In this and previous issues of News & Views, there are articles describing the changing face of healthcare, advances in the science of cardiac and pulmonary rehabilitation that have led to a significant in the recognition of our services, new legislative issues and other strategic initiatives planned and initiated by AACVPR.

Without the active support of our membership regarding each of these issues, the great work that has already been done may come to a standstill. For example, your participation is vital in the following areas:

- Planning for your program to move into the new healthcare environment (see The President’s Message; Ana Mola’s article; Lori Turner’s article)
- Disseminating information to referral sources on new scientific advances and the recognition this has achieved (see Randal Thomas’ and Marjorie King’s articles)
- Participation in the Cardiac and Pulmonary Registries (see Chris Garvey’s and Mark Vitcenda’s article)
- Utilization of the Pulmonary Rehabilitation Toolkit (see Karen Lui’s article)
- Utilizing the various education resources AACVPR offers (see Tracy Herrewig’s article and the Calendar of Events
- Program and Professional Certification

Additionally, don’t forget the two seminal events that AACVPR hosts each year:

- The 2013 Day on the Hill (March 6-7, Washington D.C.)
- The 2013 AACVPR Annual Meeting (October 3-5, Nashville Tennessee)

With a huge number of programs, activities and future directions, it is easy to get lost professionally, or just choose the easy road and not participate, leaving it to others. However, without active participation from the vast majority of AACVPR members, cardiac and pulmonary rehabilitation will be left on the drawing board as healthcare moves into a new direction. Plan now for your participation in 2013 events. Plan now to be an active participant in AACVPR and other professional activities. Plan now to become an active volunteer in...
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This issue is sponsored by:

Cardiac Science Corporation, a global leader in external defibrillation, diagnostic devices and monitoring systems, will provide data from its Quinton® Q-Tel® Rehabilitation Management Systems to the AACVPR Outpatient Cardiac Rehabilitation Registry.

The web-based registry is the first of its kind in the United States and will provide cardiac rehabilitation professionals with means to track, document and communicate patient outcomes and program performance.

“We are honored to provide data to this national registry and help sponsor AACVPR in this vital effort to help rehabilitation programs obtain useful benchmarking data,” said Neal Long, Cardiac Science president and chief executive officer.

"The registry will integrate with other AACVPR strategic initiatives, including program certification and performance measures, to increase program quality and provide data that are currently unavailable regarding the

AACVPR and help to shape our future.

Now is the time to outline the road that you will take professionally, the road your cardiac and/or pulmonary rehabilitation program will be on and the road our profession will be following. Don’t let deadlines, advances in science, and changes in legislation leave you by the side of the road. Remember the time to plan and act is now, if you don’t you may be left behind.

My grandmother started walking five miles a day when she was sixty. She’s ninety-seven now, and we don’t know where the (heck) she is.

- Ellen DeGeneres

President’s Message

Best People...
Anne M Gavic, MPA, FAACVPR

Endeavors succeed or fail because of the people involved. Only by attracting the best people will you accomplish great deeds.

- Colin Powell

At the center of AACVPR’s key initiatives this year resides the theme Best People / Best Practice / Best Performance. Each concept builds in a natural sequence with the goal of providing optimal patient outcomes within our programs.

Best is defined as surpassing all others in excellence, achievement or quality … most accomplished, most skillful …

In a professional sense then, the best people are those who are most accomplished, skillful and excellent in their craft or work —- in essence those who are highly competent.

Defining Competence

Cardiac and Pulmonary Rehabilitation / Secondary Prevention occupy a specialized niche in healthcare. Our services are unique in that a multidisciplinary team provides a multi-faceted program, including exercise training, education and counseling for risk reduction and behavior change. To accomplish this, Cardiopulmonary Rehabilitation professionals are expected to achieve and maintain knowledge, skills and abilities related to physical and emotional assessment, provision of safe and effective exercise training, education on a wide variety of topics and counseling in the art of behavior change and self care. The Core Competencies for Cardiac Rehabilitation / Secondary Prevention Professionals ¹ and the Clinical Competency Guidelines for Pulmonary Rehabilitation Professionals ² provide a detailed outline of these competencies and should be used as a guide for professional development, staff mentoring and continuing education.

Achieving Mastery

Formal healthcare training related to cardiac or pulmonary disease generally provides the foundation of knowledge, skills and abilities for work in cardiac and pulmonary rehabilitation. However, mastery of the evidence and exceptional performance of related skills comes at the price of time and commitment. On-the-job mentoring and training followed by repeat performance to the point of excellence help to build professional competence. Professionals also have a responsibility to maintain and improve competency through self-study, review of the literature, participation in continuing education opportunities and regular performance of relevant skills. AACVPR offers a broad menu of opportunities through live and archived webinars, JCRP, News & Views and the Annual Meeting and Educational Conference. Other
outcomes of cardiac rehabilitation,” said Steven Lichtman, AACVPR Past President.

The registry will allow cardiac rehabilitation professionals to track patient outcomes and program performance in accord with evidence-based guidelines. In addition, it will demonstrate the positive impact of cardiac rehabilitation on morbidity, mortality, physical function and quality of life for heart patients in the United States.

We at Cardiac Science Corporation anticipate the release of our connectivity solution to the AACVPR Outpatient Cardiac Rehabilitation Registry in 2013 Q1. Please visit our website for up-to-date Registry News by Clicking Here.

Help your patients set achievable exercise goals using

**Exerscript™**

A tool introduced at AACVPR 2012 by Kathy Berra MSN and Drs. Nanette Wenger MD, Barry Franklin PhD, and William Boden MD

To request your Exerscript™, contact exerscript@arbopharma.com

For a full presentation of Exerscript™, please visit www.aacvpr.org/arborendorsession

Measuring Competence

The remaining question is then — how do we know when competence is achieved? Determining a method of measuring professional competency against a recognized standard of quality within a profession is important, as it ensures that uniform skill set most likely to translate into a high level of safe, effective and quality care. Competency can and should be measured within the Cardiac and Pulmonary Rehabilitation Department using a variety of methods of measurement, including return demonstration, written tests, job simulation and observation. But the culmination of an individual’s commitment to excellence can potentially come through a more formal recognition. Many specialties have developed programs that provide an opportunity to recognize and certify individuals who have demonstrated competency within their profession.

