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"How am I doing?"

Ed Koch (former Mayor of New York)

As hard as it is to believe (at least for us) it’s been a year since we began as co-editors of News & Views. Taking over from Linda Hall, after her magnificent 5 year reign as editor-in-chief, was a daunting task. We believe we have carried on in the tradition of our predecessors and produced a quality product. However, as Ed Koch often asked his constituents, we are asking you “How are (we) doing?” We are asking each of our readers to use the link to the "News & Views Reader Submission Form" at the end of this newsletter to submit comments, ideas, suggestions on how to continue to improve this product. You can send this under the format of ‘Letters to the Editors’ and we will publish the most representative submissions.

"Do you realize if it weren't for Edison we'd be watching TV by candlelight?"

Al Boliska (humorist)

The New Year brings a lot of presents for members of AACVPR, many of which reside in the technological domain and many of which lie in the realm of expanding our contacts and friendships with other professional organizations and participating in multi-society initiatives.

Technological advances for AACVPR that have been, and will continue to be, highlighted in this publication over the past year:

- The development of a completely revised, online, electronic submission process for AACVPR Program Certification & Recertification (launching March 1, 2010)
- The introduction of the new and updated AACVPR Web site, with more advances yet to come
- Transitioning from teleconferences to Webinars, a new, technology for continuing education presentations as well as timely updates
- Continuing updates on the National Cardiac Rehabilitation Database, and the beginning of the development of a similar process for Pulmonary Rehabilitation.

Strengthened and new partnerships that have been presented in News & Views over the last year, including two new partners introduced in this issue:

- American Heart Association
- American Thoracic Society
- The Sudden Cardiac Arrest Association
- The Clinical Exercise Physiology Association
- The American Academy of Physical Medicine and Rehabilitation
- American Cancer Society
- American Diabetes Association
- Aligning Forces for Quality Equity Quality Improvement Collaborative
- Partnership to Fight Chronic Disease

Additional AACVPR accomplishments that have been highlighted in these pages over the past year were:

- The distribution of the AACVPR Referral Enhancement Toolkit
- The launching of a pilot program for joint Affiliate and AACVPR membership
- A redesigned, streamlined Annual Meeting
- The continued development of student resources including AACVPR scholarships
- The passage of the Pulmonary and Cardiac Rehabilitation Act
- The establishment of the AACVPR Experts council

New features that have been added to News & Views included:

- Institution of the ‘News & Views Reader Submission Form’ to encourage reader input on:
  - Innovative Programs/Best Practices
  - Breaking News
  - Letters to the Editor
  - Health Policy/Reimbursement Issues
- "Leadership" by Barb Fagan, MS, FAACVPR
- "Pulmonary Point of View" by Gerene Bauldoff, PhD, RN, FAACVPR
- "Innovative Programs & Best Practices" by Tracy A. Herrewig, MS, FAACVPR
- "Spotlight on the Professional Liaison Committee" by Marjorie L. King, MD, FACC, FAACVPR
- A column highlighting member accomplishments
- A feature to bring Breaking News to our readers. A sampling of items that have been covered include:
  - HF action trial
  - Cardiac rehabilitation and survival in older coronary patients
The leadership of AACVPR affirmed our priority strategic goals to support you and your specialty. With you and your patients in mind, these goals permeate through the work of our committees, our Board, and our staff.

"Cheers to a New Year and another chance for us to get it right!"
Oprah Winfrey

As an added bonus to this already chock full edition, here are Jody and Steve’s TOP TEN List of Cardiac and Pulmonary Rehabilitation Accomplishments and/or Milestones in 2009

1. The passage of Federal Regulation mandating Medicare coverage for Pulmonary Rehabilitation
2. The passage of Federal Regulation mandating Medicare coverage for Cardiac Rehabilitation
3. The passing of Dr. Thomas Petty, the father of Pulmonary Rehabilitation
4. The publication of several significant studies on Pulmonary Rehabilitation:
5. The publication of several significant studies on Cardiac Rehabilitation:
6. The National Quality Forum steering committee approved Set A (referral measures) of the Cardiac Rehabilitation Performance Measures, final vote on approval soon to follow.
7. Pulmonary Rehabilitation Performance Measures on outcomes were submitted to the National Quality Forum (COPD Functionality and Quality of Life).
8. The National Cardiac Rehabilitation Data Registry is now in beta testing.
9. A task force to develop a National Pulmonary Rehabilitation Data Registry has been formed by AACVPR.
10. Persons requiring oxygen for air travel are now permitted to use portable oxygen concentrators on all commercial aircraft that depart from or arrive in the US.

*With a lot of help from Chris Garvey!

Executive Director’s Corner
P. Joanne Ray, AACVPR Executive Director
Randal J. Thomas, MD, FAACVPR, AACVPR President 2009 – 2010

The Main Thing That We Do:
Saving Lives by Helping Heal Hearts, Lungs and People

2009 brought many changes our way, but one thing has remained constant… the members of AACVPR need reliable, current and trusted content, educational renewal and leadership, and support.

In November, the leadership of AACVPR affirmed our priority strategic goals to support you and your specialty. With you and your patients in mind, these goals permeate through the work of our committees, our Board, and our staff.

- Grow and Retain Membership to Strengthen AACVPR
- Enhance and Support the Quality of Cardiac and Pulmonary Rehabilitation and Prevention Services
- Improve the Use and Viability of Cardiac and Pulmonary Rehabilitation and Prevention Services

We are all faced with a dizzying array of new regulations, reimbursement changes, and a desire to consistently strive toward keeping up to date on best practices in the clinical and program management arenas. You turn to AACVPR and expect up-to-date information at your fingertips. AACVPR offers you an amazing array of tools and resources — many of which are identified in each issue of News & Views! Our strength, however, is wholly dependent upon you.

AACVPR is the premier education and advocacy organization bonding together those with a common goal of improving and celebrating cardiac and pulmonary rehabilitation. For 25 years, AACVPR has helped cardiac and pulmonary rehab professionals adapt to the complex challenges of delivering quality rehabilitation care, streamlining operations, improving referrals, and integrating new technology and innovative therapies. AACVPR champions the importance of access to rehabilitation programs and specialists, and leads efforts to respond to regulations, legislation, and policies that threaten to compromise the delivery of quality care. AACVPR represents every member of the cardiac and pulmonary rehabilitation team including the key decision makers — physicians, nurses, therapists, directors, administrators and the vendors who serve us.

AACVPR is only as strong as the quality and quantity of professionals who participate as members. We conservatively estimate that only one fifth of cardiac and pulmonary rehabilitation professionals have active memberships in AACVPR. We appreciate the passion and
contributions of those members, but realize that AACVPR can be even stronger as the number of our member professionals increases.

