

PRESIDENT'S ADDRESS



I HOPE YOU ALL HAD A HAPPY THANKSGIVING CELEBRATION WITH YOUR FAMILIES! NOW IT'S TIME TO HEAD INTO THE HOLIDAY SEASON, HOPEFULLY WITHOUT TOO MUCH STRESS!

I am proud to say that our recent MACVPR New England Symposium held on October 27th was a tremendous success. We had a record turnout of 93 participants, which included people from the neighboring states of Maine, Rhode Island, Connecticut, and New Hampshire! It is great to be able to network with clinicians from Massachusetts and from other states as well. At the meeting, we awarded the biannual

Distinguished Service Award to a very deserving winner, Ginny Dow, RN, BSN, BC, CCRP from Emerson Hospital. We had nine vendors who sponsored us and provided information on their products and services, including LSI who was our newly created Diamond level sponsor and provided us with a delicious hot and healthy lunch. Please see the highlights of the meeting in the Education Update on page 8.

On the national level, there are many changes coming this year. The good news is that CMS has finally formally recognized the benefits of cardiac rehabilitation to reduce the impact of cardiovascular disease and is developing ways to expand the use of cardiac rehab programs. As a result, bundled payments and incentive payments will start in July 2017 for select metropolitan statistical areas (MSA's). We are dedicating most of our January 2017 meeting to discussing and networking around these changes, as well as how to implement Roadmap 2 Reform (R2R) strategies that AACVPR has developed to increase enrollment and adherence in your individual cardiac rehab programs. We are lucky to have national experts such as Kate Traynor RN, MS, FAACVPR and Wayne Reynolds, RN, FAACVPR, CCRP who are local to us and can provide us with their expertise on these topics! It should be a very informative as well as an interactive meeting....not to be missed!

Unfortunately, payment rates for pulmonary rehab have decreased according to the final payment rates issued on November 3rd. These are in sharp contrast to the proposed rates that came out in July 2016 that were so promising. What a disappointment! Clarification is being sought on a number of issues and a meeting with CMS is scheduled for early December 2016.

Another upcoming change on the national level are the performance measures requirements that are coming to the 2018 Program Certification cycle; data collection for that cycle is scheduled to begin in 2017. There are four measures for cardiac rehab: optimum blood pressure control, improvement in depression, improvement in functional capacity, and tobacco use intervention. There are three measures for pulmonary rehab: improvement in dyspnea, improvement in functional capacity, and improvement in health-related quality of life. To help all of you implement these changes in your programs, especially those applying for certification in the 2018 cycle, the details of these new performance measures requirements will also be discussed as part of our informative January meeting!

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MACVPR EXECUTIVE COMMITTEE:

- PRESIDENT**
Lynne MacDonald, PT, CCRP
- IMMEDIATE PAST PRESIDENT**
Karen LaFond, MSN, RN, CCRP
- PRESIDENT ELECT**
Open Position
- TREASURER**
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- NEWSLETTER EDITOR**
Melissa Tanguay, BS, ACSM-CEP
- MEMBERSHIP CHAIR**
Diane Gaughran, BS, ACSM-RCEP, CCRP
- ADMINISTRATIVE ASSISTANT**
Jessica Dion

MISSION:

The mission of the MACVPR is to promote the practice of high standards of care in cardiovascular and pulmonary rehab in Massachusetts.

President's address, continued...

Also, on the national front, Joint Affiliate numbers are up to 15 states, including Massachusetts, which is evidence that other states are also finding the benefit of the AACVPR Joint Affiliation. As predicted, our membership numbers dipped a bit initially, but they are starting to increase again, which is a testament to the high quality educational offerings of our Educational Committee. We do receive a lot of "behind the scenes" support to run the MACVPR which we find beneficial, and I hope you all are taking advantage of the benefits that a Joint Affiliate membership affords you such as Education Advantage and legislative and reimbursement updates from AACVPR.

Massachusetts had a nice representation at the AACVPR national conference in New Orleans in September, with approximately fifteen members attending from our state. The conference was full of pertinent information to bring back to our programs on a host of clinical, programming and regulatory issues. We also had a lot of fun on Bourbon Street and enjoyed some great food and jazz music!

The Certified Cardiac Rehab Professional (CCRP) exam for professional certification will now only be offered electronically at local testing centers. The good news is that you will get your results a lot faster. As someone who recently took the exam and waited a long ten weeks for the results, this will be a nice improvement! Please see more information about this on page 5.

I want to continue to encourage more involvement with the MACVPR. I am happy to announce that in 2017 Paulette Pontier will be taking over the position of Deirdre Proudman as Education Co-Chair along with Judy Flannery. We still have an open position on the Executive Committee, namely the President Elect position. It would be a great time for someone to come in as President Elect and spend the year learning the position. This is a tremendous opportunity for personal and professional growth in a very supportive environment. I know it may seem like a scary thought to some, but really everyone has something to offer. Please contact me at lynne_macdonald@miltonhospital.org if you are interested or have any questions. I would also like to encourage anyone to attend our Executive Committee meetings. It is a great way to learn what goes on as well as be able to contribute a thought or idea to us as well. Our meetings are on Thursday mornings from 8:30-10:30am in Framingham. Our next meeting will be in February. Please contact me or Jessica, our administrative assistant, at admin@macvpr.org for more info if you would like to join us.

I would like to wish you all a Merry Christmas, Happy Holidays, and Happy New Year! Please try to find time to relax a bit and enjoy this time with your families and friends. That is what life is all about! Hope to see you all in January.



PLEASE JOIN US! **Winter 2017 Half Day Meeting -** **January 19, 2017**

*Hampton Inn & Executive Conference Center
319 Speen Street, Natick, MA 01760*

REGISTER TODAY: macvpr.org/january-2017-half-day-meeting/

8:30-8:45 AM

PRESIDENTS UPDATE

Lynne MacDonald, PT, CCRP

8:45-9:45 AM

AACVPR UPDATES, INCLUDING PERFORMANCE MEASURES FOR CERTIFICATION

Kate Traynor, RN, MS, FAACVPR

9:45-10:00 AM BREAK

10:00-11:15 AM

ROADMAP 2 REFORM: STAYING UP TO DATE WITH CMS CHANGES IN 2017 & BEYOND

Wayne Reynolds, RN, FAACVPR, CCRP

11:15-11:30 AM BREAK

11:30-12:30 AM

ROADMAP 2 REFORM PANEL DISCUSSION

Kate Traynor, RN, MS, FAACVPR

Wayne Reynolds, RN, FAACVPR, CCRP

Lynne MacDonald, PT, CCRP

Karen LaFond, RN, MSN, CCRP

Please note, the snow date for the Winter Half Day meeting is Thursday, January 26, 2016

Save the Date! Future Meetings:

- *March 13-14, 2017 - Annual Day on the Hill*
- *May 25, 2017 - Spring 2107 Half Day Meeting*
- *October 4-7, 2017 - AACVPR Annual Meeting*
- *October 26, 2017 - MACVPR 2017 New England Regional Symposium*

CONGRATULATIONS TO GINNY DOW, RN, BSN, BC, CCRP, RECIPIENT OF THE 2016 MACVPR DISTINGUISHED SERVICE AWARD!

