"Everyone has a plan ‘til they get punched in the mouth."

- Mike Tyson

As another year rolls by, it is time to for AACVPR to work toward its current priorities and goals. Central to this process is AACVPR’s mission statement: "The American Association of Cardiovascular and Pulmonary Rehabilitation is dedicated to our mission of reducing morbidity, mortality and disability from cardiovascular and pulmonary disease through education, prevention, rehabilitation, research and disease management. Central to the core mission is improvement in quality of life for patients and their families.”

In order to support an organization’s mission, a Strategic Plan must be in place to assure the viability of the organization and its adherence to its mission. Each year, key leaders from AACVPR meet to establish Strategic Goals. In the past, this process established Strategic Goals for the upcoming year. However, this process fell short for long-term planning. Last year, under the leadership of then President Randy Thomas, the AACVPR Board of Directors (BOD) established long-term Strategic Goals for the organization. This year, under the leadership of our current President, Bonnie Sanderson, the strategic planning session was dedicated to determining if the Action Plan for the upcoming year was geared toward the long term Strategic Goals. The BOD believes that this process will result in a more coordinated and successful long-term effort toward achieving our mission.

However, word on the AACVPR street has it that last year's Strategic Goals needed some clarification. Last year's Goals were:

1. Grow and Retain Membership
2. Enhance and Support the Quality of Cardiopulmonary Rehabilitation Services
3. Improve Use and Viability of Cardiopulmonary Rehabilitation Services

Response from AACVPR membership (in the form of the membership survey distributed via email) questioned whether the primary (or at least the first) Goal for our organization should be to grow membership. Well, the BOD completely agreed. At the most recent BOD meeting in December, this very issue was discussed, and as an organization it was decided not to change the Strategic Goals, but to change the direction of our efforts. This year's Goals are:

1. Improve Use and Viability of Cardiopulmonary Rehabilitation Services.
2. Enhance and Support the Quality of Cardiopulmonary Rehabilitation Services.
3. To Support Strategic Goals 1 and 2; Grow and Retain Membership – Driving Viability and Quality Through Increased Resources from Increased Membership.

We believe this subtle reworking of the Strategic Goals puts our Strategic Plan in better alignment with our Mission. However, it was decided to keep membership in this form as one of the Strategic Goals, but to change the direction...
President’s Message

Bonnie K. Sanderson, RN, PhD, FAACVPR, 2010-2011 President

Happy New Year! AACVPR is entering 2011 with lots of excitement and anticipation as we celebrate positive moves in the areas of legislation, performance measures, and membership growth. The list goes on, as you will surely note in reading this edition of News & Views!

While October’s 25th AACVPR Anniversary Celebration left us with a pleasant glow from past accomplishments, the synergistic energy I observed during our December Board of Directors meeting confirms my belief that AACVPR is ready and willing to strategically move forward. As President, I want to assure each and every one of you that your leadership does listen. We diligently reviewed results from member and non-member surveys, as well as other feedback from members with a more specific focus, such as the registry and educational needs. We reviewed financial reports, committee reports, and action plans that were submitted by committees and task forces. It’s a lot of information to collectively synthesize and help guide us to make decisions that are in AACVPR’s best interest.

However, it helps me to keep all of this in perspective by remembering the quote by Stephen Covey: “The main thing is to keep the main thing the main thing.”

What are AACVPR’s “Main Things”?

- Our Mission
- Our Strategic Goals
- Our Strategic Plan
- Our Members
- And — most importantly — Our Patients!

My goal as president is to help keep you, our members, connected and engaged — at whatever level that is most appropriate for you right now. Your input is truly valued. Thank you!

