If you have not renewed your membership for 2008-2009, this is your last issue of News & Views.

PRINTABLE VERSION

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Messages from Headquarters

Letter from the Editor: Staffing Cardiac and Pulmonary Rehab Programs

Linda K. Hall, PhD, FAACVPR
In this issue you will find a new column by David Herbert, J.D. an attorney who is a co-editor of the Exercise Standards and Malpractice Reporter, The Sports Medicine Standards and Malpractice Reporter and a Co-Author of Legal Aspects of Preventive, Rehabilitative and Recreational Exercise Programs.

Recently, AACVPR hosted a “Program Directors Conference” in Chicago. The attendance was over-whelming and the response to the educational offerings was excellent. Once again, the question of who does what in Cardiac Rehabilitation programs and who is licensed and are the licensed people responsible for the non-licensed people. David Herbert’s column will address issues related to exercise physiology and licensure.
As always, I have an opinion regarding staffing of Cardiac and Pulmonary Rehabilitation Programs.

Linda Hall’s first opinion:

• None of us who became professionals in this field majored in Cardiac or Pulmonary Rehabilitation – we generally came into our jobs because of interest, opportunity, and in some cases by accident.

• Each person that becomes a professional in the field brings their own special abilities, knowledge, and area of expertise and as they gain experience they hone skills and abilities to meet the program needs and the patient’s needs.

• The Medical Director and the Hospital’s Risk Management Department play a role in the hiring and education of team personnel and the emergency policies and procedures. Here is where I, as a program director, implemented a process to ensure that the program grew, developed and was operationally sound – the process was as follows: When we had a staff /job opening – I would meet with the current staff and ask the following questions.

  - What are our strengths? Who does what? Who does what the best? What are our weaknesses? What do we need in skills, abilities, and talents that we currently do not have?
  - If you had all the money in the world – what professional abilities would you want to hire to fill this position?

• Then I would HIRE TO OUR WEAKNESS! I would hire from a pool of interns and nursing students who had done a staffing in our program. We were able to watch, listen and experience their work ethic and communication skills as well as “their get up and go” without being told and finally, is this person a team player? Notice that in this process I did not say degree, license, undergraduate, graduate or anything such as that. We hired what we needed, and in the case of exercise physiologists, 95% that were hired were BS degreed.

Linda Hall’s second opinion:

• After the staff member was newly hired it was our job to make sure they got all of the education they needed to be a good team member. All new hires were required to do the following:

  - They were to read the AACVPR Guidelines for both cardiac and pulmonary rehabilitation –
  - They took a course offered by our hospital department of nursing, “Coronary Care Nursing,” with the knowledge that everyone from our program that had taken the course had gotten the highest grades for the class. (A record that has not yet been broken!)
  - They were enrolled in and required to pass the following: basic life support, first aid, and ACLS.
  - They had to do one month in each of the areas that we had in our program, CR, PR, Exercise Therapy, Water Aerobics, PT, OT, and Speech, CHF.
  - They had to go through the 9 hour Diabetes Self Management Education class.
  - They had to master the Senior Fitness Evaluation program and software.
  - Each area coordinator had to sign off on their skills and abilities with specific attention to the Core Function and Minimum Qualification areas in the AACVPR Guidelines.

Notice that I once again did not refer to license, certification, or degrees. The objective in all management – whether cardiac or pulmonary rehabilitation and secondary prevention programs- is to build a TEAM that functions as a unit for the safety, education, rehabilitation, and continued growth to independent living for all of the patients we serve. There is no “I” in team.

President’s Corner: AACVPR Provides Cutting Edge Information

Larry F. Hamm, PhD, FAACVPR
AACVPR’s Program Directors Conference

AACVPR held a very successful Program Directors’ Conference - Managing Contemporary Cardiac & Pulmonary Rehabilitation Programs: Strategies for Success - in Chicago on June 5, 2008. There were 233 persons in attendance and the discussion addressed a wide-ranging list of topics including Medicare compliance, patient safety goals, measuring program quality, and maintaining program vitality and viability.

The faculty included a stellar list of AACVPR members who possess a wealth of knowledge and experience - Pat Comoss, RN, BS, FAACVPR; Jody Hereford, RN, MS, FAACVPR; Karen Lui, RN, MS, FAACVPR; and Bonnie Sanderson, RN, PhD, FAACVPR. The feedback from those in attendance has been overwhelmingly positive. As a result, we are considering holding the conference at a few other select geographic locations in order to provide this educational content to additional AACVPR members at reasonable travel costs. In my opinion, having periodic conferences with a focused topic such as the one in Chicago is a valuable membership benefit and complements our other educational activities.

What is AACVPR doing related to the Field of Exercise Physiology?

Related to the topic of directing cardiopulmonary programs, I would like to take this opportunity to update you on issues concerning clinical exercise physiologists (CEPs). CEPs comprise the second largest membership category within AACVPR and we have worked for many years to support the advancement of CEPs in the field of cardiopulmonary rehabilitation. Recently, the AACVPR Board of Directors approved a new definition and classification system for exercise physiologists working in cardiac and pulmonary rehabilitation. This new definition accommodates the various educational qualifications and credentials of persons providing exercise physiology expertise.

