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

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Messages from Headquarters
"The concept of diversity encompasses acceptance and respect. It means understanding that each individual is unique, and recognizing our individual differences. These can be along the dimensions of race, ethnicity, gender, sexual orientation, socio-economic status, age, physical abilities, religious beliefs, political beliefs, or other ideologies. It is the exploration of these differences in a safe, positive, and nurturing environment. It is about understanding each other and moving beyond simple tolerance to embracing and celebrating the rich dimensions of diversity contained within each individual."

University of Oregon Students, 1999

This month’s edition of News & Views begins a supremely important series of articles addressing cultural diversity in cardiac and pulmonary rehabilitation. The first article “Perspectives and Trends in Health Care Disparities and Cultural Competency” addresses the general issues of healthcare disparities for underserved populations with regard to cardiac rehabilitation. Future articles will examine this issue for pulmonary rehabilitation, followed by reports on possible solutions as well as progress by an AACVPR task force assigned to address this area.

Why cultural diversity? Look around your rehabilitation facility. Who is working in the cardiac and or pulmonary rehabilitation programs. What is the ethnicity of your patient mix. Chances are (and fortunately this is not 100% true) is it not very “diverse”. Chances are, that even if you work in a culturally diverse neighborhood, your staff and patient mix does not match the diversity of your catchment area.

In healthcare, lack of diversity translates to differential mortality and morbidity outcomes, and this is just not acceptable. So… what can be done? As a first step keep reading the News & Views series on diversity and possible solutions to expanding our staff and clientele mix. Additionally, we will keep you up-to-date regarding the progress of AACVPR’s diversity initiative.

"Diversity has been written into the DNA of American life; any institution that lacks a rainbow array has come to seem diminished, if not diseased."

Joe Klein (journalist and columnist, 2006)

Message from the President — Expanding our Reach

Randal J. Thomas, MD, FAACVPR

During my fellowship at Stanford University 20 years ago, we carried out a survey of a national sample of cardiac rehabilitation (CR) programs. Our main goal was to identify the percentage of eligible patients participating in CR programs. We were surprised to find that a very low percentage of eligible patients participated in CR-only 11% of post MI and 23% of post CABG patients.

We also found, to our dismay, that CR participation was even lower among racial-ethnic minority groups than among the general population we sampled. As pointed out by Ana Mola in this issue of News & Views, research over many years has shown that people from racial-ethnic minority groups are between a rock and hard place — they have high prevalence rates of cardiopulmonary disease, plus significant gaps in the delivery of appropriate, lifesaving therapies.

This problem is an important, formidable one that will take long-term coordinated efforts to overcome. Is there anything that we, as cardiopulmonary rehabilitation professionals, can do to help? This is a question that has been recently given to a special AACVPR work group that includes Ana Mola. In the coming months and years, we, as an organization, will be carrying out a series of gradual but persistent steps to expand the reach of cardiac and pulmonary rehabilitation into underserved minority groups. If you are interested in helping with these efforts, please contact the national AACVPR office. Together, we can make a difference and increase delivery of rehabilitation services to all eligible patients.

Perspective and Trends in Healthcare Disparities and Cultural Competency

First in a Series

Ana Mola, MA, RN, ANP-BC

In the past decade, healthcare disparities and cultural competency have become a central theme in healthcare education, research practices, clinical care, and health policy. In response to the central issue of health disparities, the delivery of cultural competent care has become a driving force and goal of educational, professional and health service organizations. The racial and ethnic disparities that have illuminated healthcare access, and utilization of services within the diverse populations, have captured the attention of the federal government, regulatory organizations, providers and community based organizations. National concerns regarding social determinants, social injustices, and healthcare disparities have raised an awareness of the understanding of culture in healthcare delivery.¹ One of the most challenging issues for the healthcare system is the fact that the United States Bureau of Census (2000), reported that over 30% of the total population in the U.S. is comprised of various ethnicities other than non–Hispanic Whites. The U.S. Department of Commerce (2000) projects that by 2050, non–Hispanic whites will be in the numerical minority.² The United States needs to address this challenge with initiatives that address the implementation of a culturally competent healthcare delivery system.

