On June 28, 2012, the U.S. Supreme Court released their greatly anticipated ruling on the constitutionality of the Affordable Care Act (ACA) passed in 2010. The main two issues in question with this decision related to both the insurance mandate and the expansion of Medicaid. While there are political debates and positions from both sides of the aisle, the larger provisions of the Affordable Care Act address the larger issues we face as a nation related to both healthcare delivery and cost. There are numerous sections of the Act that critically affect how we measure, pay for, and improve quality of care. Additionally, in a recent news briefing (July 10, 2012), Deputy Administrator and Director for the Center of Medicare at CMS, Jonathan Blum stated: “We are communicating that the Medicare program has changed fundamentally, to keep beneficiaries well and to keep them healthy …” The court ruling, coupled with a recent decision by CMS to reduce reimbursement for many types of specialists, increase reimbursement for primary care physicians, and provide payment incentives for coordinating a patient's care after discharge, represent seismic shifts that create significant strategic implications on the future direction of the delivery and business of healthcare in the United States.

So what does all of this mean for you and for cardiac and pulmonary rehabilitation? Certainly, as with most everything in life, the devil is always in the details. However, the ACA appears to open up opportunity for our profession and our programs to innovate and redesign in response to the new business models that continue to emerge in hospitals and healthcare systems. The push to drive cost savings in healthcare continues full speed ahead. A number of systems are now being financially rewarded to implement efforts that manage the costs of certain conditions through bundled payments, value-based purchasing, penalty programs, and for a few, the shared savings program or Accountable Care Organizations (ACOs). There is a renewed dedication to focus on three key areas in which cardiac and pulmonary rehabilitation have not only potential but also a proven track record to make significant and positive impact. These three include (but are not limited to) care coordination, preventing admissions/ readmissions, and improving medication adherence.

The new models call for an approach that addresses the high cost and high risk populations from quality, cost, and experience perspectives. Not surprisingly, the populations that rise to the top of almost anyone’s cost and risk lists are the populations with which we already work and have the potential to work, including cardiovascular disease, chronic lung disease, diabetes, and heart failure (HF). Also, and not surprisingly, there is substantial evidence of the value of cardiac and pulmonary rehabilitation when it comes to improving outcomes in a number of these arenas.

Where does one begin? One very simple place to start is to familiarize yourself, your colleagues, your referring providers, and especially your hospital leaders of the evidence behind cardiac and pulmonary rehabilitation related to care coordination, readmissions, and medication adherence. A few recommended items to get you started are listed below.
Additionally, read, know, and distribute the article from Dr. Vera Bittner and the American College of Cardiology (ACC) highlighted in the “Breaking News” feature of this issue of News & Views: “A Call to Arms: Efforts to Improve Outcomes Through Cardiac Rehabilitation.”

1. Published data that show better outcomes for those participating in cardiac rehabilitation, including improvements in morbidity and mortality, reduced hospitalizations, and reduction of medical resources. 2-4
2. Published document emphasizing the important role that cardiac rehabilitation plays in care coordination.5
3. Published data documenting improvement in medication adherence for those participating in cardiac rehabilitation.6

Another critical step is to become better informed on the various strategies and programs that hospitals are implementing to improve care coordination and medication adherence while reducing unnecessary admissions, readmission, and emergency visits. If you don’t know what population health or care coordination are, then begin to immerse yourself in these concepts. Investigate the various models that address care transitions including effective strategies to curb the high 30-day mortality rates and 30-day readmission rates that tend to signal poor discharge transitions and healthcare provider follow-through. There is a role for innovation in cardiac and pulmonary rehabilitation programs and professionals as effective care managers to mitigate the poor outcomes. The upcoming AACVPR Annual Meeting is a great place to learn more about population health, delivering smarter services, innovative programming for HF, and other chronic conditions.

Cardiac and pulmonary health and rehabilitation programs have great opportunity to play a significant role in this changing world of healthcare delivery and economics, so seize the day! How will you continue to grow your role into care management and care coordination? How will you work with your hospital leadership to become population health managers? Begin now to structure your services to provide interventions that modify and improve health behaviors that reduce health risks, improve self-management skills, reduce medical costs, and improve quality of life. Begin now to investigate your organization’s strategic imperatives. Identify ways to highlight your services that provide significant value by enhancing care coordination, reducing hospital admissions/readmissions, and improving medications adherence. What role will you decide to play in this time of change? I look forward to hearing your stories and progress.

