Reminder: If you have not renewed your membership for 2010–2011, this will be your last issue of News & Views. To renew your membership, please click HERE.

Printable Version

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Messages from Headquarters

Letter from the Editors
Jody Hereford, MS, BSN, FAACVPR
Steven Lichtman, EdD, FAACVPR

"Without promotion something terrible happens… Nothing!"
(P.T. Barnum, 1871)
"Come one, come all to the AACVPR Annual Meeting to be held October 7–9 at the Frontier Airlines Center in Milwaukee, Wisconsin, starting with pre-meeting events October 6, 2010."

(Jody Hereford, Steve Lichtman, 2010)

You must be saying to yourself, here go Jody and Steve again, promoting the AACVPR Annual Meeting. Well, you are correct, we are promoting the Annual Meeting! Why you might ask: do we receive any monetary reward… No; do we achieve fame and fortune… No; do we attain position or power… No. The reason we so strongly promote the Annual Meeting is that it is the best forum for dedicated cardiac and pulmonary rehabilitation professionals to improve the care they deliver to their (our) patients.

So, why should YOU attend:

- **Connections:** The AACVPR annual conference is a great place for networking. Cardiopulmonary rehabilitation is a dynamic profession, with outstanding practitioners and educators. Hear about all the great work being done and meet people with the same interests. You can make invaluable professional connections as well as renew friendships and make new ones.
- **Leadership:** Not only can you learn from the experts, but take the opportunity to meet them, shake their hand and share a conversation. Meet the current and previous leaders of AACVPR and learn how you too can become a leader in our field.
- **Fun:** Get recharged at the AACVPR Annual Meeting and energize your passion. Enjoy the Celebration Banquet, the 25th Anniversary activities and other happenings.
- **Information:** Learn about “Best Practices”. Take home tangible, implementable ideas to grow your program and optimize outcomes for your patients. Meet industry vendors and learn about the latest tools and products to improve your practice.

However, not every member of AACVPR attends the meeting. Why, we can only speculate. Cost, time, coverage and travel are the most often heard reasons. You should not let these issues get in the way of what can be a terrific professional experience. Plan early so your facility can arrange coverage. Cost and time spent at this meeting, do not begin to compare with the value of the educational and networking opportunities that are not available anywhere else.

Finally, in this issue of *News & Views*, Sarah Grall, MS, Program Manager of the Cardiovascular Wellness & Rehabilitation Program at the Oregon Heart & Vascular Institute in Springfield, Oregon is spotlighted in the Innovative Programs/Best Practices column, writing about "Evolving Into GREATNESS – the Potential of Every Cardiac and Pulmonary Rehabilitation Program". The question remains – DO YOU HAVE THE TOOLS TO OBTAIN GREATNESS? One way to obtain them is to take advantage of the tremendous opportunities at the AACVPR Annual Meeting. **See you there!**

"Be not afraid of greatness: some are born great, some achieve greatness, and some have greatness thrust upon them."

*(William Shakespeare, 1601)*

**President’s Message**

Randal J. Thomas, MD, MS, FAACVPR
AACVPR President 2009–2010

**The Secret to Success: Teamwork**

John Wooden, legendary basketball coach at UCLA from 1948 until 1975, passed away recently at 99 years of age. Coach Wooden’s death made me stop to reflect upon the impact that he had on me as a young boy growing up in northern California in the 1960s. I still have a copy of the Wooden biography, *The Wizard of Westwood*, that was my “basketball Bible” as I grew up with hopes of someday making it big in the world of basketball.

Wooden was a remarkable coach, leading his team to 10 NCAA national championships over a 12-year span. His success has been largely credited to his famous "Pyramid of Success" that contained 25 key character strengths that he taught to each of his players. These principles had a common thread — they were character traits of individuals who made up successful teams. Coach Wooden will be missed, but his legacy of teamwork will live on.

Cardiac and pulmonary rehabilitation professionals are no strangers to the principles of effective teamwork. Whether we are working together as a team for our patients, working together as a team at the national level to strengthen the profession of cardiac and pulmonary rehabilitation, or working together as a team with other professional organizations, we understand the power of teamwork.

In coming weeks you will be hearing more about one specific example of the fruits of teamwork for our profession. After several years of teamwork by AACVPR, the American College of Cardiology, and the American Heart Association, the cardiac rehabilitation performance measures were recently endorsed by the National Quality Forum. This important step is a significant step toward having cardiac rehabilitation referral a core performance measure that is collected and tracked by the Centers for Medicare and Medicaid Services. We still have work to do in order to make this happen, but we’re getting close to seeing this wish become reality.