In 2003, the Institute of Medicine (IOM) released “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care” documenting the differences in the health and healthcare of racial and ethnic minorities compared to whites. The report highlighted the large body of research documenting the existence of variation in access to care and quality of care provided to racial and ethnic minority patients in our country. The IOM committee recommended initiatives to increase awareness to the general public, healthcare providers, academic institutions, insurance companies, and policy makers about disparities in order to align equity across all boundaries of industries and organizations involved with the delivery of healthcare services. The committee also stressed the need for minority healthcare providers to provide care in underserved communities, and of more interpreters to resolve the language barriers that affect the patient safety and quality of care.³ The Sullivan (2004) report “Missing Persons Minorities in Health Care” further prioritized the need of for the increase of minorities in the healthcare workforce and the need for standards in cultural competence. Furthermore, Healthy People 2010 objectives presented a framework for comparing disparities. A review of Healthy People in 2005 revealed significant improvement in the nation’s health had occurred, but health disparities persist and had changed only minimally.(4)

The racial and ethnic variation in cardiovascular outcomes have been observed and researched. Individuals in specific subgroups defined by race, ethnicity,
socioeconomic status and geography have a disproportionate risk burden of myocardial infarction, heart failure, stroke and other cardiovascular events. These individuals have poorer outcomes, including higher mortality and more unrecognized and untreated risk factors. The disparities not only lie in the access to healthcare and quality of care, but also from disparities in awareness and access to knowledge regarding a healthy lifestyle. (5)

Todd Brown, et al. (2009) analyzed data from 72,817 patients discharged alive after a myocardial infarction (MI), percutaneous coronary intervention (PCI), or coronary artery bypass graft surgery (CABG), between January 2000 and September 2007 from 156 hospitals participating in the AHA Get With the Guidelines Program. Overall, only 40,972 (56%) were referred to cardiac rehabilitation at discharge. A discussion point not illuminated was the fact that 7% of the overall population was African American, and 7% was Hispanic. However, only 7% of the African Americans were referred to a CRP, and 7% were not referred to CRPs. In regard to Hispanics, only 5% were referred to CRPs and 10% were not referred to CRPs. (6) It is transparent that the cardiac rehabilitation community needs to investigate the causes of under referrals and underutilization of minority patients.

In the coming months, representatives of AACVPR will be communicating perspectives and trends in cardiovascular healthcare disparities, as well as the challenges of defining and achieving cultural competency. Through efforts to raise awareness of these issues, AACVPR will be moving toward action plans to help us be part of the solution to healthcare disparities for minorities with cardiac and pulmonary disease.

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Executive Director’s Corner
Joanne Ray
AACVPR Executive Director

What Have You Done for Yourself Lately?

AACVPR is your association and is here to help advance you, your patients and your programs. As you read this issue of News & Views, as you consider your dues renewals, as you plan what’s next for you and your program — ask yourself how AACVPR can help you. Consider what role you will play in this, and what role AACVPR can play, to help make this happen. If you were to complete the following synonyms for “advance”, how would they apply? How can AACVPR continue to provide activities and benefits to advance cardiac and pulmonary rehabilitation?

Move Forward…
Bring forth for consideration or acceptance…
Boost…
Increase…
Raise…
Promote…
Gain…
Obtain advantage…
Develop further,…
Diversify…
Improve…
Progress,…
…and yes — even Payment…

We look forward to advancing together. Apply any of the above to your experience with AACVPR and share your thoughts with us by sending them to me (Joanne Ray) at jray@aacvpr.org with the subject ‘Advance’ in your email. With your help, your patients, your programs and your professional development can be enhanced by AACVPR activities and benefits. However, we need to hear from you to best help you, so I ask again — What Have You Done for Yourself Lately?

Breaking News:

National Quality Forum Endorses the Cardiac Rehabilitation Referral Performance Measures

AACVPR has some very good and long-anticipated news to pass along! The National Quality Forum, the key endorsing body for performance measures that are utilized by the Centers for Medicare and Medicaid Services, is set to announce their official endorsement of the Cardiac Rehabilitation Referral Performance Measures.

