Cardiac Rehabilitation for Cardiac Surgical Patients

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Introduction

- Overview
- Why Cardiac Rehab (CR) for surgical patients?
- Review of Cardiac Surgical Rehabilitation
  - Post operative for CABG and Valve
  - In hospital
  - Outpatient (pre and post surgically)
- Drivers to be involved with Acute CR peri-surgically
Why CR for Surgical Patients?

• An old misconception: Isn’t it Dangerous?
  – NO!
  – Many centers in many nations have reported no major complications
  – Early ICU Mobilization first mentioned in literature in 2006 in Sweden: >1200 patients with CABG and Valve with no complications due to mobilization
    • Better outcomes with shorter stays and improved function
  – There may be a decrease in muscle loss and in cognitive function with early CR post surgery
  – No reports of increased mortality with CR after cardiac surgery in outpatient or inpatient settings, although older patients have higher mortality overall (as they would in any case)
## What is Acute Rehab “Worth”?

<table>
<thead>
<tr>
<th>Difference in Patient Outcomes (Compared to SNF Patients)</th>
<th>IRF Patients had:</th>
<th>Cardiac Conditions</th>
<th>Stroke</th>
<th>Overall Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge from Initial Rehabilitation Stay</td>
<td></td>
<td><strong>11.9</strong></td>
<td><strong>16.5</strong></td>
<td><strong>13.9</strong></td>
</tr>
<tr>
<td>Mortality Rate</td>
<td></td>
<td><strong>10.7</strong></td>
<td><strong>14.3</strong></td>
<td><strong>7.9</strong></td>
</tr>
<tr>
<td>Additional Days Alive</td>
<td></td>
<td><strong>66.7</strong></td>
<td><strong>96.8</strong></td>
<td><strong>51.9</strong></td>
</tr>
<tr>
<td>Additional Days at Home</td>
<td></td>
<td><strong>72.1</strong></td>
<td><strong>92.0</strong></td>
<td><strong>51.5</strong></td>
</tr>
<tr>
<td>ER Visits per 1,000 beneficiaries per Year</td>
<td></td>
<td>5.3%</td>
<td>3.7%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Hospital Readmissions per 1,000 beneficiaries per Year</td>
<td></td>
<td>8.0%</td>
<td>10.4%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Medicare Payment during Initial Rehabilitation Stay for IRF Care</td>
<td></td>
<td><strong>$6,059</strong></td>
<td><strong>$8,335</strong></td>
<td><strong>$5,975</strong></td>
</tr>
<tr>
<td>Medicare PMPM Payment during Post-Rehabilitation Period for IRF Care</td>
<td></td>
<td><strong>-$24</strong></td>
<td><strong>$65</strong></td>
<td><strong>$79</strong></td>
</tr>
<tr>
<td>Medicare Payment per Day for IRF Care (Initial Rehabilitation Plus Post-Rehabilitation)</td>
<td></td>
<td>$9.83</td>
<td>$16.33*</td>
<td>$12.59**</td>
</tr>
</tbody>
</table>

- **Cardiac Conditions**, **Stroke**, **Overall Average**
- **Days earlier discharge**, **lower mortality**, **additional days alive**, **additional days at home**, **fewer ER visits**, **fewer readmissions**

Source: Dobson | DaVanzo analysis of research identifiable 20 percent sample of Medicare beneficiaries (and 100 percent sample of IRF beneficiaries), 2005-2009.

* = Differences are statistically significance at p<0.001; ** = Differences are statistically significance at p<0.0001.
What is Acute Rehab “Worth”?

Avoidance of All Cause Hospital Readmissions per Year

Source: Dobson | DaVanzo analysis of research identifiable 20 percent sample of Medicare beneficiaries (and 100 percent sample of IRF beneficiaries), 2005-2009.

* = Differences are statistically significant at p-value < 0.01; ** = Differences are statistically significant at p-value < 0.001; *** = Differences are statistically significant at p-value < 0.0001
What is Acute Rehab “Worth”?

