Messages from Headquarters

Letter from the Editors
What Do You Want for the New Year?
Jody Hereford, BSN, MS, MAACVPR
Steven Lichtman, EdD, FAACVPR

“A New Year’s resolution is something that goes in one year and out the other.”
— Unknown

Whoosh; that’s the sound of time going by! Welcome to, hopefully, a great start to your 2013. This year we have chosen to put a new spin on the old style of setting New Year’s resolutions. We’ve done this personally and with friends and colleagues. Our question this year is seemingly simple: “What do you want more of in your life?”

The responses we’ve heard have been interesting, intriguing, thought provoking, compelling, educational and radical. So, we ask you, what is it that you want more of this coming year? AND, how will you know when you’ve achieved it? We would also encourage you to try it out on a few friends, colleagues and family members. You’ll be surprised by what you learn.

On a similar AACVPR note, what do you want more of for your program this year? AND, how will you know when you’ve achieved it? We know that many of you might be saying: “That’s pretty obvious, what I want more of is reimbursement.” Many, as well, carry the expectation that AACVPR “should” and “will” just take care of that. Remember however, that AACVPR is you and you are AACVPR. Only with the help of dedicated volunteers, such as you, are we able to accomplish the great works of our organization. So what are you willing to do to make what you want happen? What and where are the opportunities for problem solving and to get involved? (See Barb Fagan’s column on Leadership later on in this issue.)

As 2013 moves along, ask yourself: what have you done to learn about the changing payment and organizational models that are driving up the value of both cardiac and pulmonary rehabilitation? What conversations have you had with your hospital leaders to determine your organization’s strategic imperatives? Have you looked for linkages between the value of the services that you provide and the “pain points” experienced by your hospital’s changing organizational and payment models? Are you well-versed in the outcomes of cardiac and/or pulmonary rehab? Are you well-versed in the latest publications that include performance measures for cardiac and/or pulmonary rehabilitation? Are you well-versed in which guidelines list referral to CR is a Class 1 recommendation? Can you speak to these? If not, that’s a great first step toward creating what you want.

What do you want more of and what are you willing to do to achieve it? It’s up to you!
“Always bear in mind that your own resolution to succeed is more important than any other.”
— Abraham Lincoln

President’s Message
What’s on the Horizon for AACVPR?
Anne M Gavic, MPA, FAACVPR

One thing is certain — there is never a dull moment in health care these days. Changes in both private and public payment systems keep our eye firmly on the horizon to see what’s coming next. Accountable Care Organizations are running smack dab into Accountable Care Communities driving health care providers and public health agencies to partner in improving the health of their patient populations. Value-based purchasing places a price tag on quality, challenging us to carefully assess and improve both clinical outcomes and patients’ satisfaction with their care.

Despite these changes and challenges however, there is cautious optimism. That optimism lies in the signs that preventive services are receiving a new found respect. Most of us began practicing either cardiac or pulmonary rehab from a belief that prevention and positive lifestyles can make a difference in long-term health.

A third of U.S. adults carry at least one chronic disease. Preventive care zeros in on these populations deeply entrenched in chronic disease(s). Eighty percent of our hefty health care budget is funneled into chronic disease management, not prevention. Therefore, it’s time to consider another way of managing health and disease. There are a handful of behaviors that pack a power punch when it comes to preventing disease. If we work closely with health care partners to decipher the secret of changing unhealthy behaviors, the health of our population will slowly begin to shift.

As practitioners of CR and PR we are valuable resources. Our professional team members have the knowledge, skills and expertise necessary to teach, coach and motivate change. Our facilities are stocked with educational materials and exercise equipment that offer a safe place to learn new habits. The communities we serve are seeking the credibility of their health care organizations to partner in building a seamless continuum of health care that reaches from the hospital into the home and the community. The lines are blurring between traditional health care and public health, between who should provide that care and where it should occur. I believe there is a broader reach for CR and PR professionals and services. And it’s time to take a closer look.

