Have the courage to follow your heart and intuition. They somehow already know what you truly want to become. Everything else is secondary.
– Steve Jobs

If there is one thing that I’ve noticed to be true about people involved in the field of cardiac and pulmonary health and rehabilitation, it’s that they are passionate. They’re passionate about their profession, about doing the right thing, and about doing the right thing well. I would wager that a very high percentage have followed their hearts and intuition right into this field, even though it might not have been the most popular, high-paying, high-tech, or universally accepted. They somehow knew that their focus was to create health, to hold the belief that people are a great source of their own healing, and that, together, almost anything is possible.

We live in an ever-evolving world of health care that appears to be moving into a new system that rewards value instead of volume, has a focus on health instead of illness, encourages best practices for each episode of care regardless of provider services, and values engaging the patient as a participant in their own health and care. Intuitively, we’ve always believed that a focus on health is the right thing to do, and we’ve built our careers around it. We’re now learning much about episodes of care and bundled payments, pay for value and nonpayment for readmissions, Accountable Care Organizations (ACOs), Patient Centered Medical Homes (PCMHs), population health, care coordination, care transitions, care management, patient engagement, and behavior change. These changes potentially create a great opportunity for cardiac and pulmonary health and rehabilitation professionals, and their programs, to do what we do best: create health, serve as behavior-change specialists, and activate the patient to participate in his or her own health.

During this time of change, I’d encourage each of us to continue to learn from one another, to follow our intuitions to do the right thing, to muster the courage to innovate, and to capture the opportunity in health care reform. I look forward to hearing more about the change you are leading; please keep us posted on your progress so we can share the wealth.

Intuition is the source of scientific knowledge.
– Aristotle
President's Message
How Does This All Work?

Steven W. Lichtman, EdD, FAACVPR

In my previous (and first) message last issue, I outlined the broad strokes of what the next year holds in terms of strategic goals and large strategic initiatives for AACVPR. In this message, I would like to outline how these types of initiatives get accomplished in terms of organization and procedures within AACVPR. It’s valuable for you, the members of AACVPR, to understand what our great organization does, how it gets done, and — quite frankly — where your membership and other dollars go.

AACVPR is an almost purely volunteer-driven organization. Volunteer leadership in AACVPR begins with the Board of Directors (BOD). The BOD is comprised of the Executive Committee (president, immediate past president, president elect, treasurer, and secretary) and six directors, each of whom is responsible for overseeing a “Work Group” of AACVPR committees that work toward common goals. For example, the News & Views Committee is in the Communications Work Group, along with the Website Committee.

The president appoints volunteer committee chairs, and each committee chair selects volunteer committee members. Currently there are 15 working committees in AACVPR, each with between five and 30 volunteer members: Document Oversight, Research, JCRP, Health & Public Policy, Website, News & Views, Fundraising & Corporate Relations, Professional Liaison, Certification/Recertification, Registry, Clinical Applications, Membership, Affiliate Link, Annual Meeting Program Planning, and Education. Additionally, there are eight governance committees (which oversee the internal issues of AACVPR) and three task forces (special groups that the president appoints to work on specific initiatives that do not fall under any of these current committees). The current task forces are Cardiac and Pulmonary Rehab Performance Measure Testing, International Relationships, and a new Strategic Initiative Coordination task force.

CLICK HERE to view the full AACVPR Organizational Chart.

CLICK HERE to view a full list of AACVPR Standing Committees.

All members of these groups work outside of AACVPR in his or her “real” job. Therefore, an organization like ours would collapse under its own weight if we had just volunteers. At the board’s direction, AACVPR contracts with SmithBucklin Corporation (the largest association management company in the world) to provide AACVPR with the resources, offices, full-time staff (including Executive Director Joanne Ray, managers Abigail Lynn and Jessica Eustice, Senior Associate Meghan Richards, and Associate Erica Naranjo), and support teams (such as Eric Johnson and his staff who implement the Annual Meeting) to keep the infrastructure of AACVPR intact. AACVPR staff through SmithBucklin are the only paid members of the organization.

In addition to all the committee and structural work, AACVPR volunteers and staff must plan and implement the annual meeting, webinars, Day on the Hill, etc. As our scope, initiatives, and member offerings increase, this becomes a day-to-day challenge. All AACVPR volunteers put in endless hours of work to accomplish our goals. But across the board, it is a labor of love with its own unique rewards: a sense of personal and professional accomplishment; knowing that we are doing the “right thing” for our profession and patients; and meeting and getting to work with a wonderful group of individuals. I have to commend each and all, from our paid staff, BOD, committees, and task forces to all the other “miscellaneous” volunteer individuals, for the magnificent work they perform.