Avoidance of ER visits per year

Source: Dobson | DaVanzo analysis of research identifiable 20 percent sample of Medicare beneficiaries (and 100 percent sample of IRF beneficiaries), 2005-2009.

* = Differences are statistically significant at p-value < 0.05; ** = Differences are statistically significant at p-value < 0.01; *** = Differences are statistically significant at p-value < 0.0001
What is Acute Rehab “Worth”?

Extra Days at Home IRF vs SNF

<table>
<thead>
<tr>
<th>Clinical Condition Category</th>
<th>IRF</th>
<th>SNF</th>
<th>Difference (IRF minus SNF)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amputation</td>
<td>510.6</td>
<td>425.2</td>
<td>85.4</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Brain Injury</td>
<td>517.0</td>
<td>422.0</td>
<td>95.0</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Cardiac Disorder</td>
<td>529.5</td>
<td>457.4</td>
<td>72.1</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Hip Fracture</td>
<td>581.2</td>
<td>528.4</td>
<td>52.8</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Hip/Knee Replacement</td>
<td>698.0</td>
<td>693.9</td>
<td>4.1</td>
<td>0.5188</td>
</tr>
<tr>
<td>Major Medical Complexity</td>
<td>478.7</td>
<td>405.9</td>
<td>72.8</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Major Multiple Trauma</td>
<td>611.2</td>
<td>576.4</td>
<td>34.8</td>
<td>0.0626</td>
</tr>
<tr>
<td>Neurological Disorders</td>
<td>533.0</td>
<td>487.6</td>
<td>45.4</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Other Orthopedic</td>
<td>616.3</td>
<td>587.5</td>
<td>28.8</td>
<td>0.0707</td>
</tr>
<tr>
<td>Pain Syndromes</td>
<td>602.9</td>
<td>546.0</td>
<td>56.9</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Pulmonary Disorders</td>
<td>464.0</td>
<td>416.2</td>
<td>47.7</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Spinal Cord Injuries</td>
<td>597.9</td>
<td>556.8</td>
<td>41.0</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Stroke</td>
<td>518.4</td>
<td>426.4</td>
<td>92.0</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Overall Average</td>
<td>582.3</td>
<td>530.8</td>
<td>51.5</td>
<td>&lt;.0001</td>
</tr>
</tbody>
</table>

Source: Dobson | DaVanzo analysis of research identifiable 20 percent sample of Medicare beneficiaries (and 100 percent sample of IRF beneficiaries), 2005-2009.

*Days in the home represents the average number of days per patient over two-year episode not spent in a hospital, IRF, SNF, or LTCH.
What is Acute Rehab “Worth”?  
Extra Days at Alive over 2 years IRF vs SNF
What is Acute Rehab “Cost”?  

Excess Rehab Costs of IRF vs SNF Rehab

<table>
<thead>
<tr>
<th>Clinical Condition Category</th>
<th>IRF</th>
<th>SNF</th>
<th>Difference (IRF minus SNF)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amputation</td>
<td>$3,313</td>
<td>$3,693</td>
<td>-$380</td>
<td>0.0114</td>
</tr>
<tr>
<td>Brain Injury</td>
<td>$2,199</td>
<td>$1,965</td>
<td>$234</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Cardiac Disorder</td>
<td>$2,162</td>
<td>$2,186</td>
<td>-$24</td>
<td>0.1889</td>
</tr>
<tr>
<td>Hip Fracture</td>
<td>$1,679</td>
<td>$1,598</td>
<td>$80</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Hip/Knee Replacement</td>
<td>$887</td>
<td>$844</td>
<td>$43</td>
<td>0.3236</td>
</tr>
<tr>
<td>Major Medical Complexity</td>
<td>$2,847</td>
<td>$2,696</td>
<td>$151</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Major Multiple Trauma</td>
<td>$1,609</td>
<td>$1,509</td>
<td>$101</td>
<td>0.0484</td>
</tr>
<tr>
<td>Neurological Disorders</td>
<td>$2,401</td>
<td>$2,102</td>
<td>$299</td>
<td>&lt;.0001</td>
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<tr>
<td>Other Orthopedic</td>
<td>$1,639</td>
<td>$1,578</td>
<td>$61</td>
<td>0.0072</td>
</tr>
<tr>
<td>Pain Syndromes</td>
<td>$1,794</td>
<td>$1,868</td>
<td>-$74</td>
<td>0.0247</td>
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<tr>
<td>Pulmonary Disorders</td>
<td>$2,918</td>
<td>$2,649</td>
<td>$269</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Spinal Cord Injuries</td>
<td>$1,848</td>
<td>$1,644</td>
<td>$204</td>
<td>0.0037</td>
</tr>
<tr>
<td>Stroke</td>
<td>$2,227</td>
<td>$2,162</td>
<td>$65</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Overall Average</td>
<td>$1,815</td>
<td>$1,736</td>
<td>$79</td>
<td>N/A*</td>
</tr>
</tbody>
</table>