To begin this exploration of health care changes and the relevancy of CR and PR in that context, AACVPR BOD member Dr. Patrick McBride will be leading a task force charged with investigating our role in an exciting and vibrant health care environment. Among their initial topics for discussion will be:

- Changes in health care that may affect our services
- The most effective and the most cost-effective delivery models
- The role we play in the continuum of care and decreasing readmissions
- Partnership opportunities with both public and private health care and payment organizations

I am thrilled that Dr. McBride is willing to lead this expert team and look forward to what lies ahead. Keep an eye on this column in future issues to learn the outcomes from this task force.

Executive Director’s Corner
Megan Cohen, MPA, CAE
Hello everyone and warm greetings from AACVPR Headquarters. As your new Executive Director, I wanted to take a moment to tell you how excited I am to be joining such a vibrant and healthy organization. Associations are a lot like people in many ways. Each has their own personality and their own unique way of doing things based on their culture and history. I find AACVPR to be an incredibly productive and exciting place to be in February 2013. The volunteers are amazingly passionate, dedicated and bright individuals who are all very generous with their time. The staff is hardworking and knowledgeable, each offering their own perspective on why AACVPR excels. Please know that this is not the case in every association, so I feel privileged to have been chosen to help lead you in the many exciting endeavors on the organization’s horizon.

As I reflect back on my first month, I’m amazed at how much I’ve learned in such a short amount of time. In addition to the educational materials piled high on my desk, I’ll be receiving some real-world, hands-on training by visiting a cardiac catheterization lab as well as several cardiac and pulmonary rehab centers in the months ahead, so don’t be surprised if I show up on your doorstep! I think it’s important for me to see you folks in action so I, too, can glean the same sense of pride in the profession and the commitment to the patients you help every day.

Please do not hesitate to reach out with any questions or to share your thoughts; we are always happy to hear from our members.

Kind Regards,

Megan

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**Breaking News**

**HOT OFF THE PRESS: Exercise and Pulmonary Hypertension**

*Gerilynn L. Connors, BS, RRT, MAACVPR*

Pulmonary Hypertension (PH) guidelines over the years have discouraged exercise for this patient population stating it was contraindicated, as the physiologic consequences were unknown. Yet, these patients live and work, performing daily life activities from walking up stairs, carrying groceries to possibly lifting their small child into a booster seat.

PH experts, increasingly, no longer view exercise as contraindicated and studies are supporting this. In fact, the Mereles study reported in 2006 in the *Journal of Circulation*\(^1\), titled, “Exercise and Respiratory Training Improve Exercise Capacity and Quality Of Life in Patients with Severe Chronic Pulmonary Hypertension” was the first published article to show the world exercise can be safe for PH patients.

Today, we have another exciting original research looking at the benefits of intensive treadmill exercise in the PH patient that was just published by Chan, et.al. in *Chest Journal*\(^2\), titled, “Benefits of Intensive Treadmill Exercise Training on Cardiorespiratory Function and Quality of Life in Patients With Pulmonary Hypertension.” This study provided 10 weeks, three-times-a-week brisk treadmill walking plus education to PH patients. The results showed improved 6 MWT distance, cardio respiratory function and improved quality of life.

The pulmonary rehabilitation (PR) specialist is not as familiar and often NOT comfortable working and exercising this special patient population. To help the PR professional gain knowledge and understanding of the disease, we have wonderful resources from the literature and through the Pulmonary Hypertension Association, a patient and professional non-profit organization ([http://www.phassociation.org](http://www.phassociation.org)). The Summer 2010 issue of *Advances in Pulmonary Hypertension*\(^3\), the official journal of the Pulmonary Hypertension Association was dedicated to “The Role of Exercise in PH.”
pulmonary hypertension (PH) patient. The medical literature supports this and the respiratory therapy G codes for non-COPD (G0237, G0238 and G0239) can be used for reimbursement.


Professional Liaison Committee: Harnessing Liaison Relationships Within Your Community
Marjorie King, MD, MAACVPR

AACVPR has liaison relationships with organizations that represent many of your hospital and community colleagues, including the American College of Cardiology (ACC), the American Thoracic Society, the American College of Chest Physicians, the American Heart Association, and the American College of Sports Medicine, just to name a few. As a result, tools have been developed that highlight cardiovascular and pulmonary rehabilitation for AACVPR members to use with local colleagues. Most of these are found on the AACVPR Web site, but many are also on our liaison organizations’ Web sites.