As president of AACVPR, I thank each team member of AACVPR who helps contribute to the overall success of our organization and our profession. Your cooperation, loyalty, enthusiasm, friendship, and hard work are simply remarkable. Coincidentally, they are also the same principles that formed the base of John Wooden’s Pyramid of Success.

**Breaking News!**

**NEW! Interactive Individual Treatment Plan**

This spring, AACVPR announced availability of a template for Individual Treatment Plans (ITP). The templates are intended to be used as best practice examples. A new interactive ITP is now available for AACVPR members. This interactive tool is made possible through in kind support from Cardiac Science Corporation.
Chicago Tribune features Forward by AACVPR President

On June 30, 2010 a Cardiovascular Care supplement was distributed with the Chicago Tribune. A forward written by Dr. Randal Thomas, AACVPR president, is featured on page 2 of the supplement. This message is being distributed via more than 540,000 print copies. A copy of the publication is available via the AACVPR web site. We encourage you to share this information with your patients and colleagues.

AACVPR Conferences

AACVPR 25th Annual Meeting

25th Annual Meeting — Destination: Milwaukee, Wisconsin!
AACVPR 25th Annual Meeting
October 7 – 9, 2010
Frontier 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!

AACVPR Online Store Now Available
Purchase access to educational content online now!

Available online products (synched recordings and PowerPoint presentations of webcasts) include some of the most popular sessions from the 2009 AACVPR Annual Meeting as well as some 2010 AACVPR Webcasts. AACVPR will continue to add new online products regularly.

Online product categories include:

- Behavior Change
- Cardiovascular Rehabilitation & Clinical Cardiology
- Leadership & Innovation
- Program Management
- Pulmonary Rehabilitation & Pulmonary Medicine

Visit the Online Store now!

Member Resources

AACVPR 2010 – 2011 Membership Renewal

As cardiac and pulmonary rehabilitation continues to evolve and change, AACVPR will provide you with resources you won’t find elsewhere. Renew your membership NOW to continue receiving the great benefits of AACVPR membership and reaffirm your commitment to your professional development. It truly takes each one of us, dedicated and committed, to accomplish the challenges that lie ahead.

You can renew your membership one of three different ways:

1. Renew online with a credit card,
2. Mail in a check with your membership invoice or
3. Fax your invoice with credit card information to 312/673–6924.

AACVPR membership runs from July 1 – June 30 so renew your membership with AACVPR TODAY!

AACVPR Liaison Activity

Marjorie L. King, MD, FACC, FAACVPR, Professional Liaison Committee chair

Continuing the theme of tangible benefits for AACVPR members from Professional Liaison Committee activities, I am happy to inform you that the Preventive Cardiovascular Nurses Association (PCNA) has asked us to share Medical Forms Online with AACVPR members. This new section of the PCNA web site provides information on behavior change and adherence with a special focus on older adults. The PCNA Forms tools contain PDF templates of clinical forms and patient handouts that clinicians can use in their CVD risk reduction practice (both outpatient and inpatient). These forms were developed by PCNA to assist in improving the quality of patient healthcare interactions and ultimately patient outcomes. The forms can be integrated into a patient’s medical record and include patient assessment forms, contracts, flow charts, follow-up plans & tools, patient-education materials, and a list of online resources. The forms are located on the PCNA web site and are free to all healthcare providers.

If you have not checked out the AACVPR/VDF PAD Exercise Toolkit, take a look HERE. This Toolkit was designed to help cardiac rehabilitation and wellness programs develop safe, effective exercise programs for patients with peripheral arterial disease and intermittent claudication, and was a joint effort between AACVPR and the Vascular Disease Foundation.

Learn more at the 25th Annual Meeting!

Pre-meeting Workshop — Implementing the AACVPR/VDF PAD Exercise Training Toolkit: Improving and Expanding Your Patient Services

Implementation of the AACVPR/VDF PAD Toolkit — Improving and Expanding Your Patient Services, on October 6, 2010, from 1:30 to 5:30 pm at the AACVPR Annual Meeting in Milwaukee, WI. During this workshop, Kerry Stewart, Marjorie King and Tom Draper will help you identify how to use the Toolkit to add PAD Exercise Training Programs within your existing services. The session will include evidence-based guidelines, practical information, and in-depth information about exercise assessment, prescription, and programming. It will also address business and logistical concerns about adding exercise programming for patients with peripheral artery disease.