A relationship has existed for many years between AACVPR and the American College of Sports Medicine (ACSM) related to the area of certifications. As you know, AACVPR certification efforts have always focused on certifying cardiac and pulmonary rehabilitation programs while ACSM has a long history of providing individual professional certifications. ACSM clinical credentials currently include Clinical Exercise Specialist® (previously Exercise Specialist®) and Registered Clinical Exercise Physiologist®.

Since 2004, AACVPR has dedicated financial resources to providing AACVPR representation on the CoAES (Committee on the Accreditation of
the Exercise Sciences). The CoAES is under the auspices of the Commission on Accreditation of Allied Health Education Programs and is primarily responsible for establishing standards and guidelines for academic programs involved with the preparation of students seeking employment in the health, fitness, and exercise industry. Educational curricula for students preparing to be CEPs are included in the CoAES, but CoAES activities are not limited exclusively to the clinical field.

Recently the ACSM has established a new affiliate society – the Clinical Exercise Physiology Association (CEPA). AACVPR congratulates CEPA on this achievement and we will continue to work closely with CEPA on issues that are important to CEPs. AACVPR has an ex-officio member on the CEPA Board to help facilitate the flow of information between the two organizations. For the purposes of continuity, Steven Lichtman, EdD, FAACVPR, a member of the AACVPR Board of Directors, is our representative on both the CoAES and the CEPA Board.

AACVPR continues to be dedicated to representing the interests of CEPs with either a baccalaureate or graduate degree who work in cardiac or pulmonary rehabilitation. We realize that CEPs have been and continue to be an important part of the cardiac and pulmonary rehabilitation multidisciplinary team and we are dedicated to working towards solutions addressing the long-standing lack of regulation of CEPs.

Announcing the AACVPR 2008-2009 Board of Directors

The AACVPR Nominating Committee is pleased to present the following slate of candidates for the 2008-2009 AACVPR Board of Directors:

**President-Elect:**
Randal Thomas, MD, MS, FAACVPR

**Secretary:**
Steven W. Lichtman, EdD, FAACVPR

**Directors:**
Tom Draper, MBA, FAACVPR
Bonnie Sanderson, PhD, RN, FAACVPR
Barbara Fagan, MS, FAACVPR

Continuing to serve on the AACVPR Board are the following incumbents:

**President:**
Murray Low, Ed D, FAACVPR

**Immediate Past President:**
Larry Hamm, PhD, FAACVPR

**Treasurer:**
G. Curt Meyer, MS, FAACVPR

**Directors:**
Debra Lund, MS, FAACVPR
Richard Josephson, MD, MS, FAACVPR
Mark Senn, PhD, FAACVPR

**Director-At-Large:**
Chris Garvey, FNP, MSN, MPA, AE-C, FAACVPR

In addition, the AACVPR Executive Director, Marie A. Bass, MS, CAE serves on the Board, ex-officio, without vote. A summary of each candidate's biographical information, contributions to AACVPR, and a brief personal statement can be viewed by clicking [HERE](#).

AACVPR members are asked to ratify the slate of candidates and submit their vote by **August 1, 2008**. Members are also invited to write in the names of alternative candidates. **All ballots** must be received at the AACVPR National Office no later than midnight, August 1st.

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**AACVPR Conferences**

**AACVPR 2008 Annual Meeting - September 18–21, 2008**

Online Registration for the AACVPR 23rd Annual Meeting in Indianapolis, Indiana is now live! The Annual Meeting will be held September 18–21, 2008, at the Indianapolis Convention Center. Register online by **August 18, 2008**, to take advantage of registration fee discounts.

The AACVPR Annual Meeting is a four-day event for healthcare practitioners to exchange knowledge regarding cardiovascular and pulmonary rehabilitation from the nation’s leading experts. Take time to improve clinical practice, promote scientific inquiry and advance your education while connecting with colleagues. The meeting will feature state-of-the-art presentations to keep you on the cutting edge of the cardiovascular and pulmonary field. Highlights include:

**The “tracks” are back! Focus your learning in one of four tracks, or “mix and match”**
To better help you choose sessions to meet your particular needs, the AACVPR Program Planning Committee has developed the following series of four program tracks. You may decide to attend sessions in one track only, or “mix and match,” the choice is yours!
Keynote Lectures by some of the leaders in the field:

“ACSM/ AHA Physical Activity Recommendations: Adults and Older Adults”  
Professor Steven Blair

“Does Sleep Apnea Kill You? Can Treatment Save You?”  
Barbara Phillips, MD, MSPH

“Power, Peace, Perseverance: Lessons Learned from Mother Teresa”  
Anne Ryder

AACVPR Annual Meeting Exhibit Showcase  
Thursday, September 18 – Saturday, September 20
Learn about the newest products and services available from more than 40 exhibiting companies!