At this time, an AACVPR Professional Certification Task Force is investigating the feasibility of developing a certification specific to Cardiac and Pulmonary Rehabilitation professionals. This certification would draw from the core competency documents and identify knowledge, skills and abilities necessary for certification as a highly competent cardiac or pulmonary rehabilitation professional. Aligned with the certification process would be multiple educational opportunities designed to elevate understanding of the core competencies and to translate existing knowledge into quality practice. This is an exciting proposition for AACVPR and for cardiopulmonary rehabilitation professionals seeking an opportunity to be recognized in the company of the “Best People” working in Cardiac and Pulmonary Rehabilitation.

1 Clinical Competency Guidelines for Pulmonary Rehabilitation Professionals AMERICAN ASSOCIATION OF CARDIOVASCULAR AND PULMONARY REHABILITATION POSITION STATEMENT, Journal of Cardiopulmonary Rehabilitation and Prevention, 2007;27:355–358. Linda Nici, MD, Trina Limberg, BS, RRT, Lana Hilling, RCP, Chris Garvey, FNP, MSN, MPA, Edgar A. Normandin, PhD, PT, Jane Reardon, MSN, RN, and Brian W. Carlin, MD

2 Core Competencies for Cardiac Rehabilitation/Secondary Prevention Professionals: 2010 Update POSITION STATEMENT OF THE AMERICAN ASSOCIATION OF CARDIOVASCULAR AND PULMONARY REHABILITATION, Journal of Cardiopulmonary Rehabilitation and Prevention, 2011;31:2–10. Larry F. Hamm, PhD, FAACVPR, Chair; Bonnie K. Sanderson, PhD, RN, FAACVPR; Philip A. Ades, MD, FAACVPR; Kathy Berra, MSN, ANP, FAACVPR; Leonard A. Kaminsky, PhD; Jeffrey L. Roitman, EdD; Mark A. Williams, PhD, FAACVPR.

Breaking News

**Exciting Decision on Cardiac Rehabilitation Referral Performance Measures**

Randal J. Thomas, MD, MS, FAACVPR

AACVPR received very good news recently regarding the cardiac rehabilitation (CR) referral performance measures. The measures, which had been previously been given a time-limited endorsement (2 years) by the National Quality Forum (NQF), have now been given formal endorsement by NQF!

**Background:** Formal endorsement by NQF requires evidence that a set of performance measures is valid, reliable and feasible, and that the measures are strongly linked to desired patient outcomes. A working group was convened and supported by AACVPR, the American College of Cardiology Foundation, and the American Heart Association to collect pertinent data on the CR referral performance measures in order to provide evidence to NQF about the CR referral performance measures. This project, carried out by multiple centers from around the United States, is known as the Cardiac Rehabilitation Referral and Reliability (CR3) Project. We are happy to say that the results of the project were positive, were well-received and were endorsed by the NQF oversight groups that reviewed the measures for endorsement.

**Why is this important?** The measures are now formally endorsed by NQF, and with that endorsement, the CR referral performance measures have received a "stamp of approval," clearing the way for the Centers for Medicare and Medicaid Services (CMS) and other

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*Email Template*
healthcare organizations to consider full implementation of the measures. In fact, CMS is now planning to start collecting information on the outpatient CR referral performance measures in 2014, with full accountability for healthcare providers starting in 2015. Other medical insurance organizations will probably follow suit soon.

**What to do?** It is recommended that CR professionals contact their local in-patient and out-patient quality officers and notify them of this important information. The year 2014 will be here before you know it, leaving relatively little time for in-patient and out-patient groups to get ready for this new level of accountability (healthcare organizations will be required to identify and track patients who are eligible for CR referral, and identify and track those who have and who have not made the referral).

Many thanks to all who have helped to make this important step happen!

Randal J. Thomas, on behalf of the CR3 Working Group: Jensen S. Chiu MHA; David C. Goff, Jr, MD, PhD; Marjorie King, MD, MAACVPR; Brian Lahr, MS; Steven W. Lichtman EdD, FAACVPR; Karen Lui, RN, MS, FAACVPR; Quinn R. Pack, MD, and Melanie Shahriary, BSN, RN.

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**Referral to Cardiac Rehabilitation Again Recognized as 1A Recommendation**

*Marjorie Kin, MD, FACC, MAACVPR*

As new guidelines are published about treatment of patients with heart disease, the organizations publishing these guidelines are now clearly recognizing the evidence that cardiac rehabilitation is an effective treatment to improve function, health and mortality. The most recent guidelines for treatment of patients with stable ischemic heart disease were published by a joint writing group that included representatives from large physician and nursing organizations, including primary care physicians, interventional and general cardiologists, cardiovascular surgeons, and nurses and was published in multiple journals. You can find a copy of these guidelines on the [AACVPR website in Resources for AACVPR](http://www.aacvpr.org).

Particularly note section 4.4.1.4, which gives cardiac rehabilitation the highest level of recommendation (1A) and reviews the scientific evidence for that recommendation. Referral to cardiac rehabilitation is now clearly listed as a high level recommendation in guidelines for treatment of patients following myocardial infarction, CABG, percutaneous intervention, and stable ischemic heart disease and this is published in cardiology, internal medicine, and cardiovascular surgical journals. Although physicians may not always remember to refer patients to cardiac rehab, they should have no objections to cardiac rehab programs developing systems that prompt them and others to make the referral, based on this evidence.

Please share this news with your programs Medical Director, your referring physicians and any other individual significantly involved in referring patients. The more we get this type of news disseminated, the patients will benefit from our services.

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**New AACVPR/AHA Scientific Statement: Medical Director Responsibilities**

*Medical Director Responsibilities for Outpatient Cardiac Rehabilitation/Secondary Prevention Programs: 2012 Update: A STATEMENT FOR HEALTH CARE PROFESSIONALS FROM THE AMERICAN ASSOCIATION FOR CARDIOVASCULAR AND PULMONARY REHABILITATION AND THE AMERICAN HEART ASSOCIATION*

*King, Marjorie MD; Bittner, Vera MD, MSPH; Josephson, Richard MD; Lui, Karen RN, MS; Thomas, Randal J. MD, MS; Williams, Mark A. PhD*

Medical directors of cardiac rehabilitation/secondary prevention (CR/SP) programs are responsible for the safe and effective delivery of high-quality CR/SP services to eligible...
patients. Yet, the training and resources for CR/SP medical directors are limited. As a result, there appears to be considerable variability throughout CR/SP programs in the United States in the roles, responsibilities, and engagement of CR/SP medical directors. Since the publication of the 2005 scientific statement from the American Heart Association and American Association of Cardiovascular and Pulmonary Rehabilitation regarding medical director responsibilities for outpatient CR/SP programs, significant changes have occurred. This statement updates the responsibilities of CR/SP medical directors, in view of changes in federal legislation and regulations and changes in health care delivery and clinical practice that impact the roles and responsibilities of CR/SP medical directors.