For example, ACC’s Hospital to Home (H2H) program, which was highlighted in last month’s News & Views, stresses that it is important for a patient to have an appointment at a cardiac rehab program within seven days following discharge after a myocardial infarction. This recommendation is not by chance — there is now good evidence showing that the sooner a person enrolls in cardiac rehab, the better their likelihood of attending regularly, and hence, of good outcomes. AACVPR has been working with H2H to update the cardiac rehab tools available on their Web site, so that case managers, nurses and others working on care coordination to decrease readmissions can appropriately incorporate cardiac rehabilitation into patients’ treatment. A smart cardiac rehab team would make sure that the people working on hospital readmissions in their community are aware of H2H and of the cardiac rehabilitation materials within the H2H Web site that can be used to promote cardiac rehab enrollment.

Another example of AACVPR and our members working to promote cardiovascular and pulmonary rehabilitation are the many scientific statements, position papers and guidelines related to cardiovascular or pulmonary disease and rehabilitation, especially those where our services can make a meaningful difference. Physicians and other health care providers respond to scientific evidence as they adjust treatment algorithms and we have been fortunate that writing groups for influential documents have recognized the growing evidence that cardiac and pulmonary rehabilitation are key to many patients’ recovery. AACVPR has endorsed and/or provided writing group members for many of these documents that can be found here for Cardiovascular Professional Resources and here for Pulmonary Professional Resources. Now may be a good time for your Medical Director and Program Director to discuss how to figure out how and when to use this information, as well as other information available in Resources for AACVPR Members, to promote and enhance cardiovascular and pulmonary rehabilitation within your hospital and community.

Member Resources
Innovative Programming and Best Practices
Tracy Herrewig, MS, RCEP, FAACVPR

The Innovative Programming/Best Practice column is dedicated to providing our readership an introduction to people, programs and even affiliates who demonstrate innovation in their programming and best practice in how they carry out their day to day activities whether it be patient care or administration. The end goal of which is to improve patient care, outcomes, and, of course, the patient experience.

Positive Impact: Cardiac Rehabilitation Programs Prove Invaluable
Karen Craig, MA, Manager, Cardiac Rehabilitation, Duke University Hospital

The increased emphasis on hospitals to reduce readmissions has provided cardiac rehab programs the opportunity to play a critical role in this initiative and affect the lives of many patients. By developing a process that assists patients in enrolling in a local outpatient cardiac rehab program immediately upon hospital discharge, outcomes improve and readmissions decrease.

The process for maximizing the experience for potential cardiac rehab patients starts at hospital admission. Whether the hospital has computerized or paper order entry, a process should be in place to identify these patients, begin the education/counseling process and provide an effective and efficient delivery of services for optimal disease management. Establishing a working relationship with the Cardiology Case Managers, staff nurses or even the cardiologists themselves to design a system that will identify patients and ultimately directly refer them to an early outpatient cardiac rehab program can be seamless and painless. Ideally, there is an automatic or automated enrollment system that ensures patients are discharged from the hospital with an appointment with a local cardiac rehab program so he or she can start the program without delay. At a minimum, a standard should be that all patients with a qualifying diagnosis should leave the hospital with a local program’s contact information and a referral in hand.

Patients who go through cardiac rehab have better outcomes and reduced hospitalizations. This has been highlighted in the past two issues of News & Views by Lori Turner and Ana Mola who have outlined the benefits of the “See You in 7 Challenge” and the potential return on investment in the direct referral of patients to an outpatient cardiac rehab program. The new models focus on getting patients started within days of discharge versus waiting weeks or months. When entry into cardiac rehab is delayed, the opportunity to find and fix post hospital discharge issues before they require readmission is lost. Cardiac rehab programs can positively impact the “teachable moment” by giving patients and family members the guidance, supervision and education they need. Early entry into cardiac rehab may lay the foundation of knowledge and healthy lifestyle choices before the patients return to work and it allows them to attend rehab more easily. With this early experience, they may find value in the experience and be willing to work it into their schedule even when they have returned to work.