“I really don’t mind change; you start.”
— Anonymous

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.

Hope to see you in Orlando!

Steven W. Lichtman, EdD, FAACVPR

Although I may be presenting a biased opinion, the AACVPR Annual Meeting is the yearly seminal event in cardiac and pulmonary rehabilitation. It is without question the premier conference devoted to our field, and offers unmatched educational and networking opportunities for all of us involved in rehabilitation. This year’s Meeting in Orlando, Fla, from September 5 (pre-meeting events) to the 8th, is no exception.

Each year we have added to the value of the meeting for our attendees. Some additional highlights for this year include:

- Wednesday pre-meeting sessions (plan to attend early):
  - “Implementing the Psychosocial Component in Your Rehabilitation Program: From Nuts to Bolts”;
  - “Taking the Next Steps – Moving Programs to Excellence”
- Wednesday evening sessions:
  - “Heart Healthy Culinary Workshop” (dinner included);
  - “Pulmonary Rehabilitation Toolkit – Easy Steps to Successful Utilization”;
  - “Intensive Cardiac Rehabilitation: Dr. Ornish’s Program for Reversing Heart Disease” presented by Dr. Dean Ornish himself.

This year’s keynotes are truly exceptional:

- The opening keynote is Fred Lee, author of “If Disney Ran Your Hospital: 9 ½ Things You Would Do Differently.” Mr. Lee’s book is recognized as THE source for program management. He is presenting “Learning from Disney – Going from Good to Great in Patient Perceptions and Experience.”
- Our closing keynote speaker is Dr. Wayne M. Sotile, presenting a message of challenge and inspiration designed for our patients and ourselves: “Letting Go of What’s Holding You Back!”

Our “Hands on Sessions” (first introduced two years ago) have expanded in scope and popularity. This year we are offering four topics (pre-registration necessary):

- Functional Resistance Training for Pulmonary Rehabilitation
- Functional Resistance Training for Cardiac Rehabilitation
- Cardiac Rehabilitation Exercise Prescription
- Pulmonary Rehabilitation Exercise Prescription

After the conclusion of the “official” conference and in conjunction with the COPD Alliance, plan to join us for an interactive post-meeting workshop: “Becoming COPD Prepared.”

All this is in addition to our complete educational schedule, vendor sessions, exhibition hall, oral and poster scientific and clinical presentations, affiliate meetings, and of course, our Celebration Banquet on Friday evening. This year we will also offer a Networking Breakfast in the Exhibit Showcase Friday morning.

Finally, plan to spend a fun night out with your colleagues at the Florida Affiliate Networking Event, “Howl at the Moon” a dueling piano bar (21 and over). This will be a great event.

If this all sounds like an advertisement for the meeting, that’s because it is. However, I would...
not present this to you if I did not truly believe that attendance at the AACVPR Annual Meeting is the most beneficial experience to enhance your program and help your patients. After all, I have been attending since 1996, way before I become involved in AACVPR leadership. I hope to see each and every one of you at the meeting and please make sure to say hello.

New Contributors

We at News & Views (N&V) are fortunate to welcome Ana Mola, MA, RN, ANP-BC, CTTS, and Lana Hilling, CRT, RCP, to our talented team of writers. Neither of these professionals needs much introduction as both have been active in AACVPR and have served as trusted authorities in the reimbursement realm. Both Mola and Hilling will submit regular articles to the Health and Public Policy (H&PP) Frequently Asked Questions (FAQs) column, which occurs with each edition of N&V.

Mola is a nurse practitioner and serves as Program Director for Cardiac Rehabilitation at New York University Medical Center in New York City. Additionally, Mola serves on the AACVPR Board of Directors as the liaison to the H&PP Committee. Mola will be submitting responses for the Cardiac FAQs.

Hilling is a Certified Respiratory Therapist and Respiratory Care Practitioner and serves as Program Director for Pulmonary Rehabilitation at John Muir Health in Concord, Calif. Hilling has served on the AACVPR Board of Directors and has been a frequent speaker on the topic of reimbursement for pulmonary rehabilitation. Hilling will be submitting responses on Pulmonary FAQs.

