**Appendix A**

**Cardiac Rehabilitation (CR) Availability and Funding Source by Brazilian Region**



Appendix



Appendix

CARDIAC REHABILITATION PROGRAM QUESTIONNAIRE

Instructions: 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.

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

* Director
* Coordinator / Manager / Supervisor
* *Clinician*   
  Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* *Other*

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

**Section A: General information**

1. In what country is your cardiac rehabilitation program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.b. Please, specify your country\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.c. Are you a member of ACRA?

* *Yes*
* No

In what way are Aboriginal and Torres Strait Islander people being included your program? (Enter 'not applicable' if you do not have strategies to include these populations)  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. City / Region: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(optional)
2. 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).
3. In what year was your cardiac rehabilitation program initiated? Please enter a valid four digit start year \_\_\_\_\_\_\_ (year)
4. 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*

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

6.b. 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)

\_\_\_\_\_ %

6.c. What is the direct cost to patients to participate, if they complete the program?  (Note:

Please enter amount. Enter a numeric value)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Amount

6.c2. Please specify currency

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Currency

1. 7.Is your cardiac rehabilitation program located within a hospital?
   * Yes – it is in a referral centre/ quarternary / tertiary facility and / or academic centre
   * Yes – it is in a community hospital
   * *Yes - it is in a rehabilitation hospital/ residential facility*
   * Yes – other

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

* + *No* **(skip to question 10)**

7b. Is your Phase II program a spa / residential?

* *Yes*
* No

1. **If Q7 was marked yes**, does the hospital have an inpatient cardiology service? (Check one box):

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

1. **If Q7 and Q8 were marked yes,** do they offer? (check all that apply)

* Revascularization via percutaneous coronary intervention (PCI)
* Coronary artery bypass graft surgery (CABG)
* Percutaneous valve implantation
* Implantable heart devices (pacemakers or defibrillators)
* Cardiac transplant
* None

1. In what department is the cardiac rehabilitation program situated administratively?
   * Cardiology department
   * Physical Medicine and Rehabilitation department
   * Internal Medicine department
   * Primary / general practice
   * It is in a community facility
   * None – it is stand-alone
   * *Other*   
     Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. 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**

1. How many unique cardiac rehabilitation **patients** do you provide service to **each year** in your program? (Please enter a numeric value)

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

1. How many **patients** do you have capacity to serve **each year**, in terms of staff and space? (Please enter a numeric value)

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

1. What is the cost to your program to serve one (1) patient, if they complete the program? (Note: Please specify amount. Enter a numeric value in the field)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Amount

14.b. Please specify currency

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Currency

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Are there any other Cardiac Rehabilitation programs in your area? (Check only one box)
   * Yes, within approximately a 20 km radius
   * Yes, but more than 20 km away
   * None
   * I don’t know
3. 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 | 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 | 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 | 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 |
| *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 B: DETAILS ABOUT YOUR CARDIAC REHABILITATION PROGRAM**

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
* Physical therapist
* *Other*   
   If you checked "other", please specify the heath profession here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 |  | |  |  |  |  | |  |
| Exercise equipment |  | |  |  |  |  | |  |
| Equipment / supplies for cardiovascular risk assessment (not including exercise stress tests) |  | |  |  |  |  | |  |
| Exercise stress testing on a treadmill or cycle ergometer |  | |  |  |  |  | |  |
| Patient education materials |  | |  |  |  |  | |  |
| Blood pressure assessment device |  | |  |  |  |  | |  |
| Blood collection and lipid testing |  | |  |  |  |  | |  |
| Free weights etc. for resistance training |  | |  |  |  |  | |  |

1. Which of the following components of cardiac rehabilitation are provided in your program? If they are provided, are they provided in all the models you deliver? (i.e., supervised and home-based programs)?