There is work to be done in many cardiac rehab programs regarding early admission. Identifying the delays and barriers to program entry, educating physicians and other hospital staff about the benefits of direct referral to early outpatient cardiac rehab and encouraging patients to take an active role in their healthcare will maximize the potential of these programs and lessen the potential for hospital readmissions and other undesirable outcomes.
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.

Inside the Industry

Leadership
Barb Fagan, MS, RCEP, FAACVPR

"Lost time is never found"
— Benjamin Franklin

There is a story many of you may be familiar with. Some of you may have played a role in this story as one or all four of the characters. It is the story of four people named Everybody, Somebody, Anybody and Nobody.

It goes like this...

There was an important job to be done and Everybody was sure that Somebody would do it.

Anybody could have done it, but Nobody did it.

Somebody got angry about that because it was Everybody's job.

Everybody thought that Anybody could do it, but Nobody realized that Everybody wouldn't do it.

It ended up that Everybody blamed Somebody when Nobody did what Anybody could have done.

What if more than 25 years ago, these four people were charged with the development, advancement and future vision of cardiac and pulmonary rehabilitation? More than likely, AACVPR would not exist, and neither might many of our programs. But thankfully for all of us, and more importantly the patients we serve, this did not occur. Everybody didn’t wait for Somebody and Anybody and Nobody were irrelevant. Why? Because individuals got involved, individuals had a purpose, individuals held each other accountable and individuals came together to create an amazing organization. AACVPR was built on the foundation of “the commitment to serve,” to roll up the sleeves and do the work, to be a participant in the game rather than the fans in the stands. To this …we are all grateful!

Work hard. Make a choice. Dedicate yourself to your goals. Be a part of the solution. Make a
difference. The rewards are limitless and are evidenced by the continued strong committed AACVPR leadership and identified champions that have led to the development of Core Competencies, Performance Measures, Inclusive covered diagnoses, Program Certification, Cardiac and Pulmonary Registries and JCRP — our journal dedicated to Cardiac and Pulmonary Rehabilitation.

How can you play a role? Be the "somebody" that gets involved. Day on the Hill is just around the corner, will you be there? Committees continue to seek active engaged members, have you expressed interest? The Annual Meeting encourages submissions of topic ideas and scientific or clinical abstracts, have you shared your insights? Be that "somebody" that takes AACVPR into the future — be the next Barry Franklin, Kathy Berra, Mark Williams, Jody Hereford, Karen Lui, Brian Carlin, Chris Garvey, Steve Lichtman, Mark Vitcenda, Randy Thomas, June Schulz, Tracy Herrewig or Margie King.

The time is now, the person is "YOU!"

To learn how you can become involved in AACVPR Committees, click here.

Health & Public Policies FAQs

Pulmonary Rehabilitation FAQs
Lana Hilling, CRT, RCP, MAACVPR

Q: Which G codes should one use when billing pulmonary rehabilitation? Additionally, what diagnoses are accepted and what are other 'must know' items for proper billing and reimbursement?

In November 2012, Phil Porte and Karen Lui presented a webinar on "Pulmonary & Cardiac Rehabilitation: Medicare Rules and Rates for 2012." There were many questions after their presentation. This article will address a common theme: which G codes to use, what diagnoses are accepted, and general questions about the G codes.

But first, let's clarify some necessary essentials:

Currently the only diagnosis covered by Medicare for pulmonary rehabilitation (PR) items and services is for patients with moderate to very severe chronic obstructive pulmonary disease (COPD). Moderate to severe COPD is defined as GOLD classification II, III, and IV) when referred by the physician treating the chronic respiratory disease. It is billed with the G0424 code.

Some Medicare Administrative Contractors (MACs) developed a Local Coverage Determination (LCD) to allow for provision of Respiratory Care/Respiratory Therapy services for the diagnosis and treatment of a specific illness or injury. These services are billed with the G0237, G0238 and G0239 codes. For more information on your specific MAC and possible LCD, please visit the AACVPR website.