Breaking News

AACVPR Develops Fact Sheets on Cardiac and Pulmonary Rehabilitation Performance Measures

Performance Measures (PM’s) are guidelines that are used to identify and correct gaps in care. Cardiopulmonary PM’s refer to processes or structures of care that have been rigorously tested and have been defined as such for public reporting and benchmarking. Prior to widespread dissemination, PM’s are reviewed and endorsed. One such group is the National Quality Forum (NQF), which reviews and endorses performance measures that are considered for use by the Centers for Medicare and Medicaid Services (CMS).

In 2010, the Referral to Cardiac Rehabilitation/Secondary Prevention Programs (CR) PM’s were endorsed by NQF for time-limited (2-year) use, at which time the measures will once again be reviewed and approved, depending on measure testing results. NQF approval of the Referral to CR PM’s set the stage for inclusion of these measures into measure sets for treatment of coronary artery disease in outpatient and inpatient settings. Performance measures related to Cardiac Rehabilitation/Secondary Prevention Program Delivery are currently under review by NQF for endorsement.

Two sets of PM’s for pulmonary rehabilitation were also approved by NQF in 2010. These PM’s established the 6-minute walk and health-related quality of life (HRQOL) as functional outcomes to document change in function and quality of life after pulmonary rehabilitation. These measures are intended to help hospitals, doctors, other health care providers, and patients understand the role of pulmonary rehabilitation in improving function and symptoms in chronic lung disease. This endorsement has opened the door for formally measuring and reporting the effectiveness of pulmonary rehabilitation. This is an important step in improving awareness and use of this effective service.
AACVPR has developed two fact sheets that programs will be able to use to better understand PM’s and, more importantly, to learn how to implement PM’s into your practice. Click here to access these sheets.
Please feel free to reproduce and include in promotional materials for your center.

**Peripheral Artery Disease (PAD) Performance Measures Released**
PM’s for the treatment of PAD in adults were recently released. It is anticipated that these measures will improve the diagnosis, care and outcomes for individuals with PAD. These measures were developed in a joint effort by the American Association for Vascular Surgery/Society for Vascular Surgery; Society for Cardiovascular Angiography and Interventions; Society for Vascular Medicine and Biology; Society of Interventional Radiology; and the ACC/AHA Task Force on Practice Guidelines, and were endorsed by the American Association of Cardiovascular and Pulmonary Rehabilitation; National Heart, Lung, and Blood Institute; Society for Vascular Nursing; TransAtlantic Inter-Society Consensus; and the Vascular Disease Foundation.

Of note to practitioners in the field of cardiopulmonary rehabilitation is that discussion about “Supervised exercise programs” is an included aspect of the PAD PMs. This represents an outstanding opportunity for cardiovascular rehabilitation and wellness programs to expand their patient base and program offerings.

The PAD PMs include the use of:

- Ankle brachial index
- Cholesterol-lowering medications
- Smoking cessation
- Antiplatelet therapy
- Supervised exercise
- Lower extremity vein bypass graft surveillance
- Monitoring of abdominal aortic aneurysms

The full PAD PMs can be found here.

**New COPD Patient Education Video Available**
A new patient education video, “*Take Control of Your COPD: Guidelines for Better Living*” has been made available through a partnership between AACVPR and the American Lung Association of California (ALAC) (with special thanks to Lana Hilling and John Bess who devoted countless hours to make this video a reality). This video is part of a series of patient educational video segments for people who suffer from COPD, and their caregivers. It discusses the role of pulmonary rehabilitation and strategies to improve symptom control, function and quality of life as well as collaboration with the medical team.

The knowledge and wisdom to manage COPD and to maximize one’s quality of life are known to science and taught in pulmonary rehabilitation programs. However, relatively few persons with COPD are aware of pulmonary rehabilitation or cannot access it. The amount of time required to teach patients about COPD is prohibitive for both primary and specialty medical providers. “Take Control of Your COPD: Guidelines for Better Living” offers the convenience of watching a video when and where viewers want, and chapter-by chapter as time allows.

Remember: Pulmonary rehabilitation is now a covered benefit under Medicare part B for persons with moderate to very severe COPD. Get information about a local pulmonary rehabilitation program on the AACVPR Program Directory.

