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Messages from Headquarters

Remembering Robin Cuffe

AACVPR recently lost a young and vigorous leader. Robin Cuffe died February 4th of cancer. Robin will be remembered by many, for her leadership reach was broad. As the director of the Virginia Hospital Center CR program, patients remember her for her listening skills, her smile, and her kindness. As the Virginia State Affiliate past president, her colleagues and co-workers know her for her quiet leadership and an unending passion for cardiac rehabilitation. As the chairman of the AACVPR Program Certification Committee, her reorganization to standardize the review process proved a financial and time saving process for the national organization as well as a smooth process for people seeking certification. In her personal life, Robin was an avid stamper and bird watcher, and was able to identify birds by song. She was a lifelong partner to her husband Ron and an exemplary mother to her son Matt. AACVPR will miss her professionally, for she was the quintessential example of a leader. Her friends and co-workers will miss her kind, fair, and gentle spirit. For more information CLICK HERE and to view other tributes to Robin, visit the care page opened by her husband. You may also add your own tribute for her husband and son.

Letter from the Editor: Stepping Up to the Plate

Linda K. Hall, PhD

Spring is here! I know this because baseball spring training news fills the sports section of all of the national newspapers. Who was traded, what team looks like a winner, and even predictions of future World Series teams fill opinion columns. So what has baseball got to do with cardiac and pulmonary rehab? Quite a bit, when you think about it and look at how we play the games we have to play.

In this issue of AACVPR News & Views, you will read about the "big game" that AACVPR and its regional and state societies played in Washington -- against the biggest team of all: CMS, Senators, and Representatives. A lot of preparation and pre-game training has to happen when you play in this league. Then back at home, in our own programs, we are constantly practicing and working on game strategy to:

• Increase referral rates;
• Keep patients from dropping out;
• Work with intermediaries on LCDs, NCDs, and reimbursement; and
• Struggle with our administration to stay in the game and demonstrate proven value.

Having come from a baseball-oriented family -- my grandfather played semi-pro in 1898, and a great uncle pitched for the Washington Senators in 1916 -- I know how valuable every player is. As a former program developer, manager, and director, I also know that I needed to develop a team that had the myriad of skills to keep us operational and allow us to thrive:

• Players who are willing to stay late, clean equipment, and scrub the pool floor;
• Players who love working with older people and know how to communicate with them;
• Players who won’t quit when the going gets tough or when a new job requires new skills;
• Players who are willing to "step up to the plate" in tough situations;
• Players who think out of the box to come up with new ideas -- and are willing to try them out.

Our State, Regional, and National organizations need players who are willing to be members, get active on committees, take leadership roles as presidents, secretaries, committee chairs, and do the hard work. Recently, I had just such an experience. My hospital had approached Medicaid with a disease management program for CR, PR, and DSME for 300 of their patients for one year. They liked the idea, then scheduled and cancelled several meetings. After a month of no communication, my VP said to me recently, "Great idea, good pitch, but it appears that the game was called because of lack of interest." One day later, Medicaid called, scheduled a meeting, and on February 23 we got preliminary approval.

I am reminded of Winston Churchill’s speech to the graduating class at Eaton: “Never, never, never, never give up!” So get out there and play...
President's Message: AACVPR Growing and Going Strong

Jody Heggestad Hereford, BSN, MS, FAACVPR

AACVPR has worked purposefully to increase the visibility of our organization and the awareness of the field of cardiovascular/pulmonary rehabilitation and prevention to ever-widening circles. The organization has grown significantly in stature, influence, and impact thanks to the tireless efforts of countless volunteers, both past and present. Great work continues in advancing these goals by a passionate and dedicated group of current volunteers.

AACVPR displayed an amazing show of strength March 1-2, 2007, at our 3rd Annual Day on the Hill (DOTH) initiative. The Health Policy and Reimbursement Committee did an outstanding job of securing close to 130 participants from around the country to represent our interests in Washington to key legislators and to all potential co-sponsors of our bills. The work is just beginning with DOTH, and I implore every AACVPR member to do your part even if you couldn’t join the caucus in Washington. Write to your 2 Senators and 1 Representative, asking for their co-sponsorship of S 329 and HR 552. Ask your hospital CEO, Medical Director, and other “hand-selected” patients to write to their Congressional Representatives. Find your legislators’ e-mail pages at either www.senate.gov or www.house.gov, and a template letter on the AACVPR Web site at www.aacvpr.org. Please do your part, as it is up to more than just a few of us. This is the future of our profession, our organization, and our individual programs. If you have further questions, you can call me or e-mail me; my contact information is on the AACVPR Web site. Hats off to Phil Porte, Karen Lui, June Schultz, Murray Low and countless others who made this day possible. Please see Pat Comoss’ article in this issue for more details of this important event.

Also on the Policy front, AACVPR and its partner organizations ATS, ACCP, and NAMDRC submitted a formal request to CMS for an NCD (National Coverage Determination) for pulmonary rehabilitation in November of 2006. It is important that we pursue these parallel paths (regulatory and legislative) to ensure coverage and payment. CMS posted the NCA (National Coverage Analysis) requesting public comments which concluded on January 26. The proposed Decision Memo from CMS is due on or before June 27. The final NCD is due 90 days after the decision memo is posted (as early as September 27 if the decision memo is posted June 27).

AACVPR was invited by Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to participate in the development of their “Disease Specific Care” certification for patients with Chronic Obstructive Pulmonary Disease (COPD). JCAHO began the disease specific care certifications in 2002 and is now in the process of reviewing standards and guidelines for effective patient care for individuals with COPD. The assembled group from a number of our partner organizations (including the ALA) will be asked to formulate requirements for this certification and review, and recommend clinical guidelines and outcome measures. We’re encouraged that JCAHO has looked to AACVPR as a leader in patient self-management, behavior change, and optimal care for patients with this chronic disease. We are well represented by Linda Nici, MD, and Chris Garvey, FNP, MSN, MPA.

The American College of Cardiology Foundation invited AACVPR to participate in the development of a document on cardiovascular prevention. Along with partner organizations AHA and ACCP, AACVPR is strongly represented by Gary Balady, MD, on the writing team for Clinical Competence Statement on Cardiovascular Prevention. The statement will provide standards for the minimum education, training, experience, and cognitive and clinical skills necessary for physicians to be considered competent and expert as “preventive physicians” who evaluate and treat persons deemed to be at high risk for cardiovascular disease, especially atherosclerosis, and evaluate and treat those patients with established cardiovascular diseases to prevent recurrent cardiovascular events. AACVPR is pleased to be recognized as a leader in disease prevention and health promotion for patients with cardiovascular disease.

The AACVPR/ACC/AHA Cardiac Rehabilitation Performance Measure Sets Writing Committee has completed writing the Cardiac Rehabilitation Performance Measure Sets for Referral to and Delivery of Cardiac Rehabilitation Program Services. This paper, recommended by the CMS Quality Measures and Health Assessment Group, reviews the case for including cardiac rehabilitation services in the list of quality of care indicators that CMS uses to assess the quality of care for persons with coronary heart disease. A second component of that paper identifies performance measures for cardiac rehabilitation. A draft of the paper was posted on the ACC Web site for public comment, with final approval slated for late March when it will be jointly published. Kudos to Randy Thomas as the Chair of the writing group, and thanks to other AACVPR contributors Marge King, Karen Lui, Neil Oldridge, and Ileana Piña.