This is a very important step toward improving referral of eligible patients to cardiac rehabilitation, and is the result of many months of work by a collaborative group of people from AACVPR, the American College of Cardiology, and the American Heart Association.

The AACVPR staff and leadership will be circulating more information to AACVPR members soon, to help us all understand what this good news means, to help us pass the word along to appropriate leaders and clinicians in our local areas to help implement these measures locally, regionally, and nationally. AACVPR has been in discussion with representatives from CMS, and are hopeful that CMS will now agree to include cardiac rehabilitation referral as a ‘core measure’ for patients hospitalized with a cardiac event.

We are very pleased with this important ‘tipping point’ for our profession, but recognize that there is much work ahead to implement these measures in ways that will lead to improvements in the delivery of lifesaving cardiac rehabilitation services to patients.
Take the Clinical Exercise Physiology Association Salary Survey

Clinical Exercise Physiology Association (CEPA), a member of the ACSM Affiliate Societies, is launching its first salary survey. The survey will capture important employment information specifically related to the clinical exercise physiologist including salary, scope of work, clientele, and job responsibilities. CEPA is distributing the survey to practicing clinical exercise physiologists via a number of avenues, as a result, it is likely that some people may receive the survey multiple times. We ask that you complete the survey only once, but please share the link with other clinical exercise physiologists who may not have received it. The results of this survey will be published and available free to all who provide their email addresses. To take the survey, please CLICK HERE.

Everyone completing the survey, and who provides their email address, will be entered into a drawing to win one of two free registrations for a CEPA webinar (a $50 value) or one of two Clinical Exercise Physiology books (up to an $87 value). [If you want to be specific, the two books are Clinical Exercise Physiology, 2nd ed. by Ehrman, Gordon, Visich, and Keteyian (an $87 value) and ACSM’s Resources for Clinical Exercise Physiology (a $57 value)].

Thank you for participating in this important survey.

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!

AACVPR Webcast Series

AACVPR Webcasts are the perfect format for cardiac and pulmonary rehabilitation professionals to learn about current hot topics in the field from the comfort of your home or office. Each Webcast is one–hour long and includes 45–50 minutes of speaker presentation and 10–15 minutes of participant questions. All you need to participate is a phone line and a computer with internet access!

Only one person needs to register, and you’re whole staff can participate at no additional charge. Up to three complimentary continuing education certificates are available per registration. Additional certificates may be requested for $10 each.

Upcoming Program - AACVPR 2010 Webcast Series:

Register NOW! June 24, 2010 : Specificity of Training: “Back to Work Lab”
Presented by Jenny Adams, PhD and Danielle Straus, BSN, RN–BC from Baylor Health

- Identify the history of traditional Cardiac Rehabilitation guidelines
- Understand Baylor patient case studies involving erroneous exercise prescription
- Identify the benefits of integrating a Return to Work Lab into a traditional Cardiac Rehabilitation Program
- Identify 500 and 1000 dollar budgets that will allow purchase of Return to Work Lab Equipment

For more information regarding AACVPR Webcasts, please visit the AACVPR Web site.
Update on AACVPR Liaison Activity

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

In addition to spreading the news about cardiovascular and pulmonary rehabilitation to our liaisons and alliances, the Professional Liaison Committee (PLC) promotes projects with other healthcare organizations that produce tangible tools for AACVPR members to use to improve the services they deliver in their communities.

AACVPR & Vascular Disease Foundation (VDF) Peripheral Artery Disease (PAD): Exercise Training Toolkit

Over the past year, members of the PLC have worked with experts from the Vascular Disease Foundation (VDF) to produce a Toolkit for cardiac rehabilitation professionals to use to develop supervised exercise programs for patients with peripheral artery disease (PAD) and intermittent claudication (IC). Supervised exercise has a Class I, level of evidence A, recommendation as treatment for IC in clinical practice guidelines which most vascular surgeons, cardiologists, and primary care providers recognize. However, the instruction given to most patients is generally just “go out and walk”, as they are often not aware that these patients are ideal candidates to participate in phase 3 cardiac rehab or wellness programs. At the same time, not all cardiac rehab staff members are aware of the nuances of exercise training and monitoring for these patients.

