Messages from Headquarters

Letter from the Editors

Tracy Herrrewig, MS, RCEP, FAACVPR
Steven Lichtman, EdD, FAACVPR

“The joy of life consists in the exercise of one’s energies, continual growth, constant change, the enjoyment of every new experience. To stop means simply to die. The eternal mistake of mankind is to set up an attainable ideal.” — Aleister Crowley

In many ways, this quote describes the field of cardiac and pulmonary rehabilitation. We find joy in the services we provide our patients and their families. Our energies are challenged trying to keep up with the day-to-day demands and the opportunities we all face.

Healthcare, whether it is on a national level or at our individual facility, provides almost constant opportunity for us to grow and change. Ask yourself: Are you ready for this change? Do you welcome the growth opportunities? Do you embrace, and can you articulate, the concept of value within your programs?

This is an exciting time. Growth seems to be a recurrent theme in our field:

- AACVPR membership has grown to the largest number in the organization’s history.
- The profession has grown to the point of creating the first exam for Cardiac Rehab Professional Certification, and Pulmonary Rehab Professional Certification will follow shortly.
- Our programs have, or will shortly, experience significant growth in the number of patients being served now that heart failure has been approved as a covered diagnosis for cardiac rehab.
- Pulmonary and cardiac performance measures have received national endorsement.
- The 29th Annual Meeting is scheduled for September 4-6, 2014 (Denver, CO) and will provide countless opportunities for personal and professional growth.
- Finally, be ready for growth in News & Views, which will change its format to meet the growing needs of its readers via a new digital delivery platform to enhance content & readability, vendor sponsorship, technology, and social media capabilities.

All this has happened because of the persistence of many dedicated individuals within AACVPR. They have provided the Centers for Medicare and Medicaid Services (CMS) the data and quality measures that identify cardiac and pulmonary rehab as critical aspects of healthcare. They have developed a strategic plan that will move AACVPR in a direction consistent with the long and winding road of healthcare reform. They continue to provide opportunities for input from members. They provide tools for individual programs to gather data to highlight the value of their services. They encourage each AACVPR member to grow in his/her knowledge of the changes that seem to be happening almost every day. It is this dedication to our field that is necessary for its continual growth.

As you read the articles found in this issue, ask yourself how you, too, can make a difference for your patients, your program, and your future. It’s never too early to think about joining the dedicated volunteers in AACVPR. A great start would be to make plans to attend the Annual Meeting to experience the passion, energy, and professionalism of AACVPR members.

“Without continual growth and progress, such words as improvement, achievement, and...
President’s Message

“Nobody’s as Smart as Everybody: We Have Unleashed Individual Brilliance and Aligned Our Collective Genius”

Barbra Fagan, MS, RCEP, FAACVPR

Washington DC, March 12 and 13, 2014: The excitement was palpable as more than 100 AACVPR members participated in both the Heart Failure Workshop and Day on the Hill. The day began with an afternoon session on Practical Recommendations for Incorporating Patients with Heart Failure into Cardiac Rehabilitation. Participants were treated to the collective genius of Randy Thomas, MD, Mayo Clinic; Steven Keteyian, PhD, Henry Ford Hospital; Nancy Houston-Miller, BSN, Stanford University; and Karen Lui, RN, MS, GRQ. Each shared critical elements that will aid in the delivery of care of our heart failure patients. You may purchase the sessions here.

The speakers reviewed the pathophysiology and treatment of heart failure, shared effective strategies to improve referral and enrollment into cardiac rehabilitation programs, discussed essential educational content with specific attention to self-care and self-management, and described the exercise progression and volume necessary to improve health outcomes. Discussions also centered on the eligibility criteria of patients to enroll in cardiac rehabilitation. The cardiovascular societies will jointly be developing clinically appropriate guidelines in line with the eligibility criteria in the near future.

The theme of this workshop focused on being systematic in our approach, being active in our recruitment of patients, being adaptable to meet the patients’ needs, and capitalizing on this extraordinary opportunity. As clinicians in cardiac rehabilitation, we are expected to understand the pathophysiology of the disease of the patient. Our programs should always be strategic and proactive in the engagement and recruitment of patients. Knowledge for our patients is not enough, we should be teaching self-care skills as a critical component of learning. Exercise training works, and frequency, intensity, duration, and specificity matter. These statements are true for all our patients in cardiac rehabilitation. The addition of the heart failure patient allows us to do to what we already do so well: care for and improve the health and quality of life for those we serve.