Click HERE for more information on the pre-meeting workshop. Don’t miss this opportunity to learn how to add another dimension to your facility’s services!

Education

Kathy Zarling, MS, RN, CNS, Education Committee chair

The AACVPR Education Committee is having a very active 2010!
The 'Program Leadership in the New Era' (PLINE), held on Friday, March 5, 2010, in Washington DC, just after the AACVPR Day on the Hill, drew 90 registrants, including presenters and staff. The conference was very well received, with many excellent comments and evaluations from participants.

Based on the success of this program, PLINE will be held as a pre-meeting event day (October 6th) just prior to the AACVPR 2010 Annual Meeting, from 1:00 pm – 7:45 pm on October 6, 2010 immediately preceding the AACVPR Annual Meeting. AACVPR members attending both the Leadership Conference and the Annual Meeting will receive a discounted registration. AACVPR, AARC, CME, and ANCC credits will be given out to participants. For more information on the day’s activities, please CLICK HERE.

The Education Committee has formed subcommittees to accomplish the overall committee activities:

- The 'Abstract Review Subgroup' reviews, discusses, and evaluates all clinical abstract submissions for the posters at the AACVPR Annual Meeting.
- The 'Continuing Education Credit Subgroup' reviews all applications for AACVPR sponsorship of state and affiliate meetings.
- Subgroups are formed, as needed, such as planning webcasts for the next fiscal year. (One of the goals of the Education Committee is to have each year’s webcasts planned, one year in advance to encourage attendee planning and multi-webcast registrations as well as allow more time for marketing, communication, and webcast repurposing.)
- Webcast topics will be geared to:
  - Cardiac and Pulmonary specialists
  - Program leaders as well as novice members
  - Management or clinical staff
  - Large and small programs
  - Other specialty areas of our organization
- The Webcast schedule for all of 2011 topics will be announced soon.

Please visit the AACVPR web site if you are interested in being involved as an AACVPR committee member.

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**Inside the Industry**

**Behavioral Medicine**

**AHA Advisory for Depression Screening**

Glenn Feltz, Psy.D.

Clinical Psychologist

Delta Psychology Center

Decades of research shows cardiac patients with comorbid depression are at higher risk (1.5 to 2.0 times relative risk) for adverse events and that depression can adversely affect prognosis, recovery, rehabilitation, and quality of life. In 2008 the American Heart Association recommended that all patients with cardiac disease be screened and treated (if necessary) for depression. (In 2007 AACVPR recommended screening for several psychosocial risk factors.)

In any phase of cardiac disease treatment the AHA recommends routine screening for depression. Though not recommending specific forms of evaluation, the AHA recommends physicians and other clinicians should at least ask patients two questions (taken from the Patient Health Questionnaire): in the previous two weeks have they been bothered by either "little interest or pleasure in doing things" or "feeling down, depressed or hopeless." Many other more valid and reliable measures are available, however, such as the Beck Depression Inventory (BDI-II), Centers for Epidemiology Studies Depression Scale (CES-D), and the Psychosocial Risk Factor Survey (PRFS).

The AHA advisory indicates that patients who are identified as at risk for depression should be considered for treatment with three possible options: antidepressant medication, cognitive behavioral psychotherapy, and general or structured physical activity.

The advisory is not without controversy. While research shows that treating depression can improve compliance, lifestyle change, and stress levels, no conclusive evidence exists that treating depression improves cardiac outcomes. And screening ALL cardiac patients can obviously be difficult.

**Health and Public Policy FAQs**

Karen Lui, RN, MS, FAACVPR, Health and Public Policy Committee chair

Q. What can be done about exorbitant co-payments for cardiac and pulmonary rehabilitation being charged by both private payers and Medicare managed care plans?

A. This has been addressed in previous articles and continues to be a barrier to participation for many CR/PR patients.

Medicare managed care plans, called “Medicare Advantage” plans, are within their right to charge higher co-payments than fee-for-service Medicare because beneficiaries have chosen to enroll in the Medicare managed care plan in that state. Patients may be attracted to other benefits and cost-savings that the Medicare alternative plans offer. The high co-payments that non-Medicare patients experience are often a result of the health plan that the patient (or his/her employer) has selected, sometimes to save on the cost of premium or due to cost-sharing by the employer.