Please join me in welcoming both of these experts to our already fine collection of contributors; I know we all say a collective thank you and a hearty welcome. Please send your most pressing reimbursement questions to twojtalewicz@aacvpr.org, so Ana and Lana can answer in upcoming issues of N&V.

Breaking News
A Call to Action: Efforts to Improve Outcomes Through Cardiac Rehabilitation

What are the demonstrated outcomes of cardiac rehabilitation? What is the evidence base? In which guidelines is cardiac rehabilitation a Class I recommendation and in which performance measures is referral to cardiac rehabilitation a call to action? Do you know? Do your providers know? Does your hospital leadership have a clear understanding of the science and value of cardiac rehabilitation? If you’ve been looking for a clear and succinct paper written by a physician for physicians and published through one of our partner organizations, the American College of Cardiology, this link is for you. Dr. Vera Bittner, longtime member and strong voice for the value of cardiac rehabilitation has recently published just this in CardioSource WorldNews, and the ACC has graciously granted permission for all AACVPR members to access this document.

Please refer to page 6 of the following link. Read it, know it, circulate, and distribute the important science: http://bluetoad.com/publication/?i=118240. For a more printer friendly version of the article, click here: http://www.cardiosource.org/News-Media/Publications/CardioSource-World-News/A-call-to-arms.aspx.

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.
Three Great Reasons to Attend the AACVPR Annual Meeting
Anne Gavic, MPA, FAACVPR, and Jan Foresman, RN, MS, FAACVPR
AACVPR 27th Annual Meeting Program Planning Committee Co-chairs

Join us for the AACVPR 27th Annual Meeting in Orlando, Florida, on September 6–8, 2012 (pre-meeting events are on September 5). It is the most sought-after event of the year for cardiac and pulmonary rehabilitation professionals. If you have not yet registered, below are three great reasons you should.

First, the entertainment factor. Among our fantastic speaker lineup is opening keynote speaker Fred Lee, who will entertain and educate as he suggests ways to elevate programs to excellence in patient satisfaction (think Disney). To close the meeting, longtime friend and colleague of AACVPR Wayne Sotile will share a message on how to keep your career passion and help your patients thrive. His presentation will be entertaining as well as insightful and poignant. In between, be sure to join your peers for the Affiliate Networking Event at Howl at the Moon — the dueling pianos will have you requesting song after song.

Second, the networking. The AACVPR Annual Meeting provides a unique opportunity for cardiac and pulmonary rehabilitation professionals to share insights and experiences with one another. Connections started through networking at the Annual Meeting frequently lead to invaluable long-term professional relationships.

The most important reason to attend, however, is the high-quality education. In our ever-changing healthcare environment, best practices, quality, and efficiency have never been so vital. There is no other place like the AACVPR Annual Meeting to find the information you and your program need, presented by leaders in the field. You will have access to more than 40 educational sessions, as well as vendor sessions, hands-on learning, and in-depth workshops — all in one place!

Register for the AACVPR 27th Annual Meeting today and enhance your professional growth, your program quality, and your patients’ care.

We hope to see you in Orlando!

Liaison Activity – AACVPR Joins the Million Hearts™ Initiative
Marjorie King, MD, FACC, MAACVPR

Million Hearts™ is a national initiative to prevent 1 million heart attacks and strokes over the next five years. Launched in September 2011 by the Department of Health and Human Services and co-led by the Centers for Disease Control and Prevention and Centers for Medicare & Medicaid Services, the Million Hearts™ initiative brings together public and private partners to prevent heart disease and stroke. Joining the initiative is a natural fit for AACVPR – helping patients prevent recurrent cardiovascular events is what we have been doing for decades.

The Million Hearts™ initiative seeks to:

Empower Americans to make healthy choices, such as avoiding tobacco use and reducing the amount of sodium and trans fat they eat, to reduce their cardiovascular risk.

Improve care for people who do need treatment by encouraging a focus on the
"ABCS" – Aspirin for people at risk, Blood pressure control, Cholesterol management, and Smoking cessation – four steps to address the major risk factors for cardiovascular disease and help to prevent heart attacks and strokes.