Q: What are some of the diagnoses that can be used for the G0237-G0239 codes?
A: Again, this is dependent on the LCD that your MAC publishes, but many cover such diagnoses as: Asthma, Cystic Fibrosis, Bronchiectasis, and Restrictive Lung Diseases (RLD) such as Idiopathic Pulmonary Fibrosis (IPF), Asbestosis, Sarcoidosis, Lung Transplant, etc.

Q: Do G0237, 38 and 39 need recent PFT results for qualification? Also what kind of a written order should I be looking for?
A: This would be determined by your MAC's LCD.

Q: Can we bill for G0238 and G0239 and a 6MWT on same day?
A: No, you cannot bill the G codes with another CPT code, you must use the G codes.

Q: When you are using G0237-239 can you bill for oxygen if the patient needs it?
A: No, oxygen is considered part of the services that you are providing. It isn’t a reimbursable item even during a hospitalization.

Q: If a patient is billed G0237-239 should the paperwork/charting system not have pulmonary rehabilitation (PR) on it?
A: We recommend not labeling it as PR because this patient did not qualify for PR by the CMS definition. CMS would interpret that this patient is getting only some components of pulmonary rehabilitation under only Respiratory Care/Respiratory Therapy Services, but not the comprehensive PR program.

Q: Can G0237-G0239 be used for mild COPD? (Stage I in the Gold Classification)
A: If the patient has a diagnosis that qualifies them for Respiratory Care Services under the LCD.

Q: What billing code could we use for a patient who has never smoked and has pure emphysema (DLCO 20%) but normal respiratory mechanics (spirometry)? The patient’s problem was caused by environmental exposures.
A: It depends on the other diagnoses the patient might have. It might be covered by your MAC’s LCD.

Q: Can G0424 and G0238 occur on the same day? i.e.: initial visit, initial intake (i.e.: RN assessment, 6-minute walk, exercise prescription, breathing techniques and energy conservation).
A: G0424 is a bundled code and encompasses the assessment and sessions that you described above.

Q: So, if we have a non-COPD patient enrolled in our program, we would use the G0237-39 and bill in 15-minute increments according to the specific treatment services that we provide?
A: Yes, but if you use the G0239 code it is a non-timed group code.

Q: Can RNs and Clinical Exercise Physiologists (CEPs) bill for G0237-G0239?
A: Licensed RNs or RTs may utilize these respiratory therapy services procedure codes. This does not exclude an EP from being a vital member of the PR staff, however, a licensed staff member would be the person that the billing submits the claim under.

Q: Can you please address if and when the diagnosis of Pulmonary Hypertension will be covered by any of the G codes or if there is another way to address patients with this diagnosis?
A: Some of the MAC LCDs allow coverage for Pulmonary Hypertension at this time.

Q: Are G0237-G0239 codes one charge or are we allowed to charge in 15-minute increments?
A: These respiratory care codes are not bundled, i.e., G0237 and G0238 represent 15 minutes and G0239 is an untimed group code, meaning only one group code may be billed per day.

Q: Can you clarify when the 6-minute walk could be billed?
A: If you are doing a 6-Minute Walk Test for someone that is not part of the PRP, you can bill for it using the 94620 CPT code. An example would be, if you are doing the walk for patients who have Restrictive Lung Disease, as the test is often ordered after they have a medication change and to determine if their disease is progressing.

Q: Two insurance questions:

1. When verifying insurance coverage for services using the G0237-239 codes, should we refer to it as Respiratory Care services and not Pulmonary Rehab?
2. What are the recommended CPT codes to use to crosswalk over to commercial payers for the G0237 — G0239 codes? For example, the hospital set us up to use 97150 and 97530 which is also used by physical therapy.

A: Private insurances do not have to follow CMS Guidelines. I found that the best way to determine which codes or verbiage they need to cover the services is to call and talk to someone in the insurance company that understands both coding and coverage. Then, if they
have additional questions, you are able to answer them. Most insurance companies are now able to accept the G codes. You may also want to develop a template of questions for whomever in your facility is pre-certifying your private pay patients (often times not a clinician).