Medicare Advantage affordability and co-payment amounts have recently come under increased scrutiny by the office of Health and Human Services (HHS). Health Secretary, Kathleen Sebelius, recently sent letters to top insurers’ CEOs that offer alternative Medicare plans for seniors warning them to keep their costs in check or risk being denied the ability to market them next year.

What insurers charge is left mostly to the states, but HHS intervenes in some circumstances. Health insurance is currently regulated on a state-by-state basis with some more closely overseeing health insurers than others.
If you are in a geographic area that is experiencing excessive co-payments for rehab services, it could be worthwhile to proactively seek out those payers (your state-run Medicare managed care plan(s) or your top 2-3 private payers where this is a problem. Ask for a meeting, attempt to educate that payer on the patient benefits of your services, and negotiate a more reasonable co-payment arrangement that will allow better patient participation.

An example of one effort underway is that of the Montana Outcomes Project which has documented high co-payments as a significant and increasing deterrent to utilization of rehab services. The Montana group, led by AACVPR member Mike McNamara, met recently with Montana’s Chief Medical Officer and Bureau Chief. Their plan is to move this up the chain of command through the health department with the intent of taking it to the state Insurance Commissioner.

A number of other AACVPR member programs have been successful in addressing high co-payments. If you have been able to negotiate lower co-payments for your program with local third party payers or your local Medicare managed care plan, please send a summary of your experience to the AACVPR National Office. Specific strategies that have worked will be shared in a future News & Views article.

Innovative Programs & Best Practices
Tracy A. Herron, MS, FAACVPR

This month’s column highlights the “Cardiovascular Wellness & Rehabilitation Program” at the Oregon Heart & Vascular Institute in Springfield, Oregon. The column was submitted by Sarah K. Grall, MS, Program Manager.

Evolving Into GREATNESS — the Potential of Every Cardiac and Pulmonary Rehabilitation Program

First I’ll disclose an important fact. I’m lucky. Very lucky. I had the once-in-a-lifetime opportunity to design and oversee the construction of a cardiovascular wellness center in a new 1-million square foot regional hospital in Oregon. Our little corner of the building is about 12,000 square feet. We have a walking track, locker rooms, showers, a demo kitchen, a resource library, a group exercise studio and two gyms. There is office space for all staff, tucked neatly in the middle of the activity spaces. All of this occupies prominent (and expensive) real estate on the first floor of the Oregon Heart & Vascular Institute.

A year and a half after opening, “business” is thriving. Our Supervised Exercise Program (Phase III) went from 100 to nearly 400 participants. Sure, we took some hits due to the economy, but our programs, particularly the self-pay programs, continue to grow. We offer CV risk and PAD screening, weight management, tobacco cessation, employee fitness, cooking and holistic health classes, and of course, inpatient and outpatient cardiac rehab! What you might find surprising is that we offered these services, to one degree or another, at our old facility. As you might have guessed, we were challenged by space and time. However, by thinking outside the box, we planted a seed. That seed was recognized and supported by key administrative and medical staff, ultimately leading to the high visibility program we enjoy today.

Before we moved, we changed our name to “Cardiovascular Wellness & Rehabilitation”. We were confident that we were moving in a more sustainable direction, and we wanted a name to reflect that. The programming metamorphosis began with the concept of keeping patients. Sounds kind of self-evident, but patients who experience an acute cardiovascular or pulmonary event are going to have a lifetime of disease management ahead of them. Why not offer them long-term programming and support? You can call it Phase III or you can call it something that might be more recognizable, like a Supervised Exercise Program. However, no matter what it is called you will need to break through some barriers that might keep patients from participating.

So… what can you do?

- Keep the cost reasonable
- Make it accessible
- Offer variety
- Accept any provider referrals—at risk individuals, spouses, family members, employees
- Assist with the referral process
- Change your name, especially if you offer more than just cardiac and pulmonary rehab
- From a business standpoint, consider collecting payment upfront, bill for a term rather than per session
- Develop a scholarship or sponsorship program for those that cannot afford the fee
- Market to the primary care community
- No matter what your space is, invite people into it!
- Offer screenings for the community (including your in-house employee community)
- Position a self-check blood pressure machine in your area and encourage people to use it
- Have a Heart Fair
- Put up a display (people LOVE a good nutrition display)
- Ask administrators to join you at staff meetings
- Invite your director to make rounds and mingle with the participants
- Get cozy with your Hospital Foundation staff

We all know the ‘feel good’ atmosphere of any cardiac or pulmonary rehab program. LEVERAGE THAT and share it as much as possible. Shift your thinking to accommodate people for the long haul. Convey this thinking from the moment you meet someone, whether it is a new patient in Phase II or someone who participated in a “Know Your Numbers” program. After all, good health is no accident, it is a choice that needs careful, on-going cultivation, support and expertise from some of the most talented and skilled employees in the healthcare profession — YOU!

