Messages from Headquarters

Letter from the Editor
A Call to Action: Behavior Change
Jody Hereford, MS, BSN, MAACVPR

“Let everyone sweep in front of his own door, and the whole world will be clean.”
— Johann Wolfgang von Goethe

Are you a “behavior change specialist?” Many of us involved in cardiac and pulmonary health and rehabilitation describe ourselves as behavior change specialists, but is that truly an accurate description for both the programs we lead and the participants with whom we work? In the last issue of News & Views, I posed a challenge to each of us to think about what’s new in our programs with a specific charge to take a close look at what we’re doing to operate services in accordance with current guidelines, science, and evidence base. We need to look closely at our own “front door” to ensure that our own “behaviors” have changed and we operate, on a daily basis, according to the latest research, guidelines and evidence to successfully impact and support behavior change in the participants with whom we have the privilege to work.

As a first step, you need to know the evidence to be able to design services around the best science to achieve the best outcomes. Read and reread Dr. Marjorie King's article in this issue on the latest evidence to support what we do. Do you know how many evidence-based guidelines have “Referral to Cardiac Rehabilitation” as a Class 1 recommendation? You will by the time you finish her article. As a second step, don’t keep the good news all to yourself. Be sure those who are referring (or have the potential to refer) know the value and the strength of the evidence. Ensure that your hospital leadership is well informed; they are increasingly expected to curb unnecessary admissions, readmissions and emergency visits. They need to look to the experts for addressing the high-risk and high-cost populations including CAD, COPD, heart failure and diabetes. All of these are populations with whom we have experience, expertise and data. Your programs need to mirror what works in order for consumers (providers, hospital leadership, patients and families) to buy in to what you have to offer.

Sadly, and all too often, cardiac and pulmonary rehabilitation programs who may indeed know the evidence, continue to operate in the way that it’s always been done, instead of looking at what needs to be done to produce the best possible outcomes for individuals, populations and programs. With our participants, we help them envision a better way of being when it comes to their health and then together design the steps it takes to get there. When was the last time you did that for the health of your program? What does a healthy and sustainable program look like in today’s healthcare climate? What is success, what brings about the best outcomes of success, and what are the steps it takes to get there? We know that exercise is an important component of both cardiac and pulmonary rehabilitation, and we also recognize that it is not a standalone intervention. Is that reflected in the day-to-day operations of your system of services or do all participants receive the same intervention, length of stay, and plan of care? What are you doing to ensure your participants’ continued adherence to recommended medical regimens, including medications, self-monitoring and management? How do you incorporate lifestyle and behavior choices into the services you offer? How are you addressing these questions during the time of your program, and how enduring are the choices and changes for long-term sustainability? As staff, do you sit behind the monitor as the EKG marches on or are you taking advantage of the time with your participants? Are you still enrolling patients to 36 sessions of exercise only and scratching your head when they don’t continue with behavior...
changes? As healthcare continues to shift in both payment systems and organizational structure, how are you ensuring that cardiac and pulmonary rehabilitation are a part of these new systems?

We have a great opportunity at hand to be the change we wish to see, to sweep in front of our own doors and create services that positively impact health status and improve outcomes of individuals, populations and programs. Healthcare is facing significant shifts in both payment systems and organizational structures; the need for behavior change specialists has never been more imperative. The ability to enhance sustained behavior change and patient self-management is what we are designed to do … are you doing it?

"If you don’t like change, I wonder just how well you’ll like obsolescence."
— Anonymous

President’s Message

AACVPR — What it Means to Me … and You

Steven W. Lichtman, EdD, FAACVPR

I am not just the current President of AACVPR, but of course, I am also a member. In fact, I have been a member since 1996. What drove me to originally join AACVPR was my entry into Cardiac and Pulmonary Rehabilitation as the program director at Helen Hayes Hospital. I recognized AACVPR as the premier source of information for new and developing programs, and was not disappointed regarding the information and networking that resulted from my membership.

Since then, I have experienced many different views of AACVPR: as a new member, a veteran member, a committee chair, a member of the board of directors and now as president. As my perspective has changed, my view of what our organization does and means to its members has grown.

