Messages from Headquarters

Letter from the Editors
What You Are Getting for the New Year
Jody Hereford, BSN, MS, MAACVPR
Steven Lichtman, EdD, FAACVPR

"...if you are standing still, you’re going backwards fast." — Jack Gibson (1929-2008; Australian rugby league footballer and coach)

In our last editorial we asked you: What do you want more of in this New Year?

In this editorial we are very pleased to present you with a partial summary of what AACVPR is offering you this year!

As you peruse this issue of News & Views you will learn more about several exciting AACVPR initiatives that provide tools and information to fulfill this year’s theme of “Best People …Best Practice …Best Performance” (see Anne Gavic’s “President’s Message”). Highlights from this issue:

• AACVPR’s new membership program called “EducationAdvantage” highlighted in Megan Cohen’s “Executive Director’s Corner.”
• Opportunities for reciprocal activities with the American Association for Respiratory Care (AARC) and the American College of Cardiology (ACC). See Marjorie King’s column “Update on AACVPR Liaison Activity.”
• An update on the AACVPR-led, multi-society effort that has engaged CMS in dialogue around options for coverage of select Heart Failure patients, who meet specific qualifying criteria, which could then authorize coverage of cardiac rehabilitation services. See Karen Lui’s column “Heart Failure and Cardiac Rehabilitation.”
• The continued excellence of JCRP. See Mark Williams’ column “Journal of Cardiopulmonary Rehabilitation and Prevention Highlights.”
• The anticipated go live date for the AACVPR Outpatient Pulmonary Rehabilitation Registries this summer. See Chris Garvey’s and Mark Vitcenda’s “Committee Update.”
• New patient and program education tools from the Clinical Applications Committee. See Kate Traynor’s “Committee Update.”

All of this is contained in just one issue of News & Views! Be assured that AACVPR is working on other key initiatives to benefit our membership that you will be reading about in future issues. However, the onus is on you to take advantage of what AACVPR offers. You need to think and act proactively as our scientific evidence and healthcare environment evolve; anticipate and act on what will keep your program relevant and state-of-the-art for your patients. Make sure you use your AACVPR membership to the fullest extent — or you may be going backward fast!


President’s Message
Best Practice… The Challenge of Excellence
Anne M Gavic, MPA, FAACVPR

As outlined in my column from the December/January issue of News & Views, AACVPR’s key initiatives this year reside in the theme Best People …Best Practice …Best
Performance. That article focused on “Best People,” and the second phrase in this theme, “… Best Practice…” focuses on how we build and deliver Cardiac and Pulmonary Rehabilitation (CR / PR) practice. What is it that defines “Best” in CR / PR practice?

In my view, Best Practice relates to three key areas: Alignment with Evidence; Measurement of Quality; and Innovation in Delivery. With these three solidly in place, program practice is well-positioned for excellence.

Alignment with the Evidence

CR and PR are based on strong evidence that, if used to guide program development, is likely to result in significant patient benefits. Many of these evidence based resources and guidelines are available on the AACVPR Web site.

We all need to be familiar with current evidence to ensure that the essential elements for Best Practice are included in our program design. Additionally, Program Certification provides an opportunity for programs to measure themselves against essential standards and to be recognized for quality program delivery.

Measurement of Quality

The key to maintaining and building Best Practice within a program is measurement of patient and program outcomes. The AACVPR registries provide perfect vehicles for collecting and analyzing outcome data. However, simply collecting data is not enough. Used effectively, data can provide evidence of program benefits, as well as highlight areas of strength and opportunities for improvement. More than ever, it is important that Best Practice is demonstrated through strong evidence — at the patient, program and national level.

Innovative Program Delivery and Design

Most evidence of CR / PR program benefit is based on the traditional model of program design – with exercise training, patient education and counseling for risk reduction at its core. Recent changes in reimbursement for services allow more flexibility and creativity in the way services are delivered. With an eye to this, we have a responsibility to explore new ways of improving accessibility of CR / PR services to ALL eligible patients, by investigating new and innovative delivery models. Even in the absence of standardized reimbursement, services such as home and community-based programs, and health coaching to improve patient motivation and compliance, deserve a closer look in order to promote the very best for our patients. In some cases, these new models may substitute for the time-tested traditional services. Often, however, they will enrich existing services and provide ways to reach significantly underserved populations, improve program elements, and ultimately enhance patient outcomes.

Best Practice … is a challenge to carefully examine programs and measure them against the most recent evidence; to use data for intentional program improvement; and to allow creative thinking toward the best solution for improved accessibility, cost-effectiveness and exceptional patient care.

“Unless someone like you cares a whole awful lot, Nothing is going to get better. It's not.”
— Dr. Seuss, The Lorax

Executive Director's Corner

New AACVPR Membership Category Rolls Out This Summer: EducationAdvantage

Megan Cohen, MPA, CAE

As we approach membership renewal season, our Membership & Affiliate Relations Committee has been hard at work creating some new and exciting offerings for our members. Through our surveys we’ve heard your ongoing requests to keep continuing education as reasonably priced as possible, especially for AACVPR members. We understand that continuing education is a vital component in improving the quality of care that you provide to your patients, and at the core of the association’s mission. So, this year we’ve created an education-inclusive membership (called EducationAdvantage) that gives you access to up to 10 educational Webcasts throughout the year for only $44 more in membership dues. Along with those Webcasts, we’ll provide AACVPR or nursing continuing education credits (CECs) at no extra charge. It’s a value of up to $650 in education for $44 — truly a great deal.