If you have reimbursement questions, please contact your MAC representative. Click on this link to find the chairs of each MAC.

### Cardiac Rehabilitation FAQs

**Karen Lui, RN, MS**

**Q:** Is the 36 session CR program once in a lifetime or per calendar year or per event?

**A:** Patients are eligible for CR if their diagnosis meets the criteria listed in the CMS or MAC coverage information. There is no calendar year limit on CR participation. However, a patient who enters CR with a diagnosis of AMI and had a PCI intervention with that MI is eligible for only one course of CR (i.e., concurrent diagnoses would allow one course, not two 36-session courses). So, for example, if a patient completes a CR program after having a PTCA in January and has CABG in September is eligible for another course of CR. This is stated in CMS Change Request 6850, Transmittal 126 (5-21-2010).

**Q:** If the patient comes to CR, but is unable to exercise due to a medical situation (high BP, high glucose, symptoms that contraindicate exercise that day, etc!), do we bill for the time spent with that patient?

**A:** No, at this time there is no billing code that can be used to bill for this type of event. A patient must exercise during each day that CR session(s) are received in order to be reimbursed.

**Q:** May we use CPT (93799, 99211, etc) to bill for CR assessment?

**A:** No. CMS has clearly stated that initial assessment provided by the CR staff is considered part of the comprehensive service and is not separately billable. The initial assessment & ITP development would be done with the patient in the first 1-2 CR sessions.

**Q:** Is there any coverage for Phase III (IV, maintenance) CR?

**A:** No, at this time there is no coverage for maintenance programs. Phase III-IV-Maintenance is a self-pay program and therefore not subject to CMS rules.

**Q:** May we bill separately for smoking cessation?

**A:** No. There are two CPT codes available for physicians (CPT 99406 and 99407) that are not available for CR staff to use in addressing the goal of smoking cessation as part of a comprehensive CR program.

### Nutritional Aspects of Rehabilitation

**March Is National Nutrition Month**

**Alisa Krizan, MS, RD, LD**

This year the Academy of Nutrition and Dietetics, (formerly the American Dietetic Association) will be celebrating the 40th anniversary of National Nutrition Month®. The Academy is the world’s largest organization of food and nutrition professionals. We are committed to improving the nation's health and advancing the profession of dietetics through research, education and advocacy.

This year’s theme is “Eat Right, Your Way, Every Day.” The campaign focuses this year’s attention on the importance of making informed food choices, and developing sound eating and physical activity habits. Registered dietitians (RD) play a critical role in helping people eat right, their way, every day. Registered dietitians encourage personalized healthy eating styles* and recognize that food preferences, lifestyle, cultural and ethnic traditions and health concerns all impact individual food choices.
The Academy Web site is open to the public at http://www.eatright.org/Public/. Here you will find timely, reliable scientifically based nutrition information resources covering a broad range of health topics you can trust. You will be able to find a registered dietitian in your area and links to healthy eating Web sites. You can learn about popular diet books reviewed by Academy members, download nutrition education materials and view the new culinary series "Watch and Learn."

The Academy has specialized practice groups that enable our members to improve their job performance, gain insight into specialized areas of food and nutrition, and network with colleagues. Two of my favorite practice groups are the Sports, Cardiovascular and Wellness Nutrition (SCAN) http://www.scandpg.org and the Food and Culinary Professionals http://www.foodculinaryprofs.org.

At the 2012 AACVPR meeting, I was approached on several occasions with requests for a nutrition assessment tool. On the SCAN Web site, you will find a link to the University of Wisconsin-Madison's Preventive Nutrition Inventory assessment survey.

Planning for the nutrition education sessions for the AACVPR 2013 Annual Meeting is well under way. We have a fantastic group of Registered Dietitians for this year’s conference. We are looking forward to another great series of nutritional presentations. Keep an eye on this column for updates as speakers and topic are confirmed. See you in Nashville.

*Based on 2010 Dietary Guidelines recommendations and MyPlate messages.