I would like to take the time, in this column, to share with you what I now see as president regarding AACVPR.

1. It is clear we are the most outstanding source of information on both Cardiac and Pulmonary Rehabilitation.
2. We are the leaders in establishing, promoting and supporting regulatory, legislative and reimbursement changes in both Cardiac and Pulmonary Rehabilitation.
3. We have a vastly expanded presence in the healthcare field as demonstrated by our strong liaison relationships with more than 45 other like-minded organizations, including strategic partners such as ACC, ATS, AHA, ACCP and ACSM.
4. Our tangible member benefits have grown by leaps and bounds over the last several years. To name a few:

   - Expanded educational opportunities through:
     - The AACVPR Annual Meeting (the only national level meeting devoted solely to cardiac and pulmonary rehabilitation).
     - Our newly designed and expanded Web site.
     - Our growing set of Webinars, both live and archived, as well as specific Web-based seminars.
     - Partnering with the outstanding University of Wisconsin-La Crosse Cardiac Rehabilitation Workshop.
   - Increased support and communication with our AACVPR Affiliates including expansion of the Joint Affiliate Program.
   - Our official journal, JCRP, now has received an “impact factor” identifying it as an elite research publication.
Expansion of coverage of issues important to our membership in our newly designed newsletter, *News & Views*.

- Publication of official AACVPR Guidelines such as the Guidelines for Cardiac Rehabilitation and the Guidelines for PR Programs and our Resource Manual.
- Our annual Day on the Hill advocacy event, where AACVPR members have the opportunity to present our issues to our legislators.
- Increased activity by our Document Oversight Committee resulting in many more AACVPR initiated and supported scientific statements and clinical practice guidelines.
- Formation of an International Committee to meet the needs of our globally expanding field.
- Formation of a Task Force to approach CMS to include heart failure for Medicare reimbursement in outpatient cardiac rehabilitation.
- Release of toolkits including the PAD toolkit, the Pulmonary Outcome toolkit, and the Pulmonary Rehabilitation Reimbursement toolkit.

Finally, and certainly not least, over the past year I have emphasized three major strategic initiatives: Certification, Registry and Performance Measures. I am proud to say, we are making enormous strides with these programs:

- Our program certification process continues to evolve to include the latest evidence-based practice guidelines and will, in conjunction with the Cardiac and Pulmonary Rehabilitation Data Registries, continue to strive to define quality.
- The Cardiac Rehabilitation National Data Registry is set for a launch this month. The Pulmonary Rehabilitation National Data Registry continues to make progress and is set for a 2013 launch.
- There are two sets of Performance Measures for pulmonary rehabilitation endorsed by the National Quality Forum (NQF): determining functional capacity and health-related quality of life for patients in pulmonary rehabilitation programs. The Performance Measure Set 1 (referral to CR from both an inpatient and outpatient setting) has been endorsed by NQF. Additionally, data has been submitted to NQF for extension of these endorsements.

As I travel around the country taking to our members, one thing I quite frankly hear is that professional membership (not just in AACVPR, but in all our professional organizations) is very expensive, particularly in the current economic environment. However, and I truly believe this (I pay for my own membership, not my employer), considering the cost of AACVPR membership, and how much a member can benefit from membership, joining our great organization is a necessity for CR and PR professionals, not a luxury. AACVPR leadership is devoted to making sure each of our members is aware of, and takes advantage of, the many benefits we offer. We have pledged to do a better job in the future of making every member, and every potential member, aware of the value of AACVPR membership.

**What in the World**

**International Charter on Cardiovascular Prevention and Rehabilitation: A Call for Action**

*Bonnie Sanderson, RN, PhD, FAACVPR*

The amazing and often underestimated power of developing collaborative relationships in reaching goals is true whether the goals are related to your own personal growth and development, your program or your professional organizations. AACVPR is an excellent example of engaging in collaborative relationships at the organizational level in our quest to achieve the vision to provide “Rehabilitation and preventive services for all patients with cardiac and/or pulmonary disease.” What is truly amazing is that collaborative relationships in cardiopulmonary rehabilitation have no borders.