With this in mind, the AACVPR Membership Committee is developing plans to help attract and retain as members all cardiac and pulmonary rehabilitation professionals in the United States. Access to the member–only resources — including the interpretation of reimbursement challenges and outcomes, standards of practice, referral tools, and networks of individuals with shared interests — is something that benefits all cardiac and pulmonary rehabilitation professionals. Therefore, we invite all to join with AACVPR to help share in the support of these and other membership benefits by becoming members themselves.

In the coming months, you’ll be hearing more about ways we can all work together to strengthen our profession by strengthening membership in AACVPR. For now, we encourage you to invite your colleagues to be committed cardiac and pulmonary rehabilitation professionals by joining AACVPR today! (With their permission, feel free to submit their names, titles and emails to aacvpr@aacvpr.org and we’ll forward membership information to them).

There are exciting opportunities on the horizon for our profession, but we need everyone’s support and strength to make our future as bright as possible.

We look forward to continuing to serve you.

Passing of an Icon: Dr. Thomas L. Petty

In December, pulmonary clinicians and patients lost a great leader and innovator, Dr. Thomas L. Petty. Dr. Petty’s contributions to pulmonary medicine include developing the initial evidence and practice of Pulmonary Rehabilitation, heading the groundbreaking ‘Nocturnal Oxygen Treatment Trial’ which established the impact of supplemental oxygen on survival and other outcomes, developing the first portable oxygen systems, discovering and describing Adult Respiratory Distress Syndrome (ARDS), founding the National Lung Health Education Program, chairing the National Oxygen Consensus Conferences on Long Term Oxygen and chairing the Pulmonary Education and Research Foundation. In addition to authoring over 800 manuscripts, Dr. Petty distinguished himself by his books, letters and emails written to and for patients to help improve their lives with chronic lung disease. Visit http://drtompetty.org for more information on his life and accomplishments.

Breaking News:

AACVPR Invited to Present at the Institute of Medicine

In December the AACVPR was invited by the Institute of Medicine (IOM, www.iom.edu) of the National Academies to make a presentation related to cardiovascular disability criteria. In response to this request, an ad hoc task force was created to develop the presentation. Members included were:

- Larry F. Hamm, PhD, FAACVPR (Chair and current AACVPR BOD member)
- Patrick E. McBride, MD, MPH, FAACVPR (current Chair of the AACVPR Document Oversight Committee)
- Patrick D. Savage, MS, FAACVPR (current Chair of the AACVPR Research Committee)
- Randy J. Thomas, MD, MS, FAACVPR (current AACVPR President)

On December 14, 2009, Drs. Hamm and McBride delivered the presentation in Washington, DC to the IOM Committee on Social Security Cardiovascular Disability Criteria. This committee is chaired by Nanette Wenger, MD, FAACVPR and is composed of 14 cardiologists and other medical experts in the area of cardiovascular diseases. The charge to this committee is to evaluate the current Social Security Administration criteria for cardiovascular disability, review relevant research literature and professional practice guidelines, and recommend revisions and updates to the rules and regulations for cardiovascular disability assessment and determination.

The AACVPR presentation focused on 3 recommendations:

1. To assess aerobic functional capacity, cardiopulmonary exercise testing with directly measured oxygen uptake is superior to using estimated METs from a standard graded exercise test. If cardiopulmonary exercise testing is not available, a published nomogram should be used to correct the estimated values obtained from standard graded exercise testing (Ades PA et al. Circulation 2006;113:2706-12).
2. Aerobic capacity from an exercise test, whether measured or estimated, is often not relevant to energy requirements for many job–specific tasks. Therefore, when appropriate, monitoring a person’s cardiovascular responses to job–specific tasks would add significant objective data to the disability determination process. Cardiac rehabilitation programs are ideally positioned to conduct this type of monitored assessment.
3. For selected cardiac patients who are applying for disability and who did not participate in a cardiac rehabilitation program, referral by the Social Security Administration to cardiac rehabilitation may result in some patients improving their functional capacity to the point where they no longer meet the disability criteria and could return to work.

The committee will continue their deliberations and a draft of the final report is expected sometime this spring or summer.

In preparing for this presentation, it became evident to the task force members that there is very little published information available on this topic. This fact opens several potential opportunities for AACVPR and members, including the development of a guideline for assessing cardiovascular disability, research topics, and a new business line for the assessment of energy requirements for job–specific
Cardiac Rehabilitation Performance Measure Selected for Hospital Quality Improvement Study

Jennifer Bretsch, MS
Senior Research Associate
Center for Health Care Quality
Department of Health Policy
The George Washington University Medical Center
Jennifer.Bretsch@gwumc.edu

The "Cardiac rehabilitation referral from an inpatient setting performance measure" (A-1)¹ is one of only 7 metrics being used in the Aligning Forces for Quality (AF4Q) Equity Quality Improvement Collaborative (Equity QI Collaborative), a national hospital initiative of the Robert Wood Johnson Foundation (RWJF). The aim of the Equity QI Collaborative is to improve the quality of care delivered to all patients with acute myocardial infarction (AMI) and heart failure while reducing racial and ethnic disparities. In addition to being included as 1 of 7 metrics for the Equity QI Collaborative, referral to cardiac rehabilitation in now included in the joint ACC/AHA performance measures for the care of patients post-AMI.²

Eight hospitals from across the nation have been selected to participate in the Equity QI Collaborative. As part of their involvement, hospitals are systematically collecting and reporting data on AMI patients who have been referred to an outpatient CR program prior to hospital discharge. The A-1 measure was chosen for inclusion in the limited measure set because of the substantial body of evidence supporting an exercise-based CR program to improve risk factors among patients with established heart disease and to decrease mortality.

As a by-product of the 18-month initiative, lessons learned from the benefit and burden of collecting information on referral to CR will be gathered and shared with Larry Hamm, PhD, FAACVPR, (AACVPR Past President and current Board member) who is serving as a technical advisor to the project team. At the collaborative program launch meeting last October, the hospitals noted that because of the CR measure, they are already more aware of the need to collect data, understand their referral patterns, and determine what they mean for the quality of care provided to all AMI patients, regardless of patient race or ethnicity. Because of the generosity of AACVPR, the hospitals have access to the AACVPR Referral Enhancement Toolkit and will also provide feedback on its utility.

Joining RWJF, the collaborative is led and managed by the Center for Health Care Quality at The George Washington University Medical Center School of Public Health and Health Services. For more information about the study and a list of the hospitals, visit www.rwjf.org/qualityequality/product.jsp?id=47668.

