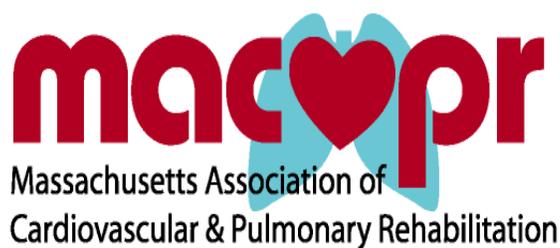


The mission of the MACVPR is to promote the practice of high standards of care in cardiovascular and pulmonary rehabilitation in Massachusetts



News

Winter 2010

Co-Presidents:

Priscilla Perruzzi BA, RRT
Kate Traynor, RN, MS

President Elect:

Vacant

Immediate Past President:

Stephanie DiCenso, MS, RCEP, CEP

Treasurer:

Susan Carrigan, BSN, RN C

Newsletter Editor:

Lynne MacDonald, PT

Education:

Deborah Sullivan MS, APRN, BC
Eileen Milaszewski, RN, BS

Certification:

Esther Burchinal, MS, CES, RCEP

Membership:

Melessa Ashworth, RN, BSN

Administrative Assistant:

Ann Stone, BS

A Publication of the
Massachusetts Association of
Cardiovascular and Pulmonary
Rehabilitation

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Co-President's Message

With the new year, comes a transition in some of the leadership of the MACVPR. In 2010, we will have the distinct honor of serving as Co Presidents- Priscilla Perruzzi, Clinical Supervisor of the Pulmonary Rehabilitation Program at Brigham and Women's Hospital and Kate Traynor, Director of the CV Disease Prevention Center/ MGH Heart Center. It is our intent (and hope!) that we continue to lead this organization as successfully as have our predecessors on the Executive Committee. Each of us hopes that the individual knowledge and expertise in cardiac and pulmonary rehab that we bring will be complimentary and benefit the MACVPR. Well, that's the plan anyways!

We follow in some pretty big footsteps that have left an indelible mark on our organization. In fact, one of the nicest comments that we heard was made to us at our January General Meeting. Robert Berry, the newly minted Manager of CV Rehabilitation at Baystate Medical Center (having hailed from Pennsylvania where he was very active in both local and national (AACVPR) CR circles), told us he thought we had a terrific state organization. It's always nice to hear remarks such as that but it means even more when the source has the depth and breadth of expertise in our field such as that of Robert. This accurate assessment of the MACVPR is a direct result of the hard work and dedication of last year's Executive Committee.

We can't offer them big bonuses such as those handed out on Wall Street, so our heartfelt thanks and respect will have to do!

*To Stephanie Dicenso, our now Immediate Past President, we are in awe of your energy, professionalism and able leadership over the past year. You will be a tough act to follow...

*To Kathy Bowers and Anne Marie Sadlowski, last year's Immediate Past Co Presidents, your influence over the last 3 years has been an asset to the organization and a model for us as a successful joint venture in leading the MACVPR. We also recognize the commitment and personal investment it took for you both to be so involved despite the challenge of the distance...

*To Deb Sullivan, our Education Chair, who thankfully will continue again this year, we speak for all when we say that the caliber of the meetings and the educational offerings are second to none: timely, informative, and extremely well received, always.

*To Lynne MacDonald, our Newsletter Editor, who is also continuing on the EC, the new format and features

are impressive and so well done we wonder if you are a closet prize winning journalist...

*To Susan Carrigan, our Treasurer, and thank heavens remaining on board for another year, your attention to detail, insightful money sense and miserly ways (kidding about that one!), have our bottom line looking good...

*To Esther Burchinal, our Certification Chair, your calm, professional demeanor in leading your committee in insightful, time consuming reviews of applications from programs across the state and working with AACVPR to ensure the integrity of the process has been impressive. Not sure what the future holds for state certification committees given the changes in the application process, but your tenure has been successful...

*And finally, to our Administrative Assistant, Ann Stone, the veritable Elmer's glue of the MACVPR, you are a gift and very much appreciated for your efficiency, dependability, and skill with which you manage the day to day operations- you better make us look just as good this year!

We welcome 2 new faces to our EC this year. Eileen Milaszewski will be joining Deb Sullivan as Education co-chair. Eileen works at the Milford Regional Medical Center and has 18 years of experience in cardiac rehab. She held the position of membership chair on the EC in the past. With the dynamic duo of Deb and Eileen at the helm of our education committee we can only expect our meetings to continue to address the "hot topics" of the year with the quality of speakers to which we have become accustomed. Melessa Ashworth a cardiac rehab nurse from Falmouth Hospital will be heading our Membership committee. As chair she will be getting the word out and encouraging professionals in the rehab community to experience the benefits of membership in our great organization. Please be sure to let Melessa know of anyone that might not be familiar with the MACVPR.

We have given much thought to the direction we'd like to take this year and found that the 2009 Strategic Plan for AACVPR was so well done and pertinent, rather than reinvent the wheel, we'd use that as our presidential "platform" and blueprint for leading the MACVPR this year! Although we outlined this at the 1/14/10 meeting, we wanted to also include it here to be sure all members understand our priorities: (continued)

.....Please turn to page 3



“.....AACVPR encourages all programs to channel any questions through the MAC Committee...”