To help explain this new offering, I conducted an interview with our Membership & Affiliate Relations Committee Co-chairs Carla Vorndran and Tom Spring.
Thank you to everyone who helped us celebrate 2013 CR and PR Weeks!
You can still purchase your CR & PR Week promotional materials by Clicking Here.

AACVPR thanks its members for the great 2013 AACVPR National Cardiac & Pulmonary Rehabilitation Weeks! Take part in shaping the look for 2014. Submit your theme ideas by April 26. Email aacvpr@aacvpr.org with your themes.

The Call for 2013-2014 Committee Members Is Now Open!
Not sure which committee might interest you? Click Here to see the Committee Purpose Statements.
Click Here to submit your 2013-2014 Committee Service Application. Applications are due Monday, April 29, 2013.

Megan: So Carla and Tom, why has your Committee chosen to offer this new category of membership?

Carla and Tom: This is a new kind of membership category that we've been considering for several years. The collaborative effort between the Membership & Affiliate Relations Committee, the Education Committee, and AACVPR Headquarters staff helped to produce a proposal that was met with enthusiastic support by the Board of Directors.

The goal of this new offering is to increase the exposure to and participation in AACVPR educational offerings via live Webcasts by adding a considerable benefit for all members within a new membership category.

AACVPR has recognized its members' needs and understands that continuing education is an important step in increasing the quality of care our members provide to their patients. As a leader in the cardiovascular and pulmonary rehabilitation field, AACVPR has acknowledged its responsibility to find new ways of meeting these educational needs. Our Webcasts are consistently rated as "high quality" by those who view them; however, they've been underutilized in recent years. With this new structure, members will be able to receive education that is vital to their professional development as part of their membership dues.

Megan: Will this opportunity be available for other types of members?

Carla and Tom: Actually as some of you know, an increasing number of our affiliate organizations are choosing to become "Joint Affiliates," an arrangement that offers both state and national membership all for one price. This same education-inclusive membership opportunity will be available as an additional benefit for all Joint Affiliate chapters.

As for the Joint Affiliate membership structure, this new benefit was a no-brainer for the Membership & Affiliate Relations Committee. Currently, much of the affiliate benefits gained from the AACVPR Joint Affiliate agreement are on the Board and organization level. Members of the Joint Affiliates may not feel that they receive direct benefits from the agreement beyond the benefits that come with AACVPR membership. Offering these individuals a membership with identified education included will give them more tangible benefits, hopefully bringing more Joint Affiliates into the fold.

Megan: What happens if the member is not available during the time of the Webcast? Do they lose their opportunity for the free education?

Carla and Tom: We realize that our members have incredibly busy schedules so we've made arrangements for live Webcasts to be made available for 30 days after the event for these members to view and receive their CEC. This later viewing opportunity will be available to anyone in the EducationAdvantage category or those members of Joint Affiliates. The only thing EducationAdvantage members will have to do is be sure to register by the live Webcast date!

Megan: Will this membership option be available in perpetuity?

Carla and Tom: The Membership & Affiliate Relations Committee, in conjunction with the Board of Directors, plans to evaluate the success and utilization of the EducationAdvantage offering at the end of each year. Currently, the program is scheduled as a three-year pilot program, after which the Board will consider the possibility of any permanent changes.

Megan: What is the launch date?

Carla and Tom: Soon! The great thing about this new membership structure is that all of our members will be able to take advantage of this new opportunity beginning July 1, 2013. Keep an eye out for messaging and invoices from AACVPR Headquarters to instruct you on how to select this new membership option.

If you have questions, please feel free to contact AACVPR Headquarters at 312/321-5146. We hope you feel as much excitement about this new opportunity as the Membership & Affiliate Relations Committee, the Education Committee and the AACVPR Board of Directors.
Innovative Programming and Best Practices

Tracy Herrewig, MS, RCEP, FAACVPR

Many cardiac and pulmonary rehab programs incorporate the use of graduate or undergraduate level interns in their programs. This requires searching out and maintaining clear communication with universities, establishing a curriculum for the intern and providing supervision/leadership for that intern. This may initially sound like more work than it is worth, but as this edition’s Innovative Programming/Best Practice column highlights, interns can contribute to not only the daily work flow but inspire us all to develop new programs to improve patient care.

The contributor for this issue’s column is Phil Lee. He provides a thorough overview of the benefits to both the student, and importantly, to the program and staff.

Potential of Interns in Cardiac Rehabilitation – a Graduate Student’s Perspective
Phil A. Lees, MS

It is clear that internships in cardiac rehabilitation (CR) provide a great opportunity for students to experience real clinical environment and to apply the knowledge, skills and experiences learned during their degree program. Once the potential benefits to both the student, and importantly, to the program and staff.