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**AACVPR's Headquarters' Office Has Moved**

Update your address books! AACVPR's Headquarters’ office moved to a new location over the Thanksgiving holiday.

**As of November 26, 2012, AACVPR’s new address is :**

330 N. Wabash Avenue, Suite 2000
Chicago, IL 60611

All phone numbers, fax numbers and email addresses will remain the same.

**AACVPR News**

**AACVPR Selects New Executive Director**

Dear AACVPR Members,

It is my privilege to announce the selection of a new Executive Director for AACVPR.

Following a diligent search and review of candidates the Board of Directors has unanimously approved Megan Cohen as the new Executive Director for AACVPR. Megan assumes responsibilities January 4, 2013.

Megan brings over 23 years’ experience in healthcare association management, most recently as Executive Director for the National Association of Medical Staff Services (NAMSS). During her tenure in association management, Megan has gained vast experience and has achieved extraordinary success in leading her association’s in areas such as certification development, enhanced education strategies and successful legislation and policy work.

Megan thrives on challenge and is bright, visionary, process-oriented and personable. She is excited to learn about every detail of AACVPR as an organization, including the nuances of each individual area of work. We are confident Megan will work with us to craft new ways to work within our mission and foster accomplishment of our key strategies. Megan is a “people person”. She is well-liked and highly respected by her peers, is approachable and direct in her communication and is looking forward to the opportunity to mentor the AACVPR staff and work beside the AACVPR leadership and volunteers. We look forward to you getting to know Megan in the coming year.
Please take a moment to watch this introductory video message from Megan.

Sincerely,

Anne M Gavic, MPA, RCEP, FAACVPR
President, AACVPR

ACSM World Heart Games

It is with great excitement that ACSM announces the 2013 World Heart Games, endorsed by AACVPR.

As clinicians, we have all witnessed the sedentary and sometimes depressing, isolated life of patients with cardiac disease. However, cardiac rehabilitation prepares patients to reenter life so that once again they fully can enjoy family activities, work and recreation. Now they even can enjoy a safe international competitive athletic event.

The location for the Olympic-style event is Agnes Scott College in Atlanta, Georgia. This college provides an excellent venue for the various sports that will be offered. Atlanta’s Hartsfield-Jackson International Airport is linked to Agnes Scott College and the host hotel by the MARTA train, which makes transportation simple and efficient. A celebration banquet will conclude the games and medals will be awarded.

The initial World Heart Games took place in May 2010 and were a tremendous success. We are expecting more than 200 national and international athletes for the 2013 Games. An exciting addition to the World Heart Games 2013 is the anticipation of offering grants to promote international participation.

This competition is open to anyone with cardiovascular disease or risk factors. Teams and individuals are welcome to compete. We look forward to hosting you and your athletes in Atlanta on May 17-18, 2013. For more information please go to the World Heart Games Web site.

F. Stuart Sanders, MD, FACP, FAACVPR, FACSM
Chair, World Heart Games 2013

World Heart Games Committee
J. Larry Durstine, PhD., FACSM, FAACVPR
William Herbert, PhD., FACSM
Carl N. King, Ed.D., MAACVPR
Karen Lui, RN, M.S., MAACVPR
John P. Porcari, PhD., FACSM, MAACVPR
Note to Members

Anne M Gavic, MPA, FAACVPR

This issue of News & Views comes on the tails of Hurricane Sandy that devastated numerous towns and cities along the northwest coast. Many of our members were affected by this storm, both personally and in their place of work. While media are no longer focused on coverage of this storm, we understand that complete recovery will continue to require significant financial and human resources and that it will be a long time before life returns to normal in those areas. To those of you who have been affected by this storm, please know that we hold you close in our thoughts and send you encouragement and support for return to full recovery.

Member Resources

Update on AACVPR Liaison Activity
Using Liaison Activities with AHA and ACC to Engage Your Cardiac Rehab Medical Director
Marjorie King, MD, FACC, MAACVPR

In light of several recent developments that resulted from AACVPR’s strategic relationships with the American Heart Association (AHA) and the American College of Cardiology (ACC), it may be time to sit down with your program’s Medical Director to do some strategic planning. Start your conversation by highlighting the articles in this issue of News & Views regarding the National Quality Forum’s endorsement of the “AACVPR/ACCF/AHA Performance Measures on Referral to Cardiac Rehabilitation/Secondary Prevention (CR/SP) Programs,” as well as the ACC Hospital to Home (H2H) program. Then, ask your Medical Director to read and discuss with you the “AACVPR/AHA 2012 Update of the Medical Director Responsibilities for Outpatient Cardiac Rehabilitation/Secondary Prevention Programs” statement.

The “Update of the Medical Director Responsibilities” article describes regulatory requirements and includes tables describing core competencies and key responsibilities for program Medical Directors. More importantly, it challenges Medical Directors to lead the “CR team and medical community toward effective changes and continuous improvement in CR/SP program delivery and patient outcomes.” Practically speaking, this challenges us all to figure out ways to use tools such as the referral to CR/SP program performance measures, H2H and registries to drive appropriate referral to, enrollment in and completion of CR, and to use patient-centered outcomes measures to assure that our programs are providing high-quality care.

As value-based purchasing becomes more entrenched in healthcare, it will become increasingly important for programs to provide evidence-based care, use performance measures and track outcomes. Providers and healthcare systems will be expected to provide services that are both cost-effective and linked to meaningful patient outcomes and will be paid based on metrics that include measurement of performance related to quality. The AACVPR Outpatient Cardiac Rehabilitation Registry was designed to help programs track and improve meaningful patient outcomes. AACVPR is also working with the AHA and ACC to promote use of the referral to CR measures within other cardiovascular disease registries and within value-based purchasing for appropriate disease conditions. However, most of the work to promote appropriate use of CR also needs to be done within communities, which is why strategic discussions among program Medical Directors and staff are critical. For example, it is important to assure that automatic and facilitated referral systems are in place.
and that local leaders of healthcare payment demonstration projects such as accountable or coordinated care organizations and medical homes are aware of both the high level of evidence to support CR as a valuable treatment, as well as the existence of measures and registries to track enrollment and participation. Clearly, this will require active participation by engaged Medical Directors in order to reach decision makers within healthcare systems and insurance companies.