The PAD Exercise Training Toolkit is available at no cost online in early June by clicking HERE. The Toolkit provides direct links to evidence-based guidelines and educational materials, and includes the following chapters:

- Rationale for Exercise Training in People with PAD
- Differential Diagnosis
- Pathophysiology and Evidenced-Based Guidelines
- Medical Clearance for Exercise
- Pre-Exercise Evaluation of Functional Cardiovascular Response
- Design of the PAD Exercise Training Program
- Interventional Treatment for PAD
- Outcomes Evaluation
- Administrative Considerations for Developing a PAD Exercise Training Program
- Resources for Health Care Professionals
- Staff Education Materials
- Sample Marketing Materials
- Resources for Patients

While access to the Toolkit is free, you will be prompted to create a user name and password. This will help VDF to track its usage as well as provide updates in research and guidelines for users as they become available.

In the near future, the Toolkit will be shared with VDF and AACVPR liaison organizations, which will reach many healthcare professionals who treat patients with PAD. The goal is to link patients to supervised exercise programs in their communities, so please consider using the Toolkit to be ready to enroll them in your phase 3 or wellness programs.

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.

Don’t miss this opportunity to learn how to add another dimension to your facility’s services!

AACVPR ITP Frequently Asked Questions

Due to the overwhelming response to the AACVPR Cardiac and Pulmonary ITP templates, AACVPR has developed a ‘Frequently Asked Questions’ document, now available on the ‘Members-only’ section of the web site. For more information, please CLICK HERE.

Update on Pulmonary Rehabilitation Requirements for Certification and Recertification

Chris Garvey, FNP, MSN, MPA, FAACVPR and Gayla Oakley, RN, FAACVPR

This update is for Pulmonary Rehabilitation programs certifying or recertifying in 2011 (reflecting services provided in 2010). A task force of Pulmonary Rehabilitation clinicians, AACVPR leadership and Certification/Recertification Committee members has begun addressing questions related to AACVPR Pulmonary Rehabilitation certification – specifically the content of the PR medical emergency policy and PR individualized treatment plan (ITP). Task force members include Gayla Oakley, Chris Garvey, Trina Limberg, June Schultz, Lana Hilling, Bonnie Fahy, Mark Zaleskiewicz and Joanne Ray.

The following will need to be included in each applicant’s emergency policy beginning in 2011 (will reflect services provided in 2010):

- Symptomatic bradycardia
- Symptomatic tachycardia
Angular and chest pain
Acute and severe dyspnea
Hyperglycemia and hypoglycemia
Hypertension and hypotension

This is a change from what will be included in the AACVPR PR Guidelines 4th edition. Airway instability and gross hemoptysis are not included in the PR emergency policy and should be part of the programs’ overall emergency management under ACLS. Acute bronchospasm is covered under acute dyspnea. Programs should have staff competencies in place for assessment, management and documentation of these clinical disorders.

The task force is working on updating the AACVPR PR ITP to support consensus from the task force, input from AACVPR members and pulmonary professional societies. It will be made available to AACVPR members once consensus is reached.

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.

Membership invoices will be arriving at your facilities or homes soon. AACVPR membership runs from July 1 – June 30 so renew your membership with AACVPR TODAY!

6th Annual Innovation Award — Deadline Extended: June 16, 2010

The Innovation Award highlights and recognizes programs that have enhanced the delivery of Pulmonary or Cardiac Rehabilitation in especially creative ways through program development and operations. Criteria for the award are based on the definition of Disease Management, as set forth by the Disease Management Association of America (DMAA).

Each year, a number of excellent and innovative programs apply. These submissions demonstrate phenomenal planning, collaboration, and integration that has helped programs grow outside the traditional boundaries. If your program applied for the Innovation Award last year, please consider applying again. Previous winners however are not eligible.

Successful applicants demonstrate excellence and innovation in program development and operations in the realm of Disease Management, including:

- Support of the physician or practitioner/patient relationship & plan of care
- Emphasis of prevention of exacerbations & complications utilizing evidence–based practice guidelines and patient empowerment strategies
- Evaluation of clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health

For a description and to view past Innovation Award recipients, please CLICK HERE.

For the 2010 Innovation Award application, please CLICK HERE.