The six-month HRR research study provided a great team-building experience for both staff and patients involved, and the final results were presented at the ACSM 2012 Annual Meeting in San Francisco. In addition, the study won second place in the statewide California State University research competition, and was acknowledged by the JMH Cardiovascular Performance Improvement (CVPI) committee.

In summary, interns may provide new energy and a new perspective to the CR process. They often ask “why,” which allows staff to re-evaluate current practice and standards.

Interns can not only assist staff in their efforts to establish new procedures or programs, but they can also contribute to research that can potentially lead to improvement in patient care and outcomes. This data may improve the program, contribute to hospital/cardiology quality measures or may even be published in nationally recognized journals to assist other programs in the field. As this one example demonstrates, it is advantageous to establish and maintain relationships with university programs that focus on developing new professionals for the field of cardiac or pulmonary rehabilitation and whose professors who can recommend students for internships or employment. It is also an important opportunity to remain connected with the research and clinical communities offered by AACVPR and ACSM. Incorporating the use of interns in your program may provide the opportunity for your program to grow through innovative ideas and the establishment of best practice guidelines.

Update on AACVPR Liaison Activity: Exciting New Program for Patients with Prediabetes
Valerie Carroll-Kramer, RN, BS, CDE, FAACVPR, AACVPR liaison to AADE and Marjorie King, MD, FAACC, MAACVPR

From our liaison relationship with the American Association of Diabetes Educators (AADE), we learned of an exciting program for patients with pre-diabetes.

Diabetes is a serious health condition that can lead to heart disease, stroke, kidney failure, high blood pressure and blindness. Pre-diabetes is a potentially reversible situation that increases the risk of developing type 2 diabetes, heart disease, and stroke. According to the Center for Disease Control (CDC) research, 79 million people in the United States are estimated to have pre-diabetes. This is equivalent to 35% of adults 20 years and older. In fact, half of all Americans aged 65 years and older have pre-diabetes. Despite these staggering statistics, the vast majority of people with pre-diabetes do not know they have the condition. Only 7% of people with pre-diabetes are aware of their condition.

Based on effective efforts researched by the National Institutes of Health (NIH) with support from the CDC, the National Diabetes Prevention Program (DPP) helps people with pre-diabetes learn about and adopt the healthy eating and physical activity habits that have been shown to reduce the risk of developing type 2 diabetes. Through the program, participants receive support and encouragement from both a trained lifestyle coach and fellow classmates as they develop and implement individualized plans for improving and maintaining overall well-being.

In September 2012, AADE received a grant from the CDC to expand availability of the National DPP. Funding from the grant is allowing AADE to provide support and resources for diabetes educators in target states interested in delivering the National DPP lifestyle program to grow through innovative ideas and the establishment of best practice guidelines.
change program to persons with pre-diabetes. Learn more about AADE and AADE’s involvement in the National DPP. Want to learn more, get involved, or follow the progress of this exciting national effort? You’ll find the latest insight about the program, the selection process, links to the lifestyle change program curriculum and the CDC’s Diabetes Prevention Recognition Program here.

AACVPR Hits the Road
Marjorie King, MD, FACC, MAACVPR

Annual meetings are a perfect time to re-connect with colleagues and meet others who share similar passions. Many of us are members of several professional organizations and this year, the Professional Liaison Committee (PLC) figured out a way to leverage our enthusiasm to help AACVPR staff be more effective in spreading the news about AACVPR, and cardiovascular and pulmonary rehabilitation to other healthcare professionals and industry leaders at annual meetings. Having a presence at these meetings is critical for AACVPR to leverage our partnerships, get a “seat at the table” for important advocacy efforts and guideline development, and for prospecting new members and vendors to become involved with AACVPR.

In November, AACVPR had a presence at the annual meeting of the American Association for Respiratory Care (AARC) in New Orleans, including a display in the vendor hall and meetings with other liaison organizations including the COPD Foundation and EFFORTS, and submitted a proposal for reciprocal activities to promote excellence in pulmonary rehabilitation to the AARC Board. Jessica Eustice, AACVPR’s Development Manager, partnered with Debbie Koehl (PLC member responsible for the AARC liaison - pictured on the left) and Brian Carlin (AACVPR Past President) to make this happen.

Joe Norman (pictured below) and Rebecca Crouch volunteered to coordinate an AACVPR display at the American Physical Therapy Association (APTA) section meetings in San Diego in January, distributing hundreds of membership brochures and fact sheets about cardiovascular and pulmonary rehabilitation.

In early March, several AACVPR members attending the American College of Cardiology (ACC) annual meeting in San Francisco and helped Jessica with an aggressive schedule of meetings with vendors, sponsors and liaison organizations. Randy Thomas (AACVPR Past President), Kathy Zarling (Chair, Education and Program Committees), Chip Lavie (Chair, Document Oversight Committee) and I participated in these meetings and offered insight into ways to strengthen these critical partnerships. We also met with ACC staff to discuss opportunities for AACVPR involvement in writing groups and to better inform ACC members about the benefits of cardiac rehabilitation, as well as with staff and volunteers from Mended Hearts, WomenHeart, and the Society for Cardiovascular Angiography and Intervention (SCAI) to discuss ways to work together to promote appropriate use of cardiac rehabilitation services. The team also met with a variety of vendors to discuss future involvement with AACVPR at our Annual Meeting and throughout the year.

