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I recently reviewed a report performed for the American College of Cardiology (ACC) titled *Survey Report: Cardiac Rehab Industry Insights and Best Practices* (1). Only a fraction of the cardiac rehabilitation (CR) programs in the United States were assessed (N = 72 of 800+ programs). The survey provided information on a wide array of topics including eligible patient participation, intensive versus traditional CR use (10% and 90%, respectively), the number sessions attended, maintenance program charges, “virtual” CR services (only 13% offering), other offerings (e.g., pulmonary, PAD, oncology), American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) program certification (75% certified), program revenues (50% reported positive net revenue), and barriers to growth.

Another area of focus was on staffing. Two items related to the reporting of staffing caught my attention. First, and I have mentioned this previously, is the disappointment I had in the listing of “Exercise Physiologist” (EP) and not “Clinical Exercise Physiologist” (CEP). A goal of those individuals who belong to the organizations that allow access to this journal (CEPA, ESSA, and CSEP) should be to promote the specialty of clinical exercise physiology. The American College of Sports Medicine recognizes CEPs and EPs as distinctly separate professionals (2). The CEP is an allied healthcare professional with specific education and practical skills to guide those with existing chronic disease (many who are newly diagnosed and with complex comorbidities) through an exercise and lifestyle modification program. I urge anyone reading this article to recognize the differences between CEPs and EPs, and when the term EP is used when CEP should have been used, please notify the author or organization of this mistake. For example, I recently asked the current president of the

AACVPR to change from EP to CEP on their registration to the annual meeting and provided rationale. It was met with acceptance, and he stated they will be making this change.

The other area in the staffing section of the ACC CR survey had to do with use of various disciplines for program staffing. It was heartening to read that 95% of programs surveyed employed exercise professionals (stated as EPs in the survey—see above). CR remains the primary location of employment of the CEP, particularly in the United States. Additionally, 89% of the programs reported using a registered nurse. Nursing involvement in CR has been traditional since its inception. However, our program at Henry Ford Hospital has not used nurses for the past 20 years. We have relied solely on appropriately trained and experienced CEPs, with physician support, to implement programming and deal with the variety of medical situations that occur (blood glucose issues, chest pain, hypotensive responses, the need for CPR and/or defibrillation). We have been able to provide safe and effective CR programming in the settings of hospital and standalone clinic while serving an extremely sick and frail population. And this has also included the implementation of several important National Institutes of Health trials (HF-ACTION, CLEVER, iATTEND) (3). Importantly, staffing with only CEPs meets the 2006 Medicare and Medicaid definition for staffing of CR programs (4). I urge you to read the point:counterpoint from the 2015 issue of the *Journal of Clinical Exercise Physiology* (only 1 issue per year at that time and any article older than 18 months is freely available) in which I debate that the CEP is the best and logical choice for the majority of staffing in CR programs (5). My goal is to continue to promote the primary use of CEPs in all exercise settings catering to those with chronic disease.

REFERENCES

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