACE inhibitor or receptor blocker, statin agent) been prescribed to the patient? If so, check the "Yes" option; if not, check the "No" option. If the medication was not prescribed because of a contraindication – the patient had negative side effects or there was another medical reason for not prescribing the medication – select the "No-Exception" option. You will be prompted to enter a reason for the exception. If the reason for the patient not being prescribed the medication is unknown or if it is not clear that the patient has been prescribed the medication, select the "Unknown" option.
Medication adherence	Is the patient adhering correctly to the medication prescription? Select the "Yes" option if the patient is taking the medication according to the prescription; otherwise, select the "No" option. If the patient is not taking the prescribed medication because of intolerance or side effects, select the "No-Exception" option. You will be prompted to enter a reason for the non-adherence. If it is not known why the patient is not taking the prescribed medication, select the "Unknown" option.
Tobacco use status	If the patient has never used tobacco products, select the "Never" option. If the patient has quit using tobacco products for at least six (6) months prior to the date of program enrollment, select the "Former" option. If the patient has quit within six (6) months of program enrollment, select the "Recent" option. If the patient is actively using tobacco products at the time of enrollment, select the "Current" option.
Tobacco use status (DC/FU)	If the patient has not used tobacco products within the past seven (7) days, enter "Abstaining." If the patient has used tobacco products within the past seven (7) days, enter "Not Abstaining."
Weight	Weigh the patient *prior to exercise* without shoes and while wearing his/her typical or usual exercise clothes. Record weight to the nearest tenth of a pound or kilogram. Select the units used for measurement (pounds or kilograms).
Height	Measure the patient's height in stocking feet to the nearest quarter inch or centimeter. Select the units used for measurement (inches or centimeters).
Waist circumference	Measure the waist circumference using the NIH criteria, i.e., a horizontal measurement at the highest point on the iliac crest. Measure to the nearest quarter inch. (Please refer to the "Assessment by Waist Circumference" in the registry tools for protocol.)

Dietary outcomes (%Kcal saturated fat intake, daily fruit/ vegetable servings, dietary assessment used)	Use a standardized, validated tool for measuring the percentage of daily calories as saturated fats and self-reported daily fruit and vegetable servings. Report values to nearest whole number. You will be given the option to select which tool was used to derive these outcomes.
Maximal METs	Use the estimated maximum MET value attained during a graded, symptom-limited, maximal exercise test (GXT). Select what type of test was performed (treadmill, bike, arm ergometer, other, or unknown).
Peak Exercise METs	For the intake value, use the estimated peak MET level attained during the third CR exercise session. For the discharge value, use the estimated peak MET level attained during the discharge exercise session or last exercise session. The estimated peak MET value should be calculated using validated American College of Sports Medicine (ACSM) equations whenever possible.
6-minute walk distance	Report the distance attained during the 6-minute walk test in feet. (Please refer to "ATS Statement: Guidelines for the Six-Minute Walk Test" [*Am J Respir Crit Care Med.* 2002; 166: 111-117. doi: 10.1164/rccm.166/1/111] for protocol.)
6-minute cycle distance	Report distance pedaled for the 6-minute cycle test in miles. Report number to the nearest tenth of a mile. (Please refer to "Validity and Reliability of the North Carolina 6-Minute Cycle Test" [Verrill et al., *J Cardiopulm Rehabil.* 2006; 26: 224-230.] for protocol.)
Exercise minutes/day	Enter the average number of minutes per day the patient engages in moderate intensity exercise on days the patient exercises or is physically active. "Moderate" intensity is defined as approximately 3–5 METs.
Exercise days/week	Enter the average number of days per week the patient engages in moderate intensity exercise and/or physical activity.
Steps per day	For the intake value, enter the average number of steps per day the patient attains during the first week of CR participation. For the discharge value, enter the average number of steps per day in the final week of CR participation.
Program discharge date	Enter the date of the last billed Phase 2 exercise session or discharge assessment session.
Completion status	The patient is defined as having completed CR when *he/she has undergone a final, formal discharge assessment session and updated treatment plan*. If neither of these criteria is met, the patient has not completed CR and reason(s) for non-completion should be entered.
Hospital readmissions and reasons for readmissions	Select the most pertinent reason for the patient's readmission to the hospital. Include readmissions that occur during the patient's participation in Phase 2 CR and those that occur during the period between the patient's discharge from Phase 2 and follow-up assessment.

Adverse events	Adverse events are medical events that require immediate cessation of exercise, assessment, and intervention by CR staff and immediate transport to an emergency department. It is assumed that a physician will be contacted regarding the patient's disposition and that the patient will be admitted to the hospital as a result of the event.
Unexpected events	Unexpected events are medically related events that require cessation of exercise and staff intervention and assessment. A physician may be contacted as part of the disposition. The patient may or may not be referred to the emergency department, depending on the situation/event.
Disposition	Select from "MD called," "ED visit," or "Hospital admission." These are not mutually exclusive, but graded in response. Depending on the severity of the event, you may elect to only contact the patient's physician. If more severe, the patient may be taken to the Emergency Department (ED). If the patient is admitted after being seen in the ED, select "Hospital admission." In the latter two cases, it is assumed that the patient's physician will be notified.