AACVPR funds are used for staff attendance at these meetings, but none are used for the volunteer’s time or travel, drawing on the commitment of dual organization members to promote AACVPR and cardiovascular and pulmonary rehabilitation. Therefore, AACVPR needs your help to continue to promote our messages. We are hoping to build on this model with other liaison organizations’ annual meetings in the future and encourage dual organization members, especially those in leadership positions, to contact Jessica at jeustice@aacvpr.org if you are interested in helping to highlight AACVPR, cardiovascular or pulmonary rehabilitation to your colleagues at a national meeting.

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
Inside the Industry

Heart Failure and Cardiac Rehabilitation
Karen Lui, R.N., C, M.S., MAACVPR

The findings from the HF-ACTION Trial have corroborated previous substantial evidence that cardiac rehabilitation (CR) is beneficial for patients with heart failure (HF). CR programs are increasingly finding this diagnosis covered by some commercial insurance plans. An example of this would be a hospital or an Accountable Care Organization (ACO) that has set a goal of reducing the 30-day hospital re-admission rate for patients with HF and, therefore, is likely to include CR as part of that patient’s early outpatient care.

Medicare is increasingly focusing on evidence-based clinical outcomes, such as reduced hospital re-admissions, improved quality of life and lower mortality rates. It would be logical for Medicare to follow private payers’ lead in covering CR for this patient population, the No. 1 reason for hospital admissions today.

AACVPR has been working closely with the American College of Cardiology (ACC), the American Heart Association (AHA), and the Heart Failure Society of America (HFSA) to further educate The Centers for Medicare and Medicaid Services (CMS) on the benefits of CR for certain heart failure patient populations. The societies are engaging in important dialogue with CMS to explore various options for coverage of select CHF patients as meeting the qualifying diagnoses that authorize coverage of cardiac rehabilitation services. The process for this is a long one with no possibility of a near-future decision, but AACVPR is committed to taking the right step for our patients.

Health & Public Policies FAQs

Cardiac Rehabilitation FAQs
Karen Lui, R.N., C, M.S., MAACVPR

Q: Are there any changes in Medicaid coverage for Cardiac rehabilitation?

A: Medicaid falls under Title XIX of Social Security Act. Medicaid must cover certain services that Medicare (Title XVII of the SSA) covers, including hospital outpatient services. Many states have specific CR policies. For example, in Texas, CR is a covered service for heart failure patients. Payment is another matter as Medicaid is a state-administered and funded program. Reimbursement is totally a state-driven decision. Therefore, in some cases, a service may be covered with a reimbursement amount of zero. Also, each state Medicaid program may decide to select different HCPCS codes than those Medicare requires for billing purposes. It may likely take networking amongst your state programs to find which codes are being reimbursed-Medicaid generally won’t share that information, so it becomes a trial-and-error exercise.

Q: If a patient completes 24 sessions, then has another qualifying event, would he/she begin a new cardiac rehabilitation program at session # 1?

A: That would depend on the “event.” For example, Transmittal 126 (Change request 6850) states, “Should a beneficiary experience more than one indication simultaneously, he or she may participate in a single series of CR or ICR sessions...” A different example would be a post-AMI patient who completes 20 sessions, but the course is interrupted due to CABG intervention. That patient would be discharged from the CR program and would re-enter with a new diagnosis post-CABG. Keep in mind, when that patient has received 16 sessions under the new diagnosis of CABG, CMS counts this as session # 36 (20+16=36) and the KX modifier will be necessary for all further CR sessions (for as long as that patient is a Medicare beneficiary).

Q: If the initial assessment takes two hours and you do a six-minute walk test with ECG, do you have to charge more than one 93798 code?

A: No, you are not required to charge for two sessions, but you are allowed to charge for two sessions if the duration of those two sessions is greater than 90 minutes. It is logical that the first day of cardiac rehab will be more time-consuming and largely 1:1 with the patient, so charging for two sessions justifies staff time dedicated to a comprehensive and individualized treatment plan. The 6MWT would serve as that patient’s exercise that day. An exercise equipment orientation/assessment (i.e., actually using equipment to...
become familiar with it and establish some level of comfort) would also appropriately be considered exercise.

Q: Can 93797 be billed for education without exercise?
A: The definition of CPT 93797 in the AMA CPT Code Book is outpatient cardiac rehab without continuous ECG monitoring. Therefore, this code is the appropriate one to use for:

1. the CMS-required education/counseling components of CR services OR
2. for non-ECG-monitored exercise.

Keep in mind that exercise is required every day the patient comes to cardiac rehab, but not required every session.