Do you have something interesting for publication? Please let us know! News & Views welcomes letters in good taste on any topic. All letters must be submitted with the writer’s name (anonymous letters will not be published). Submissions are limited to one per writer per issue and may be edited to meet space requirements.
Update on AACVPR Liaison Activity

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

2010 was a very busy year for the Professional Liaison Committee (PLC). We’d like to highlight a few activities that increased awareness about cardiovascular and pulmonary rehabilitation and improved quality of programming. Along with our liaison associations, we:

- Promoted the Year of the Lung, COPD Awareness Month, and Drive4COPD;
- Developed the PAD Exercise Training Toolkit;
- Participated in the Future of the Cardiac Care Continuum conference;
- Obtained NQF endorsement for the referral to cardiac rehab and pulmonary rehab outcomes performance measures; and
- Wrote articles for liaison organization newsletters to promote cardiac and pulmonary rehabilitation.

During 2011, the PLC plans to reach out in a focused way to patient-centered liaison organizations, with the goal of increasing awareness about cardiac and pulmonary rehab among the public. One of the reasons to partner with liaisons is to utilize and avoid duplication of existing materials and resources by providing AACVPR members access to programs and tools that our liaisons develop. This article highlights opportunities for you offered to us from the American Association of Diabetic Educators (AADE) and the Society for Cardiovascular Angiography and Interventions (SCAI).

American Association of Diabetic Educators: We are all aware that successful diabetic management requires a team effort, with a motivated patient at the center supported by their health care professionals. During rehabilitation, although we are able to provide basic diabetic education and self-management counseling, many patients may be appropriate for referral to a diabetic educator. As an essential member of the care team, diabetes educators are skilled in both the delivery of knowledge and in the interventions that create behavior change. Diabetes educators are change agents and interventionists; they have the ability to interweave all the elements of proper diabetes management, leaving the patient with an achievable blueprint for living a healthy life with their diabetes. The American Association of Diabetes Educators is the association that represents diabetes educators. For more information about the association and the professionals they support, or to look for a diabetes educator in your area, visit [www.diabeteseducator.org](http://www.diabeteseducator.org).

Society for Cardiovascular Angiography and Interventions: One new excellent source for cardiovascular patient educational materials is from SCAI, who have developed SecondsCount.org, a comprehensive, evidence-based resource for patients and their families on cardiovascular disease, with the help of several cardiac care partners, including AACVPR. With patient stories, videos, and a wealth of the most up-to-date information available on heart and vascular disease, SecondsCount.org is the perfect online addition to your cardiovascular rehab center’s counseling and education efforts. The packs are available at no cost to you and include a waiting room poster, informational patient brochures, prescription pads, appointment cards and DVD. Help spread the word to patients at your cardiac rehab facility by ordering a free SecondsCount Patient Pack today. Contact Eric Grammer at [EGrammer@SCAI.org](mailto:EGrammer@SCAI.org) and place an order today. To review the site, simply visit [www.SecondsCount.org](http://www.SecondsCount.org).
Email Template

As part of our media collaboration, Touch Briefings provides AACVPR members free access to the electronic version of *US Cardiology*. AACVPR members can access the current edition, Volume 7 Issue 2, in full in eBook format.

In the latest issue (Volume 7 Issue 2), Randall C. Thompson provides insight into the rapid evolution within cardiovascular imaging with his paper “Cardiac Computed Tomography in Private Practice Settings — A Changing Landscape.” Additionally, Joel W. Hughes et al. contributed “Behavioural Medicine for Patients with Heart Disease — The Case of Depression and Cardiac Rehabilitation.”

*US Cardiology* is a peer-reviewed bi-annual journal that includes review articles, case reports, practice guidelines, and original research. Guided by an Editorial Board of world-renowned physicians, *US Cardiology* comprises articles from recognized thought leaders to deliver comprehensive update on the most important clinical issues facing everyday cardiovascular care.