ANCC Review Course

Back by popular demand, the ANCC Review Course will be part of the AACVPR Annual Meeting again this year.  
This will be held on September 17, one day prior to the Annual Meeting.  
This review seminar offers practical applications, valuable study tips, and solid strategies for preparing for the certification exam.  
Core concentration areas pertaining to specialty areas are:

- Cardiac and Vascular Risk
- Risk Reduction
- Hypertension Management
- Dyslipidemia Management
- Pathophysiologic Processes
- Cardiac and Vascular Assessment
- Cardiac and Vascular Disease Manifestations
- Invasive Management of Cardiac and Vascular Disease
- Cardiovascular Pharmacology
- Special Situations
- Psychosocial Aspects

Up to 7.5 Continuing Education Hours will be awarded at the conclusion of this seminar, and a content slide handbook is included with this seminar.  
The cost is $175 for co-host staff or $190 for general registration.  
Register by September 7, 2008.

Member Resources

AACVPR Membership Dues Renewal

The 2008-09 membership year began July 1, 2008.  
If you have not renewed your membership for 2008-2009, this is your last issue of News & Views.  
Renew your AACVPR membership today for uninterrupted continuation of your benefits.  
As the profession continues to evolve and change, AACVPR will be here for all of us.  
Renew your membership now to continue receiving the great membership benefits and reaffirm your commitment to your profession.  
Member benefits include:

- News & Views – packed with useful information
- Timely Reimbursement Updates – with the latest critical information
- AACVPR Discussion Forum – your networking link to over 3000 members
- "Members Only" section of the Web site – your resource for answers
- JCRP – AACVPR’s popular and well-respected journal
- AACVPR printed Membership and Program Directory
- Member discounts for all AACVPR Programs and Products
- AACVPR Career Link – for online career opportunities
- Research-based resources
- AACVPR Advocacy initiative – remain an active contributor
- 2009 Day on the Hill – all members are invited to participate – earn CE, too
- Complimentary online programs for CE – for members only
- Referral Enhancement Tool Kit – coming this year for members ONLY
… And many more!
What is the Legal Authority of Clinical Exercise Physiologists to Provide Patient Services in Rehabilitation Programs?

David L. Herbert, J.D.†

Clinical exercise physiologists (CEPs), among others, have been actively involved in cardiac and pulmonary rehabilitation activities for many years. During that time, they have provided a variety of services to patients. These services have included exercise testing, prescription, training, and physical activity/lifestyle counseling. Primarily, they have worked as part of a team with other providers in efforts to provide relevant and needed services.

In 1985, the AACVPR was formed largely to improve effectiveness of rehabilitation for post-coronary patients and to promote professional development of allied health professionals engaged in delivery of such services to patients. In 1990, AACVPR published its first set of “standards and guidelines for use in the operation of cardiovascular rehabilitation programs”, Hall, “National Standards and Guidelines Developed by the AACVPR, The Exercise Standards and Malpractice Reporter 4(6):81, 1990. That publication is now in its fourth edition. The guidelines emphasize a team approach for the delivery of relevant services by a medical director, a program director who may be an exercise physiologist or other team member, a physical therapist and/or a registered nurse, all with defined certification, training and experience, as well as others including diabeticians, psychologists, massage therapists, and pharmacists.

CEPs are not licensed as health care providers in any state except Louisiana. While efforts have been put forth in other states to secure licensure for such professionals, most recently in Massachusetts, no other state has licensed CEPs to date. In the absence of licensure, some contend that the profession has found itself in a state of limbo, unable to obtain a practice base without functioning under the auspices and authority of a licensed health care provider. In Louisiana, CEPs practice under the “direction, approval and supervision of a licensed physician”. Louisiana Clinical Exercise Physiologists Licensing Act, [hereinafter Act] R.S. 37:3422(2). Louisiana CEPs are limited to the provision of services defined by reference to the formulation, development, and implementation of exercise protocols and programs. The administration of graded exercise tests and the provision of patient education regarding such exercise programs and testing in a cardio pulmonary rehabilitation program of patients with “deficiencies of the cardiovascular system, diabetes, lipid disorders, hypertension, cancer, chronic obstructive pulmonary disease, arthritis, renal disease, organ transplant, peripheral vascular disease and obesity.” Act, R.S. 37:3422(2). Practicing as a CEP, independent of a licensed physician, was not sanctioned by the Louisiana law.

CEPs need to understand that the practice of any healthcare discipline is established by state legislative bodies which determine who will be licensed and authorized to provide defined services. There are fifty different state healthcare provider licensing systems in place in the United States, each with different nuances, specifications, and requirements for practice. At the top of each state licensing scheme are physicians whose scopes of practice are the broadest of all health care providers. Within this system, other providers are authorized to provide certain health care services but on a more restrictive basis than physicians.