For more information, please contact the AACVPR National Office at aacvpr@aacvpr.org.

Inside the Industry

Leadership
Barbra Fagan, MS, FAACVPR

When asked why you chose your profession, a common theme that is recited reflects one’s desire to make a difference in the life of someone else. As you walk through your busy days and nights, focused on the many tasks and goals of the moment, it is easy to lose sight of the important role you play in healthcare and specifically in cardiac and pulmonary rehabilitation. As a result, it is important to remind each of you that you do make a difference. I would like to share with you the story of the Starfish, and to let each of you know that because you chose to care, a positive difference has occurred in the lives of our patients. Never lose the passion for what you do and to quote John F. Kennedy, "On earth, God’s work is truly our own!"

The Starfish Story
Original story by Loren Eisley
One day a man was walking along the ocean when he noticed a boy picking something up and gently throwing it into the ocean.

Approaching the boy, he asked, "What are you doing?"

The youth replied, "Throwing starfish back into the ocean. The surf is up and the tide is going out. If I don't pick them up and throw them back they will die."

"Son," the man said, "Don't you realize, there are miles and miles of beach and hundreds of starfish, you can't possibly make a difference!"

After listening politely, the boy bent down, picked up a starfish and gently tossed it back into the surf. Then, smiling at the man he said, 'I made a difference for that one!'

Nutrition Screening to Improve Energy Expenditure for Patients with Chronic Obstructive Pulmonary Disease

Alisa C. Krizan, MS, RD, LD

Individuals with pulmonary disease are frequently malnourished. Malnutrition adversely affects COPD by reducing exercise capacity and ventilatory muscle strength, contributing to impaired gas exchange, and increased risk of respiratory mortality. The etiology of undernutrition with pulmonary disease is not well understood. Several mechanisms have been proposed, including elevated energy expenditure, reduced nutritional intake and inefficiency in nutrient use. Research indicates individuals with COPD may have more impairment with daily living activities and those who are malnourished may have lower lung function measurements, increased dyspnea and lower nutritional intakes.

Prompt referral to a registered dietitian (RD) for nutrition screening may lead to faster recovery, increased muscle strength and functioning, improved lung and immune function and exercise performance. An RD will provide Medical Nutrition Therapy (MNT) for individuals with chronic obstructive pulmonary disease (COPD). MNT allows the RD to provide a patient with specific goals and ideas of how to achieve the goals of nutritional intake based on individual needs. In addition, a quality of life assessment will provide information related to the ability of an individual to obtain, prepare and consume food to meet nutritional needs.

Patients with COPD often show a marked expansion of total body water that could mask the effects of malnutrition on body weight. Registered dietitians will use BMI and weight change to monitor and evaluate weight status in individuals with COPD. Studies report that in individuals with COPD, the prevalence of lower BMI (<20 kg/m2) may be as high as 30%. The risk of COPD-related death doubles with weight loss. The primary goals of MNT are to achieve and maintain weight while improving quality of life, with the focus on prevention and reduced comorbidities.

References:


Health and Public Policy FAQ’s

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

Q: Are my Medicaid patients covered for CR/PR under the 2010 Medicare rules?

A: Medicare and Medicaid are separate programs. Medicare rules fall under Title 18 of the Social Security Act (SSA) and Medicaid rules under Title 19 of the SSA. As such, Medicaid is a federally-funded, state-run program. For specific information about Medicaid eligibility, coverage and services for your state, you would need to contact your local Medicaid office. Each state’s Medicaid office contact information can be found by visiting the Benefits.gov web site or by checking the contact information for State Medicaid offices.

Q: If my patient receives two CR or PR sessions per day, is he/she responsible for two co-payments?

A: Yes, a co-payment amount is due for each session, whether that session is provided once per day or as multiple visits in a day. You might consider the approach of informing your patient upon program entry of the maximum co-payment amount he/she would be responsible for if 36 sessions are completed.

Q: Does our billing office need to use Modifier 59 for multiple CR or PR sessions in one day?

No, the Center for Medicare Management (CMM) within CMS has clarified that for CR and PR services, Modifier 59 is NOT necessary when two sessions per day are provided.