A challenge shared by most cardiac and pulmonary health and rehabilitation programs is the low referral rate to our services. Studies suggest that only 18-20% of patients who would benefit are actually referred to cardiac rehabilitation services. A contributing factor is certainly the lack of a systematized approach to patient referrals to capture a larger audience. The AACVPR leadership has charged a new task force with identifying ways to enhance referrals and to develop systems for programs, large and small, rural and metropolitan. The Referral Enhancement Task Force (RETF), led by Board member Bryan Finn, plans to have something to present at the 2007 Annual Meeting in Salt Lake City.

These are but a few of the diverse projects with high impact for our organization, for our profession, and for our individual programs; there is
certainly more to come. I congratulate and heartily thank the countless volunteers for the incalculable hours they spend working to bring these projects, and our mission, to fruition.

**AACVPR 22nd Annual Meeting: October 18-21, 2007**

**Come Visit Salt Lake City!**

AACVPR invites you to attend the AACVPR 22nd Annual Meeting, October 18-21, 2007, at the Salt Palace Convention Center in Salt Lake City, Utah. The AACVPR Annual Meeting is the world’s premier educational and networking event for cardiovascular and pulmonary rehabilitation professionals.

AACVPR is dedicated to improving the quality of life for patients with cardiovascular and pulmonary diseases. Our membership of more than 3,000 prominent cardiovascular and pulmonary professionals from across the world works with more than 1.8 million patients a year. AACVPR provides cardiovascular and pulmonary rehab professionals with progressive education. Attending the Annual Meeting will give you the tools you need to continue to improve health outcomes for your patients.

The Program Committee has recruited internationally prominent scientists and clinicians to speak at the plenary and breakouts sessions, attendants can also learn from successful clinicians during small group roundtables. Top commercial representatives are on hand during the Exhibitor Showcase to give you a sneak peek at the latest products and services.

Pre-Meeting Workshops, featured speakers, and a variety of educational sessions are among the many assets of the AACVPR Annual Meeting. All presentations are selected from abstracts submitted to AACVPR and cover a wide range of topics. Courses are offered in the following educational tracks:

- Clinical Cardiology/Cardiac Rehabilitation
- Pulmonary Medicine/Pulmonary Rehabilitation
- Leadership and Innovation
- Nutrition and Behavior Change

Make plans today to reconnect with old friends, meet new associates, and learn about new techniques, health care advances, and products. The advanced program will be available at aacvpr.org in early June. If you have any questions, please do not hesitate to contact headquarters at 312/321-5146 or aacvpr@aacvpr.org.

More than 1,200 cardiovascular and rehabilitation professionals will be in Salt Lake City. Shouldn't YOU be there, too?

**2007 Call for Abstracts**

The 2007 Call for Abstracts form is available online at www.aacvpr.org/callforabstracts07.htm. Presenting at the Annual Meeting is an excellent opportunity to share success stories, best practices and exchange knowledge with fellow cardiovascular and pulmonary rehabilitation professionals. Abstracts will be accepted until April 11, 2007. Abstracts can be submitted online at http://www.aacvpr.org/secure/AnnualMeeting/2007/abstracts/. All abstracts will be reviewed via a blinded review process, to ensure fair judgment. Please note: There will be no rapid abstract submissions accepted for 2007.

We look forward to receiving your quality submissions. Please contact Lucy Seagraves at AACVPR headquarters at 312-673-5948 or lseagraves@smithbucklin.com with any questions.
Member Resources

Developing and Writing a Business Plan for Success, Part 3

G. Curt Meyer, FAACVPR

This is a third of a series of four articles related to writing a business plan. The previous article reviewed the identification of key stakeholders involved with the project, defining the desired condition when a business plan is implemented and identifying current conditions that both positively and negatively relate to your vision statement.

This article will address the specific ability to create the financial analysis necessary to understand how your proposed business plan will perform over a period of time. In order to accomplish this component of the business plan, you should have an intermediate level of understanding of Excel. If you are not familiar with Excel, it would make sense to incorporate into your team a member with a strong understanding of Excel or similar financial analysis software.

The first step of your financial analysis is to list the assumptions associated with the development of the business plan. These assumptions affect both the revenue and expense side of the operating pro forma. An example of some of the revenue assumptions include:

1. Current charges and anticipated increases over a 5-year period;
2. Current deductions revenue and anticipated changes over a 5-year period;
3. Expected volumes associated with the project; and
4. Mix of payment if different payment terms apply.

An example of some of the expense assumptions include:

1. The current fixed costs associated with the delivery of the process based on existing costs. This would include the space costs associated with the delivery of the service including all utilities, housekeeping, and maintenance.
2. The number hours associated with the delivery of the process to include assessment, class or intervention time, prep and cleanup time, and any other special services associated with the delivery of the service.
3. The number of hours that all staff is involved with the project and the hourly rate associated with their contribution.
4. Any medical direction, support service, or on-site contract service associated with the delivery of the service.
5. All supply materials necessary and included in the delivery of the service.
6. Any marketing or public relations announcement costs necessary to promote the project.

Once these issues have been identified, establish a minimal financial analysis associated with the delivery of a new product. The following Excel spreadsheet provides some of the key information that one could include in order to evaluate the delivery of a new disease management program that may or may not be "at risk":

CLICK HERE FOR NEW PROGRAM IMAGE

Once the initial assumptions are defined and completed as identified above you have the ability to create an operating pro forma over a period of time. The following format may be helpful in establishing your financial pro forma to look at for developing the project.

CLICK HERE FOR DISEASE MANAGEMENT PROGRAM

Using the above two formatted spreadsheets will provide a good understanding of the financial ramifications of your program. In those cases where you are truly in an "at risk" situation, you may want to provide a low, moderate, and high success pro forma that is related to the amount of risk you are taking in establishing the disease management intervention. Although these formats are general, you can take the idea and apply these concepts to your specific situation to tie in your actual financial assumptions, revenue, and expenses to establish the anticipated return on investment for the program.

Mark Your Calendars

Pulmonary Rehab Week -- Breathing Quality into Life -- March 18-24, 2007

Happy Pulmonary Rehab Week! The event planning possibilities are endless! Don't forget you can still order promotional items from Jim Coleman, Ltd. to help you celebrate.

PowerPoint presentations on cardiac and pulmonary rehabilitation are available on the AACVPR Web site in the "members only" section. They are directed toward physicians, third party payers, and the community. They can be individualized to promote your programs. Other resources are also available in the "members only" section, so be sure to take advantage of what is there.
Run For Your Legs... and Your Life!

Help raise awareness about vascular disease at the 2007 LaSalle Bank Chicago Marathon! One of AACVPR’s strategic partners, the Vascular Disease Foundation (VDF), is an official charity of the 2007 LaSalle Bank Chicago Marathon, to be held October 7. Runners must sign up by early May. 50 runners are needed to join “Team VDF” to help raise awareness and support for vascular disease educational programs.

If you’re a marathon runner, please join the Team VDF! If you aren’t a runner but know marathon runners, please let them know about this great opportunity to help this great cause of our partner organization. If you’d like to support the VDF team, please call 888-VDF-4INFO, visit www.vdf.org/LaSalleBankChicagoMarathon.php, or e-mail Christa.Saracco@vdf.org.