Due to the lack of state licensing for CEPs in all states but Louisiana, efforts are sometimes put forth for such professionals to become licensed in one state or another as healthcare providers. These efforts are based upon the justification to improve and heighten the standards of conduct for such professionals, to make them clearly defined in state healthcare provider licensing acts as authorized health care service providers and to help them secure an independent basis for third-party and governmental reimbursement for the provision of patient services. Not the least of these justifications is the need to secure clear state statutory authorization to provide specific services.

Without clear state licensing authority, CEPs now provide patient services in what some may call a “gray area”. On occasion, what these professionals can and cannot do has caused considerable concern. In the absence of state licensure for these professionals, CEPs have carved out a practice niche for themselves in rehabilitation services through the development of standards and guidelines, professional society defined knowledge bases and certification programs. While these developments have assisted in allowing CEPs to have at least a professionally defined scope of practice, the absence of legal authority for their involvement in relevant services has not addressed all the concerns.

We shall begin to explore these concerns in future issues of News and Views in the month’s ahead and in the meantime solicit reader responses to help narrow the scope of concern. The first issue to be explored will address the exercise physiologist’s role in Advanced Cardiac Life Support (ACLS) by examining AACVPR, AHA, and ACSM guidelines on this function and the legal parameters of what such professionals can and cannot do under state health care provider enactments.

† The article discusses legal and other issues associated with cardiac/pulmonary rehabilitation programs. The author is not providing legal advice or addressing individual concerns but is only presenting information for reader consideration. If legal advice is needed, the services of a

IMPORTANT: If you are renewing your membership online, you must login to the member’s only section. Please DO NOT create a new profile and join as a new member if your login does not work. Contact the AACVPR National Office at (312) 321-5146 if you need assistance.

Renew your membership in two easy ways:
1. For credit card payments, login to the Members Only Section and click “Pay My Dues” under your name or fax your payment to (312) 673-6924.

2. Download the Membership Application and mail it with a check to:
AACVPR National Headquarters
401 N. Michigan Ave, Suite 2200 Chicago, IL 60611

Please allow several weeks for processing applications that are faxed or mailed in.
AACVPR Expands it’s International Presence

Larry F. Hamm, PhD, FAACVPR, AACVPR President
The past several months have presented AACVPR with extraordinary opportunities to increase our visibility at international meetings related to cardiac rehabilitation. As President, I was invited to make presentations concerning AACVPR and cardiac rehabilitation at four international venues.

It was interesting to observe that many of the cardiac rehabilitation questions and issues are universal. Examples are: the most efficient and effective program delivery model; program costs; cost effectiveness; and interest in AACVPR structure, program certification, and advocacy. These opportunities have provided unique opportunities to have personal discussions with leaders of foreign professional societies, are also related to one of the objectives in our 2008 Strategic Plan dealing with increasing collaboration with international cardiac rehabilitation and cardiovascular disease organizations, and support the activities of the new International Subcommittee of the Professional Liaisons Committee.

Over the past several years, our increased collaboration with related national professional societies in the United States has resulted in increased professional activity and increased visibility for AACVPR. Continuing to develop opportunities with foreign associations will hopefully have similar results at the international level.

Following is short summary of these international activities.

- In December, I participated in a meeting sponsored by the Estonian Society of Cardiology in Tallinn, Estonia. About 100 cardiologists from around Estonia were in attendance and we discussed evidence-based cardiac rehabilitation and the typical program model used in the United States.

- In April, Dr. Peter Brubaker and I were invited to speak at the Cardiac Rehabilitation Workshop which was part of the 13th Angioplasty Summit – TCT Asia Pacific 2008 in Seoul, South Korea. Overall attendance at the Summit was approximately 3,000 and this was the first year that the organizers dedicated one afternoon to cardiac rehabilitation. The cardiac rehabilitation session drew more than 300 attendees. In addition to the Korean presenters, Dr. Brubaker provided an excellent overview of heart failure and I gave an AACVPR overview with emphasis on organizational structure and program certification activities. Both of us also presented cardiac rehabilitation case studies.

- The European Association for Cardiovascular Prevention and Rehabilitation (EACVPR) and AACVPR have a speaker exchange in place whereby the current president of each organization is invited to give a presentation at the other organization’s annual meeting. The EACPR Euro Prevent 2008 meeting took place in Paris in early May and there were 1,200 attendees from European countries and beyond. The topic of my presentation was a challenging one: “Cardiac Rehabilitation – Two Perspectives of the Future: An American View”. Professor David Wood, President of EACVPR discussed the European perspective of the future.

- The final opportunity was a trip to Polanica Zdrój, Poland later in May for their 3rd Cardiac Rehabilitation Symposium. There were 80 physicians from around Poland in attendance and my talk focused on the evidence and core components for cardiac rehabilitation and challenges for the future. A lively discussion followed that included the president-elect and chairperson of the cardiac rehabilitation section of the Polish Society of Cardiology.

BLUE Distinction Centers for Cardiac Care and AACVPR Program Certification

Marie A. Bass, MS, CAE
Is your facility currently seeking recognition as a BLUE Distinction Center for Cardiac Care? If your Cardiac Rehabilitation facility has been recognized as an AACVPR Certified Program, you are already on your way to earning status as a center of BLUE Distinction. The questionnaire for the application for BLUE Distinction Center recognizes AACVPR Certified Programs as those cardiac rehab programs that have been peer reviewed for compliance with nationally published guidelines and standards.