So this leaves us with you, our members. Every member in our organization strengthens our voice in Washington, with payers, sponsors, and like-minded organizations. Every member in our organization adds to our resources to expand member offerings and benefits. Every member in our organization is a potential volunteer leader to add a new set of eyes to what we do. Every member in our organization is a new conduit to providing our patients the best possible care. And finally, every member in our organization is a potential new friend. Therefore, I thank and laud you, our members, for your support of our great organization today and in the days and years to come.
Email Template

This issue is sponsored by:

[Image]

A Note from this Month’s Sponsor:

We’ve Been Here — We’ll be Here!
Since 1989, ScottCare, a Scott Fetzer, Berkshire Hathaway Company, has been committed to the cardiopulmonary rehabilitation professional and we continue to invest in product development, technology, and exceptional customer support. Our newest monitoring platform introduced in late 2010, TeleRehab VersaCare, incorporates the latest technology and clinical tools to provide users with the flexibility to customize a system to best meet their program needs. Offering a completely new clinical interface with sharpened workflow allows rehab personnel to spend more time interacting with patients and less time crunching data. As always, the integrated ScottCare Outcomes program eliminates the need for time-consuming data re-entry, importing and exporting, while providing reports useful for internal and external reporting of patient outcomes and programmatic success. Whether it is use of mobile monitoring technology within or outside of the institution, customized reports, pulmonary specific tools, integrated outcomes, an EMR interface, or multi-facility server based installations, ScottCare can meet your specific needs.

Breaking News
CMS Releases Final Medicare Hospital Outpatient Regulations for 2012
Steven W. Lichtman, EdD, FAACVPR, AACVPR President
On November 1 CMS released the final Medicare hospital outpatient regulations for 2012. Unfortunately, the decision to drastically cut the payment for pulmonary rehabilitation beginning January 1, 2012 is a reality. As the Director of an outpatient pulmonary rehabilitation program, I fully understand and appreciate the ramifications this has for all of us running programs.

Please be assured that AACVPR, in conjunction with other pulmonary societies, will be making every effort to reverse this decision. This will require active participation on the part of everyone involved in pulmonary rehabilitation, and looks to be a long and difficult path. However, if we can all stand strong and continue to serve our patients, and make a collective effort to respond to this, I am optimistic that we will overcome this most recent hurdle.

Our response will be strong and immediate, but the solution is not a fast fix, but rather a long-term effort to correct the data CMS uses to set these rates. This will require education for pulmonary rehabilitation Program Directors as well as your Chief Financial Officer.

AACVPR will remain in constant communication with our members throughout this effort. We have already had a preliminary meeting and the outcome of that meeting is highlighted below.

1. Effective 1/1/12, Medicare payment for pulmonary rehabilitation services billed thru G0424, will be approximately $37/session.
2. The reason for the payment reduction primarily lies with hospital “charges” that are reported by hospitals to CMS on their claims data.
3. AACVPR and the collective pulmonary societies will be crafting long-term strategies to address this issue in the immediate future. Unfortunately, the prospects for a short-term solution are very limited.
4. AACVPR will present a webcast on this issue on Thursday, November 17 at 12:00pm CST. CLICK HERE to register for 2012 Payment Rules for Cardiac and Pulmonary Rehabilitation at a special $35 member rate.
5. AACVPR is exploring options to give program directors additional tools for survival of pulmonary rehab programs within these fiscal constraints. CLICK HERE to see the final rule that includes rates for cardiac and pulmonary rehab. (The discussion of pulmonary rehab begins on p. 503.)

Once again, AACVPR is aware, active, and responsive to this situation.

Breaking News
Update on Cardiac Rehabilitation Performance Measures
Considerable activity continues to take place with regards to the performance measures for referral to cardiac rehabilitation. Recent activities of importance include the following:

1. Final CMS rules for the Hospital Outpatient Prospective Payment System:
The final CMS rules, released on November 1, 2011, contained a new and very important component regarding the performance measures for CR. The new rules include the final determination by CMS to begin collecting, as a chart reviewed performance measure in 2014, the performance measure for referral to CR from an outpatient setting (that is, the performance measure aimed at outpatient medical practice who care for patients who are eligible for CR). Furthermore, CMS announced that they are taking under consideration the inclusion of the performance measure for referral to CR from an inpatient setting, for possible inclusion in future Inpatient Quality Reporting rulemaking from CMS. (AACVPR will continue to follow up on this important additional step in the CMS rulemaking process.)