On the heels of a successful Heart Failure Workshop, Day on the Hill (DOTH) 2014 was underway. They say a journey of a thousand miles begins with a single step. More than 90 individuals from 32 states took that step, as they visited with members of the house and senate seeking support of S382, which would allow non-physician providers the ability to supervise cardiac and pulmonary rehabilitation. Those exceptional individuals came to Washington as ordinary people who shared a common bond: They cared. They wanted to act, to do something, to make things better for others, and by being here, and they did. The task at hand may seem insurmountable, and it has been challenging, but we must persist. Abraham Lincoln said, “The probability that we may fail in the struggle ought not to deter us from the support of a cause we believe to be just.” This is an important bill and important to the viability and growth of many of our programs. Yes, a thousand miles begins with a single step, but it needs to be by the many, not the few. Sitting on the sidelines will not help us become successful. We must all participate.

For those of you not able to attend DOTH, I would encourage you to send follow-up letters to the congressional offices visited by your colleagues. Our message was loud, and it must be louder! One voice heard multiple times does not make an issue, 20 to 30 voices with the same message makes something an issue. The more we become involved sending this very important message, the higher this rises on the radar as something to possibly support. This cannot be done by few, with the masses “hopeful” for a win. We need each of you to have a voice, because as Nelson Mandela said, “It always seems impossible until it’s done.” Do your part to make this possible.

Executive Director’s Corner

Megan Cohen, MPA, CAE
For this month’s article, I asked Dr. Marjorie King, AACVPR Past President and distinguished cardiologist, to join me in a conversation about her recent work advising the Centers for Medicare and Medicaid (CMS) and the National Quality Forum (NQF) on issues related to the Affordable Care Act.

Cohen: Dr. King, while your experience shows a long history of work on quality and performance measures, your recent AACVPR volunteer time is related to something called episode groupers. Can you tell us more on this topic? What are episode groupers?

King: Episode groupers are software tools used to aggregate insurance claims data to assess the cost of care for specific conditions (or diagnoses) and to understand the services that are used to manage that condition. Insurance companies and large health systems are currently using commercial groupers to tier physicians based on the cost of care that they provide to a beneficiary for a particular condition.

As part of the movement toward value-based, rather than volume-based, payment, Congress directed the Centers for Medicare and Medicaid Services (CMS) to develop a publicly available episode grouper to be used for value-based (outcome versus cost) physician measurement and payment incentives. Practically speaking, this means information about the average cost to treat an average Medicare patient for a specific condition over a specific period of time will be available to the public. Patients will be able to “compare” physicians and physician groups based on the value of care they give.

Cohen: What is the role of the episode grouper projects you’ve participated in as a representative of AACVPR?

King: Several years ago, Dr. Andrew Reis and I represented AACVPR in clinical workgroups for the episode grouper consortium that was awarded the contract to develop the CMS episode grouper mentioned above. This was a joint effort among Brandeis University, the American Board of Medical Specialties Research and Education Foundation, the American Medical Association Physician Consortium for Performance Improvement, the Health Care Incentives Improvement Institute, the Medicare Quality Improvement Organization for New York State, and Booz Allen Hamilton.

The CMS episode grouper software will evaluate cost data across many diseases, on of which is cardiovascular disease. I continue to represent AACVPR in the Cardiac Clinical Working Group, along with representatives from other cardiovascular, primary care, and emergency room physician organizations. Our job is to help the software developers understand the clinical logic behind the insurance claims data that their episode grouper software programs will sort and assign to various episodes of care. For example, what insurance claims are appropriate to include in a 30-day episode following a myocardial infarction or a one-year episode for a patient with heart failure? Cardiac rehabilitation is included, along with many other appropriate services.

Because the output from the episode groupers will be used for provider accountability (public reporting, adjustment of payment), Congress requires that the CMS episode grouper be reviewed and endorsed by a group such as the National Quality Forum (NQF), which is a private organization that “reviews, endorses, and recommends use of standardized healthcare performance measures.” I also represent AACVPR on the NQF Episode Grouper Expert Panel, which will be producing a report about how and whether to endorse episode groupers. The draft report was posted for public commentary in early April, with a final report posted in July.

Cohen: How might this work possibly play into the large payment picture of the future?