1. Cardiac Rehabilitation Patient Referral from an Inpatient Setting

All patients hospitalized with a primary diagnosis of an acute myocardial infarction (MI) or chronic stable angina (CSA), or who during hospitalization have undergone coronary artery bypass graft (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery, or cardiac transplantation are to be referred to an early outpatient cardiac rehabilitation/secondary prevention (CR) program. A referral is defined as an official communication between the health care provider and the patient to recommend and carry out a referral order to an early outpatient CR program. This includes the provision of all necessary information to the patient that will allow the patient to enroll in an early outpatient CR program. This also includes a communication between the health care provider or health care system and the CR program that includes the patient’s referral information for the program secondary prevention (CR) program.²

2. hammill et al retrospectively analyzed data collected on 30,161 Medicare beneficiaries over the age of 65 who attended at least one session, but no more than 36 sessions of cardiac rehabilitation between 2000 and 2005. Outcome data (endpoints of myocardial infarction or all cause death) were collected four years after attending a cardiac rehabilitation program. The data were adjusted for demographic characteristics, co-morbid conditions and any hospitalization during rehabilitation. To test for validity, comparisons were made on subsets of patients with heart failure and patients who attended more than 6 sessions, both of which compared favorably to the analysis of the entire cohort.

The median number of sessions attended was 25 (very similar to the median number of 24 found by Suaya et al). Overall mortality during cardiac rehabilitation was 2%, with incidence of MI at 16%. Mortality rates and subsequent MI at 4 years were significantly related to the number of total sessions attended. Attending 36 sessions was significantly associated with a 18% lower risk of death compared to 24 sessions, a 29% lower risk compared to 12 sessions and a 58% lower risk compared to 1 session. Risk of MI were similar: attending 36 sessions was associated with a 15% lower risk of MI compared to 24 sessions, a 28% lower risk compared to 12 sessions and a 38% lower risk compared to 1 session.

As mentioned in previous editions of News & Views, these recent studies should be a call to action. All health care practitioners working in cardiac rehabilitation need to make distribution of this information to potential referring physicians a priority. Provide a summary of the...
results of these studies (feel free to use this and previous articles in News & Views) to each of your current and potential referral sources, consider presenting at journal clubs or Grand Rounds in your local hospital systems and send out blast emails to your affiliate society members to help spread the word. Make sure that physicians know that cardiac rehabilitation is a cost effective, low tech, life-saving intervention that should be provided to all appropriate patients.


For your Information: New GOLD Guidelines Available

The "Global Initiative for Chronic Obstructive Lung Disease" (GOLD) is an organization that works with health care professionals and public health officials to raise awareness of Chronic Obstructive Pulmonary Disease (COPD) and to improve prevention and treatment of this lung disease for patients around the world. GOLD was launched in 1997 in collaboration with the National Heart, Lung, and Blood Institute, National Institutes of Health, and the World Health Organization. "GOLD's guidelines for COPD care are shaped by committees made up of leading experts from around the world." The GOLD Web site is a valuable resource for healthcare professionals involved in the rehabilitation of patients with COPD.

GOLD has just released the 2009 update of its Global Strategy for Diagnosis, Management, and Prevention of COPD Guidelines. The GOLD materials are available in several different formats; the full report, Executive Summary, Pocket Guide and Pocket Card. Information on these can be found by clicking HERE. Additionally there is an advance printing of the GOLD Pocket Guide available, which may be reviewed by visiting HERE.

For more information, or to order copies of these guidelines, go to the GOLD Web site or contact:
Jim Martino
Project Manager
US Health Network Inc.
2015 Forest Ave. Suite A1
Staten Island, NY 10303
Phone: 718/448-1200
Fax: 718/448-7852


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AACVPR Conferences

AACVPR 25th Annual Meeting

25th Annual Meeting — Destination: Milwaukee, Wisconsin!
October 7 - 9, 2010
Midwest Airlines Center
Milwaukee, Wisconsin

The AACVPR Annual Meeting is a four-day event for healthcare practitioners to exchange knowledge regarding cardiovascular and pulmonary rehabilitation. The meeting program provides education and training on the scientific principles, the latest techniques and advances, and the new challenges affecting rehabilitation today.

Plan to come and celebrate our 25th Anniversary!!!

Day on the Hill — March 3 & 4, 2010

10 Top Reasons why you should come to Washington, DC March 3 & 4, 2010

1. Democracy is not a spectator sport.
2. Health care is NOT a partisan issue.
3. You can be sure there will be issues that Congress will need to hear and can impact regarding cardiac and pulmonary rehabilitation services.

4. The over 300 AACVPR and affiliate members participating in Day on the Hill ("DOTH") over the past five years are proof that our united voices have made a difference for our patients and programs.

5. If you don’t speak up, who will?

6. It is your ongoing relationship with your US congressional members that makes you more effective.

7. You’ll be prepared — AACVPR will provide you with a review of the issues, talking points, and preparation for your meetings.

8. History shows us that together we are effective in moving issues and we’ve only scratched the surface.

9. Come and influence the outcome.

10. If you don’t participate in the process, you can’t complain about the results.

For more information, please visit the AACVPR Web site.

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**Program Leadership in a New Era — March 5, 2010**

March 5, 2010  
8:00 am - 3:30 pm  
Hyatt Regency Crystal City

Come for DOTH, and stay for the newest AACVPR educational offering! This innovative educational program is a one-day conference, packed with the information you need to know NOW. Nationally recognized speakers will address topics including the new CMS regulations, screening and enrollment, performance measures, and much more. Seven speakers, seven topics, all in one day!

Keep an eye on your email and on the AACVPR Web site for more information on registering for this exciting new program!

**Hotel & Travel Information:**  
*For both DOTH and the Program Leadership In the New Era Conference*

**Where to stay:**  
Hyatt Regency Crystal City  
2799 Jefferson Davis Highway  
Arlington, VA 22202  
703/418-1234

Room Rate is $159.00 plus tax per night, for single or double occupancy room

**How to get there:**  
The closest airport to the Hyatt Regency Crystal City is Ronald Reagan National Airport (DCA). There is a courtesy shuttle that runs from DCA to the hotel every 30 minutes.

Registration information will be sent to you via email in January, but you can reserve your hotel room today.

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**Member Resources**

**Certification, Registry, and Individual Treatment Plan: What’s New and Exciting?**  
Mark Senn, PhD, FAACVPR

I am glad you asked. Actually, much work has taken place since the last *News & Views* to keep these projects on track and moving forward to provide better tools and services for AACVPR members.

**Certification & Recertification:**  
As we reported in the last edition of *News & Views*, a dedicated team of AACVPR member/volunteers has been working diligently to restructure the Certification Program into a completely electronic process, both for the applicant and for the reviewers. This work will result in the creation of a new product called the “AACVPR Certification Center”. The Certification Center will be an online site where programs go to apply for certification and communicate with their reviewer regarding any remediation necessary to successfully complete their program certification process (please see the last issue of *News & Views* for complete details).

The Certification Center is scheduled to go live and be available to programs desiring to apply for certification or recertification on March 1, 2010. As a reminder to programs planning to apply this year, the content of the application can now be found for review and the pre-application preparation information can be found [HERE](#) for Certification and [HERE](#) for Recertification.