The Massachusetts Association of Cardiovascular and Pulmonary Rehabilitation (MACVPR) strives to recognize members for their accomplishments in the fields of cardiac and/or pulmonary rehabilitation and presents a biannual achievement award at the October MACVPR New England Cardiovascular and Pulmonary Rehabilitation Symposium. This award is given to a member in good standing who has made outstanding contributions to the field of Cardiac or Pulmonary Rehabilitation, the MACVPR/AACVPR and/or has demonstrated commendable efforts toward clinical advancement in primary and secondary prevention of people with cardiovascular and/or pulmonary disease. We were thrilled to present this year's award to Ginny Dow, RN, BSN, BC, CCRP, nurse manager of the Emerson Hospital Cardiac Rehabilitation and Prevention Program. We would like to share her letter of nomination with you below:

I nominate Ginny Dow, RN, BSN, BC, CCRP for the MACVPR DSA 2016. Ginny has gone above and beyond in her work as an RN, nurse manager of the Emerson Hospital Cardiac Rehab and Prevention Department, MACVPR member and past board member, and AACVPR member and committee member. Ginny is an unrelenting advocate for her patients and for the field of Cardiac Rehab and Health Care. She is extremely supportive of her staff and strives to support all in providing the highest quality health care for our patients and the public. She is very passionate and dedicated to the field of Cardiac Rehab and this is seen in her commitment to all the organizations she contributes to. Ginny is a long standing member of MACVPR, serving more recently as Past Chair and Co-Chair of the Education Committee and provided our organization with pertinent, informative, interesting, and high quality education programs. Ginny invested much time and effort to ensure that our meetings, including the symposiums, have met members needs and been a forum conducive to learning and networking. She paid attention to every detail needed to be certain that the meetings and symposiums run smoothly. These qualities are evident in all the work that she involves herself in. Ginny also served as MACVPR Past President as well as a board member for many years. Ginny is currently serving on the AACVPR Education Committee and has joined DOTH for the past two years advocating for CR benefits. Ginny also works closely with the AHA. In addition, Ginny presents talks on heart disease to many community



ABOVE: 2016 Award Recipient Ginny Dow, RN, BSN, BC, CCRP (center) with MACVPR President Lynne MacDonald, PT, CCRP (left) and 2014 Award Recipient, Esther Burchinale MS,CEP, RCEP, CCRP (right).

organizations, Emerson Hospital, MACVPR meetings as well as other groups. Ginny is also a BCLS Instructor to advocate and share this vital information to the public. Ginny strives to be current with the newest medical and healthcare advances and is committed to attending conferences to share with her staff and patients. She also maintains all the certifications available for a RN in this field, most recently obtaining the AACVPR CCRP. We are fortunate to have Ginny a part of our organization with her vision, passion, dedication, commitment, experience, and expertise. I strongly feel she more than deserves this acknowledgement, and I appreciate your consideration. Thank you, Ginny!

MACVPR would like to extend a very special thanks to LSI, our new Diamond Level sponsor, for their support of the October MACVPR NE CR and PR Symposium ! You can learn more about LSI by visiting lsi-medical.com.



MACVPR does not accept responsibility for the accuracy of the information produced herein. The statements and opinions contained in the articles of the MACVPR Newsletter are solely those of the individual authors and contributors and not of MACVPR. We do encourage comments, articles, and other contributions while reserving the right to reject or edit the material. The articles in the newsletter are for readers to use as they deem necessary in their programs of clinical practice and are not necessarily standards of care by MACVPR.

MEET YOUR MACVPR MEMBERSHIP CHAIR & MEMBERSHIP UPDATE

Diane Gaughran, BS, ACSM-RCEP, CCRP

Membership Chair



Hello fellow cardiac and pulmonary rehab professionals, I just want to introduce myself and update you on the membership status in the AACVPR Joint Affiliate MACVPR. I am Diane

Gaughran CCRP, RCEP from Norwood Hospital. My contact information is diane.gaughran@steward.org or (781) 278-6265 if you have any membership questions.

Currently, there are 58 hospitals in the New England area that we are aware of who have cardiac and/or pulmonary rehab programs. At the end of this update, you will find a list of these programs. If you notice any programs that have been omitted or should be removed, please let us know. I would like to reach out to all programs to encourage at least one member to join the AACVPR Joint Affiliate MACVPR. Remember, the larger our membership base, the more voice we have to help make changes in our growing fields!

I would also like to reach out to all who were past members and perhaps decided not to rejoin due to increased membership fees. In January you can register for an 18 month membership which includes a 60% savings for the first 6 months. Total cost is \$300 (\$85 for first 6 months and \$215 for following year) for your joint AACVPR/MACVPR membership. The benefits really do outweigh the cost, and include:

- Access to the MACVPR.org website “Members Only” section which includes the tri-annual “MACVPR News” newsletters
 - Two half-day complimentary membership meetings (including CECs)
 - Reduced registration fee at the October MACVPR New England Cardiovascular and Pulmonary Rehabilitation Symposium (including CECs)
 - Opportunity to meet, work with, and learn from professionals in your field
 - Share information and resources with other professionals
 - Keep informed of current job opportunities, news and events in cardiac and pulmonary rehabilitation
- Keep informed on standards of care, federal and state guidelines, reimbursement issues, and legislation for cardiovascular and pulmonary rehabilitation programs
 - Access to an AACVPR Education Advantage Membership at the Professional Membership rate, including benefits such as access to free webcasts for CECs

Please pass this information along to co-workers and others that you know might want to join.

Thank you for your assistance! I look forward to meeting you at our next half day meeting in January. Please introduce yourself.

- Diane Gaughran

MEMBERSHIP UPDATE AS OF DECEMBER 1, 2016:
We currently have 92 members from Massachusetts and Rhode Island.

