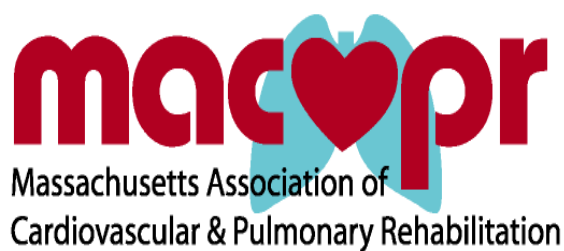


The mission of the MACVPR is to promote the practice of high standards of care in cardiovascular and pulmonary rehabilitation in Massachusetts



News

Winter 2011

Co-Presidents:

Esther Burchinal, MS, CES, RCEP

Judy Flannery, RN, BSN

President Elect:

Robert Berry, MS, RCEP

Immediate Past Presidents:

Priscilla Perruzzi, BA, RRT

Kate Traynor, RN, MS

Treasurer:

Susan Carrigan, BSN, RN C

Newsletter Editor:

Lynne MacDonald, PT

Education:

Ginny Dow, RN, BSN, BC

Deirdre Proudman, RN,BSN,CCRN

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

Happy New Year to everyone! So far 2011 has certainly been true to the phrase "in like a lion...". As the year roars in, these times continue to challenge us in the world of Cardiac and Pulmonary Rehabilitation and MACVPR, starting off with our plans for our January 27th General Meeting. We appreciate your understanding the need to postpone the meeting, and we look forward to seeing everyone on the rescheduled March 31st date. Hopefully, March will "go out like a lamb"!

With each New Year we have change at the MACVPR Executive Committee level. Judy Flannery and I (Esther Burchinal) are honored and excited to step into the Co-Presidential role. We appreciate this opportunity and feel privileged to follow in the footsteps of the very impressive 2010 MACVPR leaders as well as those of previous years. The 2010 Co-Presidents and Executive Committee (EC) members are a very dedicated, knowledgeable, and resourceful group of professionals that have invested a great deal of time, effort, and commitment to bring MACVPR to increasingly higher standards. For this and continually going above and beyond, we acknowledge and thank the following the 2010 EC members: Kate Traynor and Priscilla Perruzzi, Co-Presidents; Stephanie DiCenso, Immediate Past President; Susan Carrigan, Treasurer; Debbie Sullivan and Ginny Dow, Education Co-Chairs; Melessa Ashworth, Membership Chair; Lynne MacDonald, Newsletter Editor; and Ann Stone, Administrative Assistant. Stephanie and Debbie are leaving the EC after many years of service in various capacities and their contribution to MACVPR and the EC has been exceptional. We wish them our very best and greatly appreciate the high caliber of presidential leadership and educational programs, respectively, and more that they have provided. With change, new opportunities arise and so we welcome two new Executive Committee members to the 2011 EC. They are Robert Berry, Manager of Baystate Medical Center Cardiovascular Rehab, as President Elect and Deirdre Proudman, Manager of Lowell General Hospital Cardiac Rehab Center as Education Co-chair. Thank you Robert and Deirdre for stepping up! With their experience and expertise, the 2011 EC looks to support and provide another year of development, growth, and success for MACVPR.

Judy and I also appreciate all of you as members of this vital organization and hope to meet your needs and continue to lead MACVPR in the same successful manner as our predecessors. We welcome any thoughts, ideas, and suggestions so please feel free to contact us. We

value your input. Speaking of....

We are still in need of a Co-President-Elect so please consider this opportunity. "Inspire Yourself; Inspire Your Patients – Moving into the Decade of Change." This is the 2011 AACVPR motto that is applicable in so many ways. Another quote to contemplate is by Robert Lewis Stevenson, "Every heart that has beat strongly and cheerfully has left a hopeful impulse behind in the world, and bettered the tradition of mankind." Try substituting MACVPR or our Cardiac and Pulmonary Rehab patients and programs and perhaps you will strongly consider this position or joining any of the committees.

To support the mission of MACVPR, Judy and I have modeled our **2011 Strategic Plan** after AACVPR's plan. Our plan consists of three main goals outlined as follows:

Goal 1: Retain and increase membership to continue strengthening MACVPR. We hope to widen the professional distribution and offer incentives to join that should lead to increase in membership by 10%.