AACVPR Teleconferences

February Teleconference CD Now Available

Pulmonary Rehabilitation: A Recipe for Success
Presented by Lana Hilling, RCP
Download the CD order form: www.aacvpr.org/feb07_cdorderform.doc
Get the most current information on the implementation of patient goals and plan of care throughout each of the core components of a pulmonary rehabilitation program: patient assessment of limitations caused by chronic lung disease and clinical conditions that may affect exercise, educational needs, and psychosocial issues. The education/training component addresses medications, self-assessment techniques, breathing retraining, and energy conservation techniques. The program addresses exercises that are safe and functional for carry-over to ADLs at home, stresses the importance of a home exercise program, reviews the process to determine the need for supplemental oxygen and titration, and discusses psychosocial issues that can have an impact on the patient's ability to comply with long-term adherence. The teleconference concludes with an overview of successful program management strategies, including ways to increase referrals to your pulmonary rehabilitation program.

April Teleconference Information

Simplifying the Certification and Recertification Process
Strategies for a Successful Application
Presented by:
Bari Caplan-Bolger, MA, Co-chair of the Program Recertification Committee
Katrina Parker, MS, FAACVPR, Co-chair of the Program Recertification Committee
Gayla Oakley, RN, Chair of the Program Certification Committee

April 26 and May 3, 2006, 1-2 pm Eastern Time
(12 pm Central, 11 am Mountain, 10 am Pacific)

This two-part educational teleconference focuses on the updated AACVPR Program Certification and Recertification processes and provides practical strategies for a streamlined and successful application. The program is intended for those cardiac and pulmonary rehab programs planning to apply for Certification or Program Recertification in the coming year.

The program will highlight typical challenges encountered in the application process and identifies solutions that are applicable to both cardiac and pulmonary rehab programs. The program will focus on those components of the application that are typically problematic including: care plan, outcomes, exercise prescription, medical emergencies, staff competencies, and physician feedback. The program will provide a summary of the latest updates to the application process and standards.

Program objectives:

- Describe the updated AACVPR Program Certification and Recertification Process for Cardiac and Pulmonary Rehabilitation Programs including changes in the documentation requirements
- Highlight strategies for successful completion of program components including: care plan, outcomes, exercise prescription, medical
emergencies, staff competencies, physician feedback

- Describe and avoid typical areas of concern in unsuccessful program applications
- Provide examples of best practices in Cardiac and Pulmonary Rehabilitation Programs
- At the conclusion of this program, participants will be better prepared to successfully meet the guidelines and standards for a successful Program Certification or Recertification application.

CLICK HERE FOR THE REGISTRATION FORM

SPECIAL OFFER for AACVPR MEMBERS

Did you miss out on the following Teleconferences?

Practical Strategies for Improving Documentation of Physician Supervision in your Program - Pat Comoss, RN, BS, FAACVPR

Strategies for Increasing Patient Numbers and Referrals to your Rehab Program - G. Curt Meyer, MS, FACHE and Bryan Finn, MBA

Relating Outcomes to Quality Improvement Initiatives - Helen Graham, RN, PhD

This is only a small sampling of the many fine programs available thorough AACVPR!

AACVPR, as the gold standard for educational programs related to the care of Cardiac and Pulmonary Rehabilitation patients, is providing members with a special offer. The AACVPR teleconferences have been popular programs that provide relevant, practical solutions to your everyday challenges. In addition, the programs are designed to provide participants with resources for best practices in Cardiac and Pulmonary Rehabilitation, enhance program referrals, and provide information for the highest quality of patient care.

Many members have taken advantage of these popular teleconferences. In case you planned to register, but were unable to do so, the AACVPR is offering a very special discount to members. All CD’s of AACVPR previously presented teleconferences are 20% off, from now until May 31st. Also, when you BUY 3 CD’s at 20% off, GET THE 4th CD FREE. THIS IS A FANTASTIC OFFER! To take advantage of this promotion, please CLICK HERE for the order form.

NEW Member Benefit: Earn Complimentary CE Credit Online

AACVPR is thrilled to introduce a new online functionality so you, our dedicated members, can earn a complimentary Continuing Education credit in the convenience of your home or office! Follow this link to view the current online program, Understanding and Preventing Venous Thrombosis. Please have your membership number handy, as you will be directed to the AACVPR "members only" section of the Web site. When you’ve finished viewing the program, complete the brief evaluation at www.surveymonkey.com/s.asp?u649163144989. After completing the evaluation, AACVPR National Office will mail you a Continuing Education credit! We hope you enjoy this program and this incredibly practical format for receiving CE credit! Please contact the National Office with your comments and questions, aacvpr@aacvpr.org.

AACVPR Discussion Forum

As an AACVPR member, you are given access to the AACVPR Discussion Forum. The Forum allows you to share information with colleagues in related fields regarding many topics relating to cardiac and pulmonary rehabilitation. To access the forum, click here and login in with your AACVPR member ID and password. Once you are linked to the Discussion forum, click “Join” in the upper right-hand corner of your page. You will receive an email with your specific login information to the forum, which differs from your AACVPR member login information. Please do not hesitate to contact the National Office if you have any questions at 312-321-5146 or aacvpr@aacvpr.org.

http://www.aacvpr.org/newsletter_marapril_07.html
Make the Most of Your Career

AACVPR CareerLink has launched an exciting new feature for job seekers called My Work Style. This state-of-the-art self evaluation tool will help you to uncover your personal professional style to identify optimal work environments and potential professional obstacles. The My Work Style self-evaluation, a $100 value, is free to job seekers on AACVPR CareerLink! Visit CareerLink to learn more and get on the right career path today!

Evidence-Based Guidelines for Cardiovascular Disease Prevention In Women: 2007 Update

Updated AHA Guidelines Focus on Lifetime Risk

The American Heart Association (AHA) recently published the 2007 Guidelines for Preventing Cardiovascular Disease in Women, which includes new directions for using aspirin, hormone therapy, and vitamin and mineral supplements in heart disease and stroke prevention in women. The 2007 guidelines include a new paradigm for risk assessment based on risk factors and family history, as well as the Framingham risk score that estimates the risk of developing coronary heart disease within 10 years.

“The updated guidelines emphasizes the lifetime risk of women, not just the more short-term focus of the 2004 guidelines,” said Lori Mosca, MD, PhD, Director of Preventive Cardiology at New York-Presbyterian Hospital and chair of the AHA expert panel that wrote the guidelines. “We took a long-term view of heart disease prevention because the lifetime risk of dying of cardiovascular disease (CVD) is nearly one in three for women. This underscores the importance of healthy lifestyles in women of all ages to reduce the long-term risk of heart and blood vessel diseases.”

CVD is the largest single cause of mortality among women, accounting for 38% of all female deaths. The public health impact of CVD in women is not solely related to mortality, as advances in science and medicine allow many women to survive heart disease. In the United States, 42.1 million (36.6%) women live with CVD, and the population at risk is even larger. “Nearly all women are at risk for CVD, underscoring the importance of a heart-healthy lifestyle in everyone,” the authors wrote, aligning their recommendations with proven treatments:

• Adapt lifestyle changes to help manage blood pressure, control weight, increase physical activity, moderate/restrict alcohol, sodium, and saturated fat intake, and eat fresh fruits, vegetables, and low-fat dairy products.
• Quit smoking through counseling, nicotine replacement, or other forms of cessation therapy.
• Reduce LDL cholesterol to less than 70 mg/dL in very high-risk women with heart disease, which may require a combination of cholesterol-lowering drugs.
• Incorporate omega-3 fatty acids in the diet at least twice a week.
• Avoid relying on antioxidant supplements (such as vitamin E, C and beta-carotene) or folic acid to prevent CVD -- a change from the 2004 guidelines that did recommend it for certain high-risk women.
• Consider routine low-dose aspirin therapy for women age 65 or older regardless of CVD risk status, if benefits are likely to outweigh other risks -- a change from previous guidelines that did not recommend aspirin in lower risk or healthy women.