Source: Dobson | DaVanzo analysis of research identifiable 20 percent sample of Medicare beneficiaries (and 100 percent sample of IRF beneficiaries), 2005-2009.

*Calculated as weighted average across all conditions based on volume (number of matched pairs). Therefore, significance of the difference is not available.
Acute Rehab Additional Cost per Day

Source: Dobson | DaVanzo analysis of research identifiable 20 percent sample of Medicare beneficiaries (and 100 percent sample of IRF beneficiaries), 2005-2009.
* = Differences are statistically significant at p-value < 0.001
Classical Rehabilitation Schema

- Wenger, et al. 4 phases
  - I - acute in hospital (14 days)
  - II - recuperation (6 Weeks)
  - III - Training (3 Months)
  - IV - Maintenance (Lifetime)
Modern Rehabilitation Schema

- “Phase 0” – Pre-surgical/event (*Prehab*)
- Phase 1 – Acute in patient to d/c (3-5 days)
  - *(Early Mobilization)*
  - Phase 1B – Prolonged inpatient needs (*Posthab*)
- Phase 2 – Training (3 Months) (*Posthab*)
- Phase 3 – Maintenance (*Lifelong*)
Protocol for Cardiac Surgical Patients

- Three Stages for the preparation and Phase 1-2 transition
  - Cardiac rehabilitation before surgery if possible
    - Consider this to be “pre-hab”
  - Cardiac rehabilitation peri-operatively
    - “Early mobilization” after surgery
      - Start in ICU, mobilize like a phase 1 CR program
  - Cardiac rehabilitation after surgery
    - Consider this to be “post-hab”
    - Can be either a phase 1B to phase 2 transition
    - Preferably (if pre-hab and peri-op rehab worked) go to an outpatient phase 2 like rehabilitation program
“Phase 0” Pre-hab: Pre-Operative Rehabilitative Treatment Approaches

- Attempt to improve general conditioning
  - Graded exercise program
  - Preservation and restoration of ROM
- Education
  - About surgery, early mobilization
  - Prepare for procedure
- Goal is prevention of the effects of immobility prior to surgery
  - Prevention of sarcopenia
  - Prevention of decubiti
  - Prevention of deep venous thrombosis
  - Improvement of self image
  - Maintenance of appropriate nutrition
“Phase 0” Pre-hab: Pre-Operative Rehabilitative Treatment Approaches

• Attention to self care
  – Adaptive devices to decrease energy utilization
  – Energy conservation techniques

• Mobility issues
  – Use of assistive devices as needed
  – Use of wheelchair/scooter for longer distances

• LVAD/Transplant Patients
  – General conditioning program
Pre-Hab

• This is a preparatory rehab
  – Can be as brief as one or two sessions
    • Education
    • Preparation (for what will happen with surgery and to orient patient that therapy will start right away)
    • Family preparation
  – If longer can focus on gentle strengthening and endurance
    • High repetition, low weight exercises
    • Ambulation at safe levels (3-5 MET)
    • Include education
    • Pre-teach post surgical exercise regimen
• In some settings routine now
  – Sweden 90% with educational pre-op sessions
Pre-Hab Being Studied