This is extremely good news for CR professionals for two reasons. First, it makes official, the decision by CMS to help reduce the gap in CR referral and enrollment by holding healthcare providers accountable for the referral of eligible patients to CR. The likely effect of this decision is to increase the referral rates and subsequent enrollment rates of eligible patients into CR programs. Second, this decision provides CR professionals the opportunity to help their local hospitals and outpatient practices initiate steps to improve the CR referral performance and...
documentation, in anticipation of the new accountability they will be under beginning in 2014. The time of improved CR delivery that so many CR professional have hoped for and have worked toward appears to be getting closer to reality!

2. National Testing Project for Performance Measures for Referral to Cardiac Rehabilitation: A working group from AACVPR, ACC, and AHA have been working together during the past year to carry out a national testing project to assess the reliability and feasibility of abstracting the CR referral performance measures from patient records. Individuals from AACVPR who are helping with this project include Marjorie King, Steve Lichtman, Karen Lui, and Randy Thomas. This project is important because it will provide data that are critically important to the National Quality Forum as they consider the re-endorsement of the performance measures for referral to CR that they endorsed in 2007 (with time-limited endorsement). Such re-endorsement will be important as CMS continues with plans to include the CR performance measures in their future plans (see item 1 above). The project is also important because it has helped strengthen an already strong relationship between AACVPR, ACC, and AHA in coordinated efforts to develop and disseminate the CR performance measures.

**Breaking News**

**New Guidelines Upgrade Strength of Evidence for Cardiac Rehabilitation Referral**

*Share the news: The following news item is excellent to share with your referring physicians.*

This past month, three new guidelines have been released by the American Heart Association and American College of Cardiology Foundation, and all three contain good news for cardiac rehabilitation patients and professionals!

The evidence behind the recommendation to have patients with coronary artery disease referred to cardiac rehabilitation has been considered fairly strong in past versions of clinical practice guidelines (level 1B, with the highest level being level 1A).

Based on the accumulation of more and more evidence showing the benefits of cardiac rehabilitation, the new guidelines have upgraded the strength of evidence for cardiac rehabilitation to 1A!

This news is a great testament to both the professionals who deliver effective cardiac rehabilitation services to their patients, as well as to the researchers who have helped produce the large amount of convincing evidence of the benefits of cardiac rehabilitation for the patients we serve.

Well done, everyone!

References:

Secondary Prevention of CAD and other atherosclerotic vascular diseases: [http://circ.ahajournals.org/content/early/2011/11/01/CIR.0b013e318235eb4d.citation](http://circ.ahajournals.org/content/early/2011/11/01/CIR.0b013e318235eb4d.citation)

CABG: [http://circ.ahajournals.org/content/suppl/2011/11/07/CIR.0b013e31823b5fee.DC1.html](http://circ.ahajournals.org/content/suppl/2011/11/07/CIR.0b013e31823b5fee.DC1.html)

PCI: [http://circ.ahajournals.org/content/early/2011/11/07/CIR.0b013e31823a5596.citation](http://circ.ahajournals.org/content/early/2011/11/07/CIR.0b013e31823a5596.citation)

**Executive Director’s Corner**

**Updating Your Profile So We May Better Serve You**

P. Joanne Ray

AACVPR serves as the leading organization representing the specialized professionals in cardiac and pulmonary rehab. Through added insight of our members and your programs, we will be able to combine data to provide better overviews of the field(s), better outcomes information, better detail and tools to help you compare and benchmark your programs, and better opportunities to target communications, education, and funding requests that will
To better serve the many multidisciplinary members of AACVPR, we are expanding the level of detail and demographic information for each member and each cardiac rehabilitation and pulmonary rehabilitation program. Your voluntary cooperation will be key! In December, you'll receive a request to update your information online. This added detail is critical for many reasons:

- Outpatient Cardiac Rehabilitation Registry and Certification. Your program's profile information will be updated in a single form allowing information to flow into the new registry database (launching in June 2012), as well as your certification and recertification applications.
- Knowing more about your programs and focus of clinical work will help our volunteer leaders to develop and deliver continuing education, practice management, and patient education courses and tools.
- Focused funding from industry is key to supplement the dues dollars received from our members and allows us to expand the scope and type of activities to help you improve your personal and programmatic clinical and management education and tools. Knowing more about you and your programs helps us to target (and justify) new avenues of funding opportunities, which means more benefits for you and your staff and patients.

Frequent queries from members focus on information regarding our field(s) as a whole. Researchers (both academic and industry) seek better understanding of the profile of cardiac and pulmonary rehab programs and professionals. As the national association representing you, we should be able to provide these insights and data. With your help, we'll develop (and share) a stronger understanding and overview.