Q: Can you explain billing for orientation for cardiac rehab?
A: Exercise is required every day the patient attends CR. The first session would consist of exercise orientation (some exercise) and ITP development (i.e., initial assessment) with the patient. If that takes > 90 minutes, it would be appropriate to use one 93798 code and one 93797 code for CR services provided that day.

Pulmonary Rehabilitation FAQs
Lana Hilling, CRT, RCP, MAACVPR

This column is following up on multiple questions that Phil Porte and Karen Lui were asked after their presentation on Medicare Rules and Rates in November 2012. This article, will address questions regarding the KX modifier and the ITP.

Q: What is a KX modifier and how do you obtain information regarding its use?
A: The KX modifier serves as an attestation that the requirements for PR visits above 36 (in a lifetime, starting after 1/1/10) has been met. If you append the KX modifier to a claim, you are telling Medicare that your claim has met the specific requirements in the policy, and this documentation is available upon request from the MAC or any other auditing body. Medicare will normally pay for 36 sessions of PR, but may pay up to 72 sessions when the claim(s) for sessions 37-72 includes a KX modifier. Claims for over 36 sessions without the KX modifier will be denied. However, see the next question regarding payment for sessions 37-72.

*See CMS Change requests 6850 and 6823 for CR and PR use of KX modifier.

Q: Our billers/coders are hesitant to start using the KX modifier, but this is new only since 1/1/2010, correct? Our facility is concerned because we've not been using it.
A: Yes, the requirement for the KX modifier has been in place since 1/1/2010. This instruction was sent to all providers via CMS Change Request 6850 (CR: 5-21-2010) and CMS Change Request 6823 (PR: 5-7-2010), as stated above. (put the link here).

Q: Are critical access hospitals exempt from using the KX modifier requirement?
A: No, the same regulations and coding requirements are in place for these hospitals.

Q: Is the KX modifier needed for any sessions beyond 36 sessions for a patient with COPD? Additionally, If the KX modifier is a billing factor, how can we be sure that Medicare will approve the additional 36 sessions?
A: The KX modifier is needed for any sessions beyond 36 sessions, so you begin using it on the 37th visit. Medicare patients with COPD are only allowed 36 sessions per course and 72 for a lifetime. However, there is no guarantee that you will be paid for the additional 36 sessions. You cannot receive prior authorization from Medicare, so make sure the patient really requires additional sessions and document, document, document the need for the additional sessions.

Q: Is the KX modifier used if you use G027, G0238 and/or GO239 on the same day?
A: No, the use of these G codes does not require a KX modifier.

Q. Who would be responsible for payment if Medicare stated the additional sessions were “medically unnecessary”?
A: Most likely the patient. If the hospital is not sure if a service will be reimbursed, the patient is asked to complete an Advance Beneficiary Notice (ABN). This states that the patient is responsible if Medicare does not pay. Even if the patient does not complete an ABN, the hospital is able to hold the patient responsible, as anytime someone is admitted for any type of procedure they sign a financial responsibility form. My recommendation would be to ask for permission to extend the program for a patient and ask the business office if something could be worked out that if reimbursement is not received, that the hospital would be willing to absorb the bill. Explain that this is a test case for your program and why. It never hurts to ask.

Q: Who signs the ITP for pulmonary rehabilitation?
A: The Medical Director reviews and signs ITPs. This is solid documentation of your Medical Director’s “substantial” involvement in your program, with staff, and in “…directing the
behavioral aspects of rehabilitation

health literacy in cardiopulmonary rehabilitation: obstacle or opportunity?

Joel W. Hughes, Ph.D., FAACVPR, Colleen C. Mattson, B.A.

"Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."

— Healthy People 2010

Health literacy is considered a serious challenge for the healthcare system in America. In 2010, the U.S. Department of Health and Human Services issued a National Action Plan to improve health literacy [1]. Apparently, only 12% of adults in the United States have truly proficient health literacy, and levels of health literacy are lower for people over 65 years of age. Low health literacy has been related to worse adherence, higher healthcare costs, increased mortality and lower disease knowledge [2-5]. Poor health literacy is thought to impact prognosis in cardiovascular disease [6], and in one recent example health literacy was recently shown to predict all-cause mortality in patients with Heart Failure [7]. However, the role of health literacy in cardiopulmonary rehabilitation is not well-defined. Here are findings that directly support these conclusions, they seem reasonable. This also suggests that levels of health literacy are higher among patients participating in rehabilitation than among patients eligible for rehab. Given the chronic underutilization of rehabilitation, outreach efforts that are mindful of patients with limited health literacy may be advisable. For example, it may be necessary to review printed materials for reading level and to emphasize in-person approaches to enrolling patients in cardiopulmonary rehabilitation. This is partly a systems issue, and a frank discussion with cardiologists and hospital administrators about working together to overcome this barrier may be in order.