Q: If a patient is referred to Pulmonary Rehab, and the physician has written a diagnosis of emphysema, chronic bronchitis, or any other obstructive lung disease, and the PFT’s fall within the new criteria set forth by CMS, can the patient be admitted into pulmonary rehab with the equivalent of a qualifying diagnosis of COPD, using procedure code G0424? Does the order for pulmonary rehab have to specifically say "COPD" to be covered under the new Medicare guidelines and to use G0424 as the billing code?

A: In posing this question to the medical director of J-3, her response is as follows:

If the patient has obstructive pulmonary disease, e.g., bronchitis, emphysema, with severity as described by GOLD II, III, IV and all other Medicare requirements are met, the patient sounds like a candidate for pulmonary rehab and the code is G0424. We believe this response reflects the CMS regulation in showing that the intent to cover obstructive lung diseases and the order would not have to specifically say “COPD” to be a candidate for pulmonary rehab using the new G0424 code.
Introducing a New Column: Your Goals, Their Rules: Connecting the Dots

Connecting External Requirements to Internal Quality Efforts: What, Why, How
Pat Comoss, RN, BS, FAACVPR

Editor’s Note: It is our pleasure to introduce a new column focusing on the practical implementation of rules and regulations imposed by various regulatory and accrediting bodies. While she is a new regular contributor to News & Views, Pat Comoss is certainly not new to serving as an expert resource for AACVPR and its membership in this area and many others. We appreciate Pat’s continued contributions and her willingness to share her ideas and solutions.

As with all areas of healthcare today, cardiac & pulmonary rehab programs are besieged by countless rules & regulations. Some, like Medicare regulations, are mandatory. Others, like Joint Commission expectations, are voluntary in nature but simply by subscribing to participate we obligate ourselves to adhere to their stated expectations. Likewise for AACVPR program certification requirements.

The Conditions of Coverage (Federal Register 74;226, sections 410.47 & 410.49, Nov. 25, 2009) promulgated by Public Law 110–275, section 144, that went into effect January 1st of this year added to the burden of external requirements. So once again we are hard at work reviewing & revising rehab processes and paperwork to demonstrate and document compliance. But, as you expend that effort, keep this old saying in mind:

Necessity is the mother of invention (derived from Plato)

Consider that doing what we have to do well, not just minimally, can lead to program improvements and patient benefits. Requirements (necessity) can open opportunities (invention). Therefore, the purpose of this column is to:

• Explore connections between rules/regulations and quality improvement,
• Ask/answer if/how we can apply must do tasks to broader purposes; and perhaps most importantly,
• Move beyond the frustration of more work to the expectation of better performance.

By now you’re thinking: Isn’t superficial compliance enough? Why bother digging deeper? Perhaps because your boss and your hospital have set the bar higher than just a passing grade they expect you/your program to exceed expectations, to step-up quality at every chance. But even if they don’t, you should. If you have to change something about how your program operates, make the biggest/best change possible to add quality.

In the coming months, we will look at examples of ‘must do’ items from the quality perspective. Sources of those requirements will include Medicare, The Joint Commission (TJC), & AACVPR program certification — the 3 main authorities whose rules we accept and who in turn scrutinize what we do with them.

For now, one quick example from TJC realm. National Patient Safety Goal (NPSG) #1 = “Improve the accuracy of patient identification”. Implementation requires us to: “use at least two patient identifiers when providing care, treatment, or services”. (TJC 2010 Hospital Accreditation Standards, pg. NPSG–4). Many programs struggle with the necessity of this rule in our rehab settings where staff & patients know each other so well. But rather than resisting what seems like a silly rule, look at it from the perspective of — if we have to do it anyway, how can we make it more functional than just busy work and use it to improve program quality. Some programs have found an answer:

• Minimal compliance approach = when arriving for each rehab visit, patient signs in with name & date of birth (DOB) on individual cards/slips of paper; completed card is handed to a staff member who matches the name & DOB to the patient’s chart to begin the rehab session.
• Quality improvement approach = sign–in cards are pre–printed with a list of top priority questions that should be asked of every patient at every visit; patient is taught to answer the questions each time, which saves staff time & helps assure important information is not missed. Pertinent information is noted in the patient’s chart and the cards are used to check attendance and enter charges at the end of each day before they are shredded.