**AACVPR has pledged to support the Million Hearts™ initiative through:**

- The AACVPR National Cardiac Rehabilitation Data Registry, which tracks improvement in blood pressure and cholesterol control, tobacco use, medication adherence, and other outcome measures during and after cardiac rehabilitation. AACVPR will also offer other organizations opportunities to test innovation in secondary prevention using data from the registry.
- Partnerships with the American College of Cardiology (ACC), American Heart Association (AHA), and others to increase participation in cardiac rehabilitation and secondary prevention programs.

**Individual support for the initiative is also important**, as it shows commitment to promoting healthy choices and treating risk factors. Be one in a Million Hearts™ by pledging to get involved and see how your actions can make a positive difference. Please encourage your staff and patients to take the pledge today at [http://millionhearts.hhs.gov](http://millionhearts.hhs.gov). Please also join the Million Hearts™ conversation on Facebook and Twitter.

![Million Hearts](http://millionhearts.hhs.gov/aboutmh/partners/aacvpr.html)

**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 educational opportunities are available whenever and wherever you want. Each session purchase can be shared with your whole team. Bring your group together to watch collectively or individually. Even build an “on demand” 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

Leadership Lessons Learned on a 100-Mile Journey

Barbra Fagan, MS, RCEP, FAACVPR

This past summer I had the opportunity to participate in a 100 mile run – a bucket list event that seemed a bit daunting yet definitely possible. One-hundred miles, 27 hours, and 194,000 heart beats later, not only did I cross the finish line, I was afforded time to reflect on the journey. The journey has and always will be the reward.

Can lessons learned running 100 miles have applications to what we do in our daily lives, day jobs, or more importantly, have relevance to the patients we serve? Certainly! Allow yourself to take you there. Make the connection.

Life happens … it is not what happens but how we choose to react. When I discovered on race morning that all my fluids were sitting in my refrigerator 80 miles away, I had two ways to respond: get upset and stressed or find alternatives. Be flexible. Be determined. Be invested. You will find your way through obstacles, real or perceived.

It is not that you fall — and we all do — rather, how you get back up. Don’t worry about the bumps, you can take it. Don’t steer around challenges, ideas, and goals that scare you — drive right through them, just keep moving forward. Remember, you can press forward long after you think you can’t. You’re stronger than you think you are, and belief in yourself will carry you far.

When shortcuts present themselves (and they will), resist the urge to take them. Work hard, push through, turn a blind eye, do the work. Nothing great was ever achieved by taking the easy way around.

Surround yourself with those who believe in you. Appreciate their contributions to your success. I was greeted at mile 62 by my friend who would pace me through the night, then another at mile 87. Together, we journeyed to the finish. Make people part of the process. Celebrate the milestones. Small successes take you to your goal, rejoice, throw yourself a party, and never under appreciate the accomplishments along the way. How do you finish 100 miles? One step at a time, and I am grateful for each one.

Instead of doing all you can, do all things possible. Possibilities surround us. Explore the wonder of what surrounds you. Argue your limitations, as the only boundaries set are those we create. If you want it bad enough you will do whatever it takes to reach your goal.

Oh, the places you can go. Drink in all the wonder of it, learn all you can. My next journey is the Pikes Peak Marathon. What is yours? Make today your day!

Health & Public Policies FAQs

Pulmonary FAQ

Lana Hilling, CRT, RCP, MAACVPR

Q. What Pulmonary Function values/numbers are required in determining who is a candidate for pulmonary rehabilitation if the patient does not meet the Gold Criteria for COPD?

A. If your patient does not meet the GOLD criteria, they do not qualify for pulmonary rehabilitation, however, he or she may be eligible for respiratory
therapeutic services.

CMS stated that there may be a need for the patient to receive components of a pulmonary rehabilitation program when they don’t meet the GOLD Criteria. Some of the MACs have a Local Coverage Determination (LCD) for respiratory therapy services or respiratory care. They have a list of diagnoses that might be acceptable, but there are no specific PFT requirements. You must document the need for the patient to receive your services, for instance, the patient is more symptomatic or having repeated hospitalizations; he or she requires oxygen now or the oxygen needs have increased, and the patient doesn’t have the correct home equipment to maintain oxygen saturations; the patient is unable to manage secretion clearance or take medications correctly.

It isn’t always about the numbers. Even with the Gold Guidelines COPD Diagnoses, it is imperative that you document well and cover all of the issues/symptoms that the patient is experiencing. Remember, that is why patients need to receive our skilled care.