Reimbursement Update

Some of you may remember the movie, Animal House, some of you may be too young to remember it and some of you may think it was not that memorable a movie. Nonetheless there's a line from a scene in the movie that is perfect for our update. In one scene of the movie, there is a parade, and suddenly a car in the parade veers off the route and heads into the crowd of spectators. Chaos ensues and people start screaming and running in every direction and John Belushi tries to stop the panic and hysteria by shouting, “**Remain calm, remain calm, would everyone please remain calm..**”!

So there you have it- not eloquent but apt- the name of the game as we try to implement the new 2010 Medicare Rules for CR and PR and forge a relationship with the local Medicare contractors (MAC) is to remain calm! We're in this together and we are fortunate to have in our MACVPR leadership and membership, a vast array of resources to help us understand, interpret and put into practice the mandates of these new statutes.

We'd like to provide a short synopsis of the requirements for both CR and PR to date.

Statutory Requirements for Cardiac Rehabilitation and Intensive Cardiac Rehabilitation

MD Supervision

- a. Responsible physician must have expertise in management of individuals with CV pathophysiology
- b. MD must be licensed to practice medicine in state where program is located
- c. MD must be trained in BLS or ACLS
- d. MD must be “substantially” involved in directing the progress of the individual in the program (in consultation with the appropriate staff)
- e. CR Program must be under direct supervision of an MD (not an NP/PA/CNS)
- f. Supervising MD must be immediately available and accessible for medical consultation/emergencies while services are being provided
- g. Medical Director is responsible for program and should be aware of each pt's progress through the program
- h. For CR/ICR in hospitals or on hospital campus-MD supervision is presumed
- i. For CR/ICR in out-pt locations off campus-supervising MD must be in the provider base department
- j. For CR/ICR in a physician office-MD must be in the suite

Required Program Components for CR (Note: ICR Programs are designated through the NCD process and program requirements are different and will not be covered here in the interest of space)

- a. Qualifying diagnoses remain the same: AMI within 12 mos, stable angina pectoris, heart valve repair/replacement, PTCA or coronary stenting, heart or heart-lung transplant
- b. Physician prescribed exercise
- c. Cardiac risk factor modification (including individualized education, counseling, and behavior intervention)
- d. Psychosocial assessment
- e. Outcomes assessment
- f. Individualized Treatment Plan (ITP) that is a written plan, established, reviewed, and signed by an MD every 30 days that includes the individual's diagnosis, type, amount, frequency, and duration of services, as well as goals for the individual under the treatment plan (Note: there is an example of an ITP for CR posted in the members only section of our website)
- g. Pts must participate in **aerobic exercise every day** (not in every session if they participate in more than 1 session per day)
- h. Max 2 sessions/day for CR and 6 sessions/day for ICR
- i. If 1 session is provided in a day, duration must be minimum of 31 minutes (if 2 sessions are provided in a day, 1st session must be 60 minutes and the 2nd session at least 31 minutes in duration)
- j. Pts must receive minimum of 1 session per week and are allowed up to 36 weeks to complete 36 sessions

Coding and Billing

- a. Revenue code for CR/ICR is 0943
- b. Two CPT/HCPCS codes remain for CR and definitions are unchanged (93798 and 93797)
- c. Two new codes are available for ICR (G0422 and G0423)
- d. All preceding codes are within APC (Ambulatory Patient Classification) 0095
- e. Payment for CR/ICR codes are equivalent! (Approx \$38.36 for hospital based programs)

Statutory Requirements for Pulmonary Rehabilitation

MD Supervision

- a. Responsible physician must have expertise in the management of individuals with respiratory pathophysiology
- b. MD must be licensed to practice medicine in the state where the program is located
- c. MD must have cardiopulmonary training and/or certification including basic life support
- d. MD must be “substantially” involved in directing the progress of the individual in the program

Reimbursement Update.....continued

- e. PR must be under the direct supervision of an MD (not an NP/P/CNS)
- f. Supervising MD must be immediately available and accessible for medical consultations and medical emergencies at all times services are being furnished
- g. Medical Director is responsible for the program and should be aware of each patient's progress through the program
- h. For PR in hospital or on campus department MD supervision is presumed
- i. For PR in outpatient locations off campus –supervising physician must be in the provider based department
- J. For PR in physician office –MD must be in the suite

Required Program Components for PR

- a. Qualifying diagnoses-moderate, severe or very severe COPD using GOLD classification. Non-COPD population (interstitial lung disease, CF ,restrictive lung disease) will continue to be covered when specifically authorized by MAC via current LCD
- b. Physician prescribed exercise
- c. Education or training-must be closely and clearly related to individual's care and treatment tailored to individual's needs (includes info on respiratory problem management ,counseling if applicable, and assist in achievement of individual goals towards independence in ADL's and improved quality of life
- d. Psychosocial assessment
- e. Outcomes assessment
- f. Individualized treatment plan (ITP) that is a written plan established , reviewed and signed by an MD every 30 days and includes the individual's diagnosis, type, amount, frequency and duration of the services , as well as the goals for the individuals under the treatment plan. The ITP must be reviewed and signed by the Medical Director **prior to the start of PR.**
- g. Pts must participate in **aerobic exercise in every one hour session** (if they participate in 2 sessions in one day aerobic exercise must be evident in each session)
- h. Max 2 sessions/day
- i. If one session is provided in a day, duration must be a minimum of 31 minutes (if 2 sessions are provided in a day:
 - 1st must be 60 minutes **with aerobic exercise** and the 2nd session at least 31 minutes in duration **with aerobic exercise**
- j. No restriction on the number of days per week a patient can attend PR program. No calendar restriction on length of PR program. Up to 36 sessions authorized based on medical necessity. Additional 36 sessions at local MAC discretion