Thank you, in advance, for your prompt attention when you receive the requests next month to update the data on you and your programs.

Member Resources

Pulmonary Rehabilitation (PR) Outcome Toolkit Now Available!
CLICK HERE TO DOWNLOAD!
The Pulmonary Rehabilitation (PR) Outcome toolkit was developed by AACVPR members Chris Garvey, FNP, MSN, MPA; Gerene Bauldoff, RN, Ph.D.; and colleagues to provide fellow members with a resource of evidence-based PR outcome measures and related information. The creators sought expert opinion and input from volunteers of AACVPR, ATS, ACCP, APTA, AARC, and ERS. The intent of the toolkit is to offer resources for program quality improvement, AACVPR certification/recertification, and, ultimately, National Quality Forum (NQF) Performance Measures for PR. The toolkit contains several of the most widely used measures in each domain, with translations and additional information available online.

- **SECTION 1: FUNCTIONAL STATUS/EXERCISE CAPACITY**
- **SECTION 2: DYSPNEA MEASUREMENT**
- **SECTION 3: QUALITY OF LIFE**
- **SECTION 4: DEPRESSION**
- **SECTION 5: CHRONIC LUNG DISEASE ASSESSMENT TOOLS AND RESOURCES**
  a. COPD Assessment Test
  b. METs (metabolic equivalents)
  c. Forced Expiratory Volume In One Second (FEV1)
  d. BODE Index
  e. Six Minute Walk Test Competency
- **SECTION 6: REFERENCES**

Innovative Programs & Best Practices
Notables from the Montana Outcomes Project
Tracy Herrewig, MS, RCEP, FAACVPR
The Montana Outcomes Project started in 2005 with the goal of developing standardized cardiac rehab outcome...
measures to provide benchmarking information to participating cardiac rehab programs. The benchmarking information is used to facilitate quality improvement (QI) activities, with the overarching goal of improving patient care. Twenty-four Montana Association of Cardiovascular and Pulmonary Rehab (MACVPR) cardiac rehab programs, which include programs from Montana and Northern Wyoming, participate in the Outcomes Project. Outcomes data on 11 common cardiac rehab indicators are submitted to the Health Department for analysis on a quarterly basis. Programs receive feedback that includes their individual outcomes data plotted against the aggregate affiliate mean. This feedback highlights areas in which programs are doing well and where QI activities may be warranted.

Each year at the MACVPR annual conference, two programs are spotlighted for their superior work related to outcomes. This year, the large or interventional hospital winner was St. Patrick Hospital's Cardiac Rehab Program from Missoula, Mont., which met or exceeded the affiliate mean in 10 of the 11 indicators. This is the fourth year in a row that St. Patrick's has won this award. The small facility winner was Barrett Hospital in Dillon, Mont., which met or exceeded the affiliate mean in eight of the 11 indicators. Staff members were recognized at the annual conference and were presented plaques. A letter highlighting the program's accomplishments is also sent to the CEO of each hospital. A brief summary of each program is included below.

As you can see, whether you have a large or small program, excellence is attainable and well worth the extra effort. Our patients' lives and the future of our field depend on it.

The success of **St. Patrick Hospital’s Cardiac Rehab Program** is the result of “a model team environment that everyone should work in,” says Susi Mathis, MS, RCEP, CES, LPN. The caliber of the physicians from the International Heart Institute, the nurses, and the support staff, as well as the support of the hospital, are all reasons why the program won the MACVPR Outstanding Award for the fourth year in a row.

- **High Referrals:** Physicians see the positive outcomes of rehabilitation for their patients and refer almost every patient to the program — even if the patient doesn’t typically qualify according to indicators. These referrals, however, make it almost impossible to have any patient who needs the program to be passed over.
- **Continued Physician Commitment:** Once a physician has referred a patient, that physician is still part of the patient's team. If the patient is not meeting goals, the Rehab Program calls the physician and works to develop a plan for better outcomes.
- **Committed Medical Director:** The program would not be so successful without the commitment of Medical Director Phil Roper, MD. He believes in the positive outcomes of the program and expects patients and physicians to follow through with this life-altering therapy. His constant devotion carries significant weight in the way the program is allowed to be modified and flourish.
- **Hospital and Community Support:** The hospital's commitment to its entire heart program — from prevention to rehabilitation — is vital to the success of cardiac rehab. Its mission has never wavered to provide support to those most vulnerable. In addition to this, satisfied rehabilitation “customers” have brought their uplifting stories back to the community, and several fundraising groups, such as the Fraternal Order of Eagles, have provided many thousands of dollars in support of the program.
- **Exposure to Award-Winning Mended Hearts:** Mended Hearts, a national volunteer group that provides inspiration, hope, and encouragement to cardiac patients, is incredibly active at St. Pat's. Recently, the hospital was named Hospital of the Year for the Rocky Mountain Region by the organization. This group is vital to helping patients participate in the rehabilitation program.