King: Although Congress directed CMS to develop an episode grouper to evaluate the variation in cost of care across providers and to report these publicly in an attempt to influence and drive down cost of care, I suspect that episode grouper software will also be developed to determine the payment that will be used within bundled payment systems. There is significant variability in cost and quality of post acute care (services after hospitalization, such as rehabilitation, equipment, or home care), and episode grouper reports will highlight which regions, providers, and provider groups appear to provide higher value-based care than others.

One of my concerns, shared by others involved in patient safety and quality improvement, is that measures of quality of care must be combined with measures of cost and efficiency of care in order to paint an accurate picture about the value of a provider or a hospital system. The good news is that the CMS episode grouper development team and leadership at the NQF also seem to understand this principle.
Cohen: How might this work affect cardiac and pulmonary rehab payment in the future?

King: Episode groupers, per se, will not affect payment for cardiac or pulmonary rehab. Rather, the transition from fee for service to bundled payment for post acute care, if and when it occurs, will be the most likely time when cardiac and pulmonary rehabilitation programs may see a change in payment. On the other hand, this may be a smooth transition, if hospital systems and providers recognize our programs as efficient and producing good patient-centered outcomes, and they continue to support and grow our services.

Thank you, Dr. King, for your insight on the use of episode groupers and how they may play into payment models in our future. More information on this topic can be found in Dr. King’s JCRP article titled “Affordability, Accountability, and Accessibility in Health Care Reform: Implications for Cardiovascular and Pulmonary Rehabilitation,” Journal of Cardiopulmonary Rehabilitation and Prevention, 2013;33:144-152

Apply Now for the CCRP Exam

Applications are now being accepted for the first Certified Cardiac Rehabilitation Professional (CCRP) exam, which will be held September 3, 2014, in Denver, Colorado immediately preceding the AACVPR Annual Meeting.

Be among the first to earn the only comprehensive certification for all cardiac rehabilitation professionals – and save $50 on the examination fee – by taking the first CCRP exam.

The Candidate Handbook will be available in mid-April and includes information to help you learn more about the exam and receive preparation resources. Watch for the CCRP Study Guide in May. The Study Guide will help you focus your preparation on the content included in the professional certification exam blueprint outline.

Access these resources, FAQs, and additional information on the AACVPR Web site.

Member Resources
Comprehensive Cardiac Rehabilitation Workshop
April 28-May 1, 2014

AACVPR and the La Crosse Exercise and Health Program at the University of Wisconsin–La Crosse (UW-L) are joining together to offer a Comprehensive Cardiac Rehabilitation workshop. This workshop is considered essential for anyone who is new to cardiac rehabilitation or who needs an up-to-date refresher on current trends in the field.

The Comprehensive Cardiac Rehabilitation Workshop will not only focus on the basics, but will also provide an overview of the theory and practice of inpatient and outpatient cardiac rehabilitation. There will be a strong emphasis on exercise physiology, exercise prescription, administrative concerns, and secondary prevention strategies.

This workshop provides approximately 25 CEUs. Click here for more information about course content, registration, and housing options.

AACVPR and Affiliate Society members receive a $25 discount!

Update on AACVPR Liaison Activity

Thomas Draper, MBA, FAACVPR, Chair, Professional Liaison Committee

AACVPR is proud to partner with the American Association of Diabetes Educators (AADE) to further their mission and ours. This liaison relationship allows AACVPR and AADE members to benefit from shared professional resources, educational offerings, patient education materials, and other tools. We are pleased to feature the following article, highlighting the important AADE current initiatives. We thank AADE leadership and Barbara Masters, MSN, RN-BC, for serving as the AACVPR liaison to AADE and continuing to strengthen this partnership.

The American Association of Diabetes Educators (AADE) continues to advocate on at the state and federal levels for the role of the diabetes educator, the value of diabetes self-management education, and the potential for impact of the National Diabetes Prevention Program. We are working on a number of fronts to ensure that our members are poised for meaningful engagement in the changing healthcare setting. In addition to our research journal, The Diabetes Educator, we have launched a new magazine, AADE In Practice, aimed at providing members with practical, yet evidence-based and experiential insight that they can use in their daily work with patients. MY AADENETWORK is our online environment that builds and nurtures members’ professional development, relationships, and provides real time answers to questions – from member to member.