### Pulmonary Point of View

#### The New GOLD Classification to Predict COPD Clinical Course

Gerene Bauldoff, PhD, RN, FAACVPR

A study by Dr. Peter Lange et al published in the November 2012 issue of the American Journal of Respiratory and Critical Care Medicine describes their investigation evaluating the abilities of the new Global Obstructive Lung Disease (GOLD) Classification stratification to predict the clinical course of COPD patients. The GOLD recommendations and classification were updated in December 2011 and are available here. The GOLD classification was significantly modified from a system based primarily on FEV1 level to a new classification where daily symptoms (dyspnea and others) and history of exacerbation are also now components.

Lange et al conducted a retrospective analysis of pooled data from two independent studies: Copenhagen City Heart Study (n=5919) and the Copenhagen General Population Study (n=55,731). Both studies collected extensive information including lifestyle and health topics including medications and spirometry. The sample, drawn from both studies, included individuals who had a reported FEV1/FVC less than 70% predicted, resulting in 6,628 total subjects. The sample was subdivided by the two GOLD stratifications: Spirometry and clinical status A (low risk, less symptoms) through D (high risk, more symptoms) with additional stratification within groups C and D based on prior year exacerbations. The participant registry data was monitored for an average of 4.3 years (maximum 8.9 years). Endpoints included COPD exacerbation (medication and hospitalization), hospital admission and all-cause mortality. Results revealed that exacerbations increased by group (A = 2.2%, B=5.8%, C=25.1% and D=28.6%). All-cause mortality at one and three years were similarly distributed, except that Group B that was noted to have more severe dyspnea had poorer survival than group C in spite of a higher FEV1. The authors concluded that the new GOLD stratification performed well in identifying persons at risk for exacerbation. They recommend that the subgroup B (low risk for exacerbations but more symptoms) warrant special attention requiring special assessment and treatment to evaluate if other causes could have impacted the mortality of this group.

**Why is this important in pulmonary rehabilitation?**

These results support the use of the updated GOLD stratification system that includes assessment of exacerbation and symptoms. Please see this column October 2012 that discussed the COPD Assessment Test and as one of two tests used to assess symptoms.
The CAT and the modified Medical Research Council questionnaire are both identified as components used to assess future risk of exacerbations. The GOLD Stratification is an important updated tool that is easy to use and provides important information about health status in our population.

References:


SCIENTIFIC REVIEW

Home-Based Secondary Prevention Programs for Patients with Coronary Artery Disease: A Meta-Analysis of Effects On Anxiety – McClure et al (Canada)

CARDIAC REHABILITATION

Diagnostic Performance of Weight Loss to Predict Body Fatness Improvement in Cardiac Rehabilitation Patients – Pack et al (USA)
Correlation and Discrepancies Between Obesity by Body Mass Index and Body Fat in Patients With Coronary Heart Disease – De Schutter et al (USA)
Long-term Results of a 12-Week Comprehensive Ambulatory Cardiac Rehabilitation Program – Blum et al (Switzerland)
Psychosocial Outcomes of an Exercise Maintenance Intervention after Phase II Cardiac Rehabilitation – Pinto et al (USA)
BRIEF REPORTS

- Timed-Up-and-Go-Tests in Cardiac Rehabilitation: Reliability and Comparison with the Six-Minute-Walk-Test – Bellet et al (Australia)
- Cardiac Rehabilitation: Beginning At the Bedside – Tiller et al (Canada)

PULMONARY REHABILITATION

- Physical Activity Profile of Lung Transplant Candidates with Interstitial Lung Disease – Wilkerson et al (Canada)

BRIEF REPORT

- Development and Feasibility of a COPD Self-Management Intervention Delivered with Motivational Interviewing Strategies – Benzo et al (USA)

ASSOCIATIONS STATEMENT

- International Charter on Cardiovascular Prevention and Rehabilitation: A Call for Action – Grace et al (Canada, USA, United Kingdom)

Task Force Updates

Beta Testing Begins for AACVPR Outpatient Pulmonary Rehab Data Registry

Chris Garvey, FNP, MSN, MPA, FAACVPR

The AACVPR Outpatient Pulmonary Rehabilitation Data Registry is moving ahead on schedule with beta testing and recruitment of early adopters. Extensive work has gone into the registry to define fields for the tracking of clinical outcomes for patient management and program measurement, with the end goal being to enhance pulmonary rehab program quality improvement and effectiveness. The registry will go live summer 2013. We look forward to and encourage your participation! A 50% discount on your subscription is available for early adopters until March 29, 2013.