Pulmonary Point of View
Gerene Bauldoff, PhD, RN, FAACVPR

FDA Updated Recommendations Regarding Long-Acting Beta Agonists

The Federal Drug Administration (FDA) has published new recommendations for long-acting beta agonist (LABA) drug labels. LABAs are used in both asthma and COPD. Note that these recommendations apply only to use in asthma, not COPD. The reason for the label modification was increased risk for severe
Exacerbation of asthma symptoms, leading to hospitalizations as well as death in some who have used LABAs in asthma treatment. This risk has been noted in both pediatric and adult populations. The new recommendations include:

1. LABA use alone with a long-term asthma control medication (such as an inhaled corticosteroid) is CONTRAINDI CATED
2. LABAs should not be used in patients whose asthma is adequately controlled on low or medium dose inhaled corticosteroids
3. LABAs should only be used as additional therapy in patients taking but not adequately controlled on a long-term asthma control medication
4. Re-assessment of the need for LABAs and plans for step-down in therapy (leading to discontinuation of LABA) should occur once asthma control is achieved
5. Remember, LABAs do not relieve sudden-onset asthma symptoms. These patients should always have a rescue inhaler (i.e. albuterol) to treat these suddenly occurring symptoms

Why is this important in pulmonary rehabilitation?
As the primary source of medication education for our patients, we need to be aware of emerging information regarding medications potentially used in our patients. While these recommendations do not apply to patients with COPD, we often work with patients who carry a co-morbid diagnosis of asthma. If you have a patient found to have a positive bronchodilator response, clarification with your medical director should be pursued regarding the impact of these recommendations on the individualized treatment plan for that patient.

Reference:

JCRP Highlights
Mark A. Williams, PhD, JCRP Editor-In-Chief
JCRP Highlights — July/August 2010

This issue is highlighted by a Featured Review entitled 'Neuromuscular Electrical Stimulation and Inspiratory Muscle Training as Potential Adjunctive Rehabilitation Options for Patients with Heart Failure' and manuscripts from Italy, Canada, and the United States.

FEATURED REVIEW

- Neuromuscular Electrical Stimulation and Inspiratory Muscle Training as Potential Adjunctive Rehabilitation Options for Patients with Heart Failure. Ross Arena, PhD, PT, et al (USA, Italy)

CARDIAC REHABILITATION

- Gender Differences in Fatigue Associated with Acute Myocardial Infarction. Michelle Fennessy, MSN, RN, et al. (USA)
- Exercise Capacity in an Individual with LVAD Explantation without Heart Transplantation. Jeremy Patterson, PhD, et al. (USA)
- Prevalence of Musculoskeletal and Balance Disorders in Patients Enrolled in Phase II Cardiac Rehabilitation Program. Kakesh Goel, MBBS, et al (USA)
- Demographic and Clinical Determinants of Moderate to Vigorous Physical Activity During Home-based Cardiac Rehabilitation: The Home-based Determinants of Exercise (HOME) study. Chris Blanchard, PhD, et al (Canada, USA)
- The Relationship Between Marital Quality and Coronary Artery Bypass Surgery as Experienced by Three Couples. David Whitsett, PhD (USA)

PULMONARY REHABILITATION

- Improved Neurobehavioral Functioning In Emphysema Patients Following Medical Therapy. Elizabeth Kozora, PhD, et al. (USA)
- Relationship between BMI, Nutrition, Strength and Function in Elderly Individuals with COPD. Melissa Benton, PhD, RN, et al. (USA)

AACVPR SCIENTIFIC ABSTRACTS

To access the JCRP online, please visit the AACVPR website.

Affiliate Society News

Massachusetts Association of Cardiovascular and Pulmonary Rehabilitation (MACVPR)
Priscilla E. Perruzzi, BA, RRT and Kate Traynor, RN, MS
MACVPR Co-Presidents

Greetings from Massachusetts!

Using AACVPR goals as a strategic planning template, the MACVPR Executive Committee surveyed members regarding 5 initiatives. The 28% response rate was encouraging and has helped us identify priorities for future efforts which include further web site development, suggestions for revenue generation and enhanced member benefits.