The success of the **Barrett Hospital and Healthcare (BHH) Cardiac Rehabilitation Program** is the result of many individuals’ dedication and commitment to improving the lives of others. Most importantly, their patients are determined to improve their own health.

CR Medical Director Dr. Sandra McIntyre is a true “physician champion” who always has time to answer questions, provide direction, and share her knowledge and reasoning with staff members. This directly impacts the CR staff's knowledge and understanding of cardiac-related issues and therefore directly improves patient care. BHH staff are fortunate to work with a team of medical providers, a dietician, a social worker, nurses, and respiratory therapists who deeply care about the patients and respond quickly when concerns for their patients are voiced.

The cardiac rehab program receives strong support from the BHH administrators and the BHH Foundation. When patient referrals increased, hospital administrators responded by budgeting for an additional piece of CR equipment and by hiring an additional CR staff member. This has allowed CR staff members to devote more time to working toward patient goals and improving patient education tools.

The BHH program also credits the Montana Outcomes Project and its creator, Mike McNamara, with invaluable assistance in identifying specific needs of patients who might otherwise get overlooked. McNamara’s dedication to this project has provided a simple, time-efficient way to compare how individual CR programs fare in comparison to
other CR programs across Montana and the United States. This has also enabled greater sharing of ideas among CR programs, which the BHH program found particularly helpful as a small CR program, to get insight from other small programs that often struggle with many of the same issues.

In addition to these contributing factors, BHH has also been involved in the Montana Cardiovascular Disease and Diabetes Prevention Program (MTCVDDPP). This grant-based program has provided staff training on techniques such as “motivational interviewing” and coaching behavior change for a lifetime. The training received through the MTCVDDPP impacted the individual interactions with their patients and improved their abilities to nurture patients toward their CR goals.

BHH’s cardiac patients are a very determined group of individuals who strive to improve their health and well-being. When working with them, the CR staff tries very hard to put other pressing things aside, listen to the patient, and focus solely on their concerns. The goal is for the patient to leave each CR appointment knowing that they are important as individuals and that their goals as patients are important. Patients should leave feeling empowered for their own health, BHH’s cardiac staff works together with the entire health care team to “attack back” the patient’s cardiovascular disease.

Remember to Visit the AACVPR Education Center!

Make AACVPR your go-to resource for education and training solutions. The AACVPR Education Center has dozens of educational webcasts and sessions to meet the needs of cardiovascular and pulmonary professionals — and the collection continues to grow. Browse by category, or use the “Search” feature to find a specific topic. Log in to see exclusive member discounts of up to 50 percent!

These continuing education opportunities are available whenever and wherever you want. Each session purchase can be shared by your whole department. Bring your group together to watch collectively or individually. Even build an “on demand” continuing education program library personalized to the needs of your program and your staff. CLICK HERE to visit the Education Center! Log in to view exclusive member discounts and special offerings.

Inside the Industry

Transition to Evidenced-Based PR Outcomes

Chris Garvey, FNP, MSN, MPA, FAACVPR
AACVPR members should be aware that PR outcome requirements for certification will change from a “domain” model to evidence-based outcomes effective January 2012. When PR programs apply for certification or recertification in 2013, they will need to demonstrate evidence of one year of measurement of outcomes that include:

- Functional capacity, such as pre- and post-PR 6-minute walk test (6MWT);
- Symptoms such as maximum dyspnea with pre- and post-6MWT; and
- Quality of life measurement pre- and post-PR.

To assist in this transition to evidence-based PR outcomes, AACVPR is hosting a reduced-fee ($35 for members) webcast on Dec. 2. CLICK HERE to register today!

Effective care for patients with chronic lung disease includes measurement and analysis of evidence-based
Health & Public Policy FAQs
Processing Claims with a CWF

Murray Low, EdD, MAACVPR, FACSM, Health and Public Policy Committee Chair

Q: How will my billing office know how many sessions a Medicare pulmonary rehab patient has left of the 72 total Medicare lifetime sessions if he/she previously went through pulmonary rehab, especially if he/she came from another state or MAC?