Goal 2: Enhance and support the quality of Cardiac and Pulmonary Rehab through MACVPR involvement. We hope to accomplish this by continuing and expanding our educational and networking opportunities via meetings, newsletters, presidential updates, and reformation of regional groups. We also hope to increase the website forum utilization and the number of nationally certified programs with the return of the state AACVPR liaison.

Goal 3: Improve the use and viability of Cardiac and Pulmonary Rehab through MACVPR involvement. In conjunction with Goal 2, we hope to accomplish Goal 3 by website improvement and visibility, regional group participation, increase in revenue by increasing sponsorship and with the recent increase in membership fees, and to continue with the Regional Symposium.

As noted in AACVPR's motto... "Moving forward into a decade of change", change is certain and with change comes challenge as well as opportunities for growth.

Nationally, we have seen challenge provide opportunity as noted by the increased Medicare payment rate for Cardiac Rehab (CR) and Pulmonary Rehab (PR) for calendar rate 2011.

Co-President's Address continued

This was due in large part to the efforts of state and national members and the advocacy effort of AACVPR. The potential for even a more accurate cost computation of CR with the possibility for higher Medicare payment is possible. That is why **it is essential that all CR program managers ensure that your institution's finance department has included CR in the non standard cost center in their annual Medicare Hospital Cost Report.** For those of you have already done this, thank you. For those that have not, please be on the look out for the MACVPR email Ann sent 2/16/11 and strongly consider following through with this important step as well as responding to the email. For more information, please see the "Reimbursement Update" in this newsletter.

Other **National** challenges and opportunities include:

- ♥ Day On The Hill (DOTH): March 2-3 in Washington D.C. The effort this year is focused on lobbying for a change in language to allow the use of nurse practitioners and physician assistants for the supervision of CR and PR. This change is vital for the critical access and rural hospitals which may not have physicians on site. Once we have a bill number that contains the language change we will need to be back in touch with our US Congressmen and Senators to ask them to sign on as co sponsors.
- ♥ National Program Certification and Re-certification applications were due by Feb. 28, 2011.
- ♥ Reinstatement of the state Certification Liaison position. Robert Berry, our President Elect, holds this position. More information on certification can be found in Robert's "Certification Update" in this newsletter.
- ♥ Pulmonary Rehab Week: March 13-19, 2011 (We hope that everyone celebrated a successful Cardiac Rehab Week Feb. 13-19th!)
- ♥ The 26th Annual AACVPR Meeting: Sept. 8-10, 2011 in Anaheim, CA.
- ♥ Check the AACVPR website for informative webinars scheduled throughout the year as well as updates.
- ♥ Note that for the "MAC orphan" programs under WPS there was a teleconference on Medicare CR programs on Feb. 24, 2011 from 11:00 am-12:30pm. Judy has been in contact with the MA programs under WPS about this teleconference. If you were not contacted and did not participate in the teleconference, please contact Judy for more information.

State challenges and opportunities include:

- ♥ **SNOW!** ☺
- ♥ Membership Meeting Dates: (See the "Education Update" for more information.)
 - Winter General Membership Meeting rescheduled for Thurs. March 31, 2011 at AHA.
 - Spring General Meeting: Tues. May 10, 2011 at AHA.
 - Fall Regional Symposium: Fri. Oct. 21, 2011. Location to be determined.

- ♥ Reminder that effective January 2011, the two year membership rate increased to \$100 so that we can continue to provide high quality educational programs and other MACVPR benefits during these financially challenging times. (See the "Membership Update" for more information about membership and ideas for involvement and strengthening our organization.)
- ♥ 2012 Co-President position open. Please contact Judy, me, or any EC member if you have any questions or interest.
- ♥ Reminder that it is time to renew or add your program to the MACVPR's Online Program Directory listing. Be on the lookout for notification from Ann so that we include your program in this valuable directory. Many programs use this directory to assist with referrals to your programs.
- ♥ Clinical Exercise Physiology (CEP) Licensure initiative support. The EC has provided a letter to Massachusetts Association of Clinical Exercise Physiologists (MACEP) in support of their efforts to pursue state CEP licensure. Currently, the bill has been filed in both the MA House and Senate, with sponsors in each, and is awaiting legislative committee review. Consider contacting your legislators in support of this bill.
- ♥ Sponsor support. If you know of any company, business, or organization that is interested in sponsoring our meetings, newsletter, or website, please contact Ann. The more financial support we have, the more we can provide for MACVPR and you.
- ♥ Look for our next presidential update by email in April.