What is New? What are the Implications for Cardiac Rehabilitation?

Kathy Berra, MSN, NP & Nanette Wenger, MD

The American Heart Association’s 2007 Guidelines for Preventing Cardiovascular Disease in Women challenges all of us to focus on a woman’s lifetime risk rather than her short-term risk. This important document compels us to begin prevention early, focus on lifestyle, and initiate medical therapies as indicated. AACVPR, along with other important professional organizations, has endorsed these new guidelines. Implementation of these guidelines is the responsibility of all rehabilitation professionals. Educational efforts addressing assessment of risk, lifestyle change, and use of appropriate medical therapies for women should be provided as part of our community-based programs. As the
health care professionals known for our knowledge and skills in lifestyle change and risk reduction, we are ideally suited to help disseminate this important information to our patients, their families and our communities.

As in 2004, the 2007 updated guidelines highlight that favorable lifestyle changes can both decrease cardiovascular risk factors and prevent cardiovascular and coronary heart disease. They further emphasize that the intensity of the intervention should match the woman’s level of risk. Along with this new emphasis is a new risk classification for women -- either high risk, at risk, or optimal risk:

• **High Risk** is defined as a woman with established coronary heart disease, cerebrovascular disease, peripheral arterial disease, abdominal aortic aneurysm, end-stage or chronic renal disease, diabetes mellitus, or a Framingham risk score of > 20% (or at high risk based on another population-adapted global risk tool).

• **At Risk** is defined as a woman with ≥ 1 major risk factor for cardiovascular disease (CVD) including cigarette smoking, poor diet, physical inactivity, obesity (especially central adiposity) family history of premature CVD, hypertension, dyslipidemia, evidence of subclinical disease (eg, coronary calcification), poor exercise capacity on test and/or abnormal heart rate recovery after stopping exercise.

• **Optimal Risk** is defined as a woman with a Framingham global risk lower than 10%, with a healthy lifestyle, and no risk factors.

The rationale for the new classification is that prevention is important for all women, given their high average lifetime risk, with almost 1 of 2 women developing cardiovascular disease. The updates also aligned with the evidence, in that most clinical trials providing the evidence involved either high-risk women (those with known cardiovascular disease) or apparently healthy women. They reflected the increased appreciation of the limitations of the traditionally used Framingham Risk Score, with its narrow focus on 10-year risk, its lack of inclusion of family history, and an underestimation or overestimation of risk in many non-white populations. Further, subclinical disease has been documented among many women who score “low-risk” on the Framingham Risk Score.

Lifestyle interventions are the initial approach recommended for all women, with emphasis on smoking cessation, a heart-healthy eating pattern, regular physical activity, and weight management. As in 2004, a comprehensive risk reduction regimen, such as cardiovascular or stroke rehabilitation or a physician-guided home- or community-based exercise training program, is recommended, with expanded indications for such rehabilitation now including women with a recent acute coronary syndrome or coronary intervention, new-onset or chronic angina, recent cerebrovascular event, peripheral arterial disease, or current or prior symptoms of heart failure and a left ventricular ejection fraction below 40%.

As previously, optimal levels of lipids and lipoproteins are defined as an LDL-C < 100mg/dl, HDL-C > 50 mg/dl, and triglycerides < 150 mg/dl, initially encouraged through lifestyle approaches. For high-risk women, LDL-C lowering drug therapy should be initiated simultaneously with lifestyle interventions; newly noted is that LDL-C reduction to < 70 mg/dl may be reasonable in very high-risk women with CHD and may require an LDL-lowering drug combination.

Aspirin recommendations reflect results of the recently published Women’s Health Study, identifying 75 to 325 mg of aspirin daily in all high-risk women unless contraindicated, with clopidogrel substituted if aspirin intolerance is present. Eighty-one mg daily or 100 mg every other day of aspirin in women > age 65 should be considered if the blood pressure is controlled and the benefit for ischemia stroke and myocardial infarction prevention is likely to outweigh the risk of gastrointestinal bleeding and hemorrhagic stroke. Aspirin should be considered for women younger than 65 years of age when the benefit for ischemia stroke prevention is likely to outweigh the adverse effect of therapy. By contrast, the routine use of aspirin in healthy women < 65 years of age is not recommended to prevent myocardial infarction.

As in the 2004 Guidelines, menopausal hormone therapy is identified as an intervention that is not useful/effective and may be harmful; neither hormone therapy nor selective estrogen receptor modulators are recommended for the primary or secondary prevention of cardiovascular disease. Neither should antioxidant vitamin supplements such as vitamins E, C, and beta carotene be used for the primary and secondary prevention of cardiovascular disease. Again, based on recent clinical trials, folic acid with or without vitamin B6 and B12 supplementation should not be used for the primary or secondary prevention of cardiovascular disease. A simple algorithm based on risk status helps guide clinical decision-making and can be shared with women as a basis for their preventive cardiovascular care.

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**Guidelines for Prevention of CVD in Women: Clinical Recommendations**

**Lifestyle interventions**

**Cigarette smoking:** Women should not smoke and should avoid environmental tobacco smoke. Provide counseling, nicotine replacement, and other pharmacotherapy as indicated in conjunction with a behavioral program or formal smoking cessation program *(Class I, Level B).*

**Physical activity:** Women should accumulate a minimum of 30 minutes of moderate-intensity physical activity (eg, brisk walking) on most, and preferably all, days of the week *(Class I, Level B).* Women who need to lose weight or sustain weight loss should accumulate a minimum of 60 to 90 minutes of moderate-intensity physical activity (eg, brisk walking) on most, and preferably all, days of the week *(Class I, Level C).*

**Rehabilitation:** A comprehensive risk-reduction regimen, such as cardiovascular or stroke rehabilitation or a physician-guided home- or community-based exercise training program, should be recommended to women with a recent acute coronary syndrome or coronary intervention, new-onset or chronic angina, recent cerebrovascular event, peripheral arterial disease *(Class I, Level A),* or current/prior symptoms of heart failure and an LVEF <40% *(Class I, Level B).*

**Dietary intake:** Women should consume a diet rich in fruits and vegetables; choose whole-grain, high-fiber foods; consume

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http://www.aacvpr.org/newsletter_marapril_07.html
fish, especially oily fish* at least twice a week; limit intake of saturated fat to <10% of energy, and if possible to <7%, cholesterol to <300 mg/d, alcohol intake to no more than 1 drink per day,† and sodium intake to <2.3 g/d (approximately 1 tsp salt). Consumption of trans-fatty acids should be as low as possible (eg, <1% of energy) (Class I, Level B).

**Weight maintenance/reduction:** Women should maintain or lose weight through an appropriate balance of physical activity, caloric intake, and formal behavioral programs when indicated to maintain/achieve a BMI between 18.5 and 24.9 kg/m2 and a waist circumference ≤35 in (Class I, Level B).

**Omega-3 fatty acids:** As an adjunct to diet, omega-3 fatty acids in capsule form (approximately 850 to 1000 mg of EPA and DHA) may be considered in women with CHD, and higher doses (2 to 4 g) may be used for treatment of women with high triglyceride levels (Class IIb, Level B).

**Depression:** Consider screening women with CHD for depression and refer/treat when indicated (Class IIa, Level B).

### Major risk factor interventions

**Blood pressure—optimal level and lifestyle:** Encourage an optimal blood pressure of <120/80 mm Hg through lifestyle approaches such as weight control, increased physical activity, alcohol moderation, sodium restriction, and increased consumption of fresh fruits, vegetables, and low-fat dairy products (Class I, Level B).