Coding and Billing

- a. Revenue Code is 9048
- b. New , bundled G code for COPD patients, G0424 “pulmonary rehabilitation” includes exercise (with monitoring) per hour/per session. Additional services that are integral to PR patients such as program patient assessment, etc, cannot be separately billed. Physical therapists may no longer bill 97000 series for PR
- c. For Non-COPD patients must use previous payment methodology (G0237-39). PT may continue to bill as previously done.
- d. Payment for PR is approximately \$50.46 per session
- e. Medicare Form 700/701 is not needed
- f. Physician services not typically received by all patients to acutely provide medication via MDI or aerosol (CPT 94640) would be billed by the MD
- g. Patients who receive PFT's in a PFT lab not as part of the PR program would be billed separately

MAC Update from Wayne Reynolds: The MAC Committee is awaiting results of a yet to be held meeting of the Health Policy & Reimbursement Committee's multi society designees and Dr. Haug, the Medical Director of the J14 MAC. Once that happens, our MAC committee will attempt to clarify anything not covered in that meeting. In the meantime, please post any questions you may have on the MACVPR website's FORUM and we will try to answer them!

And lastly, remember to remain calm!

Co-President's Message.....continued

Initiative 1: Increase the financial viability, visibility, and awareness of MACVPR

Initiative 2: Enhance and support the quality of CR and PR services

Initiative 3: Enhance and support MACVPR membership benefits

Initiative 4: Increase MACVPR membership

Initiative 5: Support the sustainability and financial viability of MACVPR

At our 2/25/10 Executive Committee meeting, we will begin to focus on the specific strategies for each of these initiatives but we also need the input of the collective general membership-YOU. In the not too distant future, you will receive a short survey via email seeking your input as well. We welcome and need your thoughts and opinions about MACVPR so we can be sure to move our organization forward and be in step with you. Please take the time to complete the survey and help us help the MACVPR.

It's a dynamic and challenging time for our specialties, our programs, and the MACVPR and we are looking forward to the challenge and thank you for the opportunity to lead the organization.

Together, We Can Help To Prevent The Diabetes Epidemic: Our First Step Starts With The Newly Released ADA Guidelines

By Deborah Krivitsky M.S., R.D, LDN



“Educating patients regarding appropriate glycemic targets increases the percentage of patients achieving A₁C target levels, as patients must take an active role in their own care.”



It should come as no surprise that diabetes is reaching epidemic proportions in our country. According to the National Diabetes Clearing House, in 2007, nearly 24 million Americans have diabetes. In the US there are nearly 1.6 million cases of newly diagnosed diabetes annually. These numbers are staggering, but they don't tell the whole story. It is estimated that one fourth of Americans with diabetes are undiagnosed.

In 2009, the ADA released a new set of clinical guidelines for screening and diagnosing diabetes. In part, this was due to the standardization of Hemoglobin A₁C assays. A₁C is now recognized as a valid diagnostic tool for diabetes screening. The advantages of this technique are: that it does not require fasting, there are less day to day changes during periods of stress and illness, and a greater pre-analytical stability. Caveats, however, when using the A₁C as a diagnostic tool is that it does not apply uniformly to all ethnic groups and races as well as certain medical conditions such as hemoglobinopathies, abnormal red blood cell turnover, anemia, and pregnancy. The standard glucose criteria are indicated in these situations. Some other disadvantages of using the A₁C are cost and lack of availability in parts of the world. As A₁C use becomes more commonplace as a screening/diagnostic tool, patients will need to become familiar with the significance of values and target goals.

Diabetes is defined as an A₁C level equal or greater than 6.5%. The current guideline defines an A₁C range of 5.7% to 6.4% as pre-diabetic. Pre-diabetes is now a recognized diagnostic term. Screening criteria encompasses asymptomatic as well as symptomatic individuals. The committee notes that individuals with an A₁C of less than 5.7%, but with other risk factors including obesity and family history fall into the high risk category. This provides a tremendous opportunity for counseling and education regarding lifestyle changes to prevent progression to pre-diabetes or diabetes.

The guideline outlines criteria for diabetes screening in asymptomatic adults. Testing should be considered for all adults who are overweight (BMI >25) with additional risk factors including:

- Physical inactivity
- First degree relative with diabetes
- Member of high risk ethnic population (African American, Latino, Native American etc)
- Delivery of baby weighing 9 pounds or more or history of gestational diabetes
- Hypertension (B/P >140/90) or on therapy for HTN
- HDL-C less than 35mg/dl and/or Triglycerides greater than 250mg/dl
- Women with Polycystic Ovarian Syndrome
- IGF or IGT in previous testing
- History of CVD

Women with gestational diabetes should be screened at 6-12 weeks post partum and followed with subsequent screening to detect pre-diabetes or diabetes.

Education and counseling should be provided to individuals in the high risk group (pre-diabetes, obesity, family history etc.) and should include the following recommendations:

- Weight loss of 5-10% body weight
- At least 150 minutes of moderately intense exercise
- Follow up counseling to ensure continued compliance with recommendations

Studies have shown the benefits of lifestyle intervention and the use of pharmacologic agents (i.e. metformin) in reducing the conversion to type 2 diabetes.