**National Outcomes Data Registry:**  
Another dedicated team of AACVPR member/volunteers continues to work on the national Outcomes Data Registry project that will allow programs to enter their programmatic information and outcome and information into a web-based data registry. A participating program will be able to generate outcome reports for internal reporting and process improvement, produce benchmark comparisons, and have their...
outcome data automatically downloaded into their certification or recertification application. The development team has identified the measures to be included in the registry and the definitions for each measure. At this time, a small number of selected cardiac rehabilitation programs are reviewing the measures and their definitions for practicality and feasibility (ability to accurately and efficiently collect and report the data as well as the utility of the data to the program). We anticipate selecting a vendor to create the web-based database within the first quarter of 2010. Once a vendor has been chosen we expect the development and testing of the data registry will take 6 to 9 months. It is our hope that we will be ready to make the product available to AACVPR members by the end of 2010. Please keep in touch with this exciting project through future issues of News & Views and other AACVPR member communications. A registry for pulmonary rehabilitation is in the works as well.

**Individual Treatment Plan:**
Yet a third dedicated team of AACVPR member/volunteers are responding to the a long recognized need to help programs more effectively and efficiently develop an individualized treatment plan (ITP), previously called a care plan, for their patients. For as long as the Certification Program has been active the review teams have consistently recognized the struggle programs have with identifying and organizing the full spectrum of rehabilitative needs of their patients, and then coordinating, tracking, and documenting the interventions, specific patient responses and final interventional adjustments and dispositions at the time of discharge. With the finalization of the new CMS language, we now know what CMS expects as a requirement of reimbursement. While CMS does not require a specific form or use of specific tools, a program must demonstrate a thorough evaluation of a patient’s rehabilitation needs, goals, time frame for achieving goals, intervention plan, and assessment of intervention results. CMS also requires physician approval of the initial ITP as well as physician review and approval of the ITP every 30 days as long as the patient continues to receive services.

With these challenges and requirements in mind, the team has developed an ITP format that can be used in hardcopy or electronic format, that will assist with both certification and CMS expectations. The ITP format is currently being tested for content and usability. By mid January 2010, the format will be reviewed by AACVPR committees and submitted to the Board of Directors for final approval. Any final ITP provided by AACVPR is merely a best practice example and not a mandate for reimbursement or for AACVPR program certification. We expect the ITP format for both cardiac and pulmonary rehabilitation to be available to AACVPR membership by mid to late February 2010. Please visit the AACVPR web site for an announcement for the release of the ITP final format.

Finally, let me thank the many dedicated AACVPR member/volunteers who are working on these important projects. Each of these projects addresses issues faced by nearly every cardiac and pulmonary rehabilitation program on a daily basis. The work of these teams is a tremendous service to all of us who work to improve the quality of life for cardiac and pulmonary patients.

**New Pulmonary Guidelines**
*Chris Garvey, FNP, MSN, MPA, FAACVR*

The new 4th edition of the AACVPR Pulmonary Rehabilitation (PR) Guidelines will be available at the 2010 AACVPR Annual Meeting in Milwaukee. This edition will include evidence-based practice guidelines for PR programs, program certification strategies, outcome and psychosocial assessment tools, and new CMS coverage information for PR. Co-editors Dick ZuWallack, MD and Rebecca Crouch PT, PhD, as well as authors Carolyn Rochester, Susan Lareau, Paula Meek, Chris Garvey, Linda Nici, Jonathan Raskin, Neil McIntyre, and reviewers Dana Hilling, Gerillynn Connor, Kathleen Stewart, Jane Reardon, Joe Norman and others worked very hard within a very short time frame to create this a key resource for PR programs.

**Spotlight on the Professional Liaison Committee**
*Marjorie L. King, MD, FACC, FAACVPR, Chair AACVPR Professional Liaison Committee*

**The Power of Partnerships**
**Highlighting The Partnership to Fight Chronic Disease**

AACVPR has long valued the positive power of working together. Case in point was the passage of the legislation hardwiring both cardiac and pulmonary rehabilitation within the Medicare statute. Clearly there is strength in numbers and as Winston Churchill said, "If we are together nothing is impossible."

A recent and important partnership established by AACVPR is with a forward thinking group known as The Partnership to Fight Chronic Disease (PFCD). PFCD is a national and state-based coalition of hundreds of patient, provider, community, business and labor groups, and health policy experts, committed to raising awareness of the number one cause of death, disability, and rising health care costs in the U.S: chronic disease.

There are many opportunities for collaborative work within PFCD, including several recent initiatives where AACVPR participated as a co-signer, along with other partner organizations, in letters to Congress:

1. A letter to all Members of the House and Senate highlighting the need to address medication adherence issues in patients with chronic disease. AACVPR was able to stress the value of cardiac and pulmonary rehabilitation when it comes to medication adherence and provided a copy of the recent AJM paper from Mayo Clinic documenting improved medication adherence with cardiac rehabilitation.¹
2. A letter to Senate leaders requesting reducing the toll of chronic disease by including policies that empower people to engage in healthy behaviors and to seek, access, and follow through on recommended care.

AACVPR will continue to participate and have a voice in weekly policy update calls, bi-monthly policy working group meetings and quarterly advisory board meetings.
Leadership Committee Update
Adam deJong, MA, FAACVPR, Chair AACVPR Leadership Committee

The Leadership Committee was hard at work in 2009 and had the honor of bestowing AACVPR Fellowship status on 14 AACVPR members who passed the rigorous application process. In addition, the committee had the privilege of choosing the Baylor Heart and Vascular Hospital as the winner of the 2009 Innovative Program Award for their program “Return to Work: Live Your Action Potential Lab.” Both projects were very gratifying for the committee members as they once again were able to see the good work being done in AACVPR, both individually and programmatically. The new Fellows and the Innovative Program Award winner were recognized at the AACVPR Annual Meeting in Pittsburgh, PA.

Moving forward to 2010, however, the work has just begun. The committee met at the AACVPR Annual Meeting and identified process improvement plans for Fellowship applications. The changes were approved by the Board of Directors for implementation in 2010. Included in these changes was the creation of an application that includes two distinct tracks, research and service, that will allow a member to apply for AACVPR Fellowship based on their perceived greatest strength. For those who may be strong in both tracks, a dual track will also be available. Over the next month the committee will be revising both the applications and the scoring system to accompany the new application process. In addition, applications will only be accepted by email to the National Office (fellowship@aacvpr.org), to more easily track applications, and a $50 non-refundable application fee will be required. Furthermore, it is anticipated that by 2011, the application process will be entirely online, providing a mechanism to ensure all information required for Fellowship application was included during the application process.

Fellowship Application: February 1, 2010

Interested in becoming an AACVPR Fellow?

Applications will be available on February 1, 2010 by visiting the AACVPR Web site. Completed applications are due by April 1, 2010.

New this year: Submissions will ONLY be accepted by the National Office by emailing completed applications to fellowship@aacvpr.org. A $50 non-refundable application fee will be required.

For more information and Fellowship requirements, please CLICK HERE.