Occasionally members ask: Why is AACVPR Program Certification important? Certification provides an opportunity for program directors/managers to review their processes and compare their programs to current standards and guidelines. There are a number of other great reasons that program managers should consider applying for AACVPR Program Certification, including:

- AACVPR Program Certification is recognized by a growing number of insurance companies and contractors.
- AACVPR Certified Programs are listed on the American Heart Association patient resources Web site.
- Program Certification provides an objective assessment of adherence to updated clinical standards and guidelines.
- It requires a systematic approach to clinical care.
- It promotes a culture of quality patient care in the Cardiac and Pulmonary Rehabilitation facilities.
- It provides patients with a benchmark to compare CR and PR programs for quality care.
- It provides CR and PR program leaders with benchmarks and best practice guidelines for quality standards.

If your program is not yet designated as an AACVPR Certified Program, consider applying for program certification. New simplified and updated applications will be available on the AACVPR Web site on September 1, 2008. The deadline for Program Certification applications is December 1, 2008.
Health and Wellness Coaching: A New Model for Improving Program Effectiveness
Gloria Silverio, MA and Blaine T. Wilson, MS
The new role of the healthcare provider is to guide patients to become confident and masterful in making healthy decisions and choices everyday. Many interactions between healthcare professionals and patients, including the brief interactions in the rehabilitation setting, can do more to improve patient mastery. Many professionals continue to rely on an expert approach -telling people what to do which unintentionally denies them of a sense of being in control. Coaching psychology integrates many evidence-based theories and tools to provide the foundation for growth-promoting coaching partnerships. By delivering powerful questions and reflections, rather than mainly providing answers, coaches ask clients to do the thinking work that is vital to positive change. Order at: https://www.aacvpr.org/education/april08cdorderform.doc

Prices, Payors and Programs: Expanding Your Clinical Programs by Partnering with Insurers and Employers
Presented by Jean Einerson, MS, FAACVPR, Chair HP&R Business Committee, Joli Studley, MS, & Walt Horner, MS
U.S. health care costs doubled from 1990 to 2001 and are expected to double again by 2012. Employers and insurers are looking to hold health care costs down. Since most of the costs are due to chronic diseases, cardiac and pulmonary rehabilitation professionals are in a position to offer unique opportunities to provide preventive services for employers and insurers. This presentation considers the top five ways clinical programs can provide outreach services to an insurance company, discusses survey results the AACVPR Health Policy & Reimbursement Committee, provides an overview of how clinical programs have expanded services outside the traditional reimbursement model, and looks at partnering with an insurance company to impact programs, cardiac rehabilitation, community service, local competition, and bottom line. Order at: www.aacvpr.org/education/april08cdorderform.doc

Understanding & Utilizing Long Term Oxygen Therapy
Presented by Trina M. Limberg, BS, RRT, FAARC, FAACVPR
This teleconference presentation is sponsored by an educational grant from Nonin Medical & Respironics
Evidence-based guidelines and position papers are examined for a historical look at oxygen therapy as a treatment to improve survival in chronic lung disease patients. There will be a review of the various resources at hand for treating the ambulatory patient with exertional hypoxemia. The importance of repeated assessments with exertion and delivery devices will be stressed and the need for reproducible standards for conducting oxygen assessment will be addressed. The presentation will focus on how pulmonary rehabilitation professionals can lend their skills in the assessment, putting forth recommendations for appropriate equipment and educating patients as well as physicians in long-term oxygen therapy use. Order at: http://www.aacvpr.org/education/march08cdorderform.doc

Dietary Approaches to Prevention & Treatment of Hypertension
Presented By: Lawrence Appel, MD, MPH
Dr. Appel presents the Dietary Approaches to Stop Hypertension, known as The DASH diet. The DASH diet is based on strongly supported evidence that multiple dietary and lifestyle factors affect blood pressure, including sodium consumption, weight loss, and increased potassium intake. This presentation outlines tactics to help healthcare professionals develop and implement effective clinical strategies in dietary changes and in guiding patients to a healthier lifestyle. Order at: http://www.aacvpr.org/education/fEB08cdorderform.doc

Cardiac Rehabilitation Performance Measures: Practical Strategies for Using Them in YOUR Program
Presented by Marjorie King, MD, FACC, FAACVPR, Karen Lui, RN, MS, FAACVPR, & Randal Thomas, MD
Prepare for the future now by recognizing why performance measures are important to your program. This program was developed to help individual program managers/directors understand the importance of the new performance measures for Cardiac Rehabilitation and to utilize the new recommendations to enhance referrals to CR programs. The Cardiac Rehabilitation Performance Measures were developed to address the underutilization of cardiac rehab services by hospitals and physicians. The implementation of these measures can impact referrals into your program and assist you in capturing relevant outcomes data. This presentation will provide you with specific tools and techniques to enhance your phase II CR program. The presentation focuses on 4 main questions about the newly released AACVPR/ACC/AHA Cardiac Rehabilitation/Secondary Prevention Performance Measure Sets. Order at: http://www.aacvpr.org/education/jan08cdorderform.doc