Self-management as it relates to type 1 diabetes includes:

- Glucose monitoring with the goal of improving A₁C results of those 25 years and younger
- A₁C testing every three months and more often in some patients

Stunningly, only 12.2% of those with diabetes achieve all treatment goals:

- Controlling blood pressure <130/80 mmHg
- Achieving an A₁C < 7%
- Total cholesterol <200 mg/dl
- LDL-C <100 or < 70 depending on risk profile

It is easy to understand why there is a need to develop more effective tools and techniques to help patients reduce their risks of developing diabetes, as well as preventing the possible complications that occur with diabetes. Glycemic goals in adults with diabetes include achieving an A₁C below or around 7%. Lowering the A₁C has been shown to reduce microvascular and neuropathic complications of both type 1 and type 2 diabetes, for non-pregnant individuals. Tight glycemic control in both types of diabetes showed no reduction in CVD outcomes. Long term follow up of the DCCT and UK Prospective Diabetes Study suggest that achieving A₁C below or around 7% in the years shortly after diagnosis is made, is associated with reduction in risk of macrovascular disease. The guidelines recommend achieving an A₁C < 7% for macrovascular disease reduction. For those patients who have a short duration of diabetes, long life expectancy and no significant CVD, A₁C goals may even be lower. Those patients, however, who have a history of severe hypoglycemia, limited life expectancy, advanced microvascular or macrovascular complications, and comorbid conditions and those with longstanding diabetes, less stringent A₁C goals may be more appropriate.

The new guidelines question the benefit of tight glycemic control in critically ill patients in a hospital

The Newly Released ADA Guidelines...continued

setting. As the results from recent trials such as the NICE-SUGAR study, a multicenter, multinational randomized control trial, show no significant decrease in mortality and mortality risk with intensive glycemic control. The caution when using intensive control is the risk of hypoglycemia. The authors suggest that the benefit of tight glycemic control can only be applied to those admitted to the surgical ICU.

Changes in the recommendations include criteria for the use of ASA as a primary prevention measure. New guidelines state that not every diabetic needs to be on aspirin therapy. In lower risk patients, aspirin has a small but not statistically significant effect. ASA therapy as a primary prevention strategy should be used in those with diabetes who are at increased risk for cardiovascular disease. These include men who are older than 50 years old and women who are older than 60 years of age and who have one at least one additional major risk factor.

The chronic care model (CCM) includes five core elements for the provision of optimal care. Collaborative multidisciplinary teams provide the best care to all patients. An important part of the recommendations was the outline of a standardized means for identifying at risk patients and stressing the importance of developing individualized treatment plans. When adopting sustainable lifestyle changes, there is no "one size fits all" approach. Optimal care is provided with the input from a multidisciplinary team that includes, but is not limited to physicians, nurses, dietitian, pharmacists and mental health professionals with a professional interest as well as specialty in treating those with diabetes. Educating patients regarding appropriate glycemic targets increases the percentage of patients achieving A₁C target levels, as patients must take an active role in their own care. Strategies for improving diabetes care have resulted in improved process measures such as measurement of A₁C levels, lipid levels and blood pressure and include a delivery of diabetes self-management and education, adoption of practice guidelines that are readily available at the point of service, and the use of checklists that mirror the guidelines and serve to improve adherence to the standards of care. System changes that include pop up reminders to health care professionals and patients regarding A₁C testing, scheduled visits, planned diabetes visits and clustering of dedicated diabetes visits devoted to educate, record data, and improve adherence to standards of care. Data collected should be used to audit and provide feedback of process and outcome data to providers. Standard delivery of care includes all staff in their initiatives, redesign of delivery system, individualized education and treatment goals. This requires an organized, and coordinated health care team.

As a registered dietitian, I was very pleased to see the identification of the significance of Medical Nutrition Therapy (MNT) and the recognition of the value of MNT, which is most effective when provided by a Registered Dietitian. Registered Dietitians provide tremendous input and are valuable members of the health care team. We are the skilled, licensed professionals who are best suited to provide nutrition education that is personalized and is based on current scientific research. MNT is very complex, particularly for diabetics. An individualized approach to treatment is crucial in order to promote sustainability of dietary habits that lead to reaching A₁C goals. The ADA guidelines are in keeping with the evidenced based guidelines for diabetes published by the American Dietetic Association. Reimbursement for MNT for diabetes is now available for patients. Hopefully, this will increase availability of nutrition education and counseling to patients, as MNT is a critical cornerstone of therapy. Together, as a team, we can use the new guidelines to screen, diagnose, and educate patients. As we promote healthier habits, we can reduce the incidence and complications that arise from this potentially life threatening disease.

For more information and a review of the new guidelines please refer to:

Diabetes Care. December 29, 2009; January 2010 Supplement

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4. Nathan D.M, Kuenen J, Borg R, Zheng H, Schoenfeld D, Heine R.J. Translating the A1C Assay into Estimated Average Glucose Values. Diabetes Care 2008; 31(8):1473-8.
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Certification

2010 brings many new changes and challenges to the world of Cardiac and Pulmonary Rehab. Among those being, the new AACVPR Program Certification and Recertification process. As many of you know, the past application submission process and dates for program certification and recertification have changed so please take note.