**Health & Public Policy FAQs: Continually Changing Information, Interpretations**

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

As the new Medicare provisions for cardiac and pulmonary rehabilitation took effect in 2010, programs endeavored to implement the rules in a compliant manner. The Centers for Medicare and Medicaid Services (CMS) provided clarification on numerous aspects as the year progressed. Local Medicare contractors (MACs) have begun to publish their somewhat varied interpretations of the regulations through LCDs (Local Coverage Determinations), bulletins, articles, Open Door Teleconferences, and other communications to providers.

As with all new Medicare rules, there have been many questions. Often the answers evolve rather than providing a quick solution. Sometimes an adequate answer is not obtainable, and a program must provide some of the interpretation for itself.

The Reimbursement FAQ section of the AACVPR Web site has recently been updated with new questions and updated answers specific to *Cardiac* or *Pulmonary*. Information and interpretations will continually change and be updated, so staying current is a never-ending process and one of your more important professional responsibilities.

The bottom line is that a program needs to be knowledgeable of both local and federal regulations to meet compliance. In trying to do the right thing, a regional network of other cardiopulmonary rehabilitation professionals dealing with the same issues and challenges can be most helpful as you work with your own compliance department and administration. Being plugged into your MAC Committee, your state/regional affiliate, and AACVPR will give you the knowledge you need to be the source of accurate information — the expert, so to speak — on cardiopulmonary rehabilitation in your institution.

**Innovative Programs & Best Practices**

Tracy A. Herrewig, MS, FAACVPR

This month’s column highlights the “Core Training Program” at the Maury Regional Medical Center in Columbia, Tennessee. The article was submitted by Thomas Cobb, BS, CES, LWMC, Exercise Physiologist, Cardiopulmonary Rehabilitation, President TACVPR.

**Core Training in the Cardiopulmonary Rehab Setting**

Traditionally, cardiac and pulmonary rehab programs have consisted of mainly aerobic training with some introduction to strength and flexibility training. In some respect, aerobic training should be the preferred method of exercise due to the nature of the patient’s diagnosis, cardiovascular or pulmonary disease. However, this narrow training prescription is analogous to building a house without a foundation. The foundation (core) must be developed to provide a stable platform for the remaining construction of the home (body).

The core is defined as the lumbo-pelvic hip complex, and the thoracic and cervical spine. The core is where the
Body's center of gravity is located and where all movement begins. An efficient core is necessary for maintaining proper muscle balance throughout the entire musculoskeletal system. The musculature of the core is divided into two categories: stabilization and movement systems. The stabilization system is primarily responsible for stability of the lumbo-pelvic hip complex. The movement system is responsible for movement, force production, and force reduction of the core. Training should begin from the inside (stabilization) out (movement). This is not to say that a patient should refrain from exercise until the core is trained. Obviously, the core is at work while the patient walks, and even more so on equipment such as an elliptical. Rather, the core should be trained along with the cardiovascular system to improve movement efficiency for cardiovascular strength and endurance. Conversely, a weak core can lead to inefficient movement and unwanted injury. Rehab staff should consider several variables, similar to those for an aerobic or strength training program, before implementing core training in a cardiopulmonary rehabilitation setting.

Each patient is unique. While most will benefit from core training, there are some who will not be candidates. Many of the exercises require the patient to start flat on his/her back or knees. This sometimes presents a problem when severe arthritis or back pain are present, and for patients who are not willing to try something new.

The response and results we have seen in the Cardiopulmonary Rehabilitation Department at Maury Regional Medical Center in Columbia, TN have been very positive when implementing a core training program with the right candidates (patients). A core training program can be as easy or difficult as the rehab professional wants to create.