We have been studying how best to position diabetes educators for inclusion on healthcare teams in various settings, exploring options for providing patients with ongoing support as well as insight on approaches for overcoming potential patient barriers associated with health literacy and numeracy. We are providing insight about technology, whether that means safe engagement with medical devices developed by others, such as insulin pump or blood glucose monitoring, or understanding how best to address patient questions about mail order supplies.

We have developed a mobile app, AADE Goal Tracker app, to give people with diabetes a...
platform to compile the information about goals they set and steps they are taking to attainment as well as leveraging social media to learn from and encourage one another. As a National Accrediting Organization for Diabetes Self-Management Programs, we have seen significant improvement in behavioral and clinical outcome measures, while increasing access to diabetes self-management education. In addition, we are the only national healthcare association standing up programs to deliver the National Diabetes Prevention Program. We continue to offer a variety of educational opportunities that include on-location or online programs to help prepare those interested in sitting for the CDE as well practice tests for the BC-ADM, webinars, and enduring online materials that provide both the Continuing Education Units and the content needed for the long-term learning this field requires.

We are hosting our Annual Meeting this year in Orlando, Florida on August 6-9, which, as always, is sure to be an exciting, multidisciplinary gathering of healthcare professionals who are passionate about diabetes self-management!

**Innovative Programs and Best Practices**

*Tracy Herrewig, MS, RCEP, FAACVPR*

The Innovative Programming and Best Practices column is dedicated to spotlighting Affiliates, programs, and people that are not only being innovative in their thinking and programming but exemplify a commitment to providing the best possible service to their patients and peers. The ultimate goal is to improve patient care, outcomes, and the overall patient experience. This issue highlights Laura Raymond, RN, BS, FAACVPR.

**Sharing a Valuable Resource: Pulmonary Rehab Toolkit Guidance to Calculating Appropriate Charges for G04254**

*By Laura Raymond, RN, BS, FAACVPR*

To AACVPR members who are either considering offering pulmonary rehabilitation (PR) or already offer PR in addition to their cardiac rehab services and/or other services, I want to share this wonderful resource that absolutely made my life as a manager easier.

Many of you in a role of a director/manager know how time-consuming and challenging setting up a new service can be. It begins with defining and marketing the new pulmonary service, but then there is also reviewing CMS requirements; developing a new referral form; setting up charge master codes; establishing staff competencies; creating new job descriptions; setting medical director contracts/role responsibilities; ordering essential equipment specific to pulmonary patients; obtaining oxygen sources; establishing educational materials; seeking out appropriate parking for patients with decompensated respiratory systems; connecting with external pulmonary resources within the city, state, and national associations, and on.

I quickly discovered I had a lot to learn about PR and its complicated reimbursement. Our team ordered every free resource we could get our hands on and used every AACVPR pulmonary rehab resource available. We ordered a Pulmonary Education Program (PEP) Kit, which comes in a red box labeled PEP KIT, for Pulmonary Rehab Centers, issued by the COPD Foundation.

Excited about this box and reading everything I could get my hands on, I discovered a resource book titled “Pulmonary Rehabilitation Toolkit: Guidance to Calculating Appropriate Charges for G04254.” After reading this resource cover to cover, I recognized all my AACVPR colleagues who contributed to it. I truly could not have developed the quick understanding of the issues with CMS’s reimbursement for PR and the importance of everyone understanding PR services to help better define the comprehensive delivery of care required to provide this service. This resource taught me the step-by-step actions needed to establish charges for a single bundled code.

To all the AACVPR members who contributed to this PR resource: Thank you for your work. I am not sure you know the magnitude of how much a tool like this helps PR directors/managers across the country.

We opened our doors to PR patients one month ago and already have nine patients. I am confident this resource will help more PR directors/managers better define the necessary components to deliver PR to patients with COPD. Thank you to all of you who contributed to
Are you a part of a program or an Affiliate or are you or someone you know an example from which other AACVPR members could learn? If so, contact Tracy Herrewig to be included in future issues of News & Views.

Inside the Industry

Health and Public Policy

Zack Klint, MS, CES

This year’s annual AACVPR Day on the Hill (DOTH) was held on March 14. Many of your colleagues on the AACVPR Health and Public Policy Committee, affiliate leaders, and AACVPR members traveled to Washington, DC to engage lawmakers. Their efforts were focused on convincing lawmakers to draft, and pass into law, language that would allow non-physician practitioners (NPP) to provide “direct supervision” for cardiac, intensive cardiac, and pulmonary rehabilitation. Under the current Center for Medicare and Medicaid Services (CMS) interpretation of the legislation, only physicians can directly supervise cardiac and pulmonary rehabilitation programs. This was not the initial rational of the language and it now just needs a “technical correction” in CMS’ interpretation to allow NPPs to provide this uncompensated service.