The International Charter on Cardiovascular Prevention and Rehabilitation (ICCR) originated from some of our collaborative partners in the Canadian Association of Cardiac Rehabilitation (CACR) when they received a grant from the Canadian Institutes of Health. The purpose was to develop a united message about the importance of cardiac rehabilitation and improve patient access to services globally. AACVPR members who were invited to participate in early drafts of the charter included myself, Randy Thomas, Carmen Terzic, Reed Humphrey and Neil...
Email Template

Oidridge. As AACVPR professional liaison to CACR, I have continued close collaboration with the core developing and writing group of the charter (“Call to Action”). AACVPR was one of the first national professional organizations to endorse the charter, and it now has approximately 11 international professional organizations that have officially endorsed the charter.

The Call to Action targets cardiovascular prevention and rehabilitation organizations and established associations around the world to partner and collaborate with those responsible for administering patient care:

1. to establish cardiovascular prevention and rehabilitation as an essential, not optional, service, and
2. to support countries to establish and augment programs of cardiovascular prevention and rehabilitation, adapted to local needs and conditions, to ensure broader access to these proven services.

Please Click Here to visit the ICCR Web site to read the full charter and follow News & Views for updates as the momentum grows to unite our global message on the importance of cardiac rehabilitation. You may have seen one of the initial drafts of the charter that was included as a poster display at the AACVPR 26th Annual Meeting in California, and subsequent versions have been displayed at other international meetings. Most recently, it was presented as a scientific poster at the World Cardiology Congress meeting in Dubai in April 2012. Next steps include submitting the charter as a manuscript in a peer-reviewed scientific journal. The aim is to maintain and grow this consortium through partnership with international organizations to consider and communicate ongoing consensus on evidence-based standards for cardiac rehabilitation and prevention.

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.

Member Resources

Liaison Activity: Bringing it to Your Community for the Biggest Impact

Marjorie King, MD, FACC, MAACVPR

Past issues of News & Views highlighted the work that AACVPR has done with liaison organizations to promote awareness about the benefits of cardiac and pulmonary rehabilitation to other healthcare professionals. However, as we know, awareness does not translate into improved patient outcomes unless a patient actually attends and completes cardiac or pulmonary rehabilitation.

Allow me to walk you through where we have come with cardiac rehabilitation, as an example, so you realize how much more work is ahead of us. Ten years ago, the average cardiologist had no knowledge or awareness about cardiac rehab. Now, they see several articles or announcements a month in American College of Cardiology (ACC), Society for Cardiac Angiography and Interventions (SCAI), or American Heart Association (AHA) communications about cardiac rehab (just to name a few). This is not an accident but is a result of the following cascade of events:

- Large, well-designed scientific studies conducted by our AACVPR, AHA, and ACC colleagues have shown significant health benefits, including improved mortality, in patients who participate in cardiac rehab, compared to those who do not.
- Because that evidence is strong, the ACC/AHA clinical practice guidelines for treatment of heart disease give a high level of recommendation (IA or IB) for referral to cardiac rehabilitation, as high as the level of recommendation for treatment with aspirin, beta-blockers or statins.
• Because the level of recommendation in the guidelines is high, performance measure sets for treatment of coronary artery disease or heart attack include a performance measure to promote referral of patients to cardiac rehab.

• The referral to cardiac rehab performance measure has also been incorporated into ACC and AHA Registries for performance improvement and is gradually being incorporated into Medicare pay for performance projects.

This evidence is summarized in an AACVPR PowerPoint that you and your medical director can use to promote referral to cardiac rehab within your community to physicians, case managers, patient groups, and others.

However, patients don’t improve from cardiac rehab unless they actually attend; and, unfortunately, published studies have shown that enrollment can vary from 10 to 70 percent, depending on the community. The good news is that work by our Canadian colleagues has taught us that systematic approaches can increase referral and enrollment significantly. In fact, the Canadian Association of Cardiac Rehabilitation recently published a position statement that succinctly reviews this issue. Note that a method of referral called “liaison plus automatic” has better results than merely waiting for cardiologists to remember to refer or just including referral to cardiac rehab in discharge order sets.