Don’t despair if your Medical Director has not yet become involved with these issues. She or he may just be waiting for someone to ask. We physicians enjoy a challenge and are motivated by evidence-based interventions that improve our patients’ health. Consider sending these AACVPR/ACC/AHA articles to your Medical Director, along with links on the AACVPR Web site, such as Resources for Professionals, and then set up an appointment to have strategic discussions about how to assure your program’s viability within changes in healthcare delivery in your community. Finally, encourage your Medical Director to become an active AACVPR member, as there’s plenty for us all to do to assure that cardiac rehabilitation doesn’t become inadvertently lost as a result of healthcare payment reform. Active, engaged Medical Directors are needed – turn yours into one if you don’t have one already!

What's New on the Web site?
Tracy Herrewig, MS, RCEP, FAACVPR

Have you ever wanted to know more about cardiac or pulmonary rehab? How about more information about AACVPR? The national office receives daily phone calls and emails related to practice, reimbursement, certification, the registry and many others. To meet the needs of AACVPR members, the Web site Committee has championed a campaign to get all your questions answered. Everything you need to know is accessible from the home page, which is designed to help viewers navigate quickly and intuitively to that desired information. The information is located under the About tab or the Frequently Asked Questions link.

Information related to cardiac and pulmonary rehab in general or about the AACVPR organization can be accessed under the About tab. Click on "About Cardiac and Pulmonary Rehab" to find:

- Cardiac and Pulmonary Fast Facts
- Information related to
  - What is cardiac or pulmonary rehab
  - Benefits of cardiac and pulmonary rehab
  - Key components of each program
  - Evidence to support each program
  - Assistance to find a program
  - Reimbursement for cardiac or pulmonary rehab
- Additional resources
- A PowerPoint® presentation entitled, “Cardiac Rehabilitation: An underutilized Class 1 Treatment for Cardiovascular Disease.”

Interested in learning more about AACVPR? Under About AACVPR you will find the following information:

- Board of Directors
- Affiliate Societies
- Committees
- Fellows
- Corporate Sponsors
- Awards
- In the News
- Staff
- Liaison Organizations

Click on About AACVPR to find more information about the organization such as:
What if you want more detailed information to specific questions? Click on the **Frequently Asked Questions** from the home page. If you are not logged in or if a non-member looks here, a dropdown menu will appear that allows the viewer to see limited information. A message will also appear to remind the viewer to log in or to encourage a non-member to join AACVPR to have access to more detailed information.

If you are logged in, click here to browse questions (and more importantly, answers to those questions) specific to:

- The practice of cardiac and pulmonary rehab
- Health and public policy
- The cardiac and pulmonary registries
- AACVPR membership.

For example, the Health and Public Policy section is further organized into sub sections related to billing, Medical Director supervision, outcomes, physician Extenders, and other important information.

The reorganization was designed to help users access information in a more efficient manner. The website should be your primary resource for the information you need to successfully run your cardiac and pulmonary rehab programs. Email webmaster@aacvpr.org with suggested changes or questions about the website.

### 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 purchased 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.

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**Innovative Programming/Best Practices**
Tracy Herrewig, MS, RCEP, FAACVPR

The Innovative Programs and Best Practices section is dedicated to providing our readership an introduction to people and programs that are innovative in their thinking and in the way they provide services. The end goal of which is to improve patient care, outcomes, and of course, the patient experience.

If you have a program or idea to share, please contact Tracy Herrewig.

Taking the SEE YOU IN 7 Challenge
Lori Turner, RN-BC, MSN, John Muir Health

Hospital to Home (H2H) is a quality initiative designed to improve the transition from inpatient to outpatient status and to reduce cardiovascular-related hospital readmissions. H2H is led by the American College of Cardiology and the Institute for Healthcare Improvement. In 2011, H2H issued the See You in 7 challenge with a goal that prior to discharge all patients who have had a myocardial infarction (MI) and/or heart failure (HF) have a scheduled follow-up appointment within seven days. For patients with MI the early follow-up is to be scheduled with cardiac rehabilitation.

Following MI, cardiac rehabilitation is known to reduce mortality while early cardiac rehabilitation has shown to improve left ventricular remodeling. Along with clinical benefits, there are financial incentives for early cardiac rehabilitation. Beginning in 2013, the Center for Medicare and Medicaid Services will penalize hospitals with excessive risk-adjusted 30-day readmissions for discharged patients following MI, HF and pneumonia.

The cardiac conditioning department at John Muir Health initiated See You in 7 in January 2012. Nurse educators schedule a cardiac rehabilitation appointment within seven days of discharge for MI patients. Patients discharged to a long-term care facility or those with dementia are excluded. There is no charge for the initial cardiac rehabilitation visit and patients are not required to enroll in cardiac conditioning.

Data collected from January to June 2012 show:

- A decrease in post MI 30-day readmissions from 12% to 7.5%
- An increase in enrollment at all three John Muir cardiac conditioning sites
- Average event to start of cardiac conditioning declining from 22 days to six days

Not all patients seen for early follow-up enroll in cardiac conditioning; however, the visit provides a chance for MI patients to have early medication reconciliation, education and emotional support. Six-month data shows a benefit in having taken the See You in 7 challenge. John Muir cardiac conditioning will continue to provide early follow-up and collect data to evaluate outcomes. As the See You in 7 program is refined improved outcomes are expected.

To learn more about the See You in 7 program at John Muir Health there is a recorded webinar on the California Society for Cardiac Rehabilitation Web site at www.CSCR.org. Information on the H2H initiative and the See You in 7 challenge is available at www.h2hquality.org.
Return on Investment: Alternative Delivery of Cardiac Rehabilitation Services
Ana Mola, MA, RN, ANP-BC, CTTS, FAACVPR

The Accountable Care Act (ACA) has created a brave new world for patients, providers and hospital systems. Healthcare systems have entered the age of cost utility, return on investments and re-engineering clinical care to improve the quality of care, enhance patient and caregiver experience and incorporate best practices into clinical care delivery models. The evaluation and reimbursement of healthcare services will be based on the outcomes of our quality and safety care indicators, and the patient's satisfaction and perception of their healthcare experience.