NEW ENGLAND CARDIAC AND/OR PULMONARY REHABILITATION PROGRAMS:

MASSACHUSETTS:

Anna Jacques Hospital
Baystate Franklin Medical
Baystate Medical
Berkshire Medical Center
Beverly Hospital-Lahey
BID- Milton
BID- Plymouth
Boston Medical Center
Brigham and Women's Faulkner Hospital
Brigham and Women's Foxboro
Brockton Hospital
Cape Cod Hospital
Cooley Dickenson Hospital
Nashoba Valley
Eagle Pond Rehab and Living
Emerson Hospital
Fairview Hospital
Falmouth Hospital
Harrington Hospital
Health-South Rehab Hospital
Heywood Hospital
Holy Family
Holyoke Hospital
Lahey Clinic
Lawrence General Hospital
Lawrence Memorial Hospital
Lowell General Hospital
Martha's Vineyard Hospital
Massachusetts General Hospital
Melrose -Wakefield Hospital
Metro-West Medical center

Milford Regional Hospital
Mount Auburn Hospital
NE Sinai
Newton Wellesley Hospital
North Shore medical center
Norwood Hospital
South Shore Hospital
Southcoast -Durfee Union
Southcoast -St. Lukes
Southcoast -Toby
Spaulding Rehab Hospital
St. Annes
St. Vincent Hospital
Sturdy Memorial Hospital
UMass Memorial-Health Alliance
UMass Memorial-Marlboro
UMass Memorial- Worcester
Whittier Hospital
Winchester Hospital

RHODE ISLAND:

Miriam Hospital
Landmark Hospital
South County Hospital
New Hampshire
Dartmouth-Hitchcock Medical Center
Frisbie Memorial Hospital
St. Joseph Hospital

MAINE:

Midcoast Medical Center

FALL 2016 TREASURY REPORT

Donna Hawk, RRT, AE-C
Treasurer

AS OF DECEMBER 3, 2016:

- Checking - \$19,935.32
- Money Market - \$2635.38
- Total - \$22,570.70

GREAT NEWS! COMPUTER-BASED
CERTIFIED CARDIAC REHAB
PROFESSIONAL (CCRP) TESTING
WILL BE AVAILABLE IN 2017!



The AACVPR is excited to announce that starting on February 1, 2017

the Certified Cardiac Rehabilitation Professional (CCRP) exam will be offered to candidates in an electronic version through Pearson Vue.

Pearson Vue has thousands of testing centers across the country, so you will be able to take the exam at a site near you. To take the exam:

1. Register online through the AACVPR website. Registration is open as of December, 2016. Members will be offered a discounted testing rate.
2. Look for a scheduling follow-up email to choose your testing location
3. Schedule a testing location for a date and time in one of our three testing months (February, July, and November). You will receive email confirmation of your appointment.

After the November 9 exam in Chattanooga, TN, we will offer the paper and pencil exam only at the Annual Meeting.

Please keep your eye on the AACVPR website at AACVPR.org for official updates on the status of computer-based testing near you!

Reimbursement Update:
AACVPR Health Policy & Reimbursement Update
November 3, 2016 - From www.aacvpr.org

FINAL 2017 HOSPITAL OUTPATIENT REGULATIONS
RELEASED

■ Payment Rates

CMS (The Centers for Medicare & Medicaid Services) published the 2017 final payment and regulations for hospital outpatient services (HOPPS) on November 1, 2016. This update will briefly summarize issues that affect cardiac and pulmonary rehabilitation.

As sometimes happens, the final reimbursement amounts for pulmonary rehabilitation (PR) and respiratory care services differ from the payment proposed in July, 2016. The payment reductions from proposed to final are based on CMS analyses of more recent claims data. Furthermore, for 2017 CMS has assigned different status indicators (SIs) for G0237 and G0238 and different ambulatory payment classifications (APCs) for the PR and respiratory care procedure codes.

CMS Final 2017 OPPS Payment Rates:

HCPCS Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Minimum Unadjusted Copayment
93797	Cardiac rehab	S	5771	1.4690	\$110.18	\$22.04
93798	Cardiac rehab/monitor	S	5771	1.4690	\$110.18	\$22.04
G0422	Intens cardiac rehab w/exer	S	5771	1.4690	\$110.18	\$22.04
G0423	Intens cardiac rehab no exer	S	5771	1.4690	\$110.18	\$22.04
G0424	Pulmonary rehab w/exer	S	5733	0.7270	\$54.53	\$10.91
G0237	Therapeutic procd strg endur	S	5732	0.3782	\$28.37	\$5.68
G0238	Oth resp proc, indiv	S	5732	0.3782	\$28.37	\$5.68
G0239	Oth resp proc, group	S	5732	0.3782	\$28.37	\$5.68

The regulation finalizes the CMS proposal to implement payment changes for off-campus provider based departments (PBD), beginning January 2017. This is of concern to AACVPR, as stated in AACVPR comments submitted to CMS in July.

Based on detailed justification provided in the comment, AACVPR recommended to CMS that both cardiac rehabilitation services (CPT 93797 and CPT 93798) and pulmonary rehabilitation services (HCPCS G0424) warrant exemption from rules that would alter the current ability of hospitals to bill Medicare for these services through the hospital outpatient prospective payment system. CMS declined this recommendation.

■ Site of Service Changes

Payment for off-campus hospital departments will be based on the Physician Fee Schedule (PFS) rather than the Hospital Outpatient Prospective Payment System (OPPS), as CMS had proposed. This will have serious negative financial consequences for any future CR or PR services considering an off-campus location. Only off-campus departments that were operational prior to passage of the Bipartisan Budget Act of 2015 on 11-2-15 will be grandfathered and allowed to continue with payment based on the OPPS. If your program is off-campus (i.e., more than 250 yards from the main campus) and has been at the same physical address since prior to 11-2-15, your program is grandfathered under OPPS payment. (Please refer to CR FAQ # 38 or PR FAQ # 49 for the definition of "off-campus" and for the CMS regulation citation).

We're not in Kansas, Anymore...

A Perspective on the Upcoming Medicare Payment Changes

Wayne Reynolds, RN, FAACVPR, CCRP



WE'RE NOT IN KANSAS ANYMORE, OR ANYPLACE ELSE THAT'S FAMILIAR, WITH THE IMPENDING PAYMENT CHANGES FROM MEDICARE, WITH COMMERCIAL INSURERS LIKELY FOLLOWING SUIT AS WELL.