See the box below for a sample of this useful "rehab ticket" as patients have come to understand it. Clearly, a have–to task produced a quality improvement by aiding staff efficiency and consistency in gathering repetitive but important patient information. Watch this column for additional examples and look for quality improvement opportunities inside every mandate.

---

Welcome Back!
Day: M Tu W Th F Date: _____ Time: _____
Print Name: _______________________
Birth Date _____ / _____ / ______
Any change in medicines since last visit?
NO YES, __________________
Any pain today? NO
YES, heart/chest other _________
How bad on 1 to 10 scale? ________
Exercise since last visit? What _________
# days ______ # minutes each day ________
Next appointment with doctor is:
Date: _______ With: __________________
Measurements on arrival:
Weight: ______ lbs. B/P ________
Pulmonary Point of View
Gerene Bauldoff, PhD, RN, FAACVPR

Web site and Public Health Initiative for COPD

The American Lung Association, the COPD Foundation and NASCARTM have teamed up with Boehringer Ingelheim Pharmaceuticals, Inc to create “Drive4COPD”. This initiative aims to help millions of people affected by COPD by focusing national attention on this common and debilitating disease. The web site for this initiative is: www.drive4copd.com

The campaign includes:

- A year-long competition among the DRIVE4COPD race team members to see who can encourage the most people to take the 5 question screening questionnaire. The race team members include: award winning actor Jim Belushi, country start Patty Loveless, NASCAR champion Danica Patrick, Olympic medalist Bruce Jenner and NFL star Michael Strahan. All are participating in honor of family members who’s lives were impacted by COPD. Currently, Patty Loveless is in the lead with almost 22,000 screenings completed. As of April 18th, more than 57,000 people have completed the screening.
- An original campaign song, “Drive,” composed by country music star Patty Loveless is available for download at the DRIVE4COPD web site.
- 44 local “Pit Stop” COPD screening events will be held at NASCAR events at the raceways of Talladega (AL), Daytona (FL), Martinsville (VA), Brooklyn (MI), and Miami (FL). The DRIVE4COPD 300 took place in February 2010 in Daytona, FL, the first of the NASCAR Nationwide Series™.
- The DRIVE4COPD program can also be followed on Facebook™ and Twitter™.

Why is this important to PR practice?
It’s well known that COPD is significantly under-diagnosed in the U.S. and worldwide. This public health initiative brings together professional associations and public organizations to share the message with millions who otherwise would not be exposed to the reality of COPD. Please share this information with your staff and patients and encourage them to share with their family and friends.

JCRP Highlights
Mark A. Williams, PhD, JCRP Editor-In-Chief
JCRP Highlights – May/June 2010

This issue is highlighted by a Featured Review entitled 'Interstitial Lung Disease and Pulmonary Rehabilitation' and manuscripts from Italy, France, and the United States.

INVITED REVIEW

- Interstitial Lung Disease And Pulmonary Rehabilitation, Chris Garvey, FNP, MSN, MPA. (U.S.A)

CARDIAC REHABILITATION

- Predicting Cardiac Rehabilitation Attendance In A Gender-Tailored Randomized Clinical Trial. Theresa Beckie, PhD, et al. (U.S.A)
- Cardiovascular Rehabilitation In Coronary Heart Disease: Is There A Difference Between Diabetic and Nondiabetic Patients? Laurent Mourot, PhD, et al. (France)

HEART FAILURE

- Cardiopulmonary Exercise Testing Variables Reflect The Degree Of Diastolic Dysfunction In Patients With Heart Failure-Normal Ejection Fraction. Marco Guazzi, MD, PhD, et al. (Italy, U.S.A)

CVD PREVENTION

- Randomized Trial Assessing The Impact Of A Musculoskeletal Intervention For Pain Prior To Participating In A Weight Management Program. Richard Snow, DO, et al. (U.S.A)
- The CEMHaVi Program: Control, Evaluation, And Modification Of Lifestyles In Obese Youth: A Pilot Study. Jeremy Vanhelst, PhD, et al. (France, U.S.A)
PULMONARY REHABILITATION

- A Novel Approach To Measuring Activity In Chronic Obstructive Pulmonary Disease: Using Two Activity Monitors To Classify Daily Activity In A Sedentary Population. Miriam Cohen, MSN, et al. (U.S.A)
- Six Minute Walk Distance In Severe End-Stage COPD Patients: Association With Survival After Inpatient Pulmonary Rehabilitation. Kyle Enfeld, MD, MS, et al. (U.S.A)

To access the online JCRP, please CLICK HERE.