The revenue code that is used for G0424 is 948; for G0237, G0238 and G0239 the revenue code is 410 or 419.

If you have any questions, please contact your MAC Committee Member.

Cardiac FAQ

Ana Mola, MA, RN, ANP-BC, DNS (c)

Q: A Call to Action: How Do We Ensure a Future for Cardiac and Pulmonary Rehabilitation?

A: As our healthcare system transforms with the passage of a broad scope of healthcare reform, challenges and opportunities will arise in respect to this legislation.

The future of cardiopulmonary rehabilitation programs (CPRPs) will be impacted by these health policies and laws. The Affordable Care Act (ACA) forecasts that an additional 32 million Americans will be added to the count of the insured at a time when there is a shortage of physicians, and limited healthcare economic resources to ensure services for these healthcare consumers. In response to a new, cost effective, and innovative model of care, the AACVPR leadership has advocated a legislative technical correction to Section 144 of PL 110-275 that would allow Nonphysician Practitioners (NPPs), specifically nurse practitioners (NPs) and physician assistants (PAs), to satisfy the physician supervision requirement for cardiac and pulmonary rehabilitation sessions.

Specifically, the Center of Medicare and Medicaid Services (CMS) has ruled that as of 1-1-2010, NPPs may provide aspects of direct physician supervision in accordance with scope of practice and state licensure laws, except in the case of cardiopulmonary rehabilitation (CPR) where a physician (MD or DO) must provide the direct supervision due to the legislative language in Section 144 of PL 110-275. This CMS decision actually reduces access to the benefit, contrary to Congressional intent. CMS has responded that the solution must be a technical correction (legislative language) that includes NPPs in the definition of physician in section 1861(r)(1) of the Act. Technical corrections are not uncommon procedures as part of Congress’ authority over CMS.

Provider availability to ensure patient access of cardiac and pulmonary care is illustrated as CMS allows NPPs in critical access hospitals (CAHs) to operate without a physician on-site. Care is provided by NPs and PAs for example, to staff the emergency room with a supervising MD “on call.” Many CAHs provide CPR as part of outpatient services. CMS has stated that due to legislative language in Section 144 of PL 110-275 that refers to CPR services as “physician services,” CPRPs must have a physician on-site and immediately available to be compliant with the new coverage regulations. This will force the closure of a notable number of CPRPs programs in CAHs, particularly those located in rural areas that operate with an MD on call rather than on the premises. It will also inhibit CAHs from opening programs because of the requirement for physician supervision. Even for urban institutions that enjoy the resources of
NPPs to provide important services, this regulation is a barrier to efficiencies associated with staffing within these institutions. The reality of program closure because of provider availability and economic constrains of managing CPRPs can impact not just one, but all of our programs.

The call to action is NOW as AACVPR has advocated for a senate bill, S.2057, which was co-introduced by Senators Schumer (D-NY) and Crapo (R-ID) in February of this year. Please be aware that there is no opposition from other medical organizations regarding this technical correction, and in fact, AACVPR has the support on this effort from our partner professional associations. AACVPR is pursuing, through one of our co-introducers, a CBO (Congressional Budget Office) scoring for S.2057, in case you are asked that question by your Senator. AACVPR anticipates it will be a no-cost score, because medical supervision for hospital outpatient services is not a Medicare-reimbursed service.

It is critical that AACVPR achieve majority support for U.S. Senate bill S.2057. We need AACVPR members and members of partnering associations to act NOW for support of S.2057 bill. AACVPR has provided two easy ways to participate in this effort.

1. Visit the DOTH web page (PROVIDE LINK HERE) for a link to quick contact information for your two U.S. Senators, an initial template letter/email to send your Senators prior to a telephone follow-up call, talking points for you to use in your conversation, and a leave-behind piece to send to the congressional office.

2. At the AACVPR annual conference in Orlando, there will be a booth where you can receive assistance from the Health & Public Policy Committee in sending an email right from there.

As legislation and regulations evolve in response to new opportunities provided by the ACA, NPPs medically supervising exercise sessions in CPRPs can be an innovative model of care, which will ensure patients access to healthcare services, and address the shortage of providers.