If you attended AACVPR's annual meeting this past September, MACVPR's New England

Symposium in October, or have been paying attention to the AACVPR reimbursement updates and R2R installments you are now well aware of Medicare's impending pilot program. While many details are still pending,

SIMPLY STATED, TO PROTEST OR NOT CHANGE WILL NOT SERVE OUR PATIENTS... WE MUST EMBRACE CHANGE.

significant change is coming in the payment system. This pilot program includes bundled payments and incentives with an overall emphasis in increasing participation in cardiac rehab. Whether or not you are in one of the metropolitan areas chosen for the pilot program beginning summer 2017, it will undoubtedly lead to changes in how we all deliver our services.

The good news is that with the emphasis on increasing cardiac rehabilitation enrollments, more programs will be needed. Additional programs will be developed and programs that have been closed by some institutions will be reopened in order to meet the needs of patients covered under bundle payment. However, what may seem like "bad" news for some is that cardiac rehab programs are not going to look like they did in the past, or even like they do now.

While the traditional "tried and true" cardiac rehabilitation method of outpatient exercise programs coupled with education may still have a place, we can seriously expect that this will be happening less and less, as programs become more "hybrid" than ever before. We will also need to be working with our patients in ways we may never have imagined: home based, telephone, text or email based, doctors' offices, or fitness facilities.

Continued on page 7...



WHAT IS HAPPENING?

The Centers for Medicare and Medicaid Services (CMS) has recognized the benefits of Cardiac Rehabilitation (CR) to reduce the impact of cardiovascular disease in the U.S. and is developing ways to expand its use. In 2017, CMS will introduce pilot programs:

- ◆ to provide CR incentive payment models for AMI and CABG
- ◆ for a cardiovascular bundled payment system

This is a great opportunity for CR professionals to reform programs to enhance patient participation, individualize treatment, explore new methods of delivery, and confirm the efficacy of CR in reducing the impact of cardiovascular disease.

These pilot programs and bundled payment system are not optional. This is our future.

WHAT IS AACVPR DOING TO HELP YOU PREPARE?

AACVPR leadership is partnering with other national organizations to reform delivery of services to meet the needs of patients. We have mobilized a great deal of resources to help you meet this new future. AACVPR has created special workgroups that are developing a systematic approach for a **Roadmap to Reform** for CR services. This roadmap includes turn-key strategies, educational materials, advanced training opportunities, and an eye toward the evolving nature of CR delivery.

The goals:

- ◆ Increase referrals to CR
- ◆ Increase enrollment in CR
- ◆ Improve adherence to CR

In the next several months, additional information will become available, with an emphasis on preparing you for changes coming in the next year.

WHAT CAN YOU DO?

WE ASK THAT YOU E.M.B.R.A.C.E. THE UPCOMING CHANGES!

- E — ENGAGE** with AACVPR, your facility leadership, and your staff to evaluate what you can do.
- M — MANAGE** expectations. These changes are coming quickly.
- B — BE BOLD** and be brave. This is your opportunity to play a role in improving patient health.
- R — RESOURCEFULNESS** is key. Be creative with your thoughts about how to meet this new challenge head-on.
- A — ACCOUNTABILITY** because we must realize this is the new normal, and we are responsible for responding accordingly.
- C — COMMUNICATE** with AACVPR. Help us understand your needs.
- E — ENERGIZE** and volunteer to help. And plan to attend AACVPR's Day on the Hill, March 13-14, 2017.

WWW.AACVPR.ORG/R2R

Medicare payment changes, continued...

Change will even begin with the start dates. No longer will we be able to have patients on “wait lists” to start programs that are “full”. The expectation from payers and hospital administrators will be for immediate enrollment, as time will be considered of the utmost importance in getting patients on their path to lifestyle change in order to prevent readmissions; readmissions for which hospitals will be financially penalized if they occur during a 90 day post discharge period and potentially even beyond that.

I've already heard comments like “Over my dead body”, “The old way works, Why change?”, “That’s just not how to do it” and other phrases unsuitable for print. Simply stated, to protest or not change will not serve our patients. To quote Pogo: “We have seen the enemy and it is us”. *We must embrace change.*

First of all, this will likely be a chance for us to be allowed “out of the basement” as there is documented evidence showing that the service that cardiac rehab provides decreases rehospitalizations.

Next, this will cause many of us to be included by our hospitals on multidisciplinary teams including, but not limited to, case management, social work, finance, nutrition services, primary care offices, cardiologists, local VNA, inpatient rehab facilities and pharmacy. Since we in cardiac rehab, by nature, are already coordinating or otherwise made up of multidisciplinary teams, our expertise will be invaluable.

These new delivery systems, more individualized than ever, will be required to support our patients. This will challenge us, but it IS do-able.

In his October 27 presentation, Dr. Gary Balady very eloquently gave us both a historical perspective as well as a look to the future, encouraging us to be prepared for the impending changes and to start exploring ways to “adapt and overcome” for the benefit of our patients.

To echo Dr. Balady and expand slightly on his message, please read the R2R installments as they are released and take them to heart (pun intended!), communicate with colleagues in other programs (network like crazy!) and develop and share new ideas. To assist in this transition, AACVPR will be having webcasts and workshops, and MACVPR will have an update and panel discussion in January. My advice is to use these resources to your full advantage.

I think back to when we had cardiac rehab at the YMCA, with the only monitor being the defibrillator with quick look paddles for the walk/jog program. It was frequently difficult to educate over the loud “gym noises”, but we got it done. We have come a long way since those days and we still have a way to go, although at times it may feel like we are taking a step back in order to go forward.

In conclusion, this is a new, challenging, and exciting time for cardiac rehab, with pulmonary rehab sure to follow. While we may not like it initially, if we work through our challenges, helping each other along the way, we stand to have a significant impact on our institutions’ ability to survive and better care for our patients.

LETTER FROM THE EDITOR

When reviewing the contributions to this issue of the MACVPR news, one theme seemed to run clear throughout many of articles – change! Boy, it’s all around us. As highlighted in the Education Update, a whole session was dedicated to e-cigarettes at the recent New England Cardiac and Pulmonary Rehabilitation Symposium; these devices were barely on the radar even just five years ago. We have an article by dietician Holly Brassett, MS, RD, LDN dedicated to the revised food label, which will be required to be on all food packages in less than two years. And, of course, the big one – Roadmap 2 Reform – which has the potential to dramatically alter how cardiac rehabilitation is delivered to patients in the future.