So what does this mean to your cardiac rehabilitation program? People are more likely to change a behavior, such as attending cardiac rehab, if they not only understand how it can help them but are also motivated to overcome barriers that are standing in the way. Peer liaisons, like Mended Hearts visitors, or contacts from case managers or cardiac rehab staff can help patients transition from the “I should” to “I will” stage. Consider partnering with your local Mended Hearts chapter to help local patients work through their perceived barriers to enrollment in cardiac rehab. If you don’t have a Mended Hearts chapter or other cardiac support group in your community, consider contacting Mended Hearts to find out how to start one.

As part of a project that AACVPR is doing with Mended Hearts, we are looking for inspirational stories about people who have overcome personal obstacles to successfully pursue and complete cardiac rehab. We are open to a wide range of stories, including those about people who can speak passionately about their initial resistance to enrolling, their subsequent struggle to stick with the program, and how they have integrated (or not!) what they learned into their lives. We’d also like to hear from people who may have started and stopped several times, or people who didn’t initially do cardiac rehab when they were supposed to but then decided later to commit to it. If you know someone directly or have heard of someone who you think has a compelling story to tell, please ask them if we could be in touch with them to hear their story directly, and then please send their contact information to me at patientstories@aacvpr.org.

We’ve come so far in the past decade, working as an AACVPR community to increase awareness about cardiac rehabilitation among other healthcare professionals. It’s time to take our combined achievements into our local communities, to partner with local liaisons to improve the health outcomes of our neighbors.

Behavioral Medicine Resources on AACVPR’s Web Site

Kent Eichenauer, PsyD, FAACVPR

I hope you have seen the wonderful renovation to AACVPR’s website under the leadership of the Web site Committee Chair Tracy Herrewig and the expertise of Jessica Eustice. While the Web site Committee made the existing structure more readable and intuitive, there have also been some significant additions.

We would like to call your attention to the addition of Behavioral/Nutrition Resource Page. The psychosocial issues of our patients have gained more attention in their role related to cardiac and pulmonary morbidity and mortality. The Resource Page was developed by the Behavioral/ Nutrition Subcommittee of the Professional Liaison Committee to help programs deal more
effectively with these issues.

The Behavioral/Nutrition Resource Page provides rehab staff with scientific information about these psychosocial issues as well as some “how-to” guides to assist staff with handling sometimes difficult issues with our patients. These guides offer information related to finding a behavioral health provider, discussing a referral to a behavioral provider with a patient, and how to manage a patient with suicidal concerns.

You will also find models for integrating the psychosocial component into your program and written resources for patients, in addition to options for paying for psychosocial services.

You can access this information and more exclusive member resources by logging in to AACVPR’s Web site and visiting the Resources for AACVPR members.

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.

Nutritional Aspects of Rehabilitation

Alisa Krizan, MS, RD, LD

“Let food be thy medicine and medicine be thy food.”
— Hippocrates

Herbs and spices are among the richest sources of antioxidants. They can reduce salt, fat and sugar by adding flavor to foods without adding unwanted sodium and fat calories. Herbs are from the leaf, while spices are derived from other parts of the plant, like buds (clove), bark (cinnamon), roots (ginger), berries (peppercorns) and aromatic seeds (cumin).

Some common herbs and spices used in cooking have health benefits known to reduce blood sugar, cholesterol and high blood pressure. Some spices have medicinal properties and should not be consumed in quantities greater than normal cooking if taken with prescription...
Oxygen radical absorbance capacity (ORAC) is a method of measuring antioxidant properties in biological samples in vitro. Although research in vitro indicates that polyphenols are good antioxidants and probably influence the ORAC value, antioxidant effects in vivo are probably negligible or absent. By non-antioxidant mechanisms still undefined, flavonoids and other polyphenols may reduce the risk of cardiovascular disease and cancer.

As interpreted by the Linus Pauling Institute and European Food Safety Authority (EFSA), dietary polyphenols have little or no direct antioxidant food value following digestion. Not like controlled test tube conditions, the fate of polyphenols in vivo shows they are poorly conserved (less than 5 percent), with most of what is absorbed existing as chemically modified metabolites destined for rapid excretion.