Motivating Cardiac and Pulmonary Patients to Enjoy a Taste for Living
Presented by: Alisa C. Krizan, MS, RD, LD
This presentation provides the most current information on the Mediterranean Diet, its key holistic components, and ways to enhance our cardiac and pulmonary patients to enjoy and utilize this healthy, natural diet. This research-based presentation will show that people living in the Mediterranean region are among the healthiest in the world. The research also indicates that these individuals demonstrate low rates of chronic diseases, such as cardiac and pulmonary disease, as well as cancer. Daily recommendations will be made to include, not only a variety of healthy foods, but to include other components of healthy lifestyles, such as physical activity. Consumption of a variety of plant sources, including fruits, vegetables, potatoes, whole grains and breads, beans, nuts, and seeds, will be discussed in detail. The teleconference will conclude with the "take-away" message focusing on the ease of making simple changes in the cardiac and pulmonary diet to improve the individual's overall health by utilizing plant based foods and minimizing processed foods. Order at http://www.aacvpr.org/Sept07cdorderform.doc

Resistance Training: Rationale, Safety, Contraindications, and Prescriptive Guidelines
Presented by: Barry Franklin, PhD, FAACVPR
This presentation will focus on the role of resistance training in persons with and without cardiovascular disease, with specific reference to health and fitness benefits, rationale, relevant physiologic considerations, and safety. Participation criteria (i.e., applications in varied patient subsets) and prescriptive guidelines will also be discussed, along with recent provocative data showing that muscular strength is inversely associated with all-cause mortality and the prevalence of metabolic syndrome, independent of cardio-respiratory fitness levels. Download the order form at: http://www.aacvpr.org/june07cdorderform.doc

Expanding Your Program: Integrating Disease Management into Traditional Cardiac Rehabilitation Programs
Presented by: Mark Senn, PhD, FAACVPR
Are you looking for ways to expand your Cardiac Rehab program? This teleconference is presented by Mark Senn, PhD, whose program was honored with the 2006 AACVPR Innovation Award. The presentation is designed to offer practical strategies to integrate a disease management model into a traditional cardiac rehabilitation program. At the conclusion of this presentation, participants will be able to identify the importance of a disease management model and its value to a traditional cardiac rehabilitation program. Attendees will become familiar with a model disease management program and will have the necessary tools to implement such a program within their own facilities. Download the order form at: http://www.aacvpr.org/may07cdorderform.doc.

Inside the Industry

The Advocacy Angle: Being an Advocate for Your Rehabilitation Program

Karen Lui, RN, MS, FAACVPR

A frequent message heard from AACVPR leaders to members is the importance of making your hospital administrators, billing office, physicians, and other decision-makers familiar with the services your program provides. Make yourself known as the resource to all and they will come to you with questions, challenges, and ideas for growth.

How do you sell yourself as that resource? Knowledge is the key. You are a member of the national network of AACVPR for that reason. Here are three examples of why you should wear the "I am the expert on cardiopulmonary rehabilitation" hat in your institution.

This week a nurse who primarily does cardiac rehabilitation was told by her administration that the hospital was considering closing the pulmonary rehab program (the usual administrative reasons based on ignorance of not enough revenue, reimbursement fears, questionable patient benefit, etc). She was able to immediately provide a powerful response in the form of a packet of information that included the forthcoming legislative mandate for Medicare coverage and the most recent scientific evidence publications supporting pulmonary rehabilitation merely by making one phone call to an AACVPR resource person and utilizing the website.

A cardiac rehabilitation program in Minnesota was recently having difficulty billing for multiple cardiac rehab sessions on same day despite the new CMS regulation that allows for such delivery of CR services. By using the AACVPR MAC Committee Communication Tree and placing one call to the MAC Committee Chair, this program had written clarification from the local Medicare contractor Medical Director within one day on how to handle this billing "glitch".

As an AACVPR member, you have access to the most up-to-date information on the MAC (Medicare Administrative Contractor) process currently transitioning in your state via your MAC Committee Communication Tree. Connect with this resource. The information you receive will directly affect the operation of your rehab program. Share that knowledge with your supervisors, billing dept, and administration and you will be the resource they look to!

Disease Management: How about You?

Mark Senn, PhD, FAACVPR, Chair

The question is this: where are you in managing the chronic disease risk of your patients? I know this is a tough question to ask and an even tougher question to answer, but I hope that you will ask yourself this question and look closely at the answer. In the last newsletter I shared with you a concept and challenge for disease management in cardiopulmonary rehabilitation. My goal with this communication is to have you begin the process of looking closely at your outcome data. Ultimately this is where the rubber meets the road. When you look at the outcome data for your program what do you see?