AACVPR Call for Abstracts

Get Ready to Submit Your Abstract for the 2010 Annual Meeting

The 2010 Call for Abstracts deadline for the Annual Meeting of AACVPR in Milwaukee, Wisconsin, October 7 – 9, 2010, is now open. Presenting an abstract at the AACVPR Annual Meeting is an excellent opportunity to share your research, best practices, and highlight your facility to colleagues and leaders in the field of Cardiovascular and Pulmonary Rehabilitation.

Abstracts are reviewed by the AACVPR Research and Education Committees. Scientific Oral Presentations and posters are published in the Convention Issue of The Journal of Cardiopulmonary Rehabilitation and Prevention, and clinical posters are available in the AACVPR on-line syllabus prior to the Annual Meeting.

Click here to submit a scientific or clinical/quality improvement abstract.

Announcing: AACVPR 18-Month Membership

Do you have colleagues who have not yet made the commitment to join AACVPR? Now's their chance!

Do you know people whose New Year’s resolutions include enhancing their professional development, volunteering, attending continuing education programs or the annual conference, understanding the latest information to maximize referrals and reimbursement to their program?

If this is the year they really want to maximize the success of their program and become more involved professionally, take advantage of this special 18-month AACVPR membership.

They must act NOW for this limited time offer to join AACVPR at this special rate. Help them join today for just $250 and receive these great benefits through June 30, 2011!
Cardiac and Pulmonary Rehabilitation Week

Plan now for 2010 Cardiac and Pulmonary Rehabilitation Weeks:

Cardiac Rehab Week: February 14 – 21, 2010

Pulmonary Rehab Week: March 14 – 21, 2010

If you wish to purchase merchandise and apparel to help celebrate Cardiac and Pulmonary Rehabilitation Weeks, visit AACVPR’s logo-wear provider at www.JimColemanLtd.com/aacvpr.

For more information, a 2010 Media Kit, and a schedule of events, please visit the AACVPR Web site.

Inside the Industry

Health and Public Policy/Reimbursement

Karen Lui, RN, MS, FAACVPR, Chair AACVPR Health and Public Policy Committee

This is Where the Rubber Hits the Road!

With the passage of Legislation last year creating a specific benefit category for both cardiac and pulmonary rehabilitation, January 1, 2010 marks the implementation of the new coverage rules for our services. The Centers for Medicare and Medicaid Services (CMS) has released coverage policies for cardiac and pulmonary rehabilitation. CMS has released instructions to local Medicare contractors (MAC) who are now making software adjustments so new coding and billing rules for CR and PR will be ready by January 1, 2010, the date when the rules become effective. Depending on each MAC’s time line and process, CR and/or PR claims submitted may be held and retroactively processed by a contractor or ready to go on day one. How will you know which is the case for you? By being plugged into communication coming from the AACVPR MAC Committee that represents your program.

Six MAC regions (called “jurisdictions”) continue to be on hold until 2010 in transitioning from Fiscal Intermediaries to MACs. All other MACs are functioning and a relationship has been established by the AACVPR MAC Committee in your jurisdiction.

Here are brief summaries from two MAC Committees that have been successful in developing a relationship with their MAC Medical Director that will ultimately benefit all CR and PR programs under that jurisdiction. The other MAC Committees are in the process of seeking a similar relationship or pro-actively planning to do so when the legal holds are resolved. The important message here is MACs have the potential to be our partners in assuring sound clinical coverage policies for our patients. Your MAC needs your “coordinated” and
unified] help to better understand and implement CMS regulations. The opportunity is ours.

The J-12 Experience (Delaware, District of Columbia, Maryland, New Jersey and Pennsylvania):

The MAC J-12 Committee has had numerous meetings with Dr. Andrew Bloschichak, VP and Medical Director of Highmark Medicare Services. Most recently, the goal was to discuss the upcoming changes to coverage for cardiac and pulmonary rehabilitation. Please check out the answers to our questions in the ‘What’s New with My MAC’ section of the AACVPR Web site.

Shortly after Dr. Bloschichak was announced as our MAC J-12 Medical Director, we requested a face to face meeting with him. In June, 2008, the entire MAC Committee (many traveling several hours from four different states) met with Dr. Bloschichak. We developed a very positive relationship, and during this meeting, he agreed to speak at the TSCVPR Annual Symposium in April, 2009. When he was asked to present at the AACVPR Annual Meeting in Pittsburgh he readily agreed. He also reminded us to call his Administrative Assistant in November, 2009 to set up another face to face meeting.

Besides having well informed, involved MAC Committee Members representing all states in our MAC, what has worked for us includes:

- Submitting a well-thought out agenda prior to meetings or presentations.
- Before sharing the information gained in the meeting, putting it in writing and receiving approval before you publish it.
- Checking the MAC web site frequently for updates.
- Attending any webinars offered by your MAC dealing with cardiac and pulmonary rehabilitation. Feedback on these will be appreciated by your MAC Medical Director.
- Developing a good relationship with your MAC Medical Director’s Administrative Assistant. He or she will help you get access to your Medical Director.

The J-13 experience (Connecticut and New York):

J-13 AACVPR MAC committee members took the initiative and reached out to their MAC. Guess what… our Mac was immediately receptive! On January 28, Dr. Paul Deutsch will travel to Wallingford, Connecticut for an in-person Q & A with the Connecticut Society of Cardiovascular Rehabilitation. On January 15, Dr. Deutsch will join national pulmonary rehabilitation specialists representing AACVPR, the American Thoracic Society (ATS), the American Association for Respiratory Care (AARC), the American College of Chest Physicians (ACCP), and the National Association for Medical Direction of Respiratory Care (NAMDRC) on a conference call to review Pulmonary Rehabilitation interpretations for current CMS regulations. In fact, Dr. Deutsch let us know that he was appreciative that AACVPR members in Connecticut and New York State would provide him with an opportunity to better understand what we do and how we can best serve our patients with our new CMS regulations.

New in Nutrition
Alisa Krizan, MS, RD, LD

Dear News & Views Readers:

It is our pleasure to introduce a new column (News in Nutrition) and a new contributor (Alisa Krizan, MS, RD, LD) to News & Views. Alisa is a registered and licensed dietitian at the Mayo Clinic in Rochester, Minnesota. Alisa has extensive experience in cardiac rehabilitation, clinical dietetics, research and administration. Alisa served on the AACVPR Scientific Advisory Council as the nutrition professional from 2005-2006; the AACVPR Professional Liaison Committee for the American Dietetic Association Sports and Cardiovascular Nutrition (SCAN) Dietetic Professional Group from 2005 to the present and the AACVPR Annual Meeting Planning Committee for Nutrition from 2005 to the present.

As the News & Views nutrition contributor, Alisa will focus on the practical perspective of nutrition as well as recommendations and new practice concepts that can be applied to current cardiac and pulmonary rehabilitation programs. Members may submit questions on nutrition and related topics for Alisa through the News & Views Reader Submission Form.