The increase in antioxidant capacity of blood seen after the consumption of polyphenol-rich (ORAC-rich) foods is not caused directly by the polyphenols but most likely results from increased uric acid levels derived from metabolism of flavonoids. Scientists can now follow the activity of flavonoids in the body, and one thing that is clear is that the body sees them as foreign compounds and is trying to get rid of them.

Spices shown to have beneficial effects on the cardiovascular system are red chili peppers (reduce blood cholesterol, triglycerides and platelet aggregation), cloves (inhibit platelet activity and function as an anti-inflammatory), ginger (may reduce blood pressure), garlic (improve conditions related to high blood pressure, high cholesterol, coronary heart disease, heart attacks, and hardening of the arteries).

Your local farmer’s market is the best place for your patients to shop for herbs and spices. Most products are grown within 100 miles, which helps to preserve nutrients while contributing to sustainable agriculture.

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**Pulmonary Point of View**

**The Missing Link Between COPD and Cardiovascular Events: Airway Bacterial Colonization?**

*Gerene Bauldoff, PhD, RN, FAACVPR*

Published ahead of print in *Respiratory Medicine* (2012), Fuschillo and colleagues describe the association between COPD and atherosclerotic disease in underlying pathophysiologic mechanisms. The article covers epidemiological and clinical evidence of cardiovascular mortality and morbidity related to COPD, inflammatory pathways of both COPD and atherosclerosis, ultimately discussing the possible relationship among airway bacterial colonization, exacerbation frequency and systemic inflammation in COPD. Future directions for research are also discussed. As noted in the systematic literature review, lower lung function (FEV1) was found to increase risk for cardiovascular mortality (relative risk 3.36, CI95% 1.54-7.34). Additionally, cardiovascular risk appears to be higher in patients with chronic bronchitis as reported from a large sample study conducted in Sweden. Inflammatory pathways for both COPD and atherosclerosis are described, noting that endothelial dysfunction increases during acute exacerbation of COPD and that “infectious burden,” rather than a specific pathogen or organism, increases propensity to atherosclerosis development, which means patients who have numerous infections through the life span are more likely to develop atherosclerosis.

Oxidative stress also plays a central role in both disease processes. COPD patients with frequent exacerbations have been shown to have higher pro-inflammatory markers. Both COPD and atherosclerosis are chronic, progressive, and frequently, co-existing disorders that share risk factors and common pathogenic pathways. Inflammation and oxidative stress appear to play a central role in both diseases. It’s postulated that peak levels of systemic inflammation seen in COPD patients during exacerbation could precipitate exacerbations of...
the atherosclerotic process, such as increased risk for plaque rupture and thrombotic occlusion.

Why is this important in pulmonary rehabilitation?

While it is well-known that risk factors, such as smoking, are shared by both COPD and cardiovascular diseases, specific discussion on the relationship between COPD exacerbation inflammation and CV atherosclerotic disease is not commonly addressed in PR education. With this information, it is important that we modify our teaching about exacerbation management, promoting avoidance of infections that trigger exacerbation onset to help reduce the systemic inflammation that impacts development/progression of atherosclerosis.


Putting Your AACVPR Patient Resources to Use
Susan Koeller, RN

As we at the Alexian Brothers Cardiopulmonary Program began to prepare to celebrate Cardiac Rehab Week this past February, we were pleasantly surprised when we received a timely and informative email. The AACVPR Cardiac Rehabilitation Fact Sheet was perfectly timed for our use. It was a professional piece that accurately explained the program.

Our facility is fortunate to offer Phase 1, Phase 2 and Phase 3 Cardiopulmonary Programs, and the information sheet was a perfect addition to our New Cardiac Patient Packets. Also, we implemented the AACVPR Pulmonary Rehabilitation Fact Sheet during the pulmonary celebratory week. This well-prepared fact sheet is also now being included in the New Pulmonary Patient Packets. We have found these fact sheets so valuable that they have been utilized at in-service sessions that are given to other professional disciplines within our organization.

We are fortunate to have access to the valuable information and resources that AACVPR makes available to our staff and patients.

To find these fact sheets, along with many other resources for patients in your program, visit www.aacvpr.org/patientresources.