Affiliate Society News

Northwest Association of Cardiovascular and Pulmonary Rehabilitation (NWCVPR)
Dana Gunter, NWCVPR President

Greetings from the NW! We have been busy the past couple of months in the NW affiliate. Our 2010 Education Conference was May 1st in Seattle, WA. Topics included lifestyle and chronic disease with Miles Hassell, MD, lipid management, and counseling for tobacco cessation. We were also pleased to have Candace Steele, FAACVPR talking to us for the second year in a row. This year she updated us on the 2010 HOPPS Rule Changes. In addition, our Washington Department of Health was on hand to help us consider how we can partner together to increase participation in our programs.

We have also just elected a new executive board and the new officers were announced during our conference and took office at that time. Of note for this election we have added some new board members for the first time in this election. With the rewriting of our Constitution and Bylaws in 2009, we added 3 new board members and a President-elect position. The President-elect will hold this position for two years at which time they will become the President. Our three new board members are Regional Representatives — The Regions include Idaho, Alaska and Eastern and Western Washington. It is hoped that the new positions will increase member participation and communication throughout our affiliate. Stay tuned!

Wisconsin Society for Cardiovascular and Pulmonary Health & Rehabilitation (WISCPHR)
Heather Grant, MS, WISCPHR President

Greetings from Wisconsin!
The Wisconsin Society for Cardiovascular and Pulmonary Health and Rehabilitation has had a great year.

Annual Meeting
Our 22nd Annual Conference took place on April 16th and 17th. We offered a pre-conference leadership workshop and informative speed topics on Friday afternoon and evening. On Saturday, our main conference featured speakers Pat Comoss, Murray Low, and Dr. Theodore Gronski.

Outcomes Projects
The Wisconsin Cardiac Rehab Outcomes Registry (WiCORE) continues to be very successful. WiCORE is a patient level cardiac rehab outcomes registry that is managed with help from the Wisconsin Heart Disease and Stroke Prevention Program’ a program under the Wisconsin Department of Public Health and Family Services, which is funded by a grant from the Centers for Disease Control. In its first year, WiCORE had more than 10,000 patients entered into the registry.

WiCORE is open to individual cardiac rehab programs throughout the country as well as affiliates of AACVPR. Programs use the information from WiCORE for quality improvement projects. We also hope to use the wealth of data from this project for research in the future.

The Wisconsin Pulmonary Rehabilitation Outcomes Project (WisPRO) is a pulmonary rehab outcomes database. Over 40 programs from Wisconsin and other states participate in this program which allows programs to compare their aggregated performance outcomes to other programs. WisPRO started in 2003.

Web site
WISCPHR continues to develop our web site. The web site is a valuable tool for our membership offering access to annual meeting presentation files, educational grant application forms, professional education, membership and program directories, and internship postings.

Health Policy and Reimbursement
Wisconsin continues to wait for our MAC to be awarded and finalized along with many other states in the country. WISCPHR funded four members to participate in the AACVPR Day on the Hill in March. These dedicated members were able to continue to foster a relationship with our eight representatives and both senators as well as discuss ongoing legislative issues affecting cardiac and pulmonary rehabilitation.

WISCPHR looks forward to the 2010 AACVPR Annual Meeting in Milwaukee, WI.

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.
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

AACVPR Events and Programs:

June 16, 2010: 6th Annual Innovation Award applications due

AACVPR Webcasts:

Register Now! June 24, 2010: Specificity of Training, "Back to Work Lab"
Presented by Jenny Adams, PhD and Danielle Strauss, BSN, RN–BC from Baylor Health

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:

October 20 – 23, 2010: 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

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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