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**Behavioral Aspects of Rehabilitation**

**Behavioral and Nutrition Experts Committee**

*Maria L Buckley, PhD*

Improving quality of life (QOL) is a fundamental aim of cardiac and pulmonary rehabilitation programs. Sexual health is an aspect of QOL that is impacted negatively in many cardiac patients. This year, the American Heart Association (AHA)\(^1\) published a scientific position statement pertaining to sexual activity and heart disease. The article provides practice guidelines around sexual activity across a variety of cardiac conditions. Medication recommendations are also presented. The authors point out that while sexual functioning is reduced in many cardiac patients and that their partners are often fearful about engaging in sexual activity, these issues are inadequately addressed in the medical setting. They suggest that the healthcare provider initiate discussion of the couple's issues. A matter-of-fact and respectful approach is recommended in addressing this subject. One method is to initiate discussion via the use of open-ended questions, such as “Many people have concerns about having sex following a heart attack. What sort of concerns do you have?” Questionnaires have been developed around sexual health but have primarily been used in clinical trials and may be limited in the practical setting. More information about interviewing and measurement around sexual health can be found in an article by Jaarma and colleagues.\(^2\)

The AHA\(^1\) points out that psychological functioning, specifically anxiety and depression, is often related to reduced sexual activity, and that assessment and intervention around psychological functioning are integral to the provision of care to the patient. Evaluation of psychosocial functioning by qualified professionals is consistent with AACVPRs longstanding practice guidelines, thus many programs routinely evaluate...
psychological issues, such as anxiety and depression. The AHA paper also provides suggestions for practical education about sexual activity for cardiac patients, including feeling rested prior to having sex, being in a familiar environment with a known partner to reduce stress, avoiding heavy meals and alcohol prior to sex, and utilizing positions that do not restrict breathing.

Evaluation and intervention regarding sexual activity in the pulmonary population are limited as well. Kaptein and colleagues\textsuperscript{3} found that both male and female COPD patients reported reduced frequency of sexual intimacy compared to normal controls. Males indicated that low self-esteem interfered with their sexual experiences. Vincent and Singh\textsuperscript{4} suggest that patients and practitioners may be embarrassed to raise the topic. The authors emphasize that sensitivity to each patient’s reactions is key in discussing sexual health. Kaptein and colleagues\textsuperscript{3} found that patients did not discuss sexual health issues with their physicians. Thus, the researchers suggest that the use of a clinical instrument, such as the Respiratory Experiences with Sexuality Profile (RESP)\textsuperscript{5}, may spark conversation between the patient and provider. Vincent and Singh\textsuperscript{4} assert that pulmonary rehabilitation is the ideal setting to address this area.

As in cardiac rehabilitation, with physician clearance, qualified pulmonary rehabilitation staff can assess and provide education to the patient around timing, sexual positions, and energy conservation. Specifically, staff may suggest that the patient plan to have sex at the time of day when the patient has the most energy. Patients may wish to utilize positions that require less energy, such as side by side, female patient on top, and male patient standing behind his partner. Support from a wall, table, chair, and/or pillows may be helpful as well. Allowing the partner to remove the patient’s clothing will also enable the patient to save his or her energy for sex.\textsuperscript{4} Neistadt and Freda\textsuperscript{6} offer additional recommendations around sexual activity, including using a well-ventilated or air conditioned room, with physician clearance using rescue inhaler prior to sexual activity. The authors also provide diagrams of positions that require less energy and that do not place pressure on the diaphragm.

Sexual activity is important to many cardiac and pulmonary patients. Proper assessment, education, and treatment referrals provided in the rehabilitation setting may result in meaningful outcomes in the quality of our cardiopulmonary patients’ lives.

References:
1. http://my.americanheart.org/statements


ATS Updates Dyspnea Statement  
Gerene Bauldoff PhD, RN, FAACVPR

In February 2012, the American Thoracic Society published the updated statement on the mechanisms, assessment, and management of dyspnea. The first version of this document was published in 1999. The statement provides a comprehensive review of the physiological and pathophysiological mechanisms for the respiratory sensation of dyspnea. The impact of opioids on dyspnea sensation is described from an evidence standpoint. Steps to evaluate dyspnea are delineated. Dyspnea measurement describes the multidimensional nature of dyspnea. The domains identified include: sensory-perceptual experience, affective distress, and symptom/disease impact or burden (p.441). The important role of real-time, single scale measures to guide the plan of care is emphasized. Treatments are described in detail, providing the latest evidence for the multiple therapies from oxygen through pharmacological options to pulmonary rehabilitation and other non-pharmacologic options, including alternative and complementary medicine approaches. Research priorities are described as well, promoting continued development of new treatments aimed at the mechanisms of dyspnea using an interdisciplinary approach (cardiac and pulmonary rehabilitation are specifically mentioned) across different diagnoses.