What's Coming in JCRP

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

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 the Scientific Abstracts from the 2012 American Association of
Cardiovascular and Pulmonary Rehabilitation Annual Meeting in Orlando, Fla., Sept. 6-8, as well as Section Papers in Cardiac Rehabilitation, Exercise Testing, Nutrition, Peripheral Arterial Disease and Pulmonary Disease, including manuscripts from Brazil, Italy, Spain, Switzerland, Canada and the United States.

CARDIAC REHABILITATION

• A Comparison of Psychosocial Risk Factors Between Three Groups of Cardiovascular Disease Patients Referred for Outpatient Cardiac Rehabilitation. Stauber et al (Switzerland)
• Cardiac Rehabilitation Participant with Sickle Cell Trait and Statin-Related Hepatotoxicity. Cato et al (Canada)
• Relationship Between Acceptance of Illness and Functional Outcomes Following Cardiac Rehabilitation. Guck et al (United States)
• Variation in Patient Perceptions of Healthcare Provider Endorsement of Cardiac Rehabilitation. Tsui et al (Canada)

EXERCISE TESTING

• The Prognostic Utility of Cardiopulmonary Exercise Testing Stands the Test of Time in Patients with Heart Failure. Arena et al (Italy, United States)

NUTRITION

• A Qualitative Analysis of Coronary Heart Disease Patients' Views of Dietary Adherence and of Web-based and Mobile-based Nutrition Tools. Yehle et al (United States)

PERIPHERAL ARTERIAL DISEASE

• Comparison of Walking with Poles and Traditional Walking for Peripheral Arterial Disease Rehabilitation. Collins et al (United States)

PULMONARY REHABILITATION

• Maximal Oxygen Uptake Cannot be Estimated from Resting Lung Function and Submaximal Exercise in COPD Patients. Fregonezi et al (Brazil, Spain)

AACVPR ANNUAL MEETING SCIENTIFIC ABSTRACTS

Committee and Task Force Updates

Research Committee

Patrick Savage, MS, FAACVPR

The AACVPR Research Committee is pleased to announce that the recipient of the 2012 Michael L. Pollock Established Investigator is Nanette Wenger, MD. Dr. Wenger is being recognized for her enormous contribution to the field of cardiac rehabilitation. Dr. Wenger is a prolific and innovative researcher and a true pioneer in development of secondary prevention programs for the treatment of patients with coronary heart disease. Moreover, Dr. Wenger has been a mentor and an inspirational role model to many.

The Michael L Pollock Established Investigator award will be presented at the upcoming AACVPR 27th Annual Meeting during the Celebration Banquet and Awards Presentations on Thursday, Sept. 6. Dr. Wenger will present from 3:55 - 4:35 pm in shared session with Dr. Andy Ries, the Thomas L. Petty Pulmonary Scholar Award recipient.

AACVPR is committed to promoting research in the field of cardiopulmonary rehabilitation. Research will be presented at the Annual Meeting during the Beginning Investigator Award session and in the form of other oral and poster presentations. Research topics are numerous.
and diverse, including:

- Cardiac Rehabilitation is Associated with Reduced Long-term Mortality in Patients Undergoing Combined Heart Valve and Coronary Artery Bypass Graft Surgery
- Predictors of Successful Weight Loss in Overweight and Obese Cardiac Rehabilitation Participants
- The Impact of Risk Stratification in Cardiac Rehabilitation on LDL and Blood Pressure Goal Attainment
- Peak Oxygen Uptake and Exercise Ventilatory Parameters in Heart Failure Patients with and without Diabetes
- The Association Between Change in Depression and Improvements in Quality of Life Following Pulmonary Rehabilitation

AACVPR is grateful to all the researchers who submitted abstracts for consideration. While at the Annual Meeting, please take advantage of the opportunity to view the research presentations.

Report from the AACVPR Cardiac Rehabilitation Performance Measures (CRPM) Task Force

Randal Thomas, MD, FAACVPR

The AACVPR Performance Measures Task Force, in collaboration with colleagues from the American College of Cardiology (ACC) and the American Heart Association (AHA), has recently completed the results of the Cardiac Rehabilitation Referral and Reliability (CR3) Testing Project. The purpose of the CR3 Project was to test the reliability and feasibility of abstracting the performance measures from patient charts. Testing was performed at 13 different centers across the United States.