For more information, please visit www.aacvpr.org/PRregistry. You can direct any questions to AACVPR Headquarters at registry@aacvpr.org or 312/321-5146, option 1.

Affiliate Updates

Connecticut Society for Cardiac Rehabilitation

Eunice A. Lisk, MS CSCR President

The Connecticut Society for Cardiac Rehabilitation (CSCR) represents 32 cardiac and pulmonary programs from all over the state of Connecticut. We have 54 members and we have made a goal to increase that membership by 20% in the coming year.

Our Web site, www.CTCardicRehab.com, created in 2010, has been a great resource for members, students and the public. A recent report found that “hits” to our site had increased 362% each year since its inception. It features

- Program highlights — at each quarterly meeting, a different program gives a presentation describing their program including; staffing, hours, referral sources, student interns, etc.
● Healthy recipes
● Job opportunities
● Helpful links to the American Heart Association, Circulation and other websites related to cardiac and pulmonary rehab.
● A forum where blogs on different topics can be discussed

The CSCR holds symposiums biennially in September, and last year’s conference was a huge success. The theme of the day was “Working with the CHF Patient” and speakers included Kevin Lenhart, MD, director of the CHF clinic at St. Vincent’s Medical Center in Bridgeport, Connecticut, and Samantha Heller, MS, RD, CDN, author and TV personality. Dr. Lenhart spoke to the group about exercise guidelines for the CHF patient, and Ms. Heller spoke about nutrition for that population. The symposium was well-attended and participants were able to earn 3.0 CEUs. We look forward to planning the 2014 symposium.

The CSCR prides itself on being a small but mighty group! Our dedication to the cardiac and pulmonary patient is evident as we strive to provide stellar programs in these challenging times for healthcare. Meetings are often times for sharing ideas and gathering information to better our programs as we strive to deliver excellent service to each and every patient.

Our quarterly meetings are held at the American Heart Association offices in Wallingford, Connecticut. Our quarterly meetings are held on Thursdays at 12:30–4 p.m. and include lunch. We will meet on Thursday March 28, Thursday June 27, and September 26. For more information about becoming a member of CSCR, please contact our Membership Director Laura Johnson at ljjohnson@echn.org.

Arizona Society for Cardiovascular and Pulmonary Rehabilitation: Update
Sharon Peachey Sheremeta, Sc.D., RCEP, FACSM, President, ASCVPR

Our society continues to provide excellent networking and educational opportunities every quarter. We hold our meetings throughout the large state of Arizona, so everyone has an opportunity to attend at least one meeting each year. While our Annual Meeting is held in the greater Phoenix area, our other quarterly meetings have been held in Tucson, Yuma, Prescott and Show Low. Our summer 2013 meeting will be held in Cottonwood.

Our educational opportunities are also topical and of high-quality. In the past year, we have had speakers on Robotic Surgery, Utilization of Cardiac Rehab in the Hispanic Population and Chronic Obstructive Pulmonary Disease. For our fall 2012 meeting, we were fortunate enough to partner with the Preventive Cardiovascular Nurses Association to attend their Fall Lecture Series in Scottsdale. Our members received education on several topics from national experts, continental breakfast, heart-healthy lunch and 2.25 CEUs — all at no cost to them!

Our 21st Annual Meeting will be held on Saturday, April 20, 2013, from 8:00 a.m. until 4:30 pm at Banner Desert Medical Center in Mesa, Arizona. Our Education Committee is working hard to bring excellent speakers and timely topics to our membership. Please visit our Web site, www.ascvpr.org, for updated information about the conference.

Return to Top

Calendar of Events/Education
February 2013

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

March 2013

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