The importance of this technical correction to existing legislation cannot be understated. An ever-expanding body of evidence supports the consistent use of cardiopulmonary rehabilitation for appropriate patients, while the unintended interpretation of this regulation limits access. Whether in a rural setting, a Critical Access Hospital (CAH), or a more urban setting, you and your colleagues feel the impact. Many programs with available physician access bear the high cost of uncompensated service, while many CAH and rural hospitals are unable to provide cardiopulmonary rehab due to lack of consistent physician availability.

What can you do to help? Educate yourself about the issues impacting your profession. Visit the AACVPR website to access the DOTH page. There, you will find important information and resources so you can contact your senators and congressmen and women to support the technical correction.

The complexities of endeavors such as these often make us question if we'll ever realize the desired outcome. Despite the challenges, a dedicated group of individuals continue to pour their effort into achieving the goal. I express my sincere gratitude to all those who attended the DOTH event in 2014. I was humbled to witness the uncommon dedication to your patients, colleagues, and profession.

Behavioral Aspects of Rehabilitation

Self-managing the Inner Critic for Heart and Lung Health

Claire L. Costello, PhD, RN, CS

Our own inner dialogue can either reduce or increase our stress levels in the midst of attempting to care for the many needs of our patients. Noticing this and being a bit kinder to ourselves give us a way to relate to our patients. Self-criticism leads to inner tension, as our body releases adrenaline and cortisol in response to our stressful inner dialogue. I've been curious about how to more skillfully help my cardiac patients come to recognize this source of tension and how to consciously release it with practice.

One recent morning, I awoke and noticed tension rise in my body, along with an inner angst about, “getting it all done.” Then, I found myself asking, “In what ways can I bring more kindness to how I am talking to myself in this moment, and will that really bring me more ease and calm?” I felt relief and relaxation just
asking the question. I coaxed myself to do what I teach my cardiac patients: take a few long
exhales to calm. I then offered a kinder inner tone of voice to myself. It wasn’t automatic. I
also placed one hand on my heart and one hand on my belly as I lay there breathing. It took
a good 10 minutes staying present with myself with a gentle quality before my body felt the
kindness melt the tension.

In that moment, I made the choice to go with peace and love over fear, which is one
principle from the program we teach in our cardiac group process. Instead of just a phrase, I
had a sense of it in my body with this practice. To truly open an avenue of directed, kind
conversation with myself, along with including the body through several conscious long in-
and-out breaths with a hand on my heart and a hand on my belly, did wonders for me. And
better yet, it remained with me through the day.

Our inner critic comes in and wrestles us to the ground, and it has a powerful effect on our
body over time. How we treat ourselves in the course of a day as we deal with the daily
grind of getting here and there; making a living; taking care of our families, homes, and
health, determines the kind of pressure we feel. That pressure can be a culprit for many of
our diseases of inflammation, including heart and lung disease, which takes years off of our
life. Put simply, that kind of pressure creates vascular and metabolic changes that wear us
out.

In addition to this personal pressure, we also consciously and unconsciously respond to the
strains inherent in our ever-changing world and global happenings. Then, there are those
individual and family developmental stages of life: birth, new school, new job, aging parents,
adolescent children, marriage reconstruction, illness, death, retirement. These forces can
create or soothe our personal and collective tensions, impact our bodies, rearrange our
souls.

Sometimes, it is not until we fall ill that we pay attention to ourselves with any kind of
genuine respect (and sometimes, not even then). Sometimes illness, loss, and life transition
open a door to new consciousness and lifestyle change, allowing for a transformation, and
new growth after a whole bunch of pain.

But what would it be like to take a more proactive stance and recognize the moments in
which we could show a little more self kindness and still know that we will get things done?
Perhaps even, this enrichment, this kinder, gentler stance with ourself can become
generative to those we love and to those we serve within our community.