**Blood pressure—pharmacotherapy:** Pharmacotherapy is indicated when blood pressure is ≥140/90 mm Hg or at an even lower blood pressure in the setting of chronic kidney disease or diabetes (≥130/80 mm Hg). Thiazide diuretics should be part of the drug regimen for most patients unless contraindicated or if there are compelling indications for other agents in specific vascular diseases. Initial treatment of high-risk women‡ should be with ß-blockers and/or ACE inhibitors/ARBs, with addition of other drugs such as thiazides as needed to achieve goal blood pressure (Class I, Level A).

**Lipid and lipoprotein levels—optimal levels and lifestyle:** The following levels of lipids and lipoproteins in women should be encouraged through lifestyle approaches: LDL-C <100 mg/dL, HDL-C >50 mg/dL, triglycerides <150 mg/dL, and non–HDL-C (total cholesterol minus HDL cholesterol) <130 mg/dL (Class I, Level B). If a woman is at high risk‡ or has hypercholesterolemia, intake of saturated fat should be <7% and cholesterol intake <200 mg/d) (Class I, Level B).

**Lipids—pharmacotherapy for LDL lowering, high-risk women:** Utilize LDL-C–lowering drug therapy simultaneously with lifestyle therapy in women with CHD to achieve an LDL-C <100 mg/dL (Class I, Level A) and similarly in women with other atherosclerotic CVD or diabetes mellitus or 10-year absolute risk ≥20% (Class I, Level B). A reduction to <70 mg/dL is reasonable in very-high-risk women§ with CHD and may require an LDL-lowering drug combination (Class Ila, Level B).

**Lipids—pharmacotherapy for LDL lowering, other at-risk women:** Utilize LDL-C–lowering therapy if LDL-C level is ≥130 mg/dL with lifestyle therapy and there are multiple risk factors and 10-year absolute risk 10% to 20% (Class I, Level B). Utilize LDL-C-lowering therapy if LDL-C level is ≥160 mg/dL with lifestyle therapy and multiple risk factors even if 10-year absolute risk is <10% (Class I, Level B). Utilize LDL-C–lowering therapy if LDL-C ≥190 mg/dL regardless of the presence or absence of other risk factors or CVD on lifestyle therapy (Class I, Level B).

**Lipids—pharmacotherapy for low HDL or elevated non–HDL, high-risk women:** Utilize niacin|| or fibrate therapy when HDL-C is low or non–HDL-C is elevated in high-risk women¶ after LDL-C goal is reached (Class Ila, Level B).

**Lipids—pharmacotherapy for low HDL or elevated non–HDL, other at-risk women:** Consider niacin|| or fibrate therapy when HDL-C is low or non–HDL-C is elevated after LDL-C goal is reached in women with multiple risk factors and a 10-year absolute risk 10% to 20% (Class IIb, Level B).

**Diabetes mellitus:** Lifestyle and pharmacotherapy should be used as indicated in women with diabetes (Class I, Level B) to achieve an HbA1C <7% if this can be accomplished without significant hypoglycemia (Class I, Level C).

### Preventive drug interventions

**Aspirin, high risk:** Aspirin therapy (75 to 325 mg/d)¶ should be used in high-risk‡ women unless contraindicated (Class I, Level A). If a high-risk woman is intolerant of aspirin therapy, clopidogrel should be substituted (Class I, Level B).

**Aspirin—other at-risk or healthy women:** In women ≥65 years of age, consider aspirin therapy (81 mg daily or 100 mg every other day) if blood pressure is controlled and benefit for ischemic stroke and MI prevention is likely to outweigh risk of gastrointestinal bleeding and hemorrhagic stroke (Class IIa, Level B) and in women <65 years of age when benefit for ischemic stroke prevention is likely to outweigh adverse effects of therapy (Class IIb, Level B).

**ß-Blockers:** ß-Blockers should be used indefinitely in all women after MI, acute coronary syndrome, or left ventricular dysfunction with or without heart failure symptoms, unless contraindicated (Class I, Level A).

**ACE inhibitors/ARBs:** ACE inhibitors should be used indefinitely in all women after MI and in those with clinical evidence of heart failure or an LVEF ≤40% or with diabetes mellitus (Class I, Level A). In women after MI and in those with clinical evidence of heart failure or an LVEF ≤40% or with diabetes mellitus who are intolerant of ACE inhibitors, ARBs should be used instead (Class I, Level B).

**Aldosterone blockade:** Use aldosterone blockade after MI in women who do not have significant renal dysfunction or hyperkalemia who are already receiving therapeutic doses of an ACE inhibitor and ß-blocker, have LVEF ≤40%, with symptomatic heart failure (Class I, Level B).

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*EPA, eicosapentaenoic acid; DHA, docosahexaenoic acid; CHD, coronary heart disease; ACE, angiotensin converting enzyme inhibitor; ARB, angiotensin receptor blocker.*
**OIG/COMPLIANCE ISSUES**

To Washington and Beyond: 2007 Strategies to Secure Medicare Legislation for Cardiac & Pulmonary Rehabilitation

Pat Comoss RN, BS, FAACVPR
Karen Lui RN, MS, FAACVPR

**Strategy #1. AACVPR Visits Capital Hill – AGAIN**

Although there were still a few frozen piles of snow left from the blizzard 2 weeks earlier, the weather in Washington DC on March 1-2, 2007, was pleasant and warm for that time of year. Certainly the best we’ve had in 3 years of visits around that same time. It was a corollary to the overall experience reported by many of the nearly 150 AACVPR members who participated in this year’s Day on the Hill (DOTh). The Capitol Hill atmosphere was noticeably more relaxed and receptive. Perhaps some of that was our own experience; many of this year’s participants had been there once or twice before. Or maybe it was safety in numbers; small groups went together to each congressional office; repeat participants helped and supported first-timers. Regardless, the intended message was delivered and congressional support was solicited.

**THE MESSAGE (in brief):** Senate Bill 329 & House Bill 552 would create a benefit category for Medicare coverage of both cardiac & pulmonary rehabilitation services. Today, these services are only covered indirectly as “incident to physician services” and thereby are subject to variations in regulatory interpretations. For tomorrow, Medicare beneficiaries deserve to know they can access these services when needed – that their coverage is secure. Please support this bill by signing-on as a co-sponsor.

**THE RESPONSE (to date):** Twelve Senators & 39 Representatives have signed on. A few others have promised to do so, but obviously not enough. A majority of members in both houses of Congress need to sign on before these bills can become law. That’s 51 senatorial signatures and 218 from the House of Representatives.

Clearly, our onsite sense of receptivity has yet to translate into a commitment that counts. That commitment is needed sooner than later. So…

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**Class III Interventions (Ineffective and Possibly Harmful) for CVD or MI Prevention in Women**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Menopausal therapy:</strong></td>
<td>Hormone therapy and selective estrogen receptor modulators (SERMs) should not be used for the primary or secondary prevention of CVD (Class III, Level A).</td>
</tr>
<tr>
<td><strong>Antioxidant supplements:</strong></td>
<td>Antioxidant vitamin supplements (eg, vitamin E, C, and beta carotene) should not be used for the primary or secondary prevention of CVD (Class III, Level A).</td>
</tr>
<tr>
<td><strong>Folic acid:</strong></td>
<td>Folic acid, with or without B6 and B12 supplementation, should not be used for the primary or secondary prevention of CVD (Class III, Level A).</td>
</tr>
<tr>
<td><strong>Aspirin for MI in women &lt;65 years of age:</strong></td>
<td>Routine use of aspirin in healthy women &lt;65 years of age is not recommended to prevent MI (Class III, Level B).</td>
</tr>
</tbody>
</table>

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*Angiotensin-converting enzyme; ARB, angiotensin receptor blocker; LDL-C, low-density lipoprotein cholesterol; HDL-C, high-density lipoprotein cholesterol; CVD, cardiovascular disease; and MI, myocardial infarction.