In closing, Judy and I thank you all for the challenges and opportunities as we proceed forward as the MACVPR Co-presidents. We greatly appreciate the professionalism, expertise, and dedication of our Executive Committee; Administrative Assistant, Ann, and you the members. As we all weather, literally and figuratively, the challenges ahead, consider the opportunities that arise and "Inspire Yourself, Inspire Your Patients." Commit and contribute. Allow MACVPR and your commitment and involvement to be the means to help you, your program and patients, and MACVPR "rise above the storm" and not be buried under or pushed aside. If we can assist in any way, please let us know. We look forward to working with you throughout the year ahead.

Warm regards,

MACVPR Co-presidents,

president@macvpr.org

Esther Burchinal, MS, CES, RCEP
Emerson Hospital Cardiac Rehab

Judy Flannery, RN, BSN
Harrington Hospital
Cardiac Rehab

Reimbursement Update



This month's Update will focus on two key initiatives and the Top Ten Things you need to know about each one...

DOTH

1. Otherwise known as Day on the Hill, this is the annual lobbying effort in Washington DC coordinated by AACVPR. Check out the AACVPR Advocacy page for more info: <http://www.aacvpr.org/HealthPublicPolicy/AdvocacyDOTH/tabid/161/Default.aspx>
2. There are 4 MACVPR members participating in this year's DOTH scheduled for 3/2-3/3/11: Judy Flannery, Wayne Reynolds, Ann Stone, and Kate Traynor.
3. In total, there will be approx 70 attendees from 34 states representing their CR and/or PR Programs in Washington.
4. It is not too late to join the MACVPR delegation!
5. We have appointments to meet with representatives in both Sen. John Kerry's and Sen. Scott Brown's offices
6. We also have each made appointments to meet with our individual US Congressman
7. We will be asking our elected officials to support a "technical correction" or a change in one clause of the current legislation governing CR /PR. Presently the clause states that CR/PR are "MD supervised" services and CMS(Medicare) has interpreted that strictly and does not allow for non MD providers (such as NP or PA) to provide that supervision.
8. Further, we will ask our legislators to 'relax' the current requirement that CAH (Critical Access Hospitals) must have MDs onsite during CR sessions. These CAH facilities' Emergency Rooms are staffed often by NPs and PAs and thus the "onsite MD" requirement for CR is incongruous with that and a real barrier and management challenge for CR Programs in these CAH facilities.
9. Massachusetts had 3 CAH. One of these, Fairview Hospital (in Great Barrington, Mass) has a CR Program.
10. It is not too late to join the MACVPR delegation in Washington DC in March for this year's DOTH!

Cost Reporting

1. If you (or your program director) have already spoken to your hospital finance/revenue contact about this- THANK YOU !
2. Please be sure that your facility is continuing with their efforts to report CR as a non standard cost center
3. Here's a little history for those of you who are not sure about this "non standard cost reporting" issue... One year ago, all hospitals were asked to voluntarily include CR services in their "non standard cost center report".
4. This is a report that all finance departments submit on an annual basis to CMS (Medicare) to more closely examine the costs associated with the services in the report.
5. There is a very real possibility that if CMS looks at the CR data in these non standard cost center reports, they will see that the current reimbursement for CR services is too low. BUT we need to have a large number of hospitals reporting so they receive as much data as possible. This will be the best chance we have of CMS reconsidering our reimbursement and increasing it.
6. All you need to do is find out who is responsible for submitting these cost reports in your hospital (or ask your program director to do this). This person is usually someone in the finance/revenue department.
7. Simply ask the person if they are aware that CR services should be included in the non standard cost center report and if they are aware, have they been doing it!
8. Honestly, do not be afraid to speak with those finance people. They do not know as much about CR as you do and they really appreciate hearing from the "clinical" side as this helps them report the correct information about your program.
9. The reporting of CR services as a non standard cost center began in October 2009 and is ONGOING so please be sure to let them know that.
10. If you have questions, check out this link on the AACVPR website:

<http://www.aacvpr.org/HealthPublicPolicy/RegulatoryLegislativeResources/tabid/132/Default.aspx>

or email Kate Traynor (ktraynor@partners.org), Priscilla Perruzzi(PPerruzzi@partners.org), or

Wayne Reynolds (WReynolds@signature-healthcare.org)

***“Please
be sure that
your facility
is continuing
with their
efforts to
report CR as
non stan-
dard cost
center.”***

Update on Smoking Cessation: From Pharmacotherapies to Motivational Strategies

By Kathleen McKool, RN, MSN, CTTS-M

Massachusetts General Hospital CVD Prevention Center and Tobacco Treatment and Research Center

Smoking remains the leading cause of preventable death in the United States (1). Smoking cessation is one of the most cost effective treatments known to reduce a person's risk for the development of CHD or its recurrence, and the worsening of COPD (2, 3). Almost all other interventions for CHD and COPD are negated if a patient continues to smoke. Therefore, it is vitally important the patient quit smoking. However, when we enroll an active smoker into rehab we know we are going to be faced with our most difficult challenge- to get them to quit AND stay quit. In this article, you will learn ways to motivate your patient to make a quit attempt, the importance and use of pharmacotherapy to assist with quitting, strategies for relapse prevention, and resources to help you achieve this important goal.

How to Motivate Your Patient

Most patients know at some level that smoking is bad for them. However that is not to say they truly understand how smoking affects them physiologically (4). Cardiac patients will often say "my lungs are fine" inferring that other risk factors must be the problem. Patients with COPD don't generally experience a sudden life threatening illness. They more often experience a gradual decline and so manage to rationalize "one more day" of smoking, or worse, refuse to believe that quitting will make a difference in their health.

Most patients are aware of the dangers of nicotine and tars. What they do not appreciate is the harm caused by carbon monoxide and its displacement of oxygen. They are also unaware that smoking causes chronic inflammation that can lead to a chronically elevated WBC count. Smoking also causes endothelial injury and damages the lining of the lungs. It leads to platelet activation, clotting, and vasoconstriction. Discussing information like this in laymen's terms and in a nonjudgmental way can be both enlightening and motivating for patients.

Carbon Monoxide (CO) monitors, used in studies to validate smoking cessation, are effective as biofeedback tools to increase the motivation to quit. A CO monitor measures expired CO, and from this measure the device estimates the patient's carboxyhemoglobin (COHgb). CO monitors can be considered the "stethoscope" of smoking cessation (5). Patients generally understand that smoke inhalation can be harmful. This CO measurement or "number" puts it in objective terms for them. Simply sharing this information with the patient may start to create dissonance and thoughts that quitting really can help, even in the short term. It will also help you validate behavior change, because the patient's CO levels will normalize within 24 hours of quitting. [Note: This normalization of the CO may take longer in the COPD

patient because of air trapping and slower air exchange. Poorer exhalation may also lead to lower than expected initial CO levels. Also note that SpO2 readings are overestimated in an active smoker (6)].

A patient who has failed to quit smoking in the past may be even more resistant or reluctant to try again. Even patients who want to quit may erect defenses, because they are afraid they will fail once again. In order to motivate your patients, you must acknowledge and validate how difficult it is for them to quit. Feeling there is hope is necessary for them to try again to quit. A unique and valuable strategy to motivate your patient is to reframe those failures as "mini successes". But then be ready with new strategies and support to get them through their next quit attempt.

It is not enough that your patient wants to quit, has many good reasons for quitting, or had reasonable success quitting in the past. Your patient must reach a turning point—a sincere commitment to quitting that is more than 'lip service'. To make such a difficult commitment, your patient has to believe you are on their side, that you appreciate and understand how hard it is to give up smoking, and that you will be there for them. I make clear to my patients that commitment need not be 100%. It's sufficient to be 60% to 70% confident they can succeed. And to build their confidence, I offer my patients small steps as preparation to quitting. As an example, I might suggest a "trial 24-hour quit" with the patch, for instance, to give them some real experience with quitting and, at the same time, lessen their anxiety about giving up smoking. The bottom line then is to encourage your patient even as you acknowledge just how difficult is the task they're taking on.