The first challenge is to evaluate the indicators you are using. There are numerous outcome measures traditionally used in the cardiopulmonary rehabilitation setting. Be sure that the indicators you emphasize are the ones that are most strongly linked to the reduction of risk for progression of cardiovascular disease. The Performance Measures for Cardiac Rehabilitation1 provide a straightforward guideline to making sure you are focusing on the outcomes that will be most meaningful to your patients, your physicians, and your payors.

The performance measures precisely list the measures that impact secondary prevention; tobacco use, blood pressure control, lipid control, physical activity habits, weight management, presence or absence of DM or IFG (fasting blood glucose – 110-125 mg/dl), presence or absence of depression, exercise capacity, and use of preventive medications. Any cardiac rehabilitation program hanging out their single as a "secondary prevention program" must assess these measures either directly or via acquisition of previously completed and acceptable measures by other clinicians. It is equally important that initial measures found to be suboptimal are reassessed at or immediately post exiting the program (again either directly by the rehabilitation program or via acquisition or results from other practitioners). Only by this standard can we determine the impact of our programs, their interventions and thereby continually improve our contribution to the improved health of the patient and our contributing value to the healthcare system.

Introducing the New Clinical Exercise Association

Aaron W. Harding, M.S., RCEP, FAACVPR
On May 1st, the American College of Sports Medicine (ACSM) took a huge step toward advancing the profession of clinical exercise physiology by introducing the Clinical Exercise Physiology Association (CEPA). As the first affiliate society of ACSM, CEPA is autonomous but operates with administrative support from ACSM.

The ultimate launch of CEPA was the result of a lot of time and hard work over the past year by a group of dedicated clinical exercise physiologists, including many AACVPR members. A representative of both AACVPR and ACSM sit on the CEPA executive board as ex-officio members.

"From its very inception, AACVPR has led the advocacy efforts for clinical exercise physiologists as integral members of a multidisciplinary team in the clinical setting of Cardiac & Pulmonary Rehabilitation programs," says AACVPR President-Elect, Murray Low, EdD. "AACVPR now welcomes CEPA as a new advocacy ally for the profession of clinical exercise physiology" For more information visit the CEPA Web site at [www.acsm-cepa.org](http://www.acsm-cepa.org).

The American Academy of Medical Administrators (ACCA) Session Abstracts due July 15th.

Present a session at the March 2009 ACCA Conference in Orlando, FL. Access the [ACCA 2009 Call for Abstracts Form online](#). Submit by email by July 15.

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**Pulmonary Point of View**

### Oxygen Devices in Airlines: New Department of Transportation Regulations

**New Department of Transportation Regulations for Passengers Using Oxygen Devices on Airplanes**

On May 13, 2008, the U.S. Department of Transportation (DOT) published a final rule regarding traveling on airlines with devices, including ventilators, respirators, continuous positive pressure (CPAP) machines and portable oxygen concentrators (POC). The rule, which has wide sweeping implications for travelers with lung diseases who require oxygen, will go into effect on [May 13, 2009](#).

**Requirements**

U.S. airlines worldwide and foreign airlines on flights that depart or arrive in the U.S. will be required to allow travelers who use POCS to carry them on board for use during the flight as long as devices have been tested and labeled as meeting Federal Airline Administration (FAA) requirements and the device can be stowed safely.

**Communicating the Need to Use a Respiratory Assistive Device**

Airlines are required to inform passengers, through the reservation process, who express a desire to use a device, including a POC, the following information to help travelers prepare for their trip:

- Any weight or size limits for devices to ensure they can be accommodated in the aircraft cabin.
- Any labeling requirements to permit use on board (In a future rule, the FAA may require device manufacturers to label devices if they are FAA approved and therefore permitted on aircrafts).
- Any requirements for advance check-in. Airlines may require travelers to notify the airline up to 48 hours in advance if the traveler wishes to use a device on a domestic or international flight.
- Airlines may also require one hour advance check-in for flights. However, airlines may not deny boarding on a connecting flight because of this additional hour requirement.
- Any requirements about contacting the airline regarding the maximum flight duration and battery capacity requirements, and
- The airline may require travelers to provide a statement from a physician (medical certificate) stating that the passenger requires the use of a POC under this rule. Other devices may require a physician statement only if there is reasonable doubt that the passenger can complete the flight safely without requiring extraordinary medical assistance during the flight.

In the event the travel has connecting or codesharing flights, airlines must also inform travelers of any requirements of the other airlines or direct the passenger to contact that airline directly.

**Batteries**

The airlines may require travelers to bring an “adequate number” of fully charged batteries required to operate their POC or other device for at least 150 percent of the expected maximum flight duration. That time period is defined as the total duration of the flight from the departure gate to arrival gate, as well as in additional time for wind and weather conditions, traffic delays, instrument approach and possible missed approach at destination, as well as any other conditions that may delay arrival at the gate. The only exception to this requirement is if travelers contract directly with the airline to have the airline supply oxygen during the flight. If travelers contract directly with the airline, they are not required to have batteries that can operate their device for 150 percent of the time required. For more information regarding battery requirements, please visit the DOT’s website at [http://safetravel.dot.gov](http://safetravel.dot.gov).