- PREHAB study (Pre-operative Rehabilitation for reduction of Hospitalization After coronary Bypass and valvular surgery trial) trials.gov: (NCT02219815)
- Canadian study comparing standard of care (StanC) vs. StanC plus 8 weeks of exercise before elective CABG and Valve surgery.
  - Started 2015, enroll patients 65 years and older, with frailty, at least 6 week wait for surgery, not Class IV
  - Therapy is: After passing safety CPET, 8 week CR program with 2 supervised sessions a week, 4 educational sessions.
  - Outcome: 6 MWT, QOL and Surgical course (LOS, etc)
What do you need to start “pre-hab” CR?

- Dedicated team commitment
  - Cardiac rehab physicians, ICU nurses and staff, Cardiac Surgeons, Therapists
- Minimal equipment => use the existing CR program
  - Treadmill, Nustep, ergometers (arm and leg) light weights, telemetry, classroom, etc.
- Patient commitment
  - Pre operative therapy/education program attendance
  - Family commitment (usually they are very happy to learn)
- Re-imbursement
  - May pose challenges, but evidence coming from PREHAB
Phase 1: Acute

- Begins in Open Heart Recovery
- Early Mobilization
  - Get to discharge in 3-5 days!
- Telemetry monitoring at each stage of increased activity
- Continue patient education at this time
  - Ideally have had pre-surgical education as well
- Ends at discharge from hospital
- Low level field stress test prior to discharge
  - 6 MWT is very effective, also two flight of stairs test
  - Allows for patient confidence as well
Peri-operative Practical Issues

- Early Mobilization protocol should be in place
- Start with multidisciplinary team agreement:
  - Goal to start POD #0-1
  - Lighten sedation in ICU
  - Try to extubate in OR or POD #0
  - Get upright and sitting ASAP
    - Maybe even eat that evening
  - Include PT/OT/SLP
    - Swallowing and language assessment
    - Issue of vocal cord paralysis
    - Issues of Phrenic nerve injuries
Post-Operative Rehabilitative Treatment Approaches

• Graded aerobic conditioning program
  – Begin as soon as possible post-operatively
    • Use field test to assess at D/C and start of outpatient program
  – Early program at low levels of intensity
    • Sternal precautions may apply!!
  – Progress to an aerobic program by discharge
• Post discharge exercise tolerance test
  – Allows estimation of aerobic capacity => can use field test in low risk, CPET in high risk
  – Goal is aerobic exercise for 30-60 minutes/day at least three to five times per week at target intensity
Sternal Precautions

• For patients with Median Sternotomy
  – About 6 weeks for bone healing
  – Therapy staff trained to assess sternal stability
    • Cough test
    • Palpation
  – Sternal Precautions
    • Less than 2 Kg/4 lbs is usual
    • No asymmetric activities
    • Avoid sternal torsion or distraction
    • No pushing up from bed with arms, avoid excess use of abdominal muscles
• For patient with window procedures, clamshells, sternal precautions not an issue
Phase 1B

- Continued Inpatient Hospitalization for rehab
- Acute or subacute rehab settings
- Usually in patients with advanced needs
  - Often with co-morbidities
  - May also be more common in older patients
  - Two forms of 1B – **Acute** (Burke/Wakefield) and **Nursing Home** based or “subacute” rehab

- Goals
  - Safe independent function at home
  - Preparation for phase 2 rehab program
Medical Indications for Phase 1B Cardiac Rehabilitation

• Comorbidity
  – Stroke (long standing or peri-operative)
  – Amputation/Vascular Disease
  – Advanced Age
  – Severe Deconditioning

• Prolonged ICU Stay and Recovery
  – Often with pulmonary co-morbidity

• Inability to Progress to Ambulation
Medical Indications for Phase 1B Cardiac Rehabilitation