As cardiac and pulmonary rehab professionals, it is critical to stay well-informed of the changes that affect the field – so when patients have questions about using e-cigarettes or they encounter the new food label in stores, they are provided with the most accurate information possible. When it comes to issues like R2R, we have to be able to adapt to change that affects how we provide our services. How do we avoid becoming so bogged down in how things were done in the past, allow ourselves to think outside the box, and ultimately provide an even better service to patients in the future?

One thing about change is that it can be easier to navigate together. As an MACVPR member, we hope the organization can be a place to do just that. This is why we aim to present education sessions with current, relevant information. And this is why we are dedicating the entire half-day meeting in January to information and discussions about R2R. Hope to see you there.

As usual, if there is a topic you'd like to learn more about in the newsletter, I not only welcome, but encourage feedback. Please feel free to send suggestions or questions to mtanguay@partners.org.

Melissa Tanguay, BS, ACSM-CEP
Exercise Physiologist, Massachusetts General Hospital

2016 MACVPR New England Cardiovascular and Pulmonary Rehabilitation Symposium

Judy Flannery RN, BSN
Education Co-Chair

THE 2016 NEW ENGLAND CARDIOVASCULAR AND PULMONARY REHABILITATION SYMPOSIUM WAS HELD ON OCTOBER 27 AT THE HAMPTON INN IN NATICK. The symposium was, overall, a great success with over 90 attendees from throughout New England. We hosted five informative guest speakers, who spoke on a variety of topics including Emerging Science in Cardiac Rehab, Smoking/Vaping, Core Components of the Exercise Prescription, Active Listening, as well as information about Road to Reform or R2R. In case you missed it, here is a summary of the presentations:

SESSION 1: CARDIAC REHABILITATION 2016: IMPLEMENTING EMERGING SCIENCE IN PREVENTION

Gary Balady, MD - Director, Preventive Cardiology, Non-Invasive Cardiology Labs, Boston University Medical Center

In his lecture, Dr. Balady reviewed the scientific support for the provision of cardiac rehab to heart disease patients. Since its beginnings, cardiac rehabilitation has evolved and grown into a multi-faceted intervention program that optimizes physical, psychological and social functioning. One key event in this evolution of programs include the adoption evidence-based care in the early 1990s, which demonstrated the importance of cardiac rehab, including the relationship between the number of sessions a patient attends and the degree of benefits from the program.

In 2005, further evidence emerged that cardiac rehab programs help stabilize, slow, and reverse the atherosclerotic process. Cardiac rehab was also shown to reduce morbidity and mortality, and be an efficient venue to deliver preventative care. Jumping to more recent developments, Dr. Balady also reviewed the benefits of interval training for cardiac rehab patients along with the importance of the program for patients with peripheral artery disease and CHF.

Dr. Balady did point out that even with data supporting the importance of cardiac rehab, only 20% of eligible patients attend programs. So the question is, how do we reach the other 80% to participate in this valuable program? The American Heart Association and CMS both have started to push to find ways to include more participants, and this will likely remain a predominant focus in the near future.

SESSION 2: SMOKING/VAPING: E-CIGARETTES AND OTHER TOBACCO PRODUCTS

Ann Ottalagana, BS - Regional Director of Smoking Cessation, American Lung Association

Vaping is a relatively new phenomenon in the US, and although the AHA has taken the position against electronic cigarettes, there remains a lot of questions amongst medical providers on the topic. We were fortunate to have Ann Ottalanga at our conference, to help bring us all up to speed on this topic.

WHILE SOME RECENT STUDIES HAVE SHOWN THERE TO BE POTENTIALLY HARMFUL CHEMICALS IN THE SECOND HAND SMOKE FROM E-CIGARETTES, THE BOTTOM LINE IS THAT NO ONE REALLY KNOWS WHAT THEIR HEALTH IMPACT LONG TERM WILL BE.

The FDA definition of an E-cigarettes is “a device that allow users to inhale a vapor containing nicotine or other substances” and they made their way into the US in 2007 from China via internet sales. E-cigarettes include e-pens, e-pipes, e-hookah, and e-cigars

Continued on page 9...



E-cigarettes include e-pens, e-pipes, e-hookah, and e-cigars - this group is collectively known as ENDS (electronic nicotine delivery system).

NE CR and PR Symposium, continued...

- this group is collectively known as ENDS (electronic nicotine delivery system). E-cigarette use appears to be sharply on the rise. For example, e-cigarettes data from the CDC states that use in middle and high school has tripled in one year from 4.5 % in 2013 to 13.4% in 2014.

It was very interesting to learn that E-cigarettes are not regulated by the FDA like cigarettes and smokeless tobacco. However, even though they are not regulating the product, the FDA has stated that they have not found e-cigarettes a safe and effective way to promote smoking cessation. While some recent studies have shown there to be potentially harmful chemicals in the second hand smoke from e-cigarettes, the bottom line is that no one really knows what their health impact long term will be.

SESSION 3: CORE COMPONENTS OF EXERCISE PRESCRIPTION FOR CARDIAC AND PULMONARY POPULATIONS

Julianne DeAngelis MS, CCRP, RCEP - Miriam Hospital

Julianne helped us consider the fact that we have many special populations in our cardiac and pulmonary rehab programs; patients with pulmonary disease, vascular issues, diabetes, HIV, neurological issues and more. This means our programs are faced with a multitude of challenges each day! She encouraged us to rethink our traditional rehab session and add a mix of modalities including resistance training and HIIT (High Intensity Interval Training), as appropriate for these special populations. For instance, a recommendation for peripheral artery disease patients is exercise at an intensity that instigates 3/5 on the claudication pain rating scale in 5 to 8 minutes, then stop, rest and repeat.

SESSION 4: LISTENING TO YOUR PATIENTS PSYCHOSOCIAL ISSUES: HOW TO MAKE THE MOST OF YOUR TIME WITH PATIENTS THROUGH ACTIVE LISTENING

Glenn A. Feltz, Psy.D.,FAACVPR

This workshop provided basic skills in ways of listening to our patients that is most likely to generate helpful clinical information related to our patients' psychosocial risk factors. Skills were taught to help staff overcome a patient's initial guardedness when being interviewed, to illicit more information and gather more helpful information. One key take away is that interviewers need to recognize that our attempts to be helpful, may, in fact handicap the patient's ability to express themselves and share with us information that may be critical in their care.