The key to any successful program is setting realistic goals, providing positive feedback, and sharing enthusiasm. I would recommend taking a continuing education course, purchasing a book, and practicing core exercises before using them in a rehab setting. Above all else, exercise should be fun. If you have any questions regarding core training and implementation, feel free to contact me (tcobb@mauryregional.com). One final thought: I have never heard patients say no when I get down on the floor with them.


CEPA Releasing Salary Survey Results
Aaron Harding, MS, RCEP, FAACVPR; Dave Verrill, MS, RCEP, FAACVPR; Clinton Brawner, MS, RCEP; and Sam Headley, Ph.D., FACSM, RCEP, CSCS

The Clinical Exercise Physiology Association (CEPA) conducted a survey in the spring of 2010 on "Clinical Exercise Physiology Salaries" with 815 respondents. Highlights of the results are being published for the first time in this issue of News & Views, with the full report available for CEPA members at www.cepa-acsm.org on February 1. The purpose of this survey was to collect employment data including salary, scope of work, patient base, and job responsibilities among clinical exercise physiologists (CEPs).

The median age of the respondents was 36-40 years. Of these, 67% were women and 33% were men. Ninety-four percent worked in the United States, 4% in Canada and 2% in other countries. Nearly two-thirds of respondents worked primarily with patients with cardiovascular disease. Over 60% worked in cardiac and/or pulmonary rehabilitation programs. In addition, 747 respondents (92%) reported having a bachelor's degree or higher in exercise science without a concomitant professional degree (e.g., dietitian, nurse, etc.). Among theses 747 CEP respondents: 85% were working full time; 26% had a bachelor's degree; 67% had a master's degree; 81% had a clinical certification (e.g., ACSM Clinical Exercise Specialist or Registered Clinical Exercise Physiologist).

The median annual salary among CEPs working full time was $47,501-$50,000. Salary was higher among those with an advanced degree; however, there was a larger difference based upon years of experience. The salary for CEPs was $5,000 higher among those with a clinical certification compared to those without. Across regions within the United States, the lowest and highest median annual salary was $42,501-$45,000 (Midwest) and $67,501-$70,000 (West), respectively.

Nutritional Aspects of Rehabilitation

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Nutrition News on Diabetes

Alisa C. Krizan, MS, RD, LD

The Centers for Disease Control report that nearly 24 million Americans have diabetes. It is the sixth and seventh leading cause of death in the United States for men and women, respectively. Adults with diabetes are at greater risk for dying from heart disease than adults without diabetes (1). Heart disease and stroke account for approximately 65% of deaths among persons with diabetes (1). During 1997-2005, the age-adjusted prevalence of diagnosed diabetes in the United States increased 43%, from 3.7% in 1997 to 5.3% in 2005 (2). In 2005, cardiovascular disease affected approximately 6 million adults aged >35 years with diabetes and was a major cause of morbidity and mortality (2,3). Risk factors for heart disease among persons with diabetes include hyperglycemia, hyperinsulinemia, hyperlipidemia, hypertension, obesity, and microalbuminuria, which often precede the onset and diagnosis of diabetes (4).

A major federally funded study of 3,234 people at high risk for diabetes showed that people can delay and possibly prevent the disease by losing a small amount of weight (5 to 7 percent of total body weight) through 30 minutes of physical activity 5 days a week and healthier eating. Nutrition plays such an important role in the management of the disease and medical nutrition therapy (MNT) can prevent or delay diabetes. (5,6)

November was set aside as National Diabetes Month to increase awareness, prevention, and ways to manage disease impact. President Obama made a proclamation at the beginning of the month to increase awareness and efforts to reduce the incidence of diabetes. The proclamation specifically addressed the need for “all new health plans and Medicare to provide diabetes screening free of charge to patients and Medicare covers the full cost of (MNT) to help seniors manage diabetes.”