Our first meeting of the year was a review of the new cardiac and pulmonary rehabilitation regulations followed by a panel discussion featuring our J14 MAC committee. It was a very interactive meeting that allowed us to see areas that presented the most concerns for our programs.

In March, our Co-Presidents and MAC Committee Chair participated in the AACVPR Day On The Hill in Washington, D.C. They visited the offices of 10 US Representatives and both state senators, including the now famous Scott Brown. The MAC Chair also stopped by the Senate offices of the other states in J14.
Building on the comments from our initial meeting in May we presented "The Must Haves of ITP." This working meeting allowed members to bring their ITP’s to share ideas and get feedback on their program’s forms. It concluded with a panel discussion on the online AACVPR certification/recertification process by members who submitted this year.

We are now putting the final touches on our 2010 New England Cardiovascular and Pulmonary Rehabilitation Symposium to be held on October 23 at Lahey Clinic in Burlington, MA. In addition to our dynamic speakers we will be featuring our first poster presentation. Visit our [website](#) for more details. All are welcome!

North Carolina Cardiopulmonary Rehabilitation Society (NCCRA)
Stacey Greenway, BS, MA, NCCRA President

The NCCRA has recently made some positive updates in our web site which we hope will help facilitate communication with our membership and give potential patients information about local programs. Visit [www.nccraonline.org](http://www.nccraonline.org) to check out the latest information. We appreciate the sponsor of our web site, Life Systems International for helping us to make these changes possible.

We have also finalized the location and date of our upcoming 2011 symposium. It will be held at the Friday Center in Chapel Hill, NC, March 3rd and 4th. The President Elect and the NCCRA board are hard at work to make this a successful and educational event for our membership.

If you have any questions about our organization or would like to become involved please contact me at 252/847–2376 or stacey.greenway@pcmh.com.

New York State Association for Cardiac & Pulmonary Rehabilitation (NYSAC&PR)
Karen Pyle, RN, BSN, MEd, NYSAC&PR President

NYSAC&PR held its annual conference at the Hyatt Regency, Buffalo, NY on April 24, 2010. The Conference was preceded by the NYSAC&PR board meeting on April 23rd. Representatives of the six regions of the state (Central, Western, Long Island, Metro/NYS, Northeast and Southeast) were in attendance.

The conference was sponsored by VascuFlo Inc, KABA Healthcare, Scotcare, Dan Riley with Cardiac Science, ResMed, and Medtronics. This year’s theme was Healthcare Reform Means Cardiac and Pulmonary Rehab Reform. It was our second year of doing a one-day instead of our traditional two-day format and there continues to be favorable feedback from our members.

Presentations included: "The Latest about Diabetes and Cardiopulmonary Patients" by Sandeep Dhindsa, MD; "Exercise Prescription and Special Populations" by Allison MacKenzie, MS; "Food to Better Health" by Candis S. Possinger, MS, RD, CDN, CDE; "Motivational Interviewing" by Lewis Forte; "Pulmonary Hypertension" by Norman O. Fiorica, MD; "Cardiac CT and the Inflammatory Process" by John Corbelli, MD and ended with a panel discussion of "How to keep your program open and thriving in the current economy".

NYSAC&PR would like to thank the Western Region for hosting the annual conference and having a wonderful agenda for our members to enjoy.

2010 Calendar of Events

SAVE THE DATE!

AACVPR 25th Annual Meeting – Milwaukee, WI
October 7 – 9, 2010
Midwest Airlines Center
Milwaukee, Wisconsin

For more information, please [CLICK HERE](#).

*If you would like your Affiliate meeting to be listed in the calendar section, please email your Affiliate meeting dates to [aacvpr@aacvpr.org](mailto:aacvpr@aacvpr.org)*

AACVPR Affiliate Meetings:

July 23, 2010: California Society of Pulmonary Rehabilitation North Region Quarterly Meeting
Location: ValleyCare Healthcare, Livermore, CA
For more information, please visit the [CSPR web site](#).

Additional Events and Programs:

September 20-23, 2010: Comprehensive Cardiac Rehabilitation Workshop
Offered by the La Crosse Exercise and Health Program
University of Wisconsin-La Crosse
For more information visit: [www.uwlax.edu/sah/dehp/html/workshops](http://www.uwlax.edu/sah/dehp/html/workshops)
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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