Please check one box per row. If you only offer one model of rehabilitation and you offer the listed component, please check “yes, in all models”.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes**  **In all models** | **Yes**  **For some models** | **No** |
| Initial assessment |  |  |  |
| Individual consultation with a physician |  |  |  |
| 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) |  |  |  |
| Exercise prescription |  |  |  |
| Physical activity counseling­­­­ |  |  |  |
| Supervised exercise training |  |  |  |
| Heart rate measurement training for patients |  |  |  |
| Resistance training |  |  |  |
| Management of cardiovascular risk factors |  |  |  |
| Prescription and/or titration of secondary prevention medications |  |  |  |
| Nutrition counseling |  |  |  |
| Depression screening |  |  |  |
| Psychological counseling |  |  |  |
| Smoking cessation sessions/classes |  |  |  |
| Vocational counseling / support for return-to-work |  |  |  |
| Stress management / Relaxation techniques |  |  |  |
| *Alternative forms of exercise, such as yoga, dance, or tai chi* |  |  |  |
| Women-only classes |  |  |  |
| End of program re-assessment |  |  |  |
| Electronic patient charting |  |  |  |
| Communication of patient assessment results with their primary care provider |  |  |  |
| Follow-up after oupatient program |  |  |  |
| *Other* |  |  |  |

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

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

If applicable, please specify what components 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)

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

1. How many minutes on average is each education session? (Please enter a numeric value)

\_\_\_\_\_\_ **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 |  |  |
| Hip circumference |  |  |
| Body composition |  |  |
| Total Cholesterol |  |  |
| Cholesterol fractions (HDL-c, LDL-c) |  |  |
| Triglycerides |  |  |
| HbA1c for diabetic patients |  |  |
| Blood glucose for non-diabetic patients |  |  |
| Sleep apnea |  |  |
| Depression / Anxiety |  |  |
| Physical inactivity |  |  |
| Poor diet |  |  |
| *Other factor(s)* |  |  |

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

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* |  |  |  |
| Physical therapist |  |  |  |
| Nurse |  |  |  |
| Nurse practitioner |  |  |  |
| Psychiatrist |  |  |  |
| Psychologist |  |  |  |
| Social worker |  |  |  |
| Dietitian |  |  |  |
| Kinesiologist |  |  |  |
| Pharmacist |  |  |  |
| Exercise specialist |  |  |  |
| 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

* *Yes*
* No **(skip to question 26)**

25b. If yes, are they required to renew their CPR training regularly?

* Yes
* No

25c. If yes, is the CPR certification advanced or basic? (check one box per row)

|  |  |  |
| --- | --- | --- |
|  | Advanced CPR training | Basic CPR training |
| Physicians |  |  |
| Nurses |  |  |
| Other |  |  |

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 |  |  |  |
| Administrative office |  |  |  |
| Electronic patient charts |  |  |  |
| Resistance training equipment |  |  |  |
| Body composition analyzer |  |  |  |
| Staff meeting room |  |  |  |
| Staff office space |  |  |  |
| *Other* |  |  |  |

 Please specify what other items your program has \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

* *Yes*
* No

**SECTION C: 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
* Rheumatic heart disease
* Patients at high-risk of cardiovascular disease (primary prevention)
* Non-cardiac chronic diseases
* *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
* Intermittent claudication / peripheral vascular disease
* Cancer
* Diabetes
* Chronic lung disease
* 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

31b. If yes, Please specify the number of times in a full program the patients have an individual consult with a physician (Please enter a numeric value)

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

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 do patients come on-site each week? (Note: if you run a residential program, leave this question blank and instead answer the next question) (Please enter a numeric value in the field.)

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

33b. At your spa/residential program: On average, how many CR sessions do offer patients each day? (Please enter a numeric value in the field.)

\_\_\_\_\_ sessions / day (residential programs)

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

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

1. On average, how long is each exercise session (including warm up, aerobic exercise, strength training and/ or cool down)? (Please enter a numeric value)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ minutes / 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 6 in the first box and 14 in the second box) (Please enter a numeric value in the fields.)