The results were submitted to the National Quality Forum (NQF) on May 5, 2012, along with additional information requested by NQF as they consider re-endorsement of the AACVPR/ACCF/AHA Performance Measures for Cardiac Rehabilitation Referral. The CR3 Project results will be available soon on the NQF website and will also be published in a medical journal in the coming months (hopefully!).

The CR3 work group will be meeting with NQF in the coming month to review the materials that were submitted and to answer any questions that the NQF review committee may have about the Cardiac Rehabilitation Performance Measures. We anticipate that NQF will make a decision about the re-endorsement of the cardiac rehabilitation performance measures sometime in the next two months. If NQF votes to re-endorse the cardiac rehabilitation performance measures, it will give the Centers for Medicare and Medicaid Services (CMS) additional encouragement to continue to implement the cardiac rehabilitation performance measures into their various quality improvement activities. We’ll keep our fingers crossed!

AACVPR owes a large debt of gratitude to the individuals around the country, many of whom are AACVPR members, who helped with the CR3 Project. In addition, we are very indebted to staff members from ACC and AHA (Jensen Chui, Melanie Shahriary and Mark Stewart) who put in countless hours working with the AACVPR CRPM Task Force to complete the CR3 Project. The “quality improvement partnership” that has been developing over the past decade between ACC, AHA and AACVPR has been strengthened even more during the past year we have worked together on the CR3 project.

Stay tuned for more news soon from NQF… we hope for good news!
Affiliate Report from MSCVPR – Michigan

Jenna Brinks, MS, RCEP, President, MSCVPR

The Michigan Society for Cardiovascular and Pulmonary Rehabilitation (MSCVPR) recently hosted its annual conference, “Emerging Concepts in Cardiovascular and Pulmonary Rehabilitation.” The event featured excellent speakers and topics, including an update on the AACVPR Outpatient Cardiac Rehabilitation Registry, Pulmonary and Cardiac Rehabilitation Reimbursement information, an interactive Tai Chi demonstration, and a Coaching for Behavior Change seminar. Our yearly Executive Board transition occurs at this meeting, and the MSCVPR leadership is excited to continue moving our organization toward achieving the initiatives identified in our strategic plan, a “living” document that grows right along with us. A recent example of this includes our collaborative effort with LSI, which sponsored the redesign of the MSCVPR affiliate Web site as well as our renewed affiliation agreement with the AACVPR.

Additionally, I would like to highlight the tireless efforts of our Outcomes Committee, a group of people who help to provide programs throughout the state of Michigan working to improve the cardiac rehabilitation services we provide. This committee has been tasked with not only providing guidance for tracking outcomes and using measured variables to identify areas of opportunity but also to assist programs with creating action plans to improve patient outcomes. This year, the committee has selected the psychosocial domain to focus their efforts.

Affiliate Report from MOKSACVPR – Missouri-Kansas

Chuck Kitchen, MA, FAACVPR

The Missouri-Kansas Affiliate (MOKS) recently had its annual conference in Kansas City, Mo. More than 100 people attended the conference, which featured two presentations by AACVPR President Steve Lichtman, EdD, FAACVPR. MOKSACVPR currently has 164 members. MOKS is proud to present a Reimbursement Workshop on June 21 in Kansas City, Mo. Speakers will be Karen Lui and Jane Knipper. If you would like more information, please contact MOKSACVPR President Chuck Kitchen at Charles.kitchen@mercy.net.

At the state level, we have been blessed with a board of directors whose members are dedicated to promoting cardiac and pulmonary rehabilitation in our state and work tirelessly at doing so. Many of our members serve on multiple state committees and all step up as needed to accomplish our goals.
Calendar of Events/Education

July 2012

- How & Why to Track and Enhance Enrollment in Cardiac Rehabilitation presented by Randal J. Thomas, MD, MS & Marjorie King, MD – July 12

August 2012

- Early registration for Annual Meeting closes – Aug. 3

September 2012

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

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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