All speakers received excellent evaluations and comments such as:

- *Excellent speakers and current practical info to incorporate into our programs*
- *Topics were applicable to both disciplines*
- *Keep having great speakers*
- *Entire program related to my day to day job*

Our next meeting will be on January 19, 2017 at the same location, the Hampton Inn in Natick, MA. The focus of this meeting will be preparing us all for the upcoming R2R changes. You can find a detailed agenda on page 2 of the newsletter.

The hard work put forth to assemble the symposium's speakers, topics, vendors, and lunch were a joint effort by the Executive Committee, the Education Co-Chairs, Deidre Proudman and Judy Flannery, the Education Committee, Arlene Gaw and Jacqueline Pierce, President Lynne MacDonald, and our Administrative Assistant Jessica Dion.

Thank you to our sponsors,:



Holly Brassett MS, RD, LDN

Outpatient Dietitian, Lahey Hospital and Medical Center



SOME OF YOU MAY OR MAY NOT BE AWARE THAT THE FOOD LABEL IS GOING TO BE UNDERGOING SOME CHANGES. Why is this happening one may ask? Here is an interesting fact - the food label that we have now is more than 20 years old and is becoming outdated. With all of the updated scientific information that we have through public health research and recent dietary recommendations from

expert groups, much more accurate information on the food label needs to be represented and devised.

So what changes can we expect to see?

1) Serving size will be printed in larger print as well as the calories so that it is easier for the consumer to read and take note. The serving sizes will also change to reflect what the typical consumer is ACTUALLY eating vs. the reference amount that is seen today.

What does this mean? For example, the serving size of soda was previously 8 ounces and now is changing to 12 ounces. The reference amount for yogurt is decreasing from 8 ounces to 6 ounces. Nutrient information on the new label will be based on these updated serving sizes so it matches what people *actually* consume. Doing this will help the consumer better understand the total calories they are taking in and may influence how much of a serving is actually consumed. This will also be done with canned soups, which will help many folks in understanding what they are consuming. Let's take for example a can of Progresso soup. In a one cup serving (which is half the can) you may consume 100 calories and 600mg of sodium. Now, let's say that you consume the entire can of soup. Are the calories and sodium the same? No, they are not. At this point you are having the entire can which is 2 cups of soup which brings you to total of 200 calories and 1200 mg of sodium.

Your Guide to the Upcoming Revised Food Label

Wow!!! Today's food label will calculate all of this information for you, which will make things much more clear. If this doesn't stop some folks in their tracks I do not know what will! For some foods that could be consumed in either one sitting or multiple sittings (think bags of chips or pints of ice-cream), manufacturers are also providing side by side food labels that will show the foods "per serving" and "per package."

2) You will continue to see total fat, saturated fat and trans fats on labels but calories from fats will be removed. The logic behind this is that it is more important to understand the type of fats being consumed vs. calories from fats.

Continued on page 10...

NEW LABEL / WHAT'S DIFFERENT

Servings:
larger,
bolder type

New:
added sugars

Change
in nutrients
required

Nutrition Facts	
8 servings per container	
Serving size	2/3 cup (55g)
Amount per serving	
Calories	230
% Daily Value*	
Total Fat 8g	10%
Saturated Fat 1g	5%
Trans Fat 0g	
Cholesterol 0mg	0%
Sodium 160mg	7%
Total Carbohydrate 37g	13%
Dietary Fiber 4g	14%
Total Sugars 12g	
Includes 10g Added Sugars	20%
Protein 3g	
Vitamin D 2mcg	10%
Calcium 260mg	20%
Iron 8mg	45%
Potassium 235mg	6%

* The % Daily Value (DV) tells you how much a nutrient in a serving of food contributes to a daily diet. 2,000 calories a day is used for general nutrition advice.

Serving sizes
updated

Calories:
larger type

Updated
daily
values

Actual
amounts
declared

New
footnote

Tips for Less Holiday Stress

Pamela Katz Ressler, MS, RN, HNB-BC

Founder of Stress Resources



THE HOLIDAYS ARE STRESSFUL TIMES FOR OURSELVES AND OUR PATIENTS.

We know that high levels of chronic stress can lead to a less than robust immune system - one reason many of us seem to come down with that cold or respiratory infection at the most inopportune time over the holiday season. This year why not try some new strategies to address and combat the

increased stress that holidays bring. Here are my top five favorite tips to get you started! Feel free to share these tips with colleagues and patients...or anyone you can think of who may need some new ways to have less stress during the holiday season.



Pamela Katz Ressler, MS, RN, HNB-BC is the founder of Stress Resources (StressResources.com) located in Concord, MA. Stress Resources specializes in providing individuals and organizations with strategic, sustainable tools to build resilience and mindfulness.

STRESS RESOURCES' FIVE FAVORITE TIPS FOR REDUCING HOLIDAY STRESS:

- **Lower the bar on expectations.** Our expectations have been unnaturally shaped by sites such as Pinterest and Facebook. Try lowering the bar this year on decorations and holiday preparations and regain your sense of control.
- **Embrace both gratitude and grief.** We often forget that the holiday season is laden with emotions that can comprise grief and gratitude both for ourselves and our patients. Practice self-compassion by engaging in journaling, art, meditation or self-care activities.
- **Delegate or Delete.** Look over your to-do list and choose one item that you can either delete or delegate to someone else.
- **Practice the fine art of saying "no".** Demands for our time and energy can derail even the most effective strategy for stress reduction, holidays may exacerbate our feelings of obligation. Remember "No" can be a complete sentence.
- **Engage in mindfulness.** Mindfulness simply means pausing in the present moment to actually notice thoughts, emotions and sensations. Try pausing amidst the busyness to notice the present, not the past or the future.

As always, Pam loves comments and feedback from readers. What topics of mind/body/spirit would you be interested in exploring in future columns? Let Pam know at pressler@StressResources.com

Food Labels continued...

3) As far as vitamins and nutrients, vitamin D and potassium will be added and required on the label while vitamin A and C will no longer be necessary. You will continue to find calcium and iron which will remain the same. Why take out vitamin A and C? Interestingly enough these vitamins were lacking in many diets 20 plus years ago but today we are quite adequate. Today, we are finding individuals to have less Vitamin D and potassium hence the change.

4) Daily values for nutrients like sodium, dietary fiber and vitamin D are being updated. These changes are being based on newer scientific evidence from the Institute of Medicine and other reports such as the 2015 Dietary Guidelines Advisory Committee Report.