Vitamin D and Cardiovascular Health

Vitamin D is known as the “sunshine vitamin”. The incidence of coronary heart disease, diabetes, hypertension and prevalence of vitamin D deficiency increases in relation to one’s distance from the equator.¹ Vitamin D may be consumed in the diet or synthesized in the skin. It is hydroxylated in the liver to produce the major circulating form of the vitamin, 25-hydroxyvitamin D [25(OH)D]. The 25(OH)D₃ is transported to the kidneys and hydroxylated to form 1,25 dihydroxyvitamin D [1,25(OH)₂D] which produces the usable form of vitamin D.

Epidemiological and experimental studies suggest vitamin D may lower blood pressure and help in the primary prevention or treatment of congestive heart failure (CHF)² ³. Studies suggest that vitamin D suppresses proinflammatory cytokines and increases anti-inflammatory cytokines.

The current vitamin D recommendation for adults 51–70 years is 400 IU/day. This level will increase serum 25(OH)D₃ levels to 30 nmol/L. Food sources are limited to fatty fish or fish oil, beef liver and egg yolks. Other sources would be fortified milk, ready to eat cereal and juice. If patients’ 25(OH)D₃ levels are critically low, oral supplementation under a physicians care of 2000 IU may provide normalization of the 25(OH)D₃ levels. Clinical trials are limited in determining the effectiveness of vitamin D supplementation in controlling blood pressure or preventing hypertension. Sun exposure to the arms and/or legs for 10–12 minutes can release 10'000–20'000 IU of vitamin D.

References


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Leadership
Barbara Fagan, MS, FAACVPR

"Once upon a time..." most of us have grown to know that this phrase frequently is the beginning line of an endearing story or fairy tale. We would sit anxiously and listen as our parents, grandparents or others took us on a magical journey. The stories we heard have been indelibly marked within our memories.

Experience is a wonderful teacher. Transforming a story into a re-imagined experience, narrated with clarity and detail can give those listeners' a sense that the experience is real. A master story teller can have great influence on our behaviors.

I recently heard a wonderful story that has had a positive influence on me as a leader and I would like to share it with you. The story begins with a young man named Sam. Sam grew up in the hills of Judea learning about being a Shepherd by his old wise and well-respected grandfather. One day Sam asked to accompany him. When they got out to the flock, Sam said, "Well, let's go". And his grandfather replied, "you can not just go and be an effective Shepherd... it takes training and preparation. Like building a house, you must create the foundation first." The first thing Sam's grandfather said, "You must know your sheep" to which Sam replied, 'they're sheep... I know them'. Sam's grandfather whistled a certain way, one sheep looked up and he said 'that's Max, Max likes to stay by himself, but always comes when called', he whistled a slightly different way, another sheep looks up at the wise old shepherd, 'that's Rex, Rex is the instigator, trying to rouse up his fellow sheep'. He proceeded to whistle many different ways eliciting a single response from a particular sheep; he was able to speak to each one personality. Sam's grandfather replied, "You must know the condition of your flock." Sam's grandfather also carried with him a rod, also known as a Shepherd's crook. He would keep this crook close at his side as he stood between the flock and potential predators that may be lurking in the shadows, also standing amongst his flock to protect them from the poor choices they may select while wondering across the fields. Sam's grandfather had his Shepherd's hook which Sam couldn't wait to get his hands on. When his grandfather gave it to him, he started twirling it around like a Ninja, to which Sam’s grandfather quickly took back and said, "This is the staff of direction, to get out front and guide your sheep." As parting words to Sam, his grandfather wisely stated that, "being a great shepherd is a lifestyle, not a technique. You must have a passion for what you do. And most importantly, have a heart for sheep."

The story begins with a young man named Sam. Sam grew up in the hills of Judea learning about being a Shepherd by his old wise and well-respected grandfather. One day Sam asked to accompany him. When they got out to the flock, Sam said, "Well, let's go". And his grandfather replied, "you can not just go and be an effective Shepherd... it takes training and preparation. Like building a house, you must create the foundation first." The first thing Sam's grandfather said, "You must know your sheep" to which Sam replied, 'they're sheep... I know them'. Sam's grandfather whistled a certain way, one sheep looked up and he said 'that’s Max, Max likes to stay by himself, but always comes when called', he whistled a slightly different way, another sheep looks up at the wise old shepherd, 'that’s Rex, Rex is the instigator, trying to rouse up his fellow sheep'. He proceeded to whistle many different ways eliciting a single response from a particular sheep; he was able to speak to each one personality. Sam’s grandfather replied, "You must know the condition of your flock." Sam’s grandfather also carried with him a rod, also known as a Shepherd’s crook. He would keep this crook close at his side as he stood between the flock and potential predators that may be lurking in the shadows, also standing amongst his flock to protect them from the poor choices they may select while wondering across the fields. Sam’s grandfather had his Shepherd’s hook which Sam couldn’t wait to get his hands on. When his grandfather gave it to him, he started twirling it around like a Ninja, to which Sam’s grandfather quickly took back and said, "This is the staff of direction, to get out front and guide your sheep." As parting words to Sam, his grandfather wisely stated that, "being a great shepherd is a lifestyle, not a technique. You must have a passion for what you do. And most importantly, have a heart for sheep."

The lessons we gain from this story are as follows:

- As a leader, you must know your team; get to know them, one sheep at a time.
- Follow the status of your people as well as their work and engage your team on a regular basis.
- As a leader, build trust with your followers by modeling authenticity, integrity and compassion.
- As a leader, define the cause of your people and tell them where they fit in. Relentlessly communicate the team’s values and sense of mission. Infuse every position with importance.
- Know where you are going, get out in front and keep your team moving. Give your team freedom of movement, but know where the fence line is. Don’t confuse boundaries with briades.
- Remember that great leadership isn’t just professional; it’s personal. It is a lifestyle, not a technique. Every day you have to decide who’s going to pay for your leadership, you or your people?
- Like the wise shepherd’s parting words, as a leader, most importantly, you must have a heart for people.

New Pulmonary Rehabilitation Legislation and Opportunities for Outcomes Evaluation
Chris Garvey, FNP, MSN, MPA, FAACVPR

Centers for Medicare and Medicaid (CMS) now require measurement of outcomes for patients in Pulmonary Rehabilitation (PR) at the beginning and end of the PR program. While outcome evaluation has been historically recommended by American Thoracic Society (ATS) and other PR guideline statements and required by AACVPR certification, this new CMS requirement offers opportunities to measure, analyze and interpret important aspects of function, symptoms, mood disorders and other outcomes to better understand the effectiveness of Pulmonary Rehabilitation.

CMS requirements for psychosocial assessment include a ‘written evaluation of the individual’s mental and emotional function as it relates to their rehabilitation or respiratory condition...including response to and rate of progress under the treatment plan’. Psychosocial assessment is particularly important in the PR setting because of the increased co-morbidity and under-diagnosis of psychological disorders including depression and anxiety disorders in persons with chronic lung disease and their negative impact on function and symptoms. While a diagnosis of a psychiatric disorder must be made by a licensed professional, identification of symptoms that suggest these disorders are often the first step to accurate diagnosis and management. Once a psychiatric disorder is suspected, Pulmonary Rehabilitation staff needs to inform the patient’s physician to address further evaluation and management as well as referral to a mental health professional if needed.