The return on investment of healthcare delivery models will be based on the value of resource use, safety and quality. It is the post-discharge window that most variation in spending occurs. For example, spending on readmissions and post-acute care varies widely. Historically, cardiac rehabilitation, which has exhibited all the phases of care transition from inpatient to outpatient and community reintegration, has been a design model for over four decades that has had direct and indirect influences on post-acute care variability of cost utility.

Cardiac rehabilitation services have influenced the return on investment by virtue of positive patient outcomes that may have controlled the variability of spending in post-acute care services. For example, cardiac rehabilitation patients had three-year medication continuation rates of 44% and 48% for statins and beta-blockers respectively in a 2009 study by Shah et al. In addition, enrollment in a cardiac rehabilitation program was associated with an improved likelihood of continuing medications, with adjusted hazard ratios for discontinuation of statins and beta-blockers among cardiac rehabilitation participants of 0.66 and 0.70 respectively. Further analysis would be of value in comparing if these cardiac rehabilitation patients with good medication adherence had a lower hospital readmission rate than those patients not in cardiac rehabilitation.

There are ways to broaden the return of investment of cardiac rehabilitation services. As patients transition from Phase I to Phase II, cardiac rehabilitation providers may consider adding telehealth transtelephonic and medication adherence program as an adjunct to monitor the cardiovascular patient's heart rhythm as they adhere to their home exercise prescription and monitor the patient’s medication regime immediately upon discharge from their cardiovascular surgery or heart failure hospital admission. The cost of the telehealth transtelephonic and medication surveillance by cardiac rehabilitation experts can be an alternative method of care redesign to analyze the return of investment that can bend the cost curve on the readmission of these patients post hospital discharge. This redesign of cardiac rehabilitation would be an initial investment for hospital administration upstream for the cardiovascular surgical and heart failure patient population, but the downstream return of investment may have a bright financial outcome in this brave new world of healthcare reform.

Health & Public Policies FAQs
AACVPR Legislative & Regulatory Resources at Your Fingertips
Karen Lui, R.N., C, M.S., MAACVPR

AACVPR members often ask where to find certain regulations, Medicare requirements or documentation on how to properly code and bill for services. A spin through the pages on the AACVPR website under Health & Public Policy provides a number of valuable documents and resources. Your business and compliance departments have numerous services to oversee and will appreciate having you as a resource on accurate and current cardiac and pulmonary rehab regulations.

Once at the AACVPR homepage, click on the Health & Public Policy link from the menu that runs across the top of the page. This will bring you to a number of additional link options for further information.

- Pulmonary Rehabilitation Toolkit
- Advocacy Day on the Hill
- Medicare Administrative Contractors (MAC)* Legislative & Regulatory Resources
- Reimbursement Updates*
- Regulatory and Legislative Advocacy Actions*
- Discussion Forum – Health Policy/Reimbursement*

Pulmonary Rehabilitation Toolkit

For example, you can go immediately to a PDF version of the Pulmonary Rehabilitation Toolkit. Note that this link is in the public section of the Web site and does not require AACVPR membership to download this very important document. The toolkit is a comprehensive document that explains all of the issues associated the PR payment reduction by Medicare, along with instructions as to what (and how) steps your hospital can take to address this payment aberration.

Below is an overview of the information that is in the Pulmonary Rehabilitation Toolkit:

- 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

Medicare Administrative Contractors (MACs)

From here, you are able to also directly link to information related to your Medicare Administrative Contractor (MAC). This is where you will find information on the local rules that are managed by the MAC for your particular Jurisdiction. This page lists all MACs and who is on the AACVPR MAC Committee relating to your particular jurisdiction. All ongoing information released by your MAC is posted here and clarification of local regulations are posted in the What’s New with My MAC section of this page.

Advocacy

To access the issues that AACVPR is currently working on in Washington, DC click on the Advocacy link. These issues can and will make a difference in your program operation, so please participate when asked to step up and take action. Plans are already underway for Day
on the Hill (DOTH) 2013, as described on the link to that activity.

Regulatory and Legislative Advocacy Actions

Public comments that are submitted to CMS (Centers for Medicare & Medicaid Services) are posted chronologically under the Regulatory and Legislative Advocacy Actions* link.

Regulatory & Legislative Resources

When you click on Regulatory & Legislative Resources, you will find the following links. The Federal Register is the document that publishes Medicare regulations and any rule changes for cardiac and pulmonary rehabilitation. A click on "Thomas Library of Congress" will allow you to look up any Congressional bill, by bill number or by use of bill terms or title. The Medicare Coverage Center link takes you to the CMS Web site.

* The Federal Register
* Medicare Statute - Social Security Act
* Thomas Library of Congress
* Medicare Coverage Center

The "Downloadable PDFs" that follows the above section are CMS publications, in chronological order, that are pertinent to cardiac and/or pulmonary rehabilitation. When you hear a reference to a CMS Change Request, Transmittal, provision or MLN Matters, this is where those will be posted. The Medicare provisions (rules) for cardiac and pulmonary rehabilitation are posted here:

* 2010 Physician Fee Schedule: Section 410.49-Cardiac Rehabilitation Program: Conditions for Coverage (November 2009)
* 2010 Physician Fee Schedule: Section 410.47-Pulmonary Rehabilitation Program: Conditions for Coverage (November 2009)

These are all ways CMS communicates regulation changes and new regulations to providers. Past regulations posted in Archived Resources are for historical purposes.

Final Medicare Rules - Reference Guides

For cardiac and pulmonary rehabilitation References and FAQs, click on Members Only under the blue heading, Member Center.

This takes you to a grid titled, Resources for AACVPR Members. On the left-hand column of this grid, you will see a box listing 2011 Final Medicare Rules for CR and PR. When you open that box, you will see:

* 2011 Final Medicare Rules - Reference Guides
2011 Final Medicare Rules - Pulmonary
2011 Final Medicare Rules - Cardiac

*Frequently Asked Questions:*
Pulmonary Rehabilitation FAQs
Cardiac Rehabilitation FAQs

The posted FAQS are continually updated, most recently in November 2012.

AACVPR Reimbursement Updates

Click on Members Only under the blue heading, Member Center.

This takes you to a grid titled, Resources for AACVPR Members.
Psycbotherapy for the Heart
Kent Eichenauer, PsyD, FAACVPR
eichenauer@deltapsychologycenter.com

Psychosocial factors have been recognized as factors in morbidity and mortality in heart disease. But, studies have not been as conclusive as we would like concerning treatment of these psychosocial problems.