5) Total sugar will specify the amount contributed by "added sugar", expressed both grams and as a percentage. According to the FDA, scientific data demonstrates that it is difficult to meet nutritional needs while staying within calorie limits if more than 10 percent of your total daily calories comes from added sugar. This is also consistent with the 2015-2020 Dietary Guidelines for Americans. The addition of "added" sugar on the label distinguishes between naturally occurring sugar and "added" sugar, makes the amount of added sugar more transparent, and easier for consumers to understand how much added sugar they are actually consuming.

Manufacturers will need to use the new label by July 26, 2018, so start to look for the updated label in stores near you soon.

Over-the-Counter Cold and Flu Medications and Heart Disease

Yue See Lee RPh

Pharmacist, Beth Israel Deaconess Hospital - Milton



FLU AND COLD SEASON IS UPON US! WHEN YOU CATCH A COLD OR THE FLU, NOT ONLY DO YOU FEEL MISERABLE, BUT YOU MIGHT MISS

WORK AND FAMILY ACTIVITIES AS WELL. At this time many of us reach for over-the-counter (OTC) products to alleviate these symptoms. If you have experienced a cardiac issue, choosing an appropriate OTC medication that is safe for your heart is especially important. This installment will explore these heart healthy OTC cold and flu medication options.

An important first step is always to read labels carefully when considering which product is good for you.

Acetaminophen (Tylenol) is a commonly used to treat fever, headaches and body aches. This medication is considered to be safe for your heart, but do not exceed 3,250 mg of Tylenol a day because it can cause serious liver damage in high doses. Other products such as ibuprofen (Motrin, Advil) and naproxen (Aleve, Naprosyn) are in a category of pain medications called NSAIDs (pronounced en-seds). NSAIDs can also treat pain and fever, but evidence shows that these medications are not safe for your heart because they can increase risk for heart attack or stroke.

Bottom line: as a more heart-friendly option, choose Tylenol over NSAIDs. Use Tylenol (500 or 650 mg) sparingly and only if you do not feel better after rest and 4-6 hours, repeat the dose.

Cough is also a bothersome symptom. For mild cough, keep hydrated by drink plenty of fluids. Also, try various products

to soothe or numb your irritated throat or nasal passageways (humidifier, lozenges and sprays, etc.). To treat more severe coughing, products containing the cough suppressant dextromethorphan (DM) can be used. Be cautious about the other additional ingredients that DM is combined with.

Many OTC medications have additional ingredients such as sodium, sugar, and/or alcohol. Medications with high sodium content causes water retention which leads to increased blood pressure. Additional sugar in OTC products is problematic if you are diabetic and need to monitor sugar intake. Alcohol can also be found in OTC products and should be avoided if you have diabetes and liver issues.

Bottom line: avoid products that have high sodium, sugar, or alcohol content. Be wary of these ingredients and always consult with your pharmacist or physician.

Three decongestants on the market are Sudafed (pseudoephedrine), phenylephrine, and Afrin (oxymetazoline). If you have a cardiac condition, decongestants are generally not recommended because they can raise blood pressure and increasing your risk for heart attack and strokes. Afrin can be used temporarily to clear a stuffy nose, but use it for no more than 3 days as it loses efficacy and can cause rebound congestion.

Better options for your heart are non-medication alternatives such as saline (nasal sprays, drops, or irrigation) and humidifiers. Antihistamines such as fexofenadine (Allegra), cetirizine (Zyrtec), loratidine (Claritin), and diphenhydramine (Benadryl) are good options as well.

Bottom line: First, try non-medication alternatives. If they do not clear up your stuffy nose, antihistamines can be used but some are sedating, so check with your physician or pharmacist about these side effects. Avoid decongestants!

This article is not comprehensive but is meant as a general guideline for how to choose cold and flu medications. If your symptoms are severe and do not improve after a few days, or if you have further questions about your symptoms or medications, consult with your pharmacist or physician.

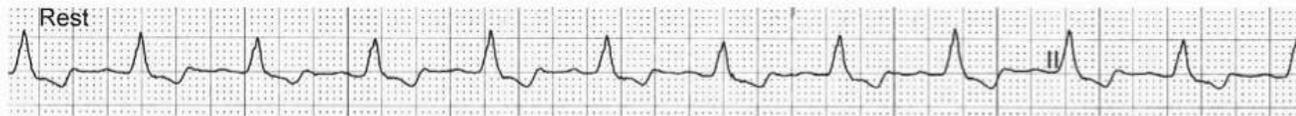
EXAMPLES OF HEART SAFE OVER-THE-COUNTER COLD & FLU TREATMENTS

- Acetaminophen (Tylenol)
- Dextromethorphan (DM)
- Fexofenadine (Allegra)
- Cetirizine (Zyrtec)
- Loratidine (Claritin)
- Diphenhydramine (Benadryl)
- Humidifiers
- Saline (nasal sprays, drops, irrigation)

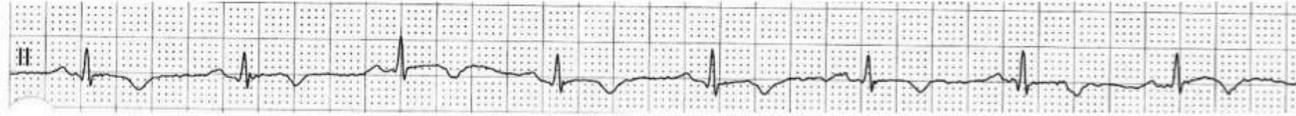
COLD AND FLU MEDICATIONS THAT MAY BE PROBLEMATIC:

- Ibuprofen (Motrin, Advil)
- Naproxen (Aleve, Naprosyn)
- Pseudoephedrine (Sudafed)
- Phenylephrine
- Oxymetazoline (Afrin) if used more than 3 days
- OTC medications with high alcohol, sugar, or sodium content

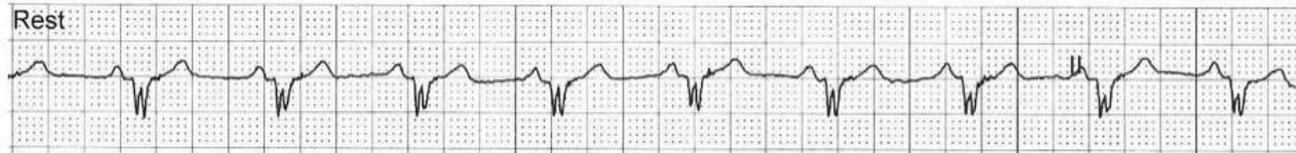
You are seated at the monitor and review the rhythms presented before you below for five new patients starting your cardiac rehabilitation today. All patients are asymptomatic, hemodynamically stable, and took all medications as directed.