Airlines are not required to allow travelers to plug in their devices nor are airlines required to provide priority seating. However, the Department of Transportation encourages the airlines to permit passengers to plug in their devices where the service is reliable. Airlines may deny boarding on the basis of safety if the passenger does not have the requisite number of batteries or the batteries are not
properly packaged. If this does occur, the airline must provide the individual traveler a written statement on why the airline refused to provide transportation to the traveler within 10 days of the incident.

**Airline Supplied Oxygen**
The Department of Transportation has not yet decided whether to require airlines to provide free in-flight medical oxygen to passengers. The Department instead announced it will soon seek additional comments about the cost of carrier supplied oxygen. The American Lung Association will submit comments on behalf of travelers requiring oxygen.

For more information: [http://safetravel.dot.gov/](http://safetravel.dot.gov/)

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**JCRP Highlights**

**Mark A. Williams, PhD, FAACVPR, JCRP Editor-In-Chief**

- This issue is highlighted by a Featured Review entitled “Arterial stiffness: A modifiable cardiovascular risk factor?” and the abstracts from the ACCP Annual meeting. Manuscripts from throughout the world including Australia, Japan, Canada, Brazil, and the United States, are presented.

**INvITED REVIEW**

**CARDIAC REHABILITATION**
- Upper body resistance training improves strength and household physical performance in women attending cardiac rehabilitation. Lola Coke, PhD, APRN-BC, et al (USA)
- Factors affecting cardiac rehabilitation referral by physician specialty. Sherry L. Grace, PhD, et al (Canada)
- Six minute walk test in permanent cardiac pacemaker patients. Lidiane Aparecida Pereira de Sousa, PT, MSc, et al (Brazil)

**PERIPHERAL ARTERIAL DISEASE**
- Effect of Gingko Biloba (EGb761) on treadmill walking time among adult with peripheral arterial disease: A randomized clinical trial. Christopher Gardner, PhD (USA)

**American Association of Cardiovascular and Pulmonary Rehabilitation - Scientific Abstracts**

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**Affiliate Society News**

**NEWS from NCCRA – the North Carolina Cardiopulmonary Rehabilitation Association**

*Mike Lippard, NCCRA President*
The North Carolina Cardiopulmonary Rehabilitation Association (NCCRA) held its 29th annual state symposium February 26-March 1. Titled "Cardiac and Pulmonary Rehabilitation as Chronic Disease Management", the education sessions were well received and educational. The meeting attracted over 200 attendees who learned from experts in a variety of fields.

Outgoing NCCRA President John Cook (Spruce Pine Hospital) inducted new President Mike Lippard (CMC-Northeast). Following the AACVPR initiative, the state programs have been lobbying our North Carolina congressional delegation to support the legislation for cardiopulmonary rehabilitation. Our Web site, www.nccraonline.org, is undergoing major reconstruction. This should allow us to communicate effectively and publicize our professions. Hopefully, this will be online by the end of summer.

Regional state meetings will be held in the summer and fall to communicate and educate our membership. Our Research Committee will present two oral communications and three poster presentations at the AACVPR annual meeting. Dave Verrill and Chad Moretz have worked hard on our state outcomes data to prepare the research for presenting. Planning has already begun for the 30th annual NCCRA symposium to be held in Charlotte in February 2009.

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**2008 Calendar of Events**
**September 22-26**  
Starting or Updating a Comprehensive Cardiac Rehabilitation Program  
University of Wisconsin-La Crosse  
For more information: John Porcari (608-785-8684 or porcari.john@uwlax.edu) or CLICK HERE

**October 13-15**  
Starting or Updating a Comprehensive Cardiac Rehabilitation Program  
University of Wisconsin-La Crosse  
For more information: John Porcari (608-785-8684 or porcari.john@uwlax.edu) or CLICK HERE

**Oct. 28, 2008**  
MACVPR will be holding its Fall Program Development Meeting at the AHA in Framingham, MA. Wayne Westcott will be our featured speaker. Please contact Molly Kim at admin@macvpr.org for more information.

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

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: CLICK HERE

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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.

**AACVPR Administrative Staff:**  
Marie Bass, Executive Director  
Abigail Lynn, Coordinator  
Meredith Bono, Sr. Associate  
Christine Ayala, Sr. Associate  
Molly Werner, Associate  
Linda Schwartz, Marketing & Communications  
Michelle Mills, Marketing & Communications  
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Kirby Carroll, Convention Services  
Christy Spahn, Convention Services  
Liz Klostermann, Convention Services  
Pat Price, Director of Sponsorship  
Rebecca Somnitz, Education & Program Services  
Jenna Countryman, Education & Program Services

401 North Michigan Avenue, Suite 2200  
Chicago, IL 60611-4267  
Telephone: 312-321-5146  
Fax: 312-673-6924  
E-mail: aacvpr@aacvpr.org  
Web site: www.aacvpr.org