Why is this important in pulmonary rehabilitation?

As dyspnea is the primary symptom we deal with in pulmonary rehabilitation, this document should be reviewed by every pulmonary rehabilitation professional and be part of every pulmonary rehabilitation program's library. While the statement is the gold standard in describing dyspnea assessment, in clinical practice some dimensions described (such as affective distress, sensory perceptual, and impact of dyspnea) are commonly evaluated as part of a valid pulmonary-specific instrument assessing health-related quality of life, such as the Chronic Respiratory Questionnaire, the St. George's Respiratory Questionnaire, or the Ferrans and Powers Quality of Life Index (Pulmonary).. In the clinical practice of pulmonary rehabilitation, our dyspnea assessment commonly uses a real-time measure, such as the Borg or RPE rating scales. The use of these rating scales is an important tool to guide interdisciplinary care and clinical management of our patients. The take home message is that while dyspnea rating is central to the care we deliver, we should also consider the other dimensions of dyspnea seen in other tools we are already using to assess the impact of dyspnea on our patients.


What's Coming in JCRP

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

Highlights

I am pleased to announce that JCRP has achieved a significant improvement (20 percent) in the Journal's Impact Factor from Thomson Reuters ISI Web of Knowledge Journal Citation Reports. The 2011 Impact increased to 1.692 from 1.415 in 2010. The ISI Impact Factor is primarily a function of the number of times that other journal articles (outside of JCRP) cited articles published in JCRP over the previous two-year period.

In addition, for the most recent month where data are available (May 2012), the number of visits to the JCRP website was just under 12,000, up 9 percent from April.

Don't forget...

To get to the online Journal Of Cardiopulmonary Rehabilitation and Prevention:

• Once logged in to the AACVPR Web site, click “Publications” and follow the directions or
• Find JCRP online at http://journals.lww.com/jcrjournal/pages/default.aspx
- Check out the “Published Ahead of Print” section for new articles, which have not yet been published in the print version of JCRP

July/August 2012 Issue

This issue is highlighted by a Scientific Review titled “The effects of satins on prevention of stroke and dementia” as well as the Scientific Abstracts from the 2012 Canadian Association of Cardiac Rehabilitation Annual Meeting. Various sections include papers in disease prevention, heart failure, exercise evaluation, nutrition, pulmonary disease, and stress management, from Brazil, Italy, Portugal, the United Kingdom, Canada, and the United States.

SCIENTIFIC REVIEW

• The effects of satins on prevention of stroke and dementia: A review. Menezes et al (USA)

PREVENTION

• Evidence for cholesterol hyperabsorbers and hyperproducers based on comparative LDL reductions achieved by ezetimibe versus statins. Senaratine et al (Canada)

HEART FAILURE

• Inspiratory muscle training reduces sympathetic nervous activity, and improves inspiratory muscle weakness and quality of life in patients with chronic heart failure: A clinical trial. Mello et al (Brazil)

EXERCISE EVALUATION

• Peak oxygen uptake prediction from a moderate perceptually-regulated 1-km treadmill walk in male cardiac patients. Chiaranda et al (Italy, USA)

NUTRITION

null
Herbal, vitamin, and mineral supplement use in patients enrolled in a cardiac rehabilitation program. Nieva et al (USA)

PULMONARY DISEASE

- Pulmonary rehabilitation in patients with bronchiectasis – findings in pulmonary function, arterial blood gases and 6-min walk test. van Zeller et al (Portugal)
- Can pedometers be used as a reliable measure of step counts in patients with chronic respiratory disease? Turner et al (United Kingdom)
- Longitudinal changes in directly-measured physical activity in patients with COPD. The trajectory of change. Agarwal et al (USA)

STRESS MANAGEMENT

- An investigation of the benefits of stress management within a cardiac rehabilitation population. Campbell et al (Canada, USA)

CACR SCIENTIFIC ABSTRACTS

Committee and Task Force Updates

National Cardiac Rehabilitation Registry Update
Mark Vitcenda, Chair, AACVPR Registry Committee

We have liftoff! The AACVPR Outpatient Cardiac Rehabilitation Registry officially launched on June 25 with a live Webcast to more than 330 CR program staff members across the country. The launch of the registry comes exactly one year and one day from the inaugural planning meeting we had with our development team in Chicago last year. At that time, we had no idea how big and how complicated the process would be, but we have made it and we are excited to share the news.