A barrier to enrollment. A recent American Heart Association (AHA) presidential advisory stated that low health literacy is one of several patient characteristics limiting enrollment in, and attendance at, cardiac rehabilitation [8]. Although we are unaware of any research findings that directly support these conclusions, they seem reasonable. This also suggests that levels of health literacy are higher among patients participating in rehabilitation than among patients eligible for rehab. Given the chronic underutilization of rehabilitation, outreach efforts that are mindful of patients with limited health literacy may be advisable. For example, it may be necessary to review printed materials for reading level and to emphasize in-person approaches to enrolling patients in cardiopulmonary rehabilitation. This is partly a systems issue, and a frank discussion with cardiologists and hospital administrators about working together to overcome this barrier may be in order.

How should low health literacy be addressed in rehabilitation? Unfortunately, there is little research on health literacy in cardiac and pulmonary rehabilitation. Whether or not to screen for low health literacy, as well as what measure to use, is not clear. Options include the Medical Term Recognition Test (METER) [9], the Short Test of Functional Health Literacy in Adults (s-TOFHLA) [10], and the Newest Vital Sign (NVS) [11]. One criticism of most measures is that they appear to primarily measure reading ability (i.e., literacy), whereas health literacy is supposed to have effects separate from education level and reading ability. Furthermore, entry to rehabilitation already includes many assessments, and the incremental value of adding health literacy has not been established. Perhaps identifying patients with a more limited ability to comprehend the material being presented would be beneficial if corrective actions were taken.

Health Literacy and patient education. Our bias is that cardiac and pulmonary rehabilitation are the premier venues for patient education, which is an area where the effects of low health literacy are likely to be evident. We recently reported that health literacy predicted both initial knowledge of cardiac disease and gains in knowledge during cardiac rehabilitation [12]. However, most patients achieved high levels of knowledge by the end of rehabilitation. Careful attention to the readability of patient education materials, combined with high quality instruction, might largely overcome deficits in health literacy. That is, patient education programs should be designed to reach as many patients as possible, regardless
of their level of health literacy. For example, patient education can include assessment of understanding (e.g., teach-back method), gently overcoming resistance (e.g., motivational interviewing), and clear goal-setting (e.g., health coaching strategies). None of these approaches are a surprise, but acknowledging the challenge of low health literacy underscores the importance of best-practices in patient education.

Ultimately, health literacy is probably an obstacle to enrollment and participation in rehabilitation. However, it is also a public health challenge that could be a real opportunity for cardiopulmonary rehabilitation programs. We already know that many Americans struggle to understand and use health information. As a comprehensive intervention for chronic illness, cardiopulmonary rehabilitation can address the mechanisms by which health literacy is alleged to increase patient risk. That is, rehab can provide the patient education and self-management training that increases knowledge, improves adherence, strengthens health communication, and protects patient safety.

Resources:


http://nnlm.gov/outreach/consumer/hlthlit.html

Reference List:


Pulmonary Point of View

The New GOLD Classification Additional Analysis: Distribution and Prognostic Validity Questions

Gerene Bauldoff, PhD, RN, FAACVPR

In the last issue of *News & Views* (Feb/March 2013), the new GOLD classification system to predict COPD clinical course was presented. However, an additional study with novel findings has been reported by Soriano et al in the March 2013 CHEST. Soriano, et al., compared the former GOLD classification to the new GOLD grading classification when applied to 11 well-defined COPD cohorts in Spain as well as the prognostic validity of the new classification distribution in up to 10 years of data to predict time to death. The total sample was 3,633 patients, with the majority moderate or higher severity. Based on spirometry alone (the old GOLD classification), the sample revealed 10.2% in the mild group, 44.8% in the moderate group, 34.9% in the severe group and 10.2% in the very severe group. To analyze the sample for the new GOLD classification, hospitalization data mMRC dyspnea scores and spirometry were used. According to the new classification
system, 33.6% of the sample was graded into patient group A (low risk, less symptoms), 16.3% into group B (low risk, more symptoms), 17.7% into group C (high risk, less symptoms) and 32.3% into group D (high risk, more symptoms). No differences were noted between the old classification and the new classification in predicting survival at one year (p = 0.53) or at 10 years (p = 0.76). COPD hospitalization-only criteria had the mildest effect on survival followed by spirometry-only criteria. However, when COPD hospitalization and spirometry are combined, an additive, harmful effect was noted.

While Soriano et al opine that the new GOLD grading makes more clinical sense (reflects both spirometry and clinically relevant information), they caution that the new classification could be misleading in predicting increasing severity and death consistently. This study finds that neither increasing severity nor consistent death predictions were found. The authors noted limitations that included lack of the COPD Assessment Test (CAT) to assess symptoms was not available early in the cohort data collection. Dependence on the mMRC alone may have underestimated symptom severity. The most important limitation identified was use of hospitalizations-only data as COPD exacerbation determination vs. including outpatient exacerbations. To address this, additional a posteriori analysis was conducted, however there were no changes in the study conclusions based on this additional analysis. In conclusion, while the authors support the new GOLD classification as a “step forward,” additional study is needed to better describe definitive thresholds based just on the new classification system, which remains controversial until more evidence is available.

Why is this important in pulmonary rehabilitation?