However, our friends in Europe recently reported at the European Society of Cardiology Congress a study that suggests more hope in this area. Adriana Roncella, MD, reported on a study not yet published at the Cardiology Congress on the relationship of psychological interventions and a significant improvement in clinical outcomes in the STEP IN AMI (Short Term Psychotherapy IN Acute Myocardial Infarction) Study.

In this study, about half of 101 AMI patients who received a PCI were randomized into the treatment group who received three months of individual psychotherapy and five sessions of group therapy. It is noteworthy that the average depression score for these patients was lower than what would be considered the mild range of depression. So, on the whole, they were not considered depressed. Also, no new psychiatric medications were added in this treatment.

Now for the results: there were 111 total new events in the one-year follow-up. The big news is that only 30% of these events occurred in the psychotherapy group. As might be expected as well, there were fewer new co-morbidities in the psychotherapy group and their hearts were in significantly better shape as measured by the NYHA class. Again, these are patients who would not generally be considered to be depressed by tests like the Beck Depression Inventory.

Yes, it would be wonderful if all patients could get this psychotherapy within the rehab program. While this may be more possible for some programs than others, this kind of research does speak to the need for rehab programs to competently assess their patients and to ensure they have arrangements for seamless referral to a behavioral provider. Please visit the Behavioral/Nutrition Resource page on the AACVPR Web site for additional information.

References:
Dr. Roncella's presentation at the European Society of Cardiology Congress is reported in:
• Should State-of-the-Art Cardiovascular Therapy Include Psych Therapy?, Cardiosource Interventional News, American College of Cardiology; Sept/Oct 2012;1:5

Dr. Roncella's presentation is available online.
Impact of Pulmonary Rehabilitation on Acute COPD Exacerbations
Gerene Bauldoff, PhD, RN, FAACVPR

An excellent review article about the impact of PR on COPD exacerbations was recently published in *Expert Reviews in Respiratory Medicine*, a Medscape® continuing education series. Dr. Samantha Kon and colleagues provide a review of the literature related to COPD exacerbations and PR. COPD exacerbations result in a decline in function and quality of life. Findings report that PR has been shown to be an effective intervention for patients who are both stable and in an acute phase of illness. While PR has been shown to reduce healthcare utilization, they extrapolated that it can also reduce the risk for further COPD exacerbations.

Some key issues include:

- COPD exacerbations are common, with a negative impact on health and survival resulting in precipitous reductions in pulmonary function, functional performance and quality of life.
- These exacerbations are a significant economic burden due to the costs related to emergent hospitalizations.
- Pulmonary rehabilitation has been supported by multiple meta-analyses and RCTs.
- Recently, PR has been found to reduce future hospitalization and mortality when provided following COPD exacerbation.
- An important, yet understudied area is PR during exacerbation on healthcare utilization and hospitalization.

Why is this important for PR?

As the evidence for PR continues to grow, this new area (PR during exacerbation) has the potential of significantly impacting where and how we provide PR. Another important consideration in support of PR is the implementation of additional readmission penalties for COPD in 2015 by CMS, where readmission within 30 days will not covered.

Reference:


Author note: I wish to thank Chris Garvey, RN, MS, FAACVPR for bringing this article to our attention at *N&V*.
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

WHAT'S COMING IN JCRP

January/February 2013 Issue

This issue is highlighted by an AACVPR Statement titled “Cardiac Rehabilitation and Cardiovascular Disability: Role in Assessment and Improving Functional Capacity A Position Statement from the American Association of Cardiovascular and Pulmonary Rehabilitation,” and a Guest Commentary titled “Energy Balance: The Key to a Unified Message on Diet and Physical Activity,” as well as various section papers in Cardiac Rehabilitation, Diabetes and Pulmonary Disease from Brazil, Argentina, Colombia, Chile, Iran, Paraguay, Peru, Uruguay, Venezuela and the USA.

AACVPR Statement

- Cardiac Rehabilitation and Cardiovascular Disability: Role in Assessment and Improving Functional Capacity A Position Statement from the American Association of Cardiovascular and Pulmonary Rehabilitation – Hamm et al (USA)

GUEST COMMENTARY

- Energy Balance: The Key to a Unified Message on Diet and Physical Activity - Sparling, et al (USA)

CARDIAC REHABILITATION

- Physiological and Exercise Capacity Improvements in Women Completing Cardiac Rehabilitation – Beckie, et al (USA)
- Emotional Distress, Alexithymia, and Coping as Predictors of Cardiac Rehabilitation Outcomes and Attendance – Jackson et al (USA)
- Availability and Characteristics of Cardiovascular Rehabilitation Programs in South America – Cortez-Bergoderi, et al (USA, Brazil, Argentina, Colombia, Chile, Paraguay, Peru, Uruguay, Venezuela)

DIABETES

- The Prevalence of Impaired Glucose Metabolism in Patients Referred to Cardiac Rehabilitation – Ettefagh, et al (Iran)

PULMONARY DISEASE

- The Use of a Home Exercise Program Based on a Computer System in Patients with COPD – Albores et al (USA)

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Task Force Updates
AACVPR Outpatient Cardiac and Pulmonary Rehabilitation Registry Update

Chris Garvey, FNP, MSN, MPA, FAACVPR
Mark Vitcenda, MS, FAACVPR

The AACVPR Outpatient Cardiac Rehabilitation Registry continues to grow by leaps and bounds. There are more than 250 programs currently participating in the CR registry, with another 238 programs in the wings going through the subscription process. (If you are one of those programs, check your program profile to see where you are in the process. If you’re having trouble navigating the hoops, or need more information, don’t hesitate to contact our support team at aacvpr@aacvpr.org or call 312-321-5146 for assistance.) So far, programs have entered more than 2,500 patient records — a 62% increase in just one month! Our registry team continues to work on improving the experience for subscribing programs, such as updating the FAQs with recently submitted questions by users, analyzing the data that has been entered for accuracy, and investigating improvements to the reporting features. We want your feedback in order to provide the best service to you. Email registry@aacvpr.org and let us know what you’d like to see for future updates.