*Pregnant and lactating women should avoid eating fish potentially high in methylmercury (eg, shark, swordfish, king mackerel, or tile fish) and should eat up to 12 oz/wk of a variety of fish and shellfish low in mercury and check the Environmental Protection Agency and the US Food and Drug Administration’s Web sites for updates and local advisories about safety of local catch.

†A drink equivalent is equal to a 12-oz bottle of beer, a 5-oz glass of wine, or a 1.5-oz shot of 80-proof spirit.

‡Criteria for high risk include established CHD, cerebrovascular disease, peripheral arterial disease, abdominal aortic aneurysm, end-stage or chronic renal disease, diabetes mellitus, and 10-year Framingham risk >20%.

‡Criteria for very high risk include established CVD plus any of the following: multiple major risk factors, severe and poorly controlled risk factors, diabetes mellitus.19 Dietary supplement niacin should not be used as a substitute for prescription niacin.

¶After percutaneous intervention with stent placement or coronary artery bypass grafting within previous year and in women with noncoronary forms of CVD, use current guidelines for aspirin and clopidogrel.20
Strategy #2: Local Practitioners to Petition Congress Members – NOW!

WHY: Getting this legislation into position for being passed this year is critical to the long-term survival of cardiac & pulmonary rehab services. Yes, you’ve heard some similar statements in years past. But 3 developments on the horizon add to this year’s urgency. Only one of them (#3) was foreseen. Yet any of them could set our efforts back for years if not wipeout a legislative fix entirely.

1. The 2007 OIG Workplan
Many cardiac rehab programs remember the HHS Office of the Inspector General (OIG) from just a few years ago! This year’s activities include 2 types of investigation that could put cardiac rehab under the federal microscope again as well as subject pulmonary rehab programs to the same high level of scrutiny:

- Evaluation of “Incident to” Services
  “The purpose of this study is to evaluate the appropriateness of Medicare services performed “incident to” the professional services of physicians. We will identify services performed “incident to” physicians’ professional services and will determine the extent to which the services met Medicare standards for medical necessity, documentation, and quality of care.”

- Outpatient Department Payments
  “We will review payments to hospital outpatient departments under the hospital outpatient PPS to determine the extent to which they were made in accordance with Medicare laws and regulations. We will review the appropriateness of payments made for multiple procedures, repeat procedures, and global surgeries.”

2. CMS’ reorganization plan for Medicare administration
Already underway, the change from current contractors called Fiscal Intermediaries (FIs) to a new payment system called Medicare Administrative Contractors (MACs) could at best change the Medicare rules under which your program operates. At worst, new MACs could disallow coverage at all, especially for pulmonary rehabilitation where no National Coverage Determination (NCD) exists. Case in point, Jurisdiction 3 (Montana, Wyoming, North Dakota, South Dakota, & Utah) was the first MAC to be put in place last Fall. Although “pulmonary rehabilitation” was previously covered by another FI, the new contractor, Noridian, will not authorize Medicare coverage for services titled “Pulmonary Rehabilitation”. This appears to be semantics at first glance, but consider: Patients who have a diagnosis of COPD without an acute respiratory event or exacerbation are not eligible for “respiratory services”; patients who have been hospitalized due to acute respiratory event are allowed “respiratory services”. The MAC is totally within its right to enforce this limited interpretation of eligibility criteria since there is no national policy explaining otherwise.

3. The 2008 Presidential election
Debates about the state of healthcare can be expected. Plans for national health insurance may be proposed. Attention to such over-arching issues will certainly outweigh any time or attention to our little issue in Congress next year. After this year, another opportunity will not be available to advance our legislation until at least after the installation of the newly elected President in 2009. And then, depending on who that may be…

HOW: We need to make this legislation happen this year! You need to do 2 specific things in the next month:

- In the next 2 weeks = write letters (by fax or e-mail) to your Senators & Congress members asking Senators to support S 329 and Representatives to sign-on to HR 552. If you have already done so, do it again - this time expressing disappointment that they have not yet signed on to their respective bills. For those who have signed on, send a thank-you note (to see the list of co-sponsors to date, go to www.thomas.loc.gov, type in S 329 or HR 552 as the bill number and hit search; when the bill is displayed, click on Bill Summary & Status & then Cosponsors to see the list).

- In early April = get together with colleagues from other cardiac or pulmonary rehab programs in your area to request a meeting with your Congressperson while they are back in their home district – their spring break from Washington DC is the first 2 weeks of April. Call now to schedule that appointment! (to identify your Congressperson go to www.house.gov, type in your zip code +4; click on the name of your Congressperson which will connect you with their website where you can find further contact information). Make this meeting into a special event to promote the value of your program and the need for this legislation to sustain it. Consider bringing a few passionate & articulate patients with you to share their personal stories with the Congressperson.

Summary: In March, AACVPR went to Washington to get the ball rolling once again. In April, we’re counting on you to build momentum to carry our legislative effort forward. Meet with your Congressperson locally. Tell him/her that your program & your patients need help now! Ask them to sign-on to S 329 or HR 552. The window of opportunity is open…

Pulmonary Point of View
Gerilynn L. Connors, BS, RRT, FAACVPR
Educating the public and health care providers about COPD, its prevention, and how to evaluate lung health can be found at the NIH awareness campaign site at www.nihhlbi.nih.gov/health/public/lung/copd/index.htm.

A recently published article in the New England Journal of Medicine (2007;356:775-89 known as the TORCH Trial (Towards a Revolution in COPD Health) of Salmeterol and Fluticasone Propionate and Survival in Chronic Obstructive Pulmonary Disease is hot off the presses. The TORCH Trial had 6,112 patients in it. Of note are the causes of death in COPD reported out in the Trial as: 35% pulmonary disease, 27% cardiovascular disease, 21% cancer and 17% other. Pulmonary rehabilitation specialists must reduce the burden both personal and financial in the world as it relates to COPD. Talk with your medical director of pulmonary rehabilitation to understand the profound outcomes reported in the TORCH Trial.

JCAHO just released another white paper, 'What Did the Doctor Say? Improving Health Literacy to Protect Patient Safety, that impacts patient safety and health care quality. There is a communication gap, not between parents and teens, but between patients and caregivers as a result of literacy, language, and cultural beliefs of the patients we serve. Pulmonary rehabilitation does take the time to educate patients about their disease processes, treatments, and prevention options, so we are a solution to this “communication gap.” Pulmonary rehabilitation makes the patient a partner in their medical care. This JCAHO report gives 35 strategies for addressing health literacy and protecting patient safety such as “teach back” and development of patient self-management skills – sounds like Pulmonary Rehabilitation to me! A complete copy of The Joint Commission white paper is available at www.jointcommission.org. Happy reading!

Web Sites to Watch

Sue Keller, BSN, MPH
To view or download documents described in “Web sites to Watch,” place the mouse over the underlined text (title or URL) so that the cursor becomes a hand, then left-click the mouse. If this doesn’t work for your computer, place the mouse cursor over the underlined text, right-click your mouse to pull up a drop-down menu. Scroll down and select “Open Hyperlink” by left-clicking your mouse.