The entire process will now be done online. Per the AACVPR website, Cardiac and Pulmonary Pre-application Preparation Packages are currently available in pdf online. **As of March 1, 2010, the launch date of the AACVPR Certification Center, the online applications will be available with applications due May 1, 2010.**

AACVPR states that they are committed to providing a simpler, easier process for applying for AACVPR Program Certification and Recertification. They indicate that the application should take less time to complete and that their application review and notification should be performed quicker. The AACVPR Certification Timeline lists July 1, 2010 as the date that the review of all applications will be completed. In August 2010, the Board of Directors will review and approve recommendations made by the National Program Certification Committee. Programs should be notified of their status by late August to early September 2010.

It is recommended that you **frequently check the AACVPR website, www.aacvpr.org/certification**, for any updated information and be aware that the time-line is subject to change. The AACVPR website provides a list of resources that are useful and necessary. It also provides samples of tabs and a directory of certified programs. Our MACVPR website, www.macvpr.org, also provides general information and the MA programs that are certified. To further assist you, we are planning a MACVPR half day May meeting that should address these changes in a networking/ workshop forum. Remember that the MACVPR forum is a helpful tool to network with others for assistance as well.

Best wishes to all and especially to those programs applying for certification and recertification by May 1st. Please let me know if your program is applying this year and if we can be of any assistance as you work towards this achievement of high quality care, excellence, and national recognition.

Esther Burchinal, MS, CES, RCEP
Emerson Hospital Cardiac Rehab Program
Certification Chair

esther@macvpr.org

“The AACVPR website provides a list of resources that are useful and necessary. It also provides samples of tabs and a directory of certified programs.”

Letter from the Editor

I was feeling a bit whimsical this month and decided to change the color scheme of the newsletter a bit to reflect Valentine's Day — hope you like it!!

I was pleased to see that a few of our members responded to our request at the January Half-Day Meeting to write clinical articles sometime in the future. This really is a great way to get involved with the organization. Please let me know when you will have time to get something completed.

Also, keep in mind if you are not the kind of person to actually “pen” an article yourself — maybe you know of someone in your organization where you work that is willing to share their expertise on a subject. It doesn't even have to be someone in your rehab department, maybe a physician or pharmacist that you work with. Keep your mind open to possibilities. Unfortunately, without your help we tend to always pull from the resources on the EC but we can only do that for so long.

This newsletter we are featuring an article submitted by Debbie Krivitsky, It is a detailed summary of the new ADA guidelines on diabetes. Pam Ressler has also provided us with a wonderful new “tool” to help deal with our patient's emotional issues, called journaling for health. We appreciate both their time and talents.

Lynne MacDonald, PT
Milton Hospital Cardiac Rehab
Newsletter Editor
newslettereditor@macvpr



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 AACVPR.

Membership Committee

Greetings from membership! Welcome to our new members and thanks to those of you who recently renewed your membership. We are currently 120 members who are professionals in cardiac and pulmonary rehab as outlined below.

A reminder of the benefits of membership for \$75 dollars for 2 years:

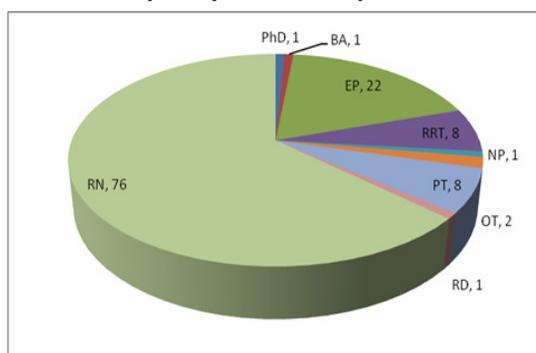
- ♥ 3 meetings per year: 2 at no charge, one at a reduced rate
- ♥ Topics directly relating to Cardiac and Pulmonary Rehab
- ♥ Timely updates on the local and national level relating to legislation, reimbursement and certification
- ♥ Tri-annual newsletter
- ♥ Opportunity for networking on an on-line networking forum

Thanks to all of you who introduced yourselves to me at the last meeting. I look forward to working with you to increase our membership in 2010. Please feel free to email me with questions or ideas to expand our membership. Remember to check page 12 to see if you need to renew your membership!!

Melessa Ashworth, RN, BSN
Falmouth Hospital Cardiac Rehab
membership@macvpr.org

A multi-disciplinary membership!

PhD – 1
OT - 2
BA – 1
RN - 76
EP – 22
RD - 1
RRT – 8
PT - 8
NP - 1



Treasurer's Report

Financially as an organization we have continued to do well which is in keeping with our **Co-President's Initiative 5: Support the sustainability and financial viability of MACVPR**. With the many changes that 2010 has brought, it is essential for the MACVPR to continue provide top quality speakers from "national" to keep our members current on national information that effects all of our programs. This of course requires that we have the finances to do so.

Sponsorship of our meetings and this newsletter continues to be critical to offset our expenses, provide up-to-date and informative meetings, and keep our membership and meeting fees low. If you have any ideas for sponsors please forward the information to Ann at admin@macvpr.org.