When the AACVPR Outpatient Pulmonary Rehabilitation Registry launches next year, it will be the first registry of its kind to measure outcomes related to PR in chronic lung disease and allow a better understanding of the benefits of pulmonary rehabilitation. In addition to 17 committee members, the registry development process has included expert involvement from top international pulmonary methodologists, scientists and clinicians. Data set measurement will include demographics, clinical and behavioral findings including functional capacity, quality of life, symptoms, mood evaluation, pulmonary function, co-morbidities and healthcare utilization. The registry will help individual programs measure and understand their program’s impact on patient care and quality, and help AACVPR to better establish and understand the impact of PR in chronic lung disease. Synergies will include one-time outcome data entry for those pursuing AACVPR program certification. PR registry beta testing will begin in early 2013, and the registry will in full operation by June 2013. We appreciate the input we have received from AACVPR members in establishing and supporting this critical tool for the care of our patients. Thank you to all the committee members for their important work in the registry’s development, including: PR registry leadership: Chris Garvey, Mark Vitcenda, Gerene Bauldoff and Mike McNamara; committee members Kent Eichenauer, Eileen Collins, Anne Gavic-Ott; Connie Paladenech, Huong Nguyen; DorAnne Donesky; John Pellicone, Steve Lichtman, Rod Stiege, Abigail Lynn, David Schmahl, Krista Betts, Blaine Jenkins and Justin Rimmer.

Affiliate Updates

Texas AACVPR Update

Dean Diersing, MS, ACSM-HFS

TACVPR represents 140 cardiac (60 AACVPR certified), and 75 pulmonary programs (11 AACVPR certified), with a membership of slightly more than 200. The TACVPR maintains a strong national presence with six members involved on AACVPR committees, eight members achieving AACVPR Fellowship status.

We continue to look for member benefits that can make a strong impact. Our Web site, www.tacvpr.org, has many interactive features such as:
Searchable map-based program directory

- Frequently Asked Questions
- Online registration capabilities with automated features to reduce the burden on our Membership Secretary
- New for 2013 – Sample Documents
- New for 2013 – Posting of our TACVPR Strategic Plan
- And much more!

- We have an active Facebook page (TACVPR) and Twitter account (@tacvpr) that allows increased networking opportunities for our members. We are also looking to launch a LinkedIn account in 2013!

Planning for our spring conference is well under way and will be held at the Courtyard by Marriott Dallas-Allen Hotel at the John Q. Hammons Center on April 12-13, 2013. This year’s theme “Building on the Best … Practices & Principles for your Program” highlights our plan to deliver many talks with valuable take-home messages. We will offer our attendees 8.5 CEUs, access to more than 15 exhibitors, breakfast buffet and lunch, as well as great networking opportunities with more than 150 attendees. Additionally, we will also have a preconference workshop offered by the Cooper Institute offering 3.5-4 CEUs.

The TACVPR celebrates many successes over its 23 years, while facing the same challenges as others across the country. We are whole heartedly committed to advocating for a strong future for Cardiac & Pulmonary Rehab programs and serving the patients of the great state of Texas!

Wisconsin Affiliate (WISCPHR) Update
Thorne Wittstruck, BS, RCEP, WISCPHR President

Greetings from Wisconsin!

The Wisconsin Society for Cardiovascular and Pulmonary Health and Rehabilitation has another great year.

Membership

WISCPHR currently has 226 members. Membership fees will remain the same in 2013. There are 141 AACVPR members from Wisconsin!

WISCPHR Member Celebrations

2012 Presidential Citation and Recognition Awardees: Bonnie Anderson and Mark Vitcenda

The Presidential Citation and Recognition award is an opportunity for the outgoing AACVPR President to formally recognize and thank individuals who have made significant contributions to the president’s term and the association as a whole.

Bonnie L. Anderson, MS, CES, RCEP, FAACVPR, Vernon Memorial Healthcare
Bonnie Anderson is the Manager of the HEART Center, a thriving cardiopulmonary diagnostics and rehabilitation program, at Vernon Memorial Healthcare in Viroqua, Wisconsin. She initiated and developed the hospital’s community wellness program and, in 1990, opened its new cardiopulmonary rehabilitation program. In addition to her administrative responsibilities, she is involved in community health and professional education, including her role as instructor for national cardiac rehabilitation workshops for the University of Wisconsin – La Crosse, where she provides best practice information on running a successful cardiopulmonary rehabilitation program. She also manages a consulting practice that provides education, resources and design assistance for cardiopulmonary rehabilitation facilities. She is a Past President and Board Member of the Wisconsin Society for Cardiovascular and Pulmonary Health & Rehabilitation (WISCPHR) and has served on numerous WISCPHR committees. She is currently a member of the AACVPR Board of Directors and serves as liaison to the Program Certification/Recertification Committee, Registry Committee and Clinical Applications Committee.

**Presidential Recognition Award: Mark Vitcenda**

**Mark Vitcenda** is a Senior Clinical Exercise Physiologist at the University of Wisconsin Hospital and Clinics’ Preventive Cardiology Program. He has 30 years of experience in cardiac rehabilitation and was the project manager for WISCPHR’s WiCORE and WisPRO outcomes projects. He is currently the Chair of the AACVPR Registry Committee. A Fellow of AACVPR, Vitcenda’s primary concerns include the assessment of outcomes in outpatient cardiac rehabilitation, assisting programs in outcomes management, and educating students and the public about the benefits of cardiac rehab.

**Congratulations to 2012 AACVPR Fellow**  
**Heather Grant, MS, FAACVPR**  
Clinical Exercise Physiologist  
UW Preventive Cardiology  
Madison, WI

**Barb Fagan is the new President Elect of AACVPR and will rotate into the office of AACVPR President next year**

**Barbra A. Fagan, MS, FAACVPR**  
Director - Health Promotion Services  
Community Memorial Medical Commons  
Menomonee Falls, WI

**Annual Meeting**  
WISCPHR is planning our 25th Annual Conference on April 19 – 20, 2012 at the Country Springs in Waukesha, Wisconsin.

**April 19:**

- Personal and Professional Development workshop (preconference) tentative schedule: Core competencies, writing policies, innovative programs and update on reimbursement and readmissions.
- Frequently Asked Questions (each presentation will be 15 minutes followed by five minutes of Q&A: Certification – Bonnie Anderson, Reimbursement – Sandra Zemke and Diana Rohloff, and Registry – Mark Vitcenda.)
- Retrospective and Future of WISCPHR: Tracy Herrewig will deliver a retrospective view of WISCPHR history. Shana Steele, President-Elect will review goal and vision for the future of our organization.
- Grand opening of the exhibit hall will include refreshments and participants will receive a ticket for a drawing during Friday night social if they can answer three questions about the vendors they visited. Also, participants will be provided with passports to be stamped by exhibitors for opportunity to win prizes after business lunch meeting on April 20.
- Friday night social will include entertainment by Comedy Sportz with drawings for prizes at end of the social event. This is a great opportunity for our members to network but also to celebrate 25 years of annual conference meetings.