Imagery can have a powerful visceral healing effect when used to mediate self-criticism. We
can use a healing inner image personally relevant to us, along with a long and easy breath,
to relax, renew, restore, and reset our perspective. Befriending ourself as opposed to
bullying ourself. Maybe we think we need that bully to “make us get it done.” Maybe that
bully could use some conflict resolution skills and kindness, too.

So, what's it going to take to be a bit kinder to ourselves and more deeply rooted into our
life? What is it going to take to come into the whole of being? This life-long practice takes
daily cultivation, like a garden, and we get a new chance every day we are here.

We enliven ourselves through our rapport with our very own being. This great relationship
deserves our best compassionate tending. And when we do so, we give much.

This article was adapted from an original article titled “On being kind to ourselves,”
published in Volume 6, No. 50 of the West Marin Citizen on June 6, 2013.

Pulmonary Point of View

The Problem of Physical Activity Measurement:
Standardizing Physical Activity Analysis

Gerene Bauldoff, PhD, RN, FAACVPR

Published ahead of print in CHEST (2014), Demeyer et al from Belgium and the Netherlands report the findings of a secondary
analysis of physical activity (PA) outcomes. This analysis was
conducted on data from a randomized, controlled trial of pulmonary
rehabilitation in patients with COPD (original study: Burtin, et al.,

The reason for this analysis is to address the issue that PA reports may have been measured under unstandardized conditions. The authors sought to find a standardized method of PA measurement and data analysis. Research questions focused on the impact of the outcome, exclusion of measuring PA on weekends, evaluating the number of days of assessment, and modification of data processing analysis. This analysis used the baseline and three-month data from a rehabilitation study of 57 patients, in which accelerometer data was available. Variables included the number of steps per day, daily time spent in at least moderate physical activity (activity above 3 METs), measurement of light activity (1-3 METs) and daily mean METs.

Two different analysis techniques were compared and were tested. Results indicated that the outcomes of number of steps and time in light activity (1.6-2.3 METs) measured on at least four weekdays for a minimum of eight hours of accelerometer wear time reduces the noise in PA data. Additionally, the study revealed that excluding weekend data and altering data processing did not affect the outcomes.

Why is this important in pulmonary rehabilitation?

While we do not yet use accelerometers as part of our clinical management or to assess outcomes, this information is important for the PR clinician. As educated consumers of published evidence, and as part of our decision-making for evidence-based practice, we need to have an understanding of the major methodological issues when we appraise research evidence. As outcomes (and their valid and reliable measurement) become a significant component of the reimbursement conversation, understanding the methodological issues of outcome measurement can be useful.

As PR professionals, it is our expertise that must be at the table when policy regarding PR reimbursement is under review. We cannot only depend on our clinical expertise, but must come armed with methodological knowledge regarding outcomes so that we can translate findings of research to the care of our patients, impact the decisions of our institutions, and influence policy debate.

Committee and Task Force Updates

Clinical Applications Committee Update

Kathleen Traynor, RN, MS, FAACVPR, Chair, Clinical Applications Committee

"The only way that we can live, is if we grow. The only way that we can grow is if we change. The only way that we can change is if we learn. The only way we can learn is if we are exposed. And the only way that we can become exposed is if we throw ourselves out into the open. Do it. Throw yourself."

— C. JoyBell C.

That quote is a perfect introduction for the Clinical Applications Committee (CAC) update.

Historically, the CAC has been focused on "translational" work, specifically developing, reviewing, endorsing, and communicating clinical tools that would assist our fellow AACVPR members in their clinical practice of CR and PR.

While the CAC is still very focused on those initiatives, our work has expanded to address a broader base of clinical issues and concerns. And as a result of AACVPR’s strategic plan unveiled in December 2013, there has also been restructuring of other committees with some of their work shifting to the CAC.

Fortunately, the CAC has retained 12 terrific members (Bonnie Anderson, Michael McNamara, Bonnie Clark, Joy Reardon, Judy Myers, Lynn Baker, Mark Vlcnnda, Nathan Boehlke, Susan Hansen, Teresa Corbisiero, Terry Verville, and Theresa Gracik; we also have our great staff liaison Abigail Lynn), who have been integral to the success of the committee in the past few years. We have added three new members (Jacqueline Bunn-
Gary, Jonathan Ledyard, and Thomas Forkner), who bring fresh insights and enthusiasm, and we have a “liaison” relationship with new two members (Kent Eichenauer and Leah Lenz) of the former Web site Committee to assist in managing that new realm of our responsibilities.