Current balances as of February 6, 2010:

| | |
|----------------------------------|-------------|
| Citizen's Bank checking: | \$7,097.05 |
| Citizen's Bank Money Market fund | \$2,626.70 |
| CD @1.75%, maturity date 4/7/10 | \$2,158.55 |
| Total | \$11,882.30 |

Susan Carrigan, BSN, RN C
UMass Memorial Med Ctr., Cardiac Rehab
treasurer@macvpr.org



Welcome New Members

| | | |
|-----------------------------------|----------------------------|----|
| Kristen Almechatt, BFA | Brigham & Women's Hospital | MA |
| Sherri-Lee Bentley, MS | Sturdy Memorial Hospital | MA |
| Robert Berry, MS,RCEP | Baystate Medical Center | MA |
| Brenda Ferguson, RN,BSN,CCRN | Health Alliance | MA |
| Esther Moverman, RRT,RCP,AC-C,TTS | Monadnock Comm. Hosp | NH |
| Deirdre Proudman, RN,BSN,CCRN | Lowell General Hospital | MA |
| Jane Schweizer, RRT | North Shore Medical Center | MA |



“Mr. Berry very generously shared a portion of his ITP and his solution to the initial, 30, 60, 90 day plan that now requires physician authorization to comply with the new Medicare rules. This can be found in the member’s only section of our MACVPR web site”

Education Committee

Our January 14th meeting was a great success! We had approximately 70 members and several nonmembers attend our Half Day Meeting entitled **2010 Final Medicare Rules for Cardiovascular and Pulmonary Rehabilitation: Tips and Strategies to Comply with the New Regulations**. Robert Berry, MS, RCEP, FAACVPR our MAC Committee Liaison and manager of the Cardiovascular Rehabilitation Program at Baystate Healthcare in Springfield MA updated us on the Cardiac Rehabilitation issues and Wayne Reynolds, RN, AACVPR-J14 MAC Committee Chair, and Coordinator of the Cardiac and Pulmonary Rehabilitation Program at Signature Healthcare, Brockton Hospital in Brockton, MA updated us on the Pulmonary rules and regulations. These sessions were followed up with a panel discussion which included Mr. Berry and Mr. Reynolds as well as past co-presidents Kathy Bowers, MEd, RNC, BSN and Ann Marie Sadlowski, BSN. This format proved to be very successful and helped to answer many of the questions our members posed to this expert group. As a follow up to this meeting Mr. Berry very generously shared a portion of his ITP (individual treatment plan) and his solution to the initial, 30, 60, 90 day plan that now requires physician authorization to comply with the new Medicare rules. This can be found in the member’s only section of our MACVPR web site macvpr.org.

As we begin the New Year as co-education chairs we invite you to share your thoughts and suggestions with us. In the next few weeks we will be coordinating our efforts with Esther Burchinal, MS, RCEP, CES our Certification Chair to provide you with information on the AACVPR National Certification process as well as readdressing the New Medicare Rules and Regulations. With the success of our last meeting we will incorporate the formal and informal networking that allowed so many to walk away with solid answers to their most important questions and concerns, into our upcoming Half-Day Meeting on May 11th.

Additional goals for the Education Committee include program planning for our October Full Day Meeting which we are hoping to combine with our New England Symposium. We are currently trying to secure a central location and optimal date. This conference will include keynote speakers, key topics for keeping up to date with the clinical issues and national trends, a poster presentation session for which members will be invited to submit their abstracts, networking opportunities and more. We are putting the planning committee together at this time and if you feel you can contribute contact one of our committee members

The education committee is eager to play an integral role with ramping up educational offerings for our website. I will need committee members to help with innovative ideas and strategies for meeting the ongoing needs of our members. One of our thoughts, spearheaded by Ginny Dow BS, RN, is a program on

How to Run a Mock Code. Our thought at this time is to have a different scenario showcased on a quarterly basis for review with your program staff or your own personal development. We are actively seeking members with the clinical knowledge of emergency procedures and protocols as well as members who have working knowledge in informatics to assist with this endeavor. Consider joining the Education Committee as this will be a fun way to get involved with your organization, keep updated on hot topics, network with your peers and contribute to your own professional growth.

We look forward to exciting changes ahead.

Education Committee Co-Chairs

Deborah Sullivan, MS, APRN, BC

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Eileen Milaszewski, RN, BS

Education Committee Members

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MACVPR Forum Update

Don't forget

to utilize the MACVPR On-Line Forum to get your questions answered. At the January Half-Day Meeting an announcement was made to utilize the Forum for any additional questions pertaining to the new Medicare regs. Bob Berry has graciously answered questions at length and even included references to help provide additional information. Some of the topics discussed were:

- ♥ Tools to measure depression and/or anxiety
- ♥ ITP Summary — how is initial aerobic exercise determined
- ♥ How accurate are 6 Minute Walk Tests
- ♥ Billing requirements for the second hour of CR
- ♥ Writing measurable goals on ITP
- ♥ Intensive CR
- ♥ Coumadin tracking

If you haven't been on before...take a few minutes to get acquainted with the layout. Either select “Active Topics” in the top right or go into “Testing Forums” to see older topics. I think you will find your time well spent.

If you have any difficulties contact Ann Stone @ admin@macvpr.org.



AACVPR Updates

Day On The Hill March 3-4, 2010

Please join AACVPR/MACVPR as we make our presence known at our nation's capital. As leaders, your continued involvement in this annual AACVPR event will truly help build our strength! Our Co-Presidents already have meetings scheduled with Senator John Kerry and their US House Reps. We would love for you to join us—please email admin@macvpr.org if you would like to join the MACVPR group traveling to Washington, DC

If you are unable to join us in DC, we still need your input....

AACVPR has identified issues that we will focus on when we meet with the legislators. In order to adequately represent your concerns, we would appreciate hearing from you, our MACVPR Members, about YOUR specific experiences with these issues. Please refer to the e-mail that was sent to you on Friday Feb 5th for specifics and respond back to us.