**April 20:**
Dr. Randall Thomas - "Performance Measures as a Pathway to High Value Care"
Dr. Randall Thomas - "How CR and PR Staff Can Optimize Their Relationships with Providers"
Kathy Zarling - "Promoting Sexual Health in CR and PR"
Laura Traynor - "Medication Compliance and more..."
Dr. Zwicke - "Pulmonary HTN"
Lunch, Business Meeting, Award of Excellence, and drawing for prizes
(Can you move the names of the speakers below to the left?)
Dr. Lieberman - "Hidden Salt in Everyday Foods and Restaurant Eating"
Dr. Davis - "Smoking Cessation"
Dr. Malmsten - "Women, CVD and Depression"
Dr. Gimelli on "TAVI"
Jane Nelson-Worell - "Lifestyle Coaching in 10 minutes of less"

Outcomes Projects

The Wisconsin Cardiac Rehab Outcomes Registry (WiCORE) has been very successful with almost 60,000 records to date. WiCORE is a patient level cardiac rehab program outcomes registry that was created with the help from the Wisconsin Heart Disease and Stroke Prevention Program, a program under the Wisconsin Department of Public Health and Family Services. The outcomes project has provided a wealth of data for benchmarking and quality improvement projects for rehab programs using the registry. Data entry into WiCORE will be discontinued December 31, 2012 to ensure that all WISCPHR members make the transition to the AACVPR Cardiac rehab national registry. Thirty-eight WISCPHR sites have paid to join the AACVPR Cardiac rehab national registry currently.

The Wisconsin Pulmonary Rehabilitation Outcomes Project (WisPRO) is a pulmonary outcomes database similar to WiCORE. Once the AACVPR Pulmonary rehab national registry opens, WisPRO will eventually be closed to allow for transition into the national registry.

Telecommunications

The Web site, telecommunications, and newsletters committees have recently been merged into the Telecommunications committee. Global Meet has been recently provided for all WISCPHR committees, but also to regional representatives for teleconferencing and Webinar style meetings. One regional rep from each region will be on this committee and will be trained on global meet. Regional reps will also be given administrator rights to the WISCPHR Web site to post minutes / reports and update the Web site as frequently as necessary. Chad Johnson is chairing this committee with Co-chairs: Kelly Shields and Chad Sauvageau. The Telecommunications Committee is seeking an additional co-chair to assist in delegation of committee projects and training of WISCPHR members.

Quality Improvement

WISCPHR is currently developing a committee from the following proposal from Mark Vitcenda:

- Oversight of the Registry projects and use of the aggregated data from these projects and outcomes data from other sources in developing statewide initiatives for QI in patient care and program processes.
- Development of educational materials and tools for assisting programs in QI project planning and data analysis. These could include handouts, webinars or conference presentations focused on general and specific QI topics. Committee will work with Leadership and Education committees in development.
- Promoting WISCPHR QI initiatives to partners such as patients, physician groups, hospital administrators, the WI Heart Disease and Stroke Alliance, WI Department of Public Health, etc. Also, it is responsible for finding funding to promote initiatives and education efforts.
- Committee would meet quarterly to review outcomes project data, current research and assess trends in outcomes. Committee would propose QI initiative(s) based on reviews. Committee would define current "problem," investigate approaches to improve process or patient outcomes, develop educational materials for programs, study results of initiative project and develop report summarizing findings and future directions. Report would be disseminated to WI CR/PR programs and partners.
Leadership

Chair Tracy Herrewig has been very busy updating WISCPHR bylaws with the assistance of the Board of Directors (BOD) including committee chairs and regional reps. Tracy is also creating a policy/procedure manual for WISCPHR to outline current processes and to provide guidelines for emerging leaders. Julie Lee is updating the regional rep binders to assist in training and assistance in transition to the regional rep position. Updates to the binder will be included in the policy and procedure manual.

Additional Projects: increasing participation at regional meetings (used Survey Monkey to determine regional needs), developing leadership succession training and annual strategic planning, letters of recognition to employers (for succession to a leadership role within WISCPHR, Day on the Hill Participants, and etc.), and planning for personal and professional development workshop. Committee includes a regional rep from each region to allow feedback and assistance in all leadership projects from each region.

Affiliate Reciprocity

After being contacted by Whitney Quast from MNACVPR, WISCPHR plans on developing reciprocity between the two affiliates for conference meetings at membership price with conference info from MNACVPR to be included in WISCPHR Web site and newsletter.

Day on the Hill (DOTh)

WISCPHR continues to send four WISCPHR members annually with plans on sending four members again in 2013. Two of the members sent annually to DOTh have at least one year of experience with this event.

Committee Chair Succession

WISCPHR committees have strong leadership with some chairs who have continuously chaired for more than eight years. Currently WISCPHR is seeking co-chairs for all committees to allow for transition into the chair at a later date and to allow for a more regular rotation.

Calendar of Events/Education

January 2013

Webcast: Establishing a Network in your Institution for Women with Heart Disease, presented by Ann de Velasco, RN, Baptist Hospital of Miami – Tuesday, January 22 – Subscribe here.

February 2013

Webcast: Cardiac Rehabilitation Outpatient Data Registry Update, presented by Mike McNamara, MS, FAACVPR, MT Dept of Public Health & Human Services & Mark Viccenda, MS, RCEP, FAACVPR, Univ of WI Hospitals and Clinics – Tuesday, February 19 – Subscribe here.

March 2013

Webcast: Cardiopulmonary Rehabilitation and Diabetes Medication, presented by Leigh Taylor, PharmD, Lahey Clinic – Tuesday, March 19 – Subscribe here.

April 2013

AACVPR & UW-La Crosse Collaboration, Comprehensive Cardiac Rehabilitation Workshop – April 22-25
October 2013

AACVPR 28th Annual Meeting, Gaylord Opryland Hotel, Nashville, Tennessee – October 3-5 – Click here for more information.

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.

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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