In brief, here are the highlights of the CAC’s upcoming work for this year:

1. We will continue our original “translational” work on clinical tools to assist our fellow members in their clinical practice of CR and PR. To that end, we have just completed a draft of a comprehensive resource.
2. We will assist the AACVPR staff in fielding clinical issues/inquiries that they receive via email or phone from members.
3. We will assist with the AACVPR Web site content review. The specific content areas include books about CR and PR, resources for members, and resources for patients.

Recently, the CAC members completed a draft of a comprehensive reference for certification that is a joint effort between the CAC and the Program Certification Committee. This resource will be made available to members to assist them with applying for certification or re certification. Stay tuned for more information.

The CAC is throwing itself into new work arenas and uncharted territory, but our original focus of clinical support for members remains front and foremost in all we do.

Thanks to the CAC members for their hard work and responsiveness and for being such a great team.

Registry Committee Update

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

The Cardiac Rehabilitation Registry continues to gain momentum, with more than 400 programs actively using the Registry and more than 45,000 records entered. Now that the CR Registry is in its stride, the Registry Committee is developing policies and procedures that help monitor the quality of data, to assure users that the outcomes data they see on their reports are accurate and valid. Committee members recommend procedures to monitor data quality at the Registry level on a regular basis, but users can perform data checks at any time. (One of the responsibilities of the principal user is to ensure that data entered by your program is accurate, so PUs, this message is for you!)

You already have several tools within the Registry to do data checks. For example, you can quickly check on the status of patient records by looking at the “Program Completion” column. (If you have a large number of records entered, use the “Display Count” option to display up to 100 records on a page.) Scan the “Completion” column, looking for records marked as “Incomplete.” If you know a patient has completed the program, or conversely, if they are a dropout, but the record is marked as “Incomplete,” you can open the patient file, enter any missing information, and mark the record as “Complete” or “Not Complete” in the “Program” tab.

Likewise, scan the “Start Date” and “DC Date” columns for blanks. This will alert you to the current status of the patient (i.e., if they have started or completed the program). We recently reminded users to check their patient lists for incorrect patient ages by clicking on the “Age” column header. This will sort the records by age in ascending or descending order (depending on how many times you click on the header), providing an easy way to find patient records with incorrect ages. You can use the same method of clicking on the column header to sort records for all the other columns. Using the Patient List, Performance Report and Data Extraction utility on a regular basis, perhaps monthly or quarterly, will help you monitor your data quality and catch problem entries early before they affect your program outcomes.

Lastly, we have received good feedback regarding our first set of enhancements rolled out in December of last year. We are already making a list of possible additions for the next phase. Be sure to download the updated versions of the data definitions and comments document and the reformatted data sheets. We are also working on policies and procedures for data requests for research and publication. And please do not hesitate to contact our Support Team with questions or ideas for the Registry.

The Pulmonary Rehabilitation Registry is one of the largest
databases to collect and report important clinical outcomes in chronic lung disease. The population is heterogeneous, regarding geographic setting, and the socioeconomic status of the payer and PR programs. Since going live in mid-2013, 126 PR programs have entered more than 1,000 complete patient records into the Registry. Recent PR Registry updates include updating the Registry data sheet and responding to the user survey feedback in both Registry updates and revised FAQs. Several experts are currently updating the PR outcome toolkit, and a newly revised toolkit is expected in mid-spring.

Next steps: A subcommittee that represents Research and Registry Committees is addressing future research and data use practices for the Registries.

Calendar of Events

AACVPR Webcasts

April

Thursday, April 24, 2014, 12:00 p.m. CT. Individual Treatment Plan: Answers to the Top 10 Questions. Presented by: Bonnie Anderson, MS & Gayla Oakley, RN, FAACVPR. Attendees earn 1.0 AACVPR or Nursing Continuing Education Credit.

Learn more and register today.

May

Tuesday, May 13, 2014, 12:00 p.m. CT. Why Is My Patient So Irritable? Dealing with Anger/Hostility. Presented by: Kent A. Eichenauer, PsyD, FAACVPR and Glenn A. Feltz, PsyD, FAACVPR. Attendees earn 1.0 AACVPR or Nursing Continuing Education Credit.

Learn more and register today.

These AACVPR Webcasts are free to AACVPR EducationAdvantage members (registration required to obtain CEs). To learn more about the EducationAdvantage membership, please click here.

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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