Various tools are available for psychosocial assessment including the Geriatric Depression Scale (GDS), Center for Epidemiological Studies Depression scale (CES-D), the Patient Health Questionnaire (PHQ) – 9 and others. The GDS is a 15-item tool that uses a score of 5 – 8 to suggest mild depressive symptoms, 8 – 11 for moderate symptoms and 12 or greater for severe symptoms. The CES-D is a 20-item tool using a 0-3 scale. A score of less than 16 is considered normal, 16 to 24 suggests borderline depression symptoms and a score of 24 and greater indicate immediate need for referral and evaluation. The two components of the PHQ-9 include assessment of symptoms and functional impairment used to make a tentative depression diagnosis, and a severity score to help select and monitor treatment. Other screening tools include the Hospital Anxiety and Depression Scale, Hopkins Symptom Check List, Prime MD (Primary Care Evaluation of Mental Disorders) and others. Tools for screening anxiety include the Hamilton Anxiety Rating Scale, Beck Anxiety Inventory and State-Trait Anxiety Inventory. The Hospital Anxiety and Depression Scale, Hopkins Symptoms Check List and Patient Health Questionnaire measure multiple dimensions of psychological function and provide a subscore for anxiety-related symptoms.
Functional capacity is often measured with pre and post Pulmonary Rehabilitation field tests such as the six minute walk test and the incremental or endurance shuttle walk tests. Symptom measurement often target dyspnea and fatigue. Simple rating tools include the Borg scale and the visual analog scale (VAS). The Borg Scale uses a 10 point scale and is often used to evaluate dyspnea and fatigue often related to exercise. The VAS rates dyspnea on a 100 mm scale or line. Other tools used to measure changes in dyspnea include the Baseline (BDI) and Transitional (TDI) Dyspnea Indexes, Medical Research Council (MRC) and University of California San Diego (UCSD) Shortness of Breath Questionnaires. Other outcomes include measures of function status and tools include the Pulmonary Functional Status and Dyspnea Questionnaire, Pulmonary Functional Status and Dyspnea Questionnaire (modified) and the Pulmonary Function Status Scale.

Health related quality of life (HRQL) evaluates a patient’s quality of life in the context of a health issue. Tools often measure physical function, symptoms and emotional function. Measurement tools include the Medical Outcomes Study or short form (SF)-36–which measures domains of physical and emotional function as well as subcategories of fatigue, activity limitation and psychological distress. However, dyspnea is not specifically evaluated by the SF36. The Saint George Respiratory Questionnaire (SGRQ) evaluates activities, impact of disease and symptoms of dyspnea, cough, sputum and wheeze. The SGRQ has been validated for several obstructive lung diseases. The Chronic Respiratory Disease Questionnaire (CRQ) includes domains of dyspnea, fatigue, emotion, and mastery. The composite (total) score of these domains reflects health-related quality of life. The Seattle Obstructive Lung Questionnaire evaluates physical function, emotion, coping skills and treatment satisfaction. The total score evaluates HRQL.

Considerations for selection of outcome measurement tools or questionnaires include validity in patients with lung disease, ease and time needed for completion, availability in foreign languages, cost, and complexity of scoring. Key aspects of outcome tracking include sharing pre and post PR results with patients and their physicians and inputting data in a spreadsheet format for program evaluation and possible use in future research and possibly registries. Discuss interest in using this data in research with your hospital investigational review board to determine their requirements and process for approval.

Further information on outcomes measurement and evaluation including access to specific tools can be found in the members-only section of the AACVPR Web site.

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**Innovative Programs & Best Practices**

**Tracy A. Herrewig, MS, FAACVPR**

**BEST PRACTICE**

June Schult, RRT, FAACVPR
Pulmonary Rehabilitation Coordinator
Sanford USD Medical Center
Sioux Falls, SD

How many times have you heard one of your patients say, "Why didn’t my doctor send me here sooner?" Good question! Wish I knew the answer. We started our program in 1986 so I don’t think it’s because we’re the new kids on the block. While we still hear that question we have taken some steps to help educate the public and the physicians about this well-kept secret called Pulmonary Rehabilitation. Here are some of the things we’re doing:

We will gladly speak at any meeting or class we’re invited to. We have done presentations for clinics, pharmacy students, exercise physiology students, physical therapy students, family practice residents, etc. We talk about the evidence-based guidelines to show that pulmonary rehab is based on studies and research and has been evaluated in a large number of clinical trials and we can show that it does work. We explain how referrals are made to the program, what the criteria is for accepting patients into the program, components of the program and what we offer for maintenance exercise classes after the patient has completed his/her program. We know that we can explain our program better than anyone else so we welcome the opportunity to showcase what it is that we do.

We also want the public to know that we’re here if they need us, so we try to get our name in the media when we can. A year or so ago we started a harmonica group with some of our pulmonary rehab graduates. As we’ve gotten better, and maybe braver, we’ve been invited to entertain at several functions within the community. A couple of months ago the local newspaper called and said they had heard of our group and wanted to come out and do a story on us. As a result there was a nice article in the newspaper along with pictures and quotes from some of our harmonica players and the opportunity for us to explain that these people had gone through our Pulmonary Rehab program and playing the harmonica is a great breathing exercise. Since that article was in the paper we have received several calls from people in the surrounding area wanting to know more about Pulmonary Rehab and a couple calls for us to come and play at different functions. More opportunities!

When you get the chance to market your program, take advantage of it. Don’t be the best kept secret in your hospital!
development for teletraining in COPD. Bianying Song and colleagues from the University of Braunschweig in Germany constructed a decision support system that observes and controls physical ergometer training in exercise sessions with COPD patients. In this case, a decision support system is software that includes a set of rules regarding the continuation or modification of intensity of a stationary bicycle training session. According to the authors, heart rate (HR), oxygen saturation (SO2) and blood pressure (BP) were used to supervise the physical status of the participant. Respiratory rate as a parameter could also be included. The authors discuss the use of lactate as a potential parameter, but without a non-invasive, continuous monitoring device, lactate measurement outside of the laboratory setting remains beyond current technology. There were nine rules developed and tested. Exercise intensity was reduced by 15% when: SO2 < 90%; HR increases by 5 BPM; systolic BP increases by > 5mmHg; or the systolic BP > 180mmHg. Exercise was stopped if: SO2 < 80%; HR > maximum HR; systolic BP > 220mmHg or diastolic BP > 180mmHg. Exercise intensity was increased by 10% if the HR was < 65% of the maximum HR.