Q: How will my billing office know when to begin using the KX modifier for a Medicare cardiac rehab patient referred to our program, particularly if that patient has come from another part of the country? (Remember: there is no lifetime limit on number of CR sessions.)

Q: What, exactly, is the Common Working File referred to in both the cardiac and pulmonary rehabilitation Change Request instructions to provider billing/coding departments?

A: The same answer applies to all three questions! The Common Working File (CWF) is the master record of all Medicare beneficiary information and claim transactions, including Medicare Part A, Part B, and Durable Medical Equipment data. The claims processing systems interface with the CWF to verify the beneficiary's entitlement to Medicare, deductible status, and available benefits. The CWF also reviews claims history to check for duplicate services, inpatient or Skilled Nursing Facility (SNF) stays, and other insurance that may pay primary to Medicare, secondary to Medicare, or in place of Medicare. As a final step in processing, most claims are sent to the CWF for review and validation of claim data. The CWF performs limited Part A/B crossover editing to insure services are not paid twice on different types of claims. This is how CMS tracks total number of sessions a pulmonary or cardiac rehabilitation patient has once that patient becomes a Medicare beneficiary. Remember that a Medicare patient is limited to 72 lifetime sessions of pulmonary rehabilitation, with the possibility for more in rare situations, based on local contractor discretion. (This limit does not pertain to respiratory care/therapy services for non-COPD Medicare patients.) Your billing office utilizes the CWF in the submission of numerous Medicare claims.

How does the CWF work? The information for each beneficiary is stored in the CWF Master Record. Each CWF Master Record contains but is not limited to:

- Complete entitlement
- Utilization of Medicare benefits
- Claim history
- Medicare Secondary Payer (MSP) and Health Maintenance Organization (HMO) data
- CMN information
- Beneficiary demographics, such as address and date of birth

The Master Record is updated daily. The data stored on the Master Record comes from government agencies, such as the Social Security Administration (SSA), the Coordination of Benefits Contractor (COBC), and other entities involved with Medicare. The beneficiary must notify the SSA of name changes, changes of address, and other beneficiary information in order for the CWF to be updated. Medicare contractors cannot update the CWF information. The CWF creates daily reports for Medicare contractors to use in determining when claims may have been paid in error, which results in overpayment requests to suppliers. This occurs for Home Health, SNF, and HMO claims.
Barbra Fagan, MS, RCEP, FAACVPR

_I saw an angel in the rock and carved until I set her free._
– Michelangelo

If given the opportunity to create the way you deliver cardiopulmonary rehabilitation with consistent quality outcomes, would you do it the same way? If the answer to this question is no, ask yourself, “Why not?” If the answer is yes, ask yourself, “Why are we doing it this way?” Let’s all take this time to explore innovative ways to better serve our patients.

Simply looking at the current delivery system and process may only allow us to see what’s wrong with the current practice. While this approach does have its benefits, most often we only make small incremental improvements. What if you could “transform” your program, not simply improving on what you already have but altogether what you “could” have?

Most often in health care, we rely on left-brain analytical and logical thinking. We set up routine patterns of perception and behaviors, and we rarely deviate from the norm. To implement transformational change, we need intuitive and possibility-oriented thinking. Start with a blank canvas; paint your masterpiece by asking your questions in a new way and choosing to see the possibilities.

Could your initial intake be focused on getting to know your patients better, determining their goals and dreams rather than their heart rate, EF, and diagnosis? What if you asked your patient this question, “If you could do anything and knew you wouldn’t fail, what would that be?” Do you have standard initial exercise prescriptions that are the same for each and every person, or do you allow the patient to participate in this process? Are you taking multiple blood pressures on patients that are not hypertensive? Are you telling the patient what is best for them or leading them to guided discovery? Are you exploring principles of coaching?

There is an old story about four cardiopulmonary rehab professionals named Everybody, Somebody, Anybody, and Nobody. They were all in search of new and better ways to serve our patients and produce quality programming. Everybody was sure that Somebody would come up with great ideas. Anybody could have, but Nobody did. Somebody got upset about that because it was Everybody’s responsibility. Everybody thought that Anybody could do this, but Nobody realized that Everybody wouldn’t. It ended up that Everybody blamed Somebody, when Nobody did what Anybody could have.

AACVPR continues to support innovative programming. Think new, think fresh, and don’t settle. There is much more that we can all do to keep our industry on the cutting edge. It takes the involvement of all our members, not just the contribution of a few. Incredible things happen when you are open to possibilities.

Behavioral Aspects of Rehabilitation

Hostile? You Got the Wrong Person!