Big shout-outs are due to the members of the AACVPR Registry Committee, who provided valuable clinical input and direction; to our development team at Cissec Corporation, whose technical expertise created the nuts and bolts of the registry; to the staff at SmithBucklin, who did much of the heavy lifting in scheduling meetings, providing legal expertise, coordinating communications, and prodding the process forward; to numerous past and current champions on the AACVPR Board of Directors, who provided the impetus (and approvals) to get the project on its feet; and to our corporate partners—Life Systems International (LSI) Inc., Cardiac Science Corporation, and ScottCare Cardiovascular Solutions—for their generous financial support of this venture.

Next Steps

As of June, more than 500 programs have begun the registry subscription process, and nearly 100 are ready to start entering data. Interested in joining these programs in the registry project? Everything you need can be found on the AACVPR CR Registry home page. Stamp this address on the inside of your eyelids, palms, wrists, or wherever it will be handy: www.aacvpr.org/CRRegistry.

The first resource you'll want to check out is the step-by-step instructions on how to join the registry, from signing up, to submitting the Participation Agreement and payment, to training. When all the steps have been completed, you will receive access to the live registry and will be able to start entering data.

Principal User

Each program will designate a “Principal User” for the registry. These principal users are crucial to the success of the project. They will coordinate their programs' activities regarding
registry data entry, act as the point person for internal questions regarding the registry, be the main contact person between the program and AACVPR regarding registry news, and ensure high-quality data collection and entry.

Learn More at the Annual Meeting

I’ll be providing updated information on the CR Registry on Thursday, September 6, at the **AACVPR 27th Annual Meeting in Orlando**. Be sure to stop in and see what all the excitement is about!

Affiliate Updates

**Affiliate Report from The New York State Association for Cardiac and Pulmonary Rehabilitation (NYSAC&PR)**

*Karen Pyle RN, BSN, MEd., President NYSAC&PR*

New York has been working on projects with the National AACVPR to streamline the processes of member communication. The National office has been instrumental in helping update email contacts and ways for the regional presidents to have access to their members in the region with the most updated information. This is very useful in NYS since it is divided into six regions, with each region having their own leadership that holds small conferences and meetings throughout the year. This allows those regional presidents to contact their members in a timely manner with the most updated information available.

Other changes this year have been New York holding board meetings via telephone conferences. These have been successful at getting people together for a short period of time, without hours of travel. We have held these more frequently as needed to get input on projects for the year.

The biggest project being worked on is NYSAC&PR hosting their first Webcast, which will be held July 19, 2012. This Webcast is in place of New York State’s Annual Meeting. It is allowing members of NYS and non-members to earn three CEC’s and have some great speakers without leaving their own work place. The speakers include:

- **Steven Lichtman, EdD, FAACVPR**, presenting *Working Together for the Future: An AACVPR Update*
- **Dr. John Bisognano, PhD**, presenting *Challenges in Treating Hypertension*
- **Karen Pyle RN, BSN, MEd.**, presenting *State and Regional Reports and Updates*
- **Lisa Benz Scott, PhD**, **Shannon Gravely, PhD**, and **Sherry Grace, PhD**, presenting *Lessons Learned from Research to Reduce Barriers to Enrollment into Outpatient Cardiac Rehabilitation.*

This promises to be great information at a very reasonable price. We would like to thank the National AACVPR for their help with these updates and changes within the state over the past year.
September 2012

- Annual Meeting Pre-Meeting Events – Sept. 5
- AACVPR 27th Annual Meeting in Orlando – Sept. 6-8

April 2013

- AACVPR & UW-La Crosse Collaboration, Comprehensive Cardiac Rehabilitation Workshop – April 22-25

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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