Impact on PR practice
This article is the first publication to discuss software and technology development needed for telerehabilitation in pulmonary rehabilitation. While the article is quite technical in describing the software development and the operating platforms used, the use of clinical rules are central to the safe application of exercise training that is supervised from a distance. As PR professionals, we need to clarify the clinical parameters that are integral to our clinical decision-making. As telemedicine and telerehabilitation continue to develop and mature, we can serve as the clinical experts in the development, dissemination and integration of these new technologies into pulmonary rehabilitation.

Effectively care for patients
Understand the latest reimbursement guidelines
Register for upcoming educational opportunities
Review new research related to cardiac or pulmonary rehab

The Web site Committee has expanded its membership to include members of many AACVPR committees to improve the scope, accuracy and timeliness of information posted on the Web site. With the expert knowledge of Meredith Bono and the assistance of all other National Office staff the committee has made, and continues to make, many improvements and updates to the Web site.

The Web site is designed primarily for professionals but patients and family members will also find valuable information on the Web site. You can find:

- Information about the organization and its members
- Organization events and educational opportunities
- Reimbursement resources and updates including the MAC map and legislative/regulatory information
- Certification resources, timelines and updates
- Resources and publications for medical professionals, affiliates, students, patients
- Cardiac or pulmonary rehab program listing
- Links to other professional organizations for professional or patient information
- Scientific information supporting cardiac and pulmonary rehab

Each upcoming issue of News & Views will feature updates on the Web site (www.aacvpr.org). Click on any of the primary links listed across the top of the page to find information/resources you may need. It’s all on the Web site. If you need it, it is there. If not, let us know and we will get it there.

Affiliate Society News

**Iowa Association of Cardiovascular & Pulmonary Rehabilitation (IACPR)**

*Diane McGrew, BSN, RN, BC, IACPR President*

The Iowa Association of Cardiopulmonary Rehabilitation’s annual meeting was held during the Tri-Network Conference, which also includes a day-and-a-half of education sessions and networking opportunities. Many hospitals have instituted budget cuts which make it difficult for staff to attend out-of-town conferences, so everyone’s attendance was much appreciated. Nancy Steingreaber was recognized as the Distinguished Member of the Year for her contributions to the Tri-Network Committee. She has been on this committee for over ten years, serving as committee chair during the years Iowa hosted the conference. The next Tri-Network Conference will be held April 23–24 in Sioux Falls, SD.

At the time of the annual meeting, IACPR had 163 members. It again provided continuing education for its members by utilizing the Iowa Communications Network (ICN) twice this year. The Board of Directors is looking into the possibility of utilizing webinars in the future.

Also at the time of the annual meeting, Iowa had 36 certified cardiac rehab programs and 22 certified pulmonary rehab programs. We were proud to report that, in the United States, Iowa ranked first in the number of certified cardiac rehab programs per capita and was tied with Wisconsin for the most certified pulmonary rehab programs per capita.

Visit our comprehensive Web site at www.iacpr.net to learn more about our affiliate.

**Louisiana Association of Cardiopulmonary Rehabilitation (LACVPR)**

*Jarrod Mitchell, LACVPR President*

The LACVPR affiliate has launched a new Web site this summer, lacvpr.webs.com. The Web site describes our organization, gives news updates, a calendar, and a forum for discussion. Also completed this year was a directory of all the cardiac and pulmonary rehab programs in the state. LACVPR members received a hard copy of that directory as a benefit, which we believe will help foster communication and help with transfer of patients in some cases. Our organization has been working to help each center comply with the new CMS guidelines and changes. Also during this past holiday and Christmas season, many centers throughout the state participated in weight loss or maintenance challenges.

**Tennessee Association of Cardiovascular & Pulmonary Rehabilitation (TACVPR)**

*Bringing New Life to the Heart & Lungs of Tennesseans*

*Tami Conner, RN, FAACVPR, CWC, TACVPR President*

The Tennessee Association of Cardiovascular and Pulmonary Rehabilitation (TACVPR) Program Planning Committee is busy planning our Spring Conference. This state meeting will be in April 2010 in Columbia, TN. Our biggest request from members is to have Dr. McKinney from Cahaba to be our key note speaker at this conference. Members will share practices, and program information with colleagues in the fields of Cardiovascular and Pulmonary Rehabilitation.

Our yearly fall conference was held in November at St. Thomas Hospital, hosted by Dianne Davenport and went well. Pat Benfield, RN,
MA, FAACVPR supplied our members with excellent knowledge on certification and recertification processes and was well received by members. The BOD and Committee Members also sat in on the Reimbursement Teleconference held by the AACVPR and learned many interesting facts.

Our Web site is completed and we invite you to take a tour at www.tacvpr.com.

**Members of the TACVPR:** If your hospital in Tennessee would like to be placed in the online directory or if you have any questions please, notify tamiconnorrn@hotmail.com

Wishing everyone a blessed and prosperous New Year!

Tami

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**Reader Submission Form**

Do you have something interesting for publication? If so, please send all submissions to aacvpr@aacvpr.org and include 'N & V Reader Submission' in the subject line. Feel free to send in multiple topics. While not all submissions will be published, we will do our best to include as much reader content as possible. Email us – we’d love to hear from you!

Please **CLICK HERE** for the *News & Views* Reader Submission form.

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**2010 Calendar of Events**

**SAVE THE DATES!**

March 3 & 4, 2010: Day on the Hill, Washington, D.C.
March 5, 2010: Program Directors’ Conference, Washington, D.C.

*If you would like your Affiliate meeting to be listed in the calendar section, please email your Affiliate meeting dates to aacvpr@aacvpr.org*

- **March 10 – 12, 2010** ACCA Cardiovascular Administrators’ Leadership Conference  
  *Staying Out in Front of Reform: Economics and Quality*  
  CONFERENCE REGISTRATION IS NOW OPEN!  
  Location: Sheraton Atlanta Hotel, Atlanta, GA  
  Immediately preceding the Annual Scientific Session of the American College of Cardiology  
  For more information, please visit: [http://www.aameda.org/Conference/ACCA/ACCAMain.html](http://www.aameda.org/Conference/ACCA/ACCAMain.html)

- **May 14 – 15, 2010** The ACSM World Heart Games  
  Registration is now open!  
  Location: Agnes Scott College, Decatur, GA  
  For more information, please visit: [www.acsm.org/worldheartgames](http://www.acsm.org/worldheartgames)

- **October 20 – 23, 2010** CARDIOMETABOLIC Health Congress  
  Sheraton Hotel, Boston, MA  
  For more information, please call 877/571-4700  
  Email us at: info@cardiometabolichealth.org  
  Visit us at [www.cardiometabolichealth.org](http://www.cardiometabolichealth.org)

**Ongoing**

- Health Coach Training and Certification  
  Sponsored by Wellcoaches Corporation  
  For more information: HealthCoach@wellcoach.com or [www.wellcoach.com](http://www.wellcoach.com)

- Continuing Education Programs on CARG, 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](http://www.heartcmeprograms.org)
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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