Kent Eichenauer, PsyD

“Don’t call ME hostile!” This is one response we fear that we are going to hear from patients when we share test results with them. In fact, talking about hostility is harder than talking about depression, even though it is also a significant psychosocial risk factor. One reason is because this is an area where we are more likely to have blind spots and not see ourselves as clearly as others see us.

First, let us clarify a distinction between hostility and anger. Anger is the _feeling_, and hostility is the _attitude or mindset_. A person with more of a hostile attitude easily finds lots of opportunities to feel angry or frustrated. Patients with problems in this area might have a hard time seeing that there is anything wrong with their attitudes and maybe just cannot understand why others don’t see things their way. It is easy for the patient to feel, “I’m right, and they’re wrong.”
This lack of insight is highlighted in recent studies. One study found that the spouse’s ratings of a subject’s hostility was a better predictor of coronary artery calcification (a precursor for CAD) in the subject than the person’s own self-ratings were.¹ In other words, our spouses frequently see us more clearly than we see ourselves when it comes to hostile attitudes.

Similarly, a recent issue of the Journal of the American College of Cardiology reported that a subject’s hostility as observed through a structured clinical interview, as opposed to the subject’s self-report, helped predict that person as twice as likely to develop CAD over a 10-year follow-up.² In this case, our behavior with a skilled interviewer can reveal a hostile attitude that we might not always admit to but can still be harmful to our cardiac health.

Rehab programs can choose from a variety of assessment tools to measure hostility and anger. Some tools measure hostility and anger in particular, such as the State Trait Anger Expression Inventory-2. Others combine to measure additional important psychosocial risk factors like the Symptom Checklist-90 (depression, anxiety, hostility, and others) and the Psychosocial Risk Factor Survey (depression, anxiety, anger/hostility, and social isolation). Please feel free to contact me (eichenauer@deltapsychologycenter.com) with any questions in this area.


infusions (currently in Phase II testing) and alveolar growth factor were also discussed. The future is bright for COPD treatment!

Remember, all of these presentations are available in the AACVPR Education Center. CLICK HERE to get to the “Annual Meeting” section. So even if you couldn't attend the meeting, the great information is at your fingertips! Nonattendees can buy all of the Pulmonary Rehabilitation track proceedings for only $125 and share them with your whole team!

What's Coming in JCRP

Mark A. Williams, Ph.D., MAACVPR, JCRP Editor-In-Chief

TO GET TO THE JOURNAL OF CARDIOPULMONARY REHABILITATION AND PREVENTION:

● FROM THE AACVPR WEBSITE, CLICK “PUBLICATIONS” AND FOLLOW THE DIRECTIONS OR
● FIND JCRP ONLINE BY CLICKING HERE

Online, take a look at:

● Published Ahead of Print (PAP): Articles not yet available in the Print Version of JCRP can be found by clicking "Published Ahead of Print." Recent PAP additions include "Clinical Research in Cardiac Rehabilitation and Secondary Prevention: Looking Back and Moving Forward," “Aspirin for Primary Prevention of Myocardial Infarction: What Is The Evidence?", "The Development of A Self-Reported Version of the Chronic Heart Questionnaire," and "The Congruence of Patient Communication Preferences and Physician Communication Behavior In Cardiac Patients."
● Collections: There are several current Collections of articles to access by clicking "Collections." Two examples are "AACVPR Statements" and "Review Articles from 2010." All articles in these two collections are free to all JCRP online users.
● Most Popular: In this area, click "Most Viewed" to see which JCRP articles your colleagues are reading, many of which are free to all JCRP online users.

January/February 2012 Issue

This issue is highlighted by an Invited Review titled “Aspirin for Primary Prevention of Myocardial Infarction: What Is The Evidence?” as well Section Papers in Cardiac Rehabilitation and Pulmonary Rehabilitation, and includes manuscripts from The Netherlands, Switzerland, Italy, Spain, Canada, and the United States. INVITED REVIEW

● Aspirin for Primary Prevention of Myocardial Infarction: What is the evidence? Kappagoda et al (USA)

CARDIAC REHABILITATION

Rehabilitation Referral In Increasing Equitable Access and Utilization. Grace et al (Canada)

- Evaluation of the Recommended Core Components of Cardiac Rehabilitation Practice: An Opportunity for Quality Improvement. Zullo et al (USA)

Brief Reports

- The Independent Effect of Traditional Cardiac Rehabilitation and the LEARN Program on Weight Loss: A Comparative Analysis. Aggarwal et al (Canada, USA)

PULMONARY REHABILITATION

- A Simple Method for Home Exercise Training in COPD Patients: 1-year Study. Luca et al (Italy)

Affiliate Reports

Missouri-Kansas Is Outstanding!