NEW FOR 2010 – AACVPR is offering a one-day, power-packed educational event:

“Program Leadership In the New Era” March 5, 2010

This program is geared toward both program and medical directors and includes topics such as:

2010 Medicare Cardiac and Pulmonary Rehabilitation Regulations: What is Said and What it Means

Presented by: Karen Lui, RN, MS, FAACVPR

Screening and Enrollment

Presented by: Richard A. Josephson, MS, MD FACC, FAHA, FACP, FAACVPR

Cardiac Breakout: A New Cardiac Rehabilitation Recipe: An Opportunity to Deliver a Gourmet Service

Presented by: Larry F. Hamm, PhD, FAACVPR and

Karen Lui, RN, MS, FAACVPR

Pulmonary Breakout: Translating Pulmonary Rehabilitation Coverage Changes into Daily Operations and Opportunities

Presented by: Chris Garvey, FNP, MSN, MPA, FAACVPR

Practical Implementation of Psychosocial Measurement: Utilizing the Results

Presented by: Joel Hughes, PhD

Update on Performance Measures in Rehabilitation: Challenges, and Opportunities

Presented by: Randal J. Thomas, MD, FAACVPR

Managing Your Program's Fiscal Strength: What you need to know, what you need to do

Presented by: Murray Low, EdD, FAACVPR

If you have any questions on DOTH or the Program Leadership In the New Era conference, please contact the AACVPR National Office at (312) 321-5146

AACVPR Webinars

Management of Hyperglycemia for Patients with Heart Disease:

How Low Should We Go?

Feb. 16, 2010 11 AM ET

Presented by: Mary Korytkowski, MD

Therapeutic Options for the Patient with Refractory Hyperlipidemia

March 30, 2010

Presented by: Carl E. Orringer, MD

Visit www.aacvpr.org for more information on all of these upcoming national events.

AACVPR 25th Annual Meeting

A Look to the Past A Road to the Future

Milwaukee, Wisconsin

Oct. 7-9, 2010

Midwest Airlines Center



A regular column designed to help you better understand your patients' needs and promote self healing during rehabilitation and

"...expressing emotions by journaling for health appears to protect the body against damaging internal stress and supports a healthy immune system"

Connections: Mind/Body/Spirit

By Pamela Katz Ressler, RN, BSN, HN-BC

Anger is a universal human emotion. In its helpful form, it can propel us forward, motivate us, or create a release from tension. In its unhealthy form, it can isolate us, increase stress hormones, decrease our immune system, break down communication, exacerbate medical conditions, increase symptoms of depression, and make it more difficult to function in the world.

Individuals living with chronic illness, as well as their families, often find themselves struggling with the emotion of anger. While it may be appropriate to refer individuals or their family members for mental health consultation for assistance in working with their anger; there are also holistic strategies that can be integrated into a care plan to encourage patients to work with their anger to promote overall healing and wellbeing.

Meditation, music therapy, yoga, and journaling are all holistic strategies that can be incorporated into a plan of care for anger management. In this column we will focus on the tool of journaling for health for anger management.

You may be familiar with the use of traditional journaling -- writing about your thoughts, ideas, dreams or insights and the reading over what you have written to help you gain new understanding or to chronicle a time in your life. Traditional journaling produces a **product**, some type of record to examine or to share with others. In contrast, journaling for health is a **process** that does not produce a lasting product. The written product in journaling for health is immediately destroyed without rereading. This type of journaling was first proposed and researched by Dr. James Pennebaker at the University of Texas. In his research, Dr. Pennebaker and his colleagues have observed that people who engage in journaling for health report less negativity, and decreased depressive symptoms. Additionally, expressing emotions by journaling for health appears to protect the body against damaging internal stress and supports a healthy immune system.

Here are the basic steps to journaling for health:

1. Find a place where you will not be disturbed for at least 15-20 minutes.
2. Choose some sort of writing material that you will not want to keep (this is important!) -- choose scrap paper, paper bags, paper towels, even a roll of toilet paper!
3. Choose a writing implement -- pencil, chalk, pen, crayon, marker, etc.
4. Set a timer for 15-20 minutes
5. Begin writing about your anger or an event that caused an upsetting emotion. If words do not flow out, make marks, squiggles, or write swear words. Keep the anger or emotion flowing out onto the paper. Often you will begin writing and then write the same word or phrase over and over again. Your words and sentences do not need to make sense.
6. DO NOT censor or reread what you are writing, simply keep your writing instrument moving.
7. At the end of 15-20 minutes, stop writing. VERY IMPORTANT: Do not, under any circumstances, reread or save the "journal", rather immediately destroy it!

8. Be creative...shred it, burn it, tear it up into little pieces, or flush it (hence the writing on toilet paper suggestion). The therapeutic result is the letting go process or the release of anger that is difficult to express appropriately. It is the **PROCESS** and not the **PRODUCT** of journaling in this way that creates the healing benefits.

Try this for yourself, before you teach your patients. It is very cathartic after a really difficult day!

To learn more about this unique approach to journaling for health, you may want to take a look at these resources:

- <http://homepage.psy.utexas.edu/HomePage/Faculty/Pennebaker/Home2000/WritingandHealth.html>
- Pennebaker, J.W. Opening Up: The Healing Power of Expressing Emotions, 1997.
- Pennebaker, J.W. Writing to Heal: A Guided Journal for Recovering from Trauma and Emotional Upheaval, 2004.