As Representative Danny K. Davis (D-IL) recently reported in a statement on the floor of the House of Representatives, “We must work to get medical nutrition therapy covered by Medicare for beneficiaries diagnosed with pre-diabetes. Nutrition therapy provided by registered dietitians has a proven track record of preventing diabetes through lifestyle changes that simply cannot be made without this assistance for the majority of those who suffer.” He went on to say, “Consider that the total cost of diabetes in 2007 was determined to be $218 billion.”

Marion Franz, MS, RD, reported in his article “The Evidence for Medical Nutrition Therapy for Type 1 and Type 2 Diabetes in Adults,” published in the December 2010 Journal of the American Dietetic Association, “MNT plays a critical role in managing diabetes and reducing the possible complications related to poor glycemic, lipid, and blood pressure control (7). The need to provide patients with evidence-based nutrition care is essential to providing optimum diabetes care.” She went on to report, “The evidence is strong that MNT provided by RDs (Registered Dietitians) is an effective and essential therapy in the management of diabetes. RDs are uniquely skilled in this process.”

To find a registered dietitian in your area, go to the American Dietetic Association Web site at: http://www.eatright.org/. As reported earlier in this edition, to look for a diabetes educator in your area, visit www.diabeteseducator.org.

The Impact of Inhaled Corticosteroids on Increased Risk of Diabetes  
Gerene Bauldoff, PhD, RN, FAACVPR  
Suissa and colleagues reported, in the American Journal of Medicine, on the impact of inhaled corticosteroids on increased risk of diabetes (1). The study group included 388,584 patients from the Quebec health insurance databases who were prescribed respiratory medications between 1990 and 2005. Of these, 30,167 developed diabetes during the 5-year period (incidence rate of 14.2/1000/year). Of more concern, 4 years later, those who were initiated on an oral hypoglycemic advanced to insulin therapy for DM control (incidence rate of 19.8/1000/year). A positive association was found between current corticosteroid use and rate of diabetes progression (RR 1.34; 95% CI, 1.17-1.53). Differential findings were noted where patients on the highest doses of inhaled corticosteroids (equivalent to fluticasone ~ 1000ug/day) had the greatest risk for diabetes progression (RR 1.64; 95% CI, 1.52-1.76). These findings are different from prior reports that may have been underpowered due to small sample sizes.

Why is this important in pulmonary rehabilitation? A significant portion of our PR population is prescribed inhaled corticosteroids. With this new information, it is important that we modify our teaching related to inhaled steroid medications to include the risk for developing diabetes for these patients, especially those who are prescribed the highest doses.

LITERATURE UPDATE

• The JCRP is available online!

Committee and Task Force Updates

Cardiac Rehab Registry a Go!
Mark Vitcenda, MS, FAACVPR, CR Registry Committee Chair

After almost five years of discussions and planning, the AACVPR Board of Directors gave their approval on December 10, 2010, to fully fund the development of the country’s first nationwide outpatient cardiac rehabilitation outcomes registry. This is a momentous milestone for AACVPR and CR programs in the US (pulmonary practitioners don’t worry: a pulmonary rehab registry is under development and is expected soon after the CR registry launches). The CR registry will provide participating programs with a unique and powerful tool for tracking patient outcomes and program performance in meeting evidence-based guidelines for secondary prevention of heart and vascular disease.

Now the real work begins. The Registry Committee has laid the initial foundation with regard to the outcome measures that will be included in the registry. The Registry Committee will work closely with national experts and pilot programs to fine-tune these. But there’s a lot more to do than just put together a database. To illustrate how complex this project is, here are other aspects that the Registry Committee, Dr. Carl King (the Project Manager), AACVPR, and the developer, AMEDCO, will be working on while the registry takes shape:

- Creating and testing the web-based user interface for function, clarity, accuracy, and security.
- Creating supporting documents such as user agreements, FAQs, help text and technical manuals for users and programmers.
- Developing and testing the reporting features of the registry for accuracy and validity.
- Developing and testing user support functions and training modules.
- Working with commercial partners such as ScottCare, Cardiac Sciences, Life Sensing International, and others to develop, test and implement methods for transferring data from commercial outcome applications to the registry.
- Working with interested partners in health care on continued funding opportunities.