- Complex Patient Populations
  - Post Transplant
  - Complex Cardiac Surgical Patients
  - LVAD
- Severe Congestive Heart Failure
  - When on Stable Regimen
- Severe Cardiac Arrhythmias
  - Only after adequate control is achieved/AICD in place
Phase 2

- Usually 36 sessions over 12 weeks
- Can now be up to one year to complete
- Done with medical supervision
- Also known as “monitored” cardiac rehab
- Available at Blondell/New Rochelle/Burke
  – We need to build more capacity
- Insurance covered for post MI, post cardiac revascularization (CABG and PCI), transplant, HF
- Grossly underutilized nationally – only 20-30% of eligible
- Class 1A support for efficacy
Phase 3

• Most important and also with poorest use
• Known as “Maintenance”
• Can be done in an unsupervised setting
  – Some in wellness programs at original CR
  – Some in community
  – Technology can help
• NOT covered by insurance
Early Mobilization Model is best

- Sweden with 90% contact on POD #1, 93% on POD#2, 69% POD#3, 28% POD #4-5 => decrease part due to discharges
  - 1-3 sessions on POD#1
  - 1-2 sessions POD#2/3
  - 1 session POD #4/5
- Exercises: POD#1: Standing and transfer to standing >93%
  - Walking in room 28%, walking in corridor 28%
  - POD#2: walking in room 79%, walking in corridor 66%
  - POD#3: walking in corridor 93%, Stair Climbing 21%
  - POD#4: Stair Climbing 38%
- Sternal Precautions: no arms for transfers (97%)
  - No weight more than 2 kg (41%)
  - No stomach muscles to raise from supine to sitting (41%)
Early Mobilization Model is best

- Exercises: POD#1: Standing and transfer to standing >93%
  - Walking in room 28%, walking in corridor 28%
  - POD#2: walking in room 79%, walking in corridor 66%
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  - POD#4: Stair Climbing 38%
- Sternal Precautions: no arms for transfers (97%)
  - No weight more than 2 kg (41%)
  - No stomach muscles to raise from supine to sitting (41%)
What do you need to start peri-operative CR?

- Dedicated team commitment
  - Cardiac rehab physicians, ICU nurses and staff, Cardiac Surgeons, Therapists

- Minimal equipment
  - Bed cycle ergometers, leg weights (ankle sand bags), for minimally invasive/non sternotomy patients => Theraband and light arm weights, bedside cycle ergometers, portable telemetry for hall walking

- Patient commitment
  - Pre operative therapy/education helps here
  - Family commitment (usually they are very happy)
Need to Get Better Rehab for Cardiac Surgical Patients

- In general very little rehab historically, but increased now
- Growth potential
- Possible approaches to increase interest
  - Rehab can offer more access, path to Phase 1B
  - Multidisciplinary principles apply
  - Dual Disability (e.g. stroke/other issues post surgery, etc)
- But since so many patients – might set protocols
  - Special assessment for those patients out of the ordinary
Goals of Post Op Cardiac Rehabilitation

- Similar goals to all other types of rehabilitation
  - Restoration of function
  - Social function
  - Education
  - Secondary prevention
- Multidisciplinary approach
Drivers for Post Operative Cardiac Rehab

- Need to decrease acute length of stay
  - Already successful in several settings
  - Role in post surgery, early mobilization
  - Role for pre surgical education and therapy
- Decrease readmission rates
  - Especially in USA since Medicare forces <30 day re-hospitalizations to be non-reimbursed
  - Penalties exist for excess readmission
- Improved outcomes
  - Especially in post surgical patients
Complete program design:
- Role for “pre-habilitation”
  - Aim to increase strength
  - Intervene early post surgery (as early as POD 0)
    - Start in ICU
    - Maximize education and function in a short time.
  - Refer for outpatient phase 2 rehabilitation
- Applies to all procedures
  - Evidence of benefit and safety in CABG and Valve surgeries
- Includes LVAD/Transplant
Targeting Readmissions