37b. Insert here the staff number in the staff-to-patient ratio: \_\_\_\_\_\_

37c. Insert here the patient number in the staff-to-patient ratio: \_\_\_\_

1. Which healthcare professionals are usually present during exercise sessions? (Check one box in each row)

|  |  |  |
| --- | --- | --- |
|  | Present | Not usually present |
| Cardiologist |  |  |
| Physiatrist (Physical Medicine and Rehabilitation) |  |  |
| Sports Medicine Physician |  |  |
| *Other Physician* |  |  |
| Physical therapist |  |  |
| Nurse |  |  |
| Nurse practitioner |  |  |
| Psychiatrist |  |  |
| Psychologist |  |  |
| Social worker |  |  |
| Dietitian |  |  |
| Kinesiologist |  |  |
| Pharmacist |  |  |
| Exercise specialist |  |  |
| Community health worker |  |  |
| *Other* |  |  |

Please specify which other physician is usually present during exercise sessions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please specify which other healthcare professionals are usually present during exercise sessions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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 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 D- 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

41b. **If Q41 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 Q41b was marked: home–based program, please answer the following questions**:

1. When did the home-based program start? (Please enter a 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*

44b. **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
* Not enough other resources
* Patients’ risk too high for unsupervised exercise
* *Other*

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, for how many sessions (i.e., formal contact with the Cardiac Rehabilitation staff) do patients complete in the home-based program each month? (Please enter a numeric value in the field)

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

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

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

1. Does the home-based 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 other method of monitoring please specify:

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

Please specify what other method of monitoring is used in your 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 |  |  |  |  |  |  |  |
| Mobile phone |  |  |  |  |  |  |  |
| Smartphone app |  |  |  |  |  |  |  |
| Text messages |  |  |  |  |  |  |  |
| Log or diary (paper) |  |  |  |  |  |  |  |
| Telephone (landline) |  |  |  |  |  |  |  |
| In-person / on-site visit |  |  |  |  |  |  |  |
| *Other* |  |  |  |  |  |  |  |

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

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. Which providers interact directly with the patients in the home-based cardiac rehabilitation program? Please check all that apply:
   * *Physician*

 Please specify the specialty of the physician who interacts directly with the patients in the home-based program \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* + Nurse
  + Exercise physiologist
  + Physical therapist
  + *Other*

Please specify who interacts with the patient in the home-based program\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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?

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

**If Q41b 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 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? (Please enter a numeric value)

\_\_\_\_\_\_\_\_\_\_\_\_ sessions

60. 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

61. Which type of provider is most responsible to supervise the Community-based exercise sessions? Please check one box:

* *Physician type*

Please specify the specialty \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Nurse
* Exercise physiologist
* Physical therapist
* *Other*

Please specify who is the most responsible to supervise the community-based program\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_ weeks

63. On average, for how many sessions do patients complete in the community-based program each month? (Please enter a numeric value in the field. Leave blank if unknown)

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

64. On what basis are patients offered a community-based program? (check all that apply)

* + Risk stratification
  + Patient indication
  + Distance to main Cardiac Rehabilitation centre
  + Time or work constraints during the Cardiac Rehabilitation centre hours
  + Transportation barriers
  + Patient choice
  + Cost
  + We do not have a main centre in a clinical setting
  + *Other*

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

65. Does the community-based 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

65.b. Please specify what other method of monitoring is used in your community-based program

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

Please specify what other method of monitoring is used\_\_\_\_\_\_\_\_\_\_\_\_\_\_

66. 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?

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

**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.   
Results will be available at our website:** [*www.globalcardiacrehab.com*](http://www.globalcardiacrehab.com)

Resources: CACR\_Program Survey\_2009; EACPR\_ CR Program Survey; South American Survey CR Survey, AACVPR 2013