What an exciting time! We’ll keep AACVPR members regularly informed of our progress and will notify membership as we get closer to our “go live” date in early 2012. In the meantime, keep up the great work that you’re doing on collecting and using your outcomes data to improve your patients’ care.

Affiliate Reports

Arizona Stays Active
Cindy L. Via, RN, B.A.M.

The Arizona Society for Cardiovascular and Pulmonary Rehabilitation (ASCVPR) has had a busy year. We hold quarterly meetings in various areas across the state of Arizona, providing educational updates and lectures focused on cardiac and pulmonary care. We have just over 100 members, including our very active board members who participate in AACVPR Annual Meetings and poster board presentations. Our BOD supports and facilitates AACVPR initiatives and reaches out to our individual hospital leadership teams, keeping them in the loop on important topics such as cost reporting requirements. Our group provides supplemental funds for several of our members to attend the AACVPR Annual Meeting.

ASCVPR supports and encourages our fellow members to participate in the Montana Outcomes project, as we believe that this is an integral part of formulating best practices for both cardiac and pulmonary rehabilitation. We hold a 1.5-day annual state conference each year, providing a wide range of educational lectures from Cardiologists, Pulmonologists, Registered Dietitians, and Mike McNamara, the manager of the Montana Outcomes Registry, and other well-known national lecturers. This year’s state conference will be May 6-7 at Mesa’s Banner Desert Medical Center. Please visit www.ASCVPR.org for details.
Michigan Charts the Unknown
Tom Spring MS, ACSM-CES/CPT

2010 brought with it an air of change and excitement to the Michigan Society for Cardiovascular and Pulmonary Rehabilitation (MSCVPR). After embarking on the joint-affiliate pathway with the national office in 2009 and receiving the honor of Affiliate of the Year, Michigan members were asked to embrace the decision to move forward into uncharted territory. Thus far, we have seen growth in our affiliate that was a little unexpected:

- Our 2010 conference had the highest attendance in many years, enjoying talks by Barry Franklin, Joe Piscatella, and many others.
- Our membership has grown by 25%.
- We have been on the forefront of the Montana Outcomes project, with Michigan programs contributing a significant portion of data for analysis.
- Michigan members can be found in numerous leadership roles within the AACVPR and we are proud to have had several past and present board members, committee chairs and members, and multiple contributions to other areas of the national office activities.

2011 promises to be another exciting year, featuring perhaps our most star-studded and comprehensive conference to date, including Steve Lichtman, John Porcari, and many more! We plan to release the first summary document of the outcomes project for all Michigan programs to use for quality improvement and patient engagement, which was a goal set by the board when the project started. Strengthening state membership value and opportunity and connections with the AACVPR continues to be our goal and mission, with 2011 being a very important year for the MSCVPR. Follow us at [http://mscvpr.org/](http://mscvpr.org/). Happy New Year!

Calendar of Events/Education

January 27, 2011
AACVPR Webcast: Putting Performance Measures into Practice to Improve Cardiac Rehabilitation Program Enrollment & Quality of Care

Presented by Randal J. Thomas, MD, FAACVPR, and Marjorie King, MD, FACC, MAACVPR

[Click here for more information!](#)

March 2 & 3, 2011: Day on the Hill
Healthcare Reform in an Ongoing Process
[Click here for more information!](#)

March 4, 2011: Program Leadership in the New Era
8:00am – 3:30pm at the Sheraton National, Arlington, VA
[Click here for more information!](#)

AACVPR Webcasts
[Click here for up-to-date webcast information!](#)

September 8-10, 2011: 26th AACVPR Annual Meeting
Anaheim Marriott Hotel, Anaheim, CA
[Click here for more information!](#)
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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