• Pilot in high risk patients with long stay/complications
  – Old age, frail, multiple co-morbidities
  – “Frequent Flyers” with many past readmissions
• Start with outpatient screening
  – *Consider a prehab program*
  – Education essential
• Peri-op have nurse and therapist focus on patient
  – See them in ICU and early mobilization focused on decreased complications and immobility
• On d/c get enrolled in an outpatient rehab course, consider this even though not insurance covered
  – Will recoup costs on decreased readmissions/complications
Experiences with CR after Surgery

- Insurance coverage for post Cardiac Surgery CR in all areas below
  - Canada: CABG 62/100,000 in a year
    - Referral rates for CR are 51.8%
    - Overall referral rates 33%
  - Europe: High in Europe of over 86% after CABG
    - Transplant 46%, Valve Surgery 60%, AICD 14%, LVAD 11%
  - USA: CABG/Valve surgery referral rate from 40-60%
    - Post MI referral 20-40%
Experiences with CR after Surgery

- No insurance coverage for post Cardiac Surgery CR or low referral in all areas below
  - China: <1% participation, essentially no referrals
    - 4.3-7.8%
  - Japan: 4-8% participation, poor referrals
    - 5-12% in post AMI patients
- Interesting fact: Cardiac death rates declining in all of these locations EXCEPT Japan, where it is increasing
  - Similar in China – despite high volume of procedures, mortality rising
Personal Experience

• How did I get started in Early mob, post operative CR, Pulmonary rehab, and transplant?
  – Most interesting patient population as AMI and PCI patients became protocol driven and routine
  – Many complications in very ill post surgical and transplant patients
    • Intervention in Cardiac ICU on Decubiti/DVT/PE
    • Decreased from 1-2/month to 1-2/year
  – Facilitate mobilizing patients
    • Work with ICU staff, Physicians, Therapists
  – Be willing to take on complex patients with complications
    • Made the acute rehab (phase 1B) easier with better outcomes
Conclusions

- Cardiopulmonary Rehab is an important part of cardiac surgical care: Pre, Peri, and Post operatively
- Think to add rehabilitation at all stages of care
  - Pre-surgery, in-hospital, post-surgery
- Use local rehabilitation services for Posthab
  - Leverage your outpatient cardiac rehab service
- Acute Rehab for patients with need for Phase 1B
- Work with insurance providers (secondary coverage)
  => Find out or negotiate for coverage
- Must think to treat all operative cardiac patients!
Burke Now Part of Montefiore HS
Burke Integration Timeline

1/1/2016
Burke introduced into Montefiore Healthcare System.

5/25/2016
Set up metrics, established goals & identified barriers.

8/1/2016
In-service on all campuses, initiated on-site screener, and initiated monthly meetings.

10/19/2016
Discussion of expansion to Sound Shore Mount Vernon.

11/1/2016
Neurology identification pathway.

6/20/2016
Began peer to peer process, second level review process.

9/1/2016
Obtained Healthfirst contract and initiated virtual tour on patient television.

12/1/2016
Created streamline process for Lubin & Burk referrals.

1/1/2017
Burke television ads running on in-patient televisions.
Introduction of Services at MHS

• Referring to Burke just got easier due to our on-site Burke screeners.
• Burke offers a variety of services such as
  ➢ Cardiac Rehabilitation
  ➢ Pulmonary Rehabilitation
  ➢ Robotic Assisted Therapy
Burke Rehabilitation - 2016

- Total # of Referrals
- Cases Accepted
- # of Placements

Jan-16  Feb-16  Mar-16  Apr-16  May-16  Jun-16  Jul-16  Aug-16  Sep-16  Oct-16  Nov-16  Dec-16

Referral Data
Cases Accepted
# of Placements
Acute Rehab Specifics

- Wakefield: 16 beds general unit
- Burke 150 beds with several specialty units
  - 30 beds dedicated to cardiopulmonary rehab
  - With “60% Rule” means they can have up to 60 non classical diagnosis patients vs 6 at 4E
  - Experienced with transplant, LVAD, complex cardiac surgical patients
- Needs: Insurance, pre-certification, prescreen
  - We will do for you!
  - Refer them and we will do the rest