It is estimated that 70% of smokers want to quit smoking, yet only 40% make a serious attempt to quit, and only 5% succeed at an attempt. For a nice educational piece to start a smoking cessation conversation, turn to the CDC’s quit guide at http://www.cdc.gov/tobacco/quit/smconsumr.pdf. Also worth viewing is the latest Web site of the latest smoking cessation pharmaceutical aid, www.chantix.com. Chantix received expedited review from the FDA in May of 2006 and has been shown to be superior to bupropion. Chantix has its own support program that delivers e-mail prompts to encourage quitting and smoking cessation. Click “Getquick” to access the 52-week support program that delivers e-mail prompts daily for the first week, twice a week for weeks 13-24, once a week for weeks 25-52. The American Lung Association also has a freedom from smoking online program and an action plan, available at http://www.lungusa.org.

Two exciting new releases discuss women and heart disease. The AHA just released its updated Evidence-Based Guidelines for Cardiovascular Disease Prevention in Women. The update printed in the March 20, 2007, journal Circulation includes new updates on physical activity, LDL goal, and aspirin therapy. Secondly, a risk score calculator just for women is available at www.reynoldsriskscore.org. Unlike the Framingham Risk calculator, the Reynolds Risk Score includes c reactive protein as a measurement.

Also worth downloading is the ACC/AHA’s newly released Prevention of Premature Discontinuation of Dual Antiplatelet Therapy in Patients with Coronary Artery Stents: a Science Advisory (Circulation, Feb. 13, 2007).

If you have any interesting Web sites you would like to share, e-mail Sue Keller at skeller@acc.org.

JCRP Highlights

Mark A. Williams, PhD, JCRP Editor-In-Chief
An exciting development for JCRP occurred in mid-January as the Journal’s submission process went online through the new Editorial Management system. The new system provides JCRP editors, reviewers, and staff with a state-of-the art method for receiving manuscript submissions and tracking the review process, while at the same time allowing authors a standardized submission process and providing a simple procedure for their own tracking of the manuscript’s process. Access the JCRP submission site at www.editorialmanager.com/jcrp/default.asp.
We are very excited about this new capability to increase the efficiency of the peer-review process. If you have any questions or comments regarding the new Editorial Manager system, the Web site, or anything else related to the JCRP, please feel free to contact the editors directly (using the Contact Us link on the main menu) or Managing Editor Abigail Lynn (at 312-321-5146 or jcrp@smithbucklin.com).

In the March/April 2007 issue of JCRP, the lead article is a timely featured review by Roberto Benzo from the University of Pittsburgh addressing pulmonary rehabilitation in lung cancer and the opportunities for scientific research and its utility within the clinical arena.

Articles directed at Cardiac Rehabilitation include an outstanding paper by Dr. Jonathon Powell and colleagues from the National Heart, Lung, and Blood Institute and the National Institutes of Health regarding the role of cardiac rehabilitation in increasing circulating endothelial progenitor cells and intravascular nitric oxide. The article is followed by an excellent Invited Editorial by Drs. Florian Custodis and Ulrich Laufs from Homberg/Saar, Germany. The paper and its accompanying editorial provide exciting new information and perspective on the role of exercise in improving endothelial function. Additional CR articles include a very interesting study of the cardiovascular responses to water immersion in coronary patients by Schega and colleagues from Belgium and Germany, as well as a paper from Jones and associates reminding us all that just exercising in the CR clinical setting may not provide enough activity to meet the current physical activity guidelines.

This issue also features a section on the Psychosocial Aspects of CR including work from Dr. John Todaro and colleagues describing the prevalence of anxiety disorders; a paper on the role of social factors on exercise tolerance by Dr. Shawn Fraser and co-investigators (Canada); and a description and evaluation of a program of psychosocial training for CR staff by Dr. John Sharp and associates from the United Kingdom, accompanied by an Invited Editorial by Dr. James Blumenthal which discusses the roles and limitations of such an approach.

Lastly, in the area of peripheral arterial disease, a study by Galea and Bray from Canada looks at the role of perceived pain intensity as a moderator of the relationship of intention to exercise versus exercise behavior.

**Featured Review Article**
Benzo: Pulmonary rehabilitation in lung cancer: A scientific opportunity

**Cardiac Rehabilitation**
Paul et al: Endothelial progenitor cell mobilization and increased intravascular nitric oxide in patients undergoing cardiac rehabilitation
Custodis and Laufs: Physical exercise and endothelial progenitor cells
Schega et al: Cardiovascular responses during thermoneutral, head-out water immersion in patients with coronary artery disease
Jones et al: An assessment of the total amount of physical activity of patients participating in a Phase III cardiac rehabilitation program

**Psychosocial Aspects of Cardiac Rehabilitation**
Todaro et al: Prevalence of anxiety disorders in men and women with established coronary heart disease
Fraser et al: The enduring impact of social factors on exercise tolerance in men attending cardiac rehabilitation
Sharp et al: Outcome evaluation of brief psychosocial training for cardiac rehabilitation staff
Blumenthal: Psychosocial training and cardiac rehabilitation

**Peripheral Arterial Disease**
Galea and Bray: Determinants of walking exercise among individuals with intermittent claudication. Does pain play a role?

**Committee News**

**Heart and Lung Games Committee**

Laura Benson, MS, FAACVPR, Heart and Lung Games Committee Chair
The 2006 Heart and Lung Games were held at Harper College in Palatine, Illinois. We had six states participate and two international teams from Italy and Scotland. More than 180 people were in attendance as participants, spouses, coaches, staff members, volunteers, and -- of course -- our committee members. We added three new events to the games: bocce ball, 100-meter swim, and the softball throw. Despite the unusually warm Memorial Day weekend in Chicago (95 degrees), everyone had a great time and plans to attend the 2009 games.

We have a DVD available highlighting the games and will provide copies to any interested programs. Our current committee members, including a few new members, are: Dr. Stuart Sanders, Dr. Carl King, Ed Haver, Constance Thieme, Barbara Dalrymple, Heather Montilla, and Laura Benson. The committee is busy looking for our May 2009 games site. If you or someone you know would like to host the 2009 games (great PR for your program!), please send an e-mail to lbenson@harpercollege.edu.
Document Oversight Committee

Have you ever had an idea about a position paper that you think AACVPR should consider writing? If so, the AACVPR Document Oversight Committee (DOC) is just the answer for you. Members of AACVPR who have ideas for position papers and similar documents that they would like to suggest to AACVPR can do so by submitting a proposal for a possible position paper to the DOC using the forms that can be found at the following link: http://www.aacvpr.org/resources/doc_submission_form.doc

Once suggestions have been received, they go through the following process steps:
1. Review by the DOC; priority score given and recommendation made to the AACVPR Board of Directors to accept or reject the proposal.
2. AACVPR Board of Directors reviews the proposal and the DOC recommendations, and then votes to accept or reject the proposal.
3. A writing committee chair is recommended by the DOC and approved by the BOD for all approved position papers.
4. The writing committee chair recommends members of the writing committee to the DOC for approval.
5. The DOC coordinates with the writing committee chair to meet standards and deadlines for the position paper, with the final goal of getting the document published in the medical literature.

Joint papers that are developed in conjunction with other organizations also go through a similar process through the DOC.

If you have any questions regarding the DOC or related processes, feel free to contact Meredith Bono, the AACVPR Coordinator of the DOC, at mbono@smithbucklin.com or Randy Thomas, current chair of the DOC, at thomas.randal@mayo.edu.