Cristy Baldwin, MOKSACVPR President

2011 has been an exciting year for the Missouri-Kansas Association of Cardiovascular and Pulmonary Rehabilitation (MOKSACVPR). We were humbled and honored to be selected as the AACVPR Outstanding Affiliate for 2011, and members attending the AACVPR conference in Anaheim were treated to special recognition at the Celebration Banquet.

Additional highlights in 2011 include:

- The recent launch of the MOKSACVPR website, www.moksacvpr.org, following a major $10,000 system upgrade. New features include an interactive site map of CR and PR programs in Missouri and Kansas and an expanded Members Only Section.
- The addition of a new member benefit with our first free webinar for MOKS members only in November. This is a joint effort with Academy Medical and, if successful, will become a regular benefit to MOKS members.
- Plans are already under way for the 2012 annual education conference on April 13-14 in Kansas City. Many speakers are confirmed, and we are working with both new and previous sponsors for the event.
- Plans are also being made to begin smaller regional networking events throughout Kansas and Missouri to encourage participation in the organization by members and potential members who live in smaller geographic areas.

Texas Maintains Strong Presence

Erika Abmas, RRT, AE-C, TACVPR President

The Texas Association of Cardiovascular and Pulmonary Rehabilitation (TACVPR) represents 140 cardiac programs (45 AACVPR-certified) and 75
pulmonary programs (eight AACVPR-certified), with a membership of nearly 200. TACVPR maintains a strong national presence, with six members involved on AACVPR committees and five members achieving AACVPR Fellowship status.

We’ve just gone through a total overhaul of our website, www.tacvpr.org, and have added many interactive features for our active membership, including:

- A searchable map-based program directory;
- A Frequently Asked Questions section; and
- Online registration capabilities, with automated features to reduce the burden on our Membership Secretary.

We were also excited this year to launch our own Facebook page that allows increased networking opportunities for our members. In addition, we were honored to be recognized as the 2010 AACVPR Affiliate of the Year. Planning for our spring conference is well under way and will be held in Austin on April 20-21, 2012. We will offer attendees 8.5 CEUs, access to more than 15 exhibitors, breakfast buffet and lunch, and great networking opportunities with more than 140 other attendees. The TACVPR celebrates many successes over its 20 years, while facing the same challenges as others across the country. We are whole-heartedly committed to advocating for a strong future for cardiac and pulmonary rehab programs and serving the patients of the great state of Texas!

Calendar of Events/Education

Upcoming AACVPR Webcasts

Click here for up-to-date information on upcoming webcasts!

- December 2: Pulmonary Rehabilitation Outcomes Toolkit (Chris Garvey, FNP, MSN, MPA, FAACVPR)
- December 15: Pulmonary Rehabilitation Research: Translating the Research into Clinical Practice (Brian Carlin, MD, MAACVPR)
- January 26, 2012: Smoking Cessation: Updates in Research and Practice (Ana Mola, MA, RN, ANP-BC, CTTS)
- February (Date TBA): Cardiac Rehabilitation Research: Year in Review (Murray Low, EdD, FACSM, MAACVPR)

AACVPR members can register for AACVPR webcasts online using a credit card! Click here to register.

Program Leadership in the New Era (PLINE) Webcast Series

8 Great Speakers, 7 Relevant Topics, 1 Power-Packed Program!
Share this virtual conference on running a successful rehabilitation program with your entire professional team. The webcasts can be purchased as individual sessions or as a package.

- Medicare Regulations for Cardiac & Pulmonary Rehabilitation: 2010 Review - 2011 Preview (Phillip Porte)
● New Process for Patient Recruitment, Enrollment, and Retention (Richard Josephson, MS, MD, FAACVPR)
● The State of Pulmonary Rehabilitation: Guidelines, Reimbursement, and Outcomes (Chris Garvey, FNP, MSN, MPA, FAACVPR & Gerene Bauldoff, RN, PhD, FAACVPR)
● AACVPR Core Competencies for Cardiac Rehabilitation and Secondary Prevention Professionals: 2010 Update (Larry Hamm, PhD, FAACVPR)
● Individualized Treatment Plans — The Roadmap to Success for Your Programs (Gayla Oakley, RN, FAACVPR)
● Motivational Interviewing for Behavior Change (Michael Burke, EdD)
● Managing Your Program’s Fiscal Strength: What You Need to Know, What You Need to Do! (Murray Low, EdD, FACSM, FAACVPR)

Get on-demand access and continuing education credits. Click here to register.

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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