These results add to the knowledge base for the updated GOLD stratification system that includes assessment of exacerbation and symptoms. The GOLD Stratification is an important updated tool that is easy to use and provides important information about health status in our population; however, it should not be the only tool or classification we use in determining the therapeutic course of COPD.

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CARDIAC REHABILITATION

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- Predicting Mortality 12 years After an Acute Cardiac Event: Comparison Between Inhospital and 2-month Assessment of Depressive Symptoms in Women – Murphy et al (Australia)

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- Barriers to Cardiac Rehabilitation Use in Canada versus Brazil - Lima de Melo Ghisi et al (Canada, Brazil)
- Cardiac Rehabilitation: Beginning at the Bedside – Tiller et al (Canada)
- Patient Participation In A Cardiac Rehabilitation Program – McDonall et al (Australia)

PULMONARY REHABILITATION

- Pulmonary Rehabilitation and Interstitial Lung Disease: Aiding the Referral Decision – Warrington et al (United Kingdom)

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)

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Committee Updates

Registry Committee Updates
Chris Garvey, FNP, MSN, MPA, FAACVPR
Mark Vitcenda, MS, RCEP, FAACVPR

Beta Testing Underway for AACVPR Pulmonary Rehab Registry

The AACVPR Outpatient Pulmonary Rehabilitation 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!

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

AACVPR Registries Roadshow Heads to Spring Affiliate Meetings

The AACVPR registry projects continue to grow and attract interest from members and healthcare professionals across the country. The Cardiac Rehabilitation Registry, launched in June of last year, now has more than 300 active subscribers who have entered data on nearly 8,000 patients. Subscribing programs come from 36 of the United States, representing a cross-section of small to large institutions. Last month, Mark Vitcenda, Co-chair of the Registry Committee, and Mike McNamara, Board Liaison to the committee, presented to 90 interested attendees a Webcast on the registry projects.

During the upcoming spring affiliate meetings, representatives from AACVPR leadership and the Registry Committee will be providing further updates about the registry projects to
AACVPR affiliate societies. These meetings are key opportunities for AACVPR to showcase the benefits of registry participation for programs, and they allow members to ask questions, which has been vital to registry development. Member questions and comments continue to drive improvements in the registry projects, and this summer the Registry Committee will review the registry data and decide on critical updates based on subscriber input.

Registry FAQ

Q: We have three staff members who will be entering data into the registry. Can we just share one login?

A: No. Each person who accesses the registry must have his/her own unique login information. This is required by HIPAA regulations and allows AACVPR to know who last accessed the patient’s record in case of a security breach. Therefore, do not share your personal login information with others. If you forget your username or password, contact the Registry Support Team at registry@aacvpr.org or use the “Forgot Password” link on the main login page.

AACVPR thanks the following sponsors for their support of the registries: Founding Sponsor LSI, as well as Cardiac Science Corporation, Janssen Healthcare Innovation, RMCRA, and ScottCare Cardiovascular Solutions.

Clinical Applications Committee Update
Kate Traynor, RN MS FAACVPR, Chair

The Clinical Applications Committee (CAC) has 16 members inclusive of both CR and PR professionals, two AACVPR Board Directors, and an AACVPR staff liaison.

The CAC is charged with “translational” work, specifically to help develop, review, endorse, and/or communicate any clinical tools or products that are developed under the direction of the AACVPR Board of Directors. To this end, the committee is involved in two initiatives:

The first involves a review of a patient education program developed by an AACVPR corporate partner. The program content, format and clinical pertinence will be evaluated.

The second initiative is the development of a resource to assist CR and PR programs prepare to apply for program certification. Working in tandem with the Certification Committee on the development, this resource is intended to provide a comprehensive “tab by tab” reference for CR and PR professionals to assist them in preparation for certification.

AACVPR Program Certification Update
Bonnie Anderson, MS, FAACVPR

Another AACVPR Certification Cycle is underway and reviewers are diligently assessing all submitted programs for compliance with published guidelines, evidence-based medicine, best practice, and expert opinion as outlined in the required elements for program certification. There are currently 1,669 cardiac and pulmonary programs that have been certified by AACVPR. What a testament to the dedication and commitment of both cardiac and pulmonary programs across the country! This robust process continues to grow and improve. I’ve been asked why it takes so long to find out the status of an application after it is submitted on or before February 28. I thought you might be interested to learn about some of the important behind-the-scenes activity that is necessary to make this process work and some of the enhancements that are already being put into place for the next cycle. There were 574 program applications submitted during this cycle; 175 of those for first time applicants.

Program Certification Committee Structure
AACVPR Board Liaison – Bonnie Anderson
Certification Center Staff Lead – Kate Murphy & AACVPR Staff

Before any given cycle is open for applicants on December 1st, the Certification Leadership Team and AACVPR Staff are already hard at work on the following year’s application, incorporating the suggestions of the Cardiac and Pulmonary Expert Panels to make sure the application truly reflects the items of greatest significance for improved patient outcomes as indicated by the latest evidence. In addition, updates and improvements are being built into the online application system in an effort to make the process clearer, easier, and more user-friendly. Training sessions are held for all new and seasoned reviewers to assure that everyone is familiar with the online system and required elements. Best Practice samples are selected from the previous year’s applications. Forms, templates, and Webcasts are developed through cooperation of the Certification Committee, the Education Committee, and the Clinical Applications Committee.