Affiliate Society News

California Does its Part for Cardiac Rehab

Sharon Randles, BSN, RN

The California Society for Cardiac Rehabilitation (CSCR) celebrated the Silver Anniversary of their Annual Conference on March 16-17 in Berkeley, California. Where has the time gone? President-Elect Terri Nielsen and her committee did an outstanding job. Speakers included Joe Piscatella, Pat Comoss, and Kathy Berra, as well as local MDs and RNs including CSCR board member Cathy Luginbill. Our 2007-2008 board was installed and a new CSCR year has begun. Congratulations to our new members. Our membership is currently 242.

The healthcare financial climate remains difficult. We continue to see long-standing programs closing, laying off staff, and having to have other belt-tightening moves despite the new Medicare diagnoses. We made a good showing in Washington, DC, at the 3rd Annual Day on the Hill and will do our part to help pass new legislation.

Montana Develops Outcomes Program

The Montana Association of Cardiovascular and Pulmonary Rehabilitation (MACVPR) launched a region-wide outcomes project in July 2006. MACVPR, in collaboration with the Montana Cardiovascular Health Program (CVH), developed a comprehensive outcomes program. Participating programs collect and send their outcomes data to the CVH Program for analysis. The data will be aggregated, and a regional benchmark will be established. Participating programs will receive quarterly feedback, with their individual program data plotted against the regional benchmark. The first quarter’s data have been collected and will be presented at MACVPR’s annual conference in April. For more information, please contact Mike McNamara at mmcnamara@mt.gov.

Indiana Prepares for Annual Conference
Susan Bauman, BSN, BC, ISCVPR President

ISCVPR is busy putting on the final touches of our 20th Annual Conference. The conference is March 14-15 in Indianapolis. We are looking forward to topics such as the Spirit of Caregiving, Harmonica training (we even get to play!), smoking cessation, Taku-Sabo Syndrome, PAD, Children's obesity, Women's heart disease, and much more! This is a very exciting event for us, as we are celebrating 20 years of ISCVPR. Several of our Past Presidents who have moved on to other things are coming back. Amazingly, we are also honored to have two of our founding members continue to work on the ISCVPR Board - thank you to Susie Carter & RoseMary Wasielewski!

We just returned from a fabulous session at Day on the Hill. Nine Indiana delegates were able to attend and through those nine constituents we were able to see all but one of our legislators from Indiana. Just today, I received an email that Congressman Souder is signing on as a Co-Sponsor!

ISCVPR is also very excited to reach out to 160 members in 2006-07. This is our strongest membership and we look forward to reaching out to even more programs and professionals in 2007-08.

To all... be well, be strong, be hopeful.

Serving together,
Susan Bauman, BSN, BC
ISCVPR President

Maryland Prepares for 15th Annual Education Conference

Preeti Benjamin, MACVPR President

The year truly began when the Centers for Medicare Services actually expanded the diagnoses that should receive cardiac rehab! They concluded that cardiac rehabilitation is reasonable and necessary following acute myocardial infarction (AMI), coronary artery bypass graft (CABG), stable angina pectoris, heart valve repair or replacement, percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting, and heart or heart lung transplant. It had been long awaited!!

The wheels on the bus go round and round! The MACVPR sponsored a bus to encourage all its members to attend the 21st AACVPR National Conference. About fifteen of us, boarded a bus headed to the hills of Charleston, West Virginia. We all had a great time! The time spent on the bus really allowed us to get to know one another more.

We had a great turn out for our fall dinner meeting in the Heart of Little Italy Baltimore with leading specialist Dr. Myung Park on Pulmonary Hypertension. This really opened our eyes to the devastating statistics and treatment options for this population. These dinners are of vital importance because our state and membership is so vast and spread out it is difficult for all the members to attend our business meeting regularly and the dinners make it a more amiable event to network and get the latest information.

The Maryland ACVPR affiliate society is busy planning for the 15th annual full day educational conference that will be held on Tuesday, April 17, 2006. The conference committee has been working diligently on making this an event to remember and without their commitment and dedication this event could never be as successful as it has been. The topics range from the "Atrial Fibrillation and its Treatment's Including the Maze Procedure," "Congestive Heart Failure and Transplantation Criteria," to "Developing an Effective Smoking Cessation Program in Cardiovascular and Pulmonary Rehabilitation" and to "Erectile Dysfunction" all presented by experts.

We will be having a new Web site host and will be having a face-lift. In the upcoming months, please visit our Web site at www.macvpr.com. The Maryland affiliate society is looking forward in meeting the other affiliates that compromise the AACVPR to celebrate the 22nd year anniversary in beautiful Salt Lake City, Utah.

2007 Calendar of Events

| October 18 - 21 |
Salt Lake City, Utah
AACVPR 22nd Annual Meeting
For more information: www.aacvpr.org/meeting/

March 11-17
Pulmonary Rehab Week
Breathing Quality into Life

April 26
Part I of the teleconference: *Simplifying the Certification and Recertification Process: Strategies for a Successful Application*
Presented by:
Bari Caplan-Bolger, MA, Co-chair of the Program Recertification Committee
Katrina Parker, MS, FAACVPR, Co-chair of the Program Recertification Committee
Gayla Oakley, RN, Chair of the Program Certification Committee

April 23-27
University of Wisconsin-La Crosse
Starting or Updating a Comprehensive Cardiac Rehabilitation Program
For more information: John Porcari (608-785-8684 or porcari.john@uwlax.edu) or www.uwlax.edu/sah/lehp/workshops.htm

May 3
Part II of the teleconference: *Simplifying the Certification and Recertification Process: Strategies for a Successful Application*
Presented by:
Bari Caplan-Bolger, MA, Co-chair of the Program Recertification Committee
Katrina Parker, MS, FAACVPR, Co-chair of the Program Recertification Committee
Gayla Oakley, RN, Chair of the Program Certification Committee

June 13-15
Québec, Canada
5th Québec International Symposium on Cardiopulmonary Prevention/Rehabilitation
Quebec, Canada
For more information: info@symposiumrehabilitation.org or www.symposiumrehabilitation.org

September 24-28
University of Wisconsin-La Crosse
Starting or Updating a Comprehensive Cardiac Rehabilitation Program
For more information: John Porcari (608-785-8684 or porcari.john@uwlax.edu) or www.uwlax.edu/sah/lehp/workshops.htm

October 8-10
University of Wisconsin-La Crosse
Starting or Updating a Comprehensive Cardiac Rehabilitation Program
For more information: John Porcari (608-785-8684 or porcari.john@uwlax.edu) or www.uwlax.edu/sah/lehp/workshops.htm

Ongoing
Health Coach Training and Certification
Sponsored by Wellcoaches Corporation
For more information: HealthCoach@wellcoach.com or www.wellcoach.com

Continuing Education Programs on CABG, Heart Failure (three-part series), Best of Sessions 2005, Women & Heart Disease, and the newly released PAD
Offered by the American Heart Association and the American Stroke Association
For more information: www.heartcmeprograms.org

As a benefit of AACVPR Membership, take advantage of Complimentary Online CE Programs on Chronic Heart Failure: Focus on the Outpatient Setting and Health Benefits of Omega-3 Fatty Acids and Walnuts
Offered by the Preventive Cardiovascular Nurses Association
For more information: www.pcna.net

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**AACVPR National Office Contact Information**

Please continue to send your questions and comments to AACVPR News & Views via aacvpr@aacvpr.org. Don't hesitate to suggest how AACVPR News & Views can continue to provide you access to information about our profession and AACVPR.

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