Pamela Katz Ressler, RN, BSN, HN-BC is the founder and president of Stress Resources www.stressresources.com located in Concord, MA. Stress Resources specializes in stress management and holistic healthcare education and consultation for healthcare providers, organizations, and individuals. Pam is a frequent speaker to local, national, and international audiences on topics relating to stress management, resiliency strategies, therapeutic communication, and holistic healthcare. She is also an adjunct faculty member at the University of Massachusetts Boston, College of Nursing and Health Sciences, teaching courses in stress management for healthcare providers. Pam's new CD, Opening the Door to Meditation, was recently released and is available on www.stressresources.com

Remember to Celebrate....

Cardiac Rehab Week

Feb 14-20, 2010

Pulmonary Rehab Week

March 14-20, 2010

If you would like to share how your program celebrated we'd be happy to include it in the next newsletter!!



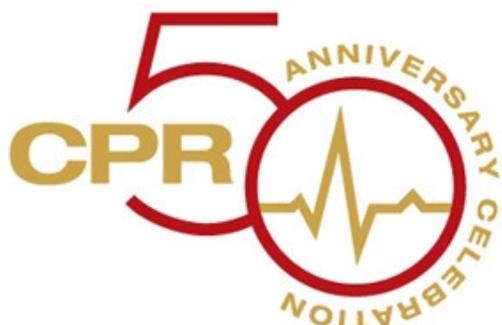
Clinical Resources



Speak Up for Heart Disease – Go Red Today!

Research has shown that **80% of heart attacks in women are preventable** if women make the right choices for their hearts, such as changing their eating habits, getting regular exercise and managing their cholesterol and blood pressure. **Choose to empower your patients** with the truth about heart disease. Go Red For Women® has tools to help you and your patients combat this important health risk including the most up to date American Heart Association evidence-based guidelines for cardiovascular disease in women and patient education materials. There are a lot of great tools for professionals through at <http://www.goredforwomen.org/professionals/>

Join the Go Red for Women movement to connect with colleagues and patients nationwide who share your commitment to prevent heart disease. Register now and see how you can help women live longer and stronger. **To join the Go Red movement, visit www.surveymonkey.com/s/GoRedMACVPR.**



Celebrate the 50th Anniversary of CPR!

In 1960, a group of resuscitation pioneers combined mouth-to-mouth breathing with chest compressions to create Cardiopulmonary Resuscitation, the lifesaving action we now call "CPR." This action, when provided immediately after a sudden cardiac arrest, can double – even triple – a victim's chance of survival.

Join us throughout this anniversary year as we celebrate CPR and the people whose lives it has saved over the last 50 years!

Save the Date

**Half Day Meeting
Tuesday, May 11, 2010
8:00 am to 12:00 pm**

**Keeping Current in 2010:
Focus Groups to Guide you
through the
Individualized Treatment Plan
and
Certification Process**

This meeting will provide any updates available as well as focus groups, networking forum and breakout sessions to provide you with the most up-to-date information to comply with the new Medicare regulations and the new AACVPR certification process.

**American Heart Association
20 Speen Street
Framingham, MA**

**Watch your emails for the
on-line registration link
to this important meeting coming soon**

PLEASE RENEW YOUR MEMBERSHIP

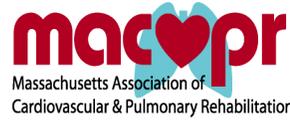
The following individual memberships have either expired since January 2010 or will expire before the next newsletter.

Please take a moment to renew now to avoid missing benefits such as announcements, updates and the "Members Only" section of the web site which includes the newsletter and on-line forum.

| | | |
|----------|------------|----------|
| Regina | Stevenson | 1/1/2010 |
| Debbie | Brissenden | 1/1/2010 |
| Diane | Graham | 1/1/2010 |
| Michelle | Kobbs | 1/1/2010 |
| Jody | Donahue | 1/1/2010 |
| Monica | Maldari | 4/1/2010 |
| Kathleen | McKool | 4/1/2010 |

Reminder:

The Executive Committee is still trying to fill the **President Elect** position for 2010. It is a great opportunity for you to get involved with your organization. Remember we always work together as a team, no one has to do it alone. Consider sharing the position. If you are interested in Co-President Elect but don't know of another person to share the job with, let us know and we can assist in finding someone. **Consider joining the EC...you won't regret it!!**



_____ Date
 Check# _____
 Cash
 Database
 Intranet
 Email
 Receipt
 Card

MEMBERSHIP APPLICATION

Or

Download application from www.macvpr.org

Name (with Credentials): _____

Mailing Address you want the card sent :

Home/Work (Please circle)

Work #: _____

Home #: _____

E mail: _____

Profession: _____

Institution: _____

Cardiac Pulmonary

New or Renewing Membership

\$75 for a Two year membership

(Begins on the first day of the month joined and ends two years from that date)

\$25 for a One Year student membership

(Students must be enrolled in a minimal of 12 credits per quarter and provide copy of schedule with membership application.)

How did you learn about the MACVPR?

Are you currently a member of the American Association of Cardiovascular and Pulmonary Rehab (AACVPR)?

Yes No

If you do not want your email and/or mailing address shared with the AACVPR please check here _____

Mail check or money order to:

MACVPR

C/O Ann Stone

PO Box 426 Woods Hole, MA 02543

admin@macvpr.org