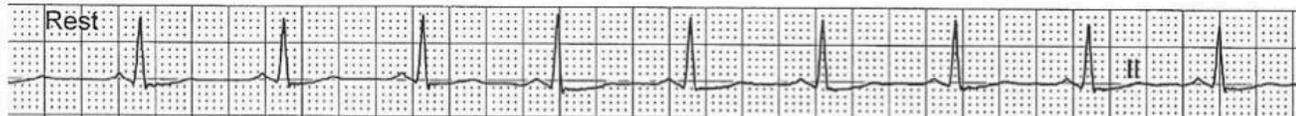
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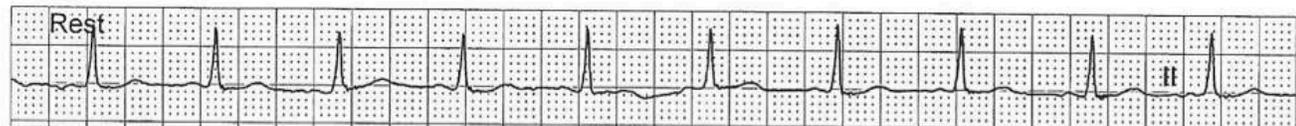
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3



4

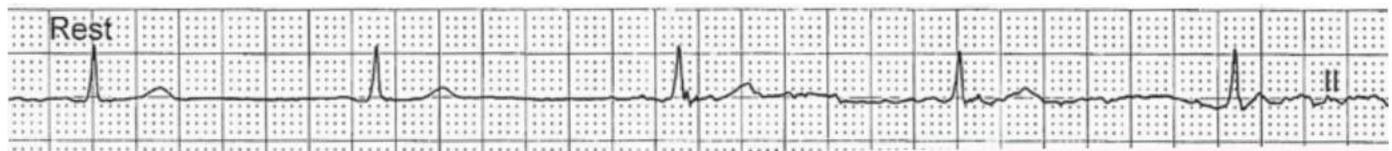


5

QUESTION 1 - Which patients are in sinus rhythm?

- a. Patients on monitors 4 and 5
- b. Patients on monitors 2, 4, and 5
- c. None of the patients
- d. All except monitor 1
- e. All of the patients

On session 14 you notice monitor 5 presents with the following resting strip. The patient is a 79 year old female with history of hypertension, hypercholesterolemia, OSA (uses CPAP), coronary artery disease, and aortic stenosis. She is 5 months s/p CABGx2 and AVR. Postoperative course was complicated by volume overload requiring aggressive diuresis and hypoxia. Medication list includes aspirin, furosemide, lisinopril, amlodipine, atenolol, and atorvastatin. BP is 120/82 and heart rate is regular at 40-50 beats per minute. O2 saturation is 99% on room air. She took all meds except atorvastatin and is asymptomatic. Rhythm change was documented with evaluation of 12 lead ECG which captured a heart rate of 41 and expert opinion was sought from the cardiologist.



QUESTION 2 - This rhythm represents:

- a. Junctional rhythm
- b. Sinus bradycardia
- c. Complete heart block
- d. Sick sinus syndrome
- e. Atrial fibrillation with a slow ventricular response

ANSWER TO QUESTION 1: All the patients are in sinus rhythm

The standard calculation used to convey heart rate is beats per minute (bpm). A normal heart rate that originates in the sinus node is 60-100 bpm. Automaticity refers to the areas of the heart that have the ability to initiate a pacemaker impulse. Every cell in the heart is capable of initiating an action potential and stimulating the heart to beat but routinely these foci are found in the sinus node, the atrioventricular node, and the ventricles. Each area of automaticity carries a different intrinsic heart rate. All of these areas are capable of initiating a cardiac impulse, but all slower foci are suppressed by their faster counterparts. The sinus node has an intrinsic rate of 60-100 bpm and is represented by a P wave. The atrioventricular node (AV) has an intrinsic rate of 40-60 bpm, and the ventricles trigger at 20-40 bpm. If an automaticity area fails to generate an impulse, the next fastest pacemaker will become dominant and set the pace. If the calculated heart rate is between 60 and 100 and there is a normal upright P wave before each QRS, the automaticity focus generating that impulse is within the sinus node. The sinus rhythms above are not all "normal" sinus rhythms and may also include inverted T waves, intraventricular conduction disorders or left bundle block, but they are all sinus.

ANSWER TO QUESTION 2: Sinus bradycardia

If the impulse is less than 60 bpm but there is still an upright P wave before each QRS, this is consistent with sinus bradycardia. The presence of a normal P wave defines its origin in the sinus node. The heart rate was between 40-60 bpm and 12 lead ECG confirmed the presence of P waves which were unable to be clearly detected on the cardiac rehabilitation monitor. No P waves, an inverted P wave, or retrograde P waves would indicate a junctional rhythm, and the impulse is being generated by the atrioventricular node. Junctional rhythms are frequently associated with overmedication, CAD, or the normal aging process of the conduction system. The patient was positive she did not double up medication this day.

If bradycardia produces signs and symptoms of instability (eg, acutely altered mental status, ischemic chest discomfort, acute heart failure, hypotension, or other signs of shock that persist despite adequate airway and breathing), the initial treatment is atropine.

If bradycardia is unresponsive to atropine, intravenous (IV) infusion of adrenergic agonists with rate-accelerating effects (dopamine, epinephrine) or transcutaneous pacing (TCP) can be effective (Class IIa, LOE B) while the patient is prepared for emergent transvenous temporary pacing if required.

The patient continued to exercise (sitting) to assess for chronotropic incompetence or an inability of the sinus node to effectively increase the sinus rate and allow for the physiologic demand that is present with activity. As seen above her heart rate did increase appropriately with activity. Nursing management involved examination of her medication list for rate slowing medications such as beta blockers, calcium channel blockers, digoxin, or antiarrhythmic medications such as amlodipine and atenolol. Medical management of this patient included stopping her atenolol and decreasing her amlodipine by her cardiologist as her sinus bradycardia continued with symptoms of lightheadedness and fatigue. Follow up appointment one week later after medication adjustment revealed NSR at a rate of 78 and a controlled blood pressure. She reported feeling better and is no longer dizzy. Patient education included self pulse check, home BP monitoring, medication compliance, and review of proper response to symptoms.

Questions or comments on this vignette and may be sent to Deirdre.Proudman@lowellgeneral.org.

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