Then, on March 1 of each year (the day after the application period closes), Kate and her team begin the painstaking process of reviewing all submitted applications to assure that all faxed documents were uploaded to the online application so that they are available for viewing by the review team; that all payments were credited to the proper application; and that the applications are assigned randomly to reviewers via the online reviewer dashboard. Then the review process begins.
Certification Review Team
Co-Chairs – Kim Beyer and Laura Raymond

There are currently 30 reviewers representing 17 states (California, Iowa, Illinois, Indiana, Kansas, Michigan, Missouri, North Carolina, Nebraska, New Jersey, Pennsylvania, South Carolina, Texas, Utah, Virginia, Wisconsin, and West Virginia).

- NEW THIS YEAR – We are actively seeking representation on the application review team for the next review cycle from every state. If you would be interested in joining this dynamic team and meet the qualifications listed below, please submit the volunteer committee service application which can be found on the AACVPR website.

Minimum Qualifications:
- You must actively work in a currently certified early outpatient PR or CR program
- You must have been directly involved with the certification process at your facility
- You must be a current AACVPR member in good standing
- You must complete the AACVPR Committee Service Application
- You must commit and have ability to serve approximately 5-10 hour/week during the review cycle

49 States currently have at least one CR or PR program that is certified by AACVPR. We are working to get 100%!

There were 574 applications for certification this cycle; 179 pulmonary and 395 cardiac.

2013 Certification Process Timeline

Dec 1 – Feb 28: Program Application Submission
Mar 8 – May 31: Review Process
June 1 – August 31: Cert Leadership Review
- Quality Control Review of MINIMUM of one program from each reviewer
- Re-review of ALL programs denied during initial review process

Inter-Rater Reliability Review (IRR Process)
- Blinded re-review of applications by another reviewer to verify validity of review process

Board Liaison Review
- Review and analysis of all programs recommended for denial (as necessary)

Board of Directors Review and Vote
- Summary of all denied programs with reasons for denial

August 31: Programs notified of status
Sept 1 - Oct: Remediation Process
- Available only to qualifying programs with MINOR deficiencies
- NEW THIS YEAR – Application weighting system to allow for potential remediation of more than one page of the application depending upon severity of error or omission

November: Programs in Remediation are notified of Board decision following status update and vote

Certification Remediation, Known as Conditional Certification during the last cycle, the name was changed to Certification Remediation to better represent the function of the committee. Each page of the application is ‘weighted’ based on critical values and if applications meet specific criteria to be eligible, remediation allows those programs to make minor modifications or improvements in their applications to fully comply with all stated requirements in order to be granted certification. Chair – Barbara Flato

Certification Mentoring
- “How-To” Kits…Clinical Applications Committee – Chair - Kathleen Traynor (NEW THIS YEAR: Watch for more information about this exciting opportunity to learn how to get it right before you apply! Includes resources, templates and a self-assessment tool.)
- Webcasts and Education…Education Committee — Gayla Oakley – Chair
Certification Application Clinical Consultants

- **Pulmonary Rehabilitation Expert Panel** — Trina Limberg – Chair
- **Cardiac Rehabilitation Expert Panel** — Jeanne Ruff – Chair

These groups are working to bring the latest Guidelines, Evidence, Expert Opinion and Best Practice to the Certification Leadership for inclusion in the certification applications, while being a clinical resource for the review team. The work of these individuals will assure that we are constantly working toward improved patient outcomes for our CR and PR patients as evidenced by the AACVPR Program Certification Process.

YOU are passionate about your programs and the patients you care for. Thank you to all the Committee Chairs and Committee members for VOLUNTEERING their valuable and precious time and expertise to help us all achieve excellence in the areas where we work!

 Affiliate Updates

**Kentucky Cardiopulmonary Rehab Association (KCRA)**
*Peggy Cox, RN, RRT, KCRA President*

We had our Annual KCRA Conference March 13 and 14, 2013, at the Four Points Sheraton in Lexington, KY. The KCRA would like to thank our host, vendors and our multiple guest speakers at the meeting. Our preconference allowed networking and an in-depth discussion with Jim Rosneck, the MAC-15 AACVPR chairperson. He had his work cut out for him; distinguishing the rules and regulations for both cardiac and pulmonary rehab for us and discussing the continuous ADRs most facilities are finding are a part of life. There was a lively networking opportunity before and after the session too. The day of the conference we were able to learn from our many guest speakers about mechanical circulatory devices, TAVR procedures. We also learned what the local ALA and AHA are involved with and about harmonic therapy for respiratory patients. Each of the attendees was provided with harmonicas and instructions on use with their pulmonary patients. We also learned strategies, non-surgical and nutritionally, to use with our bariatric patients. Overall, the meeting was a success and we are currently in the process of beginning conference preparations for next year which will be in Louisville, Kentucky.

 Calendar of Events/Education

**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.