Pharmacotherapy Options

Many patients are discouraged by the litany of side effects (or fears of side effects) from the various medications available for smoking cessation. Even worse, you may hear patients claim that medications didn't help with their cravings, causing them to fail. A major deterrent to the use of nicotine replacement therapy (NRT), such as nicotine patches, in this population is the fear that if they "slip" and have a cigarette while on NRT, they might suffer a heart attack. It is therefore critical that you have the most accurate and up to date information about the safest and most effective pharmacotherapy options available to assist them with quitting.

In 2008, the U.S. Department of Health and Human Services issued an updated Clinical Practice Guideline for Treating Tobacco Use and Dependence (7). This guideline identifies seven first-line medications (five nicotine and

"If you accept the position that nicotine is an addiction and smoking a chronic disease ,.....keeping patients on medication for a longer time period makes sense. ."



Update on Smoking Cessation...continued

two non-nicotine – bupropion and varenicline) to recommend for all patients attempting to quit smoking (with the exception of groups such as pregnant women and adolescents, where safety and efficacy is still being studied).

What the guidelines support, but is not yet reflected in drug inserts, is that for those who have failed monotherapy (using the patch alone, for example), combination therapy should be the next step. The guidelines also support the practice of having patients take the meds longer than the generally recommended treatment periods. If you accept the position that nicotine is an addiction and smoking a chronic disease (a concept promoted by the guidelines), keeping patients on medication for a longer time period makes sense. Consider the parallel case of a drug-dependent patient, who is never prescribed just three months of methadone treatment.

The table below lists the odds ratio of successfully quitting for first line treatments alone and in combination vs. placebo vs. the gold standard of the patch alone. Varenicline leads other monotherapies. However, combining a nicotine patch with short acting nicotine such as nicotine gum or lozenge is the most effective therapy available. Generally, when I discuss this latter option with patients, their eyes light up! Why? By combining the patch with short-acting NRT, the patient gains a new coping strategy to deal with breakthrough cravings instead of smoking. I often suggest that patients consider placing a piece of nicotine gum or lozenge on their bedside table to use as soon as they wake up. This gives them a strategy to cope with that early morning craving that is often the one they dread the most.

A final word about helping your patients choose the pharmacotherapy option that is best for them: The criterion for pharmacotherapy is the same as the one to select the best exercise equipment. The question to ask is: What are

you most likely to use? Personal preference, affordability, ease of use, and very often successful vicarious experiences (“My daughter quit smoking using Varenicline so I think I’d like to try that.”) all effect the patient’s choice. Remember: While it is your role to support their choice, you should also have other options in mind should problems arise.

Strategies to Prevent Relapse

You may all find a poignant message in the story one of my patients told me about how he relapsed and began to smoke again. He had gone to see his primary care physician for his first visit since his discharge after an MI. The PCP asked the patient if he was smoking. The patient said he hadn’t smoked since discharge. The doctor simply remarked that was good and said that was one less thing to worry about. This matter-of-fact response made my patient so distraught and angry that as soon as he left the office he bought himself a pack of cigarettes! Patients need to know that we understand and appreciate how very difficult it is to quit smoking.

Relapse prevention is the hottest topic in tobacco treatment research today. Theories for relapse abound (8). No treatment or combination of treatments has proved the secret to success. What we do know is that extending pharmacotherapy treatment, like continuing Varenicline for an additional 3 months if the patient has successfully quit, improves quit rates. Providing on-going support is another important piece of this puzzle. As with any addiction, moments occur when the temptation to start smoking again is excruciating. You need to encourage your patients to maintain vigilance for a full year after quitting. When you ask people who have relapsed how it is that they started smoking again, nearly all will tell you that they were convinced they could have “just one”. We need to address that looming danger and common misunderstanding early on. Having a plan for dealing with that little voice inside telling them that “one won’t hurt” is essential.

Medication	Odds ratio (95% C.I.) vs. PLACEBO	Odds ratio (95% C.I.) vs. NICOTINE PATCH
	Single agents	Single agents
Varenicline (Chantix)	3.1 (2.5-3.8)	1.6 (1.3-2.0)
Bupropion SR	2.0 (1.8-2.2)	1.0 (0.9-1.2)
Nicotine replacement therapy		
Nicotine Nasal Spray	2.3 (1.7-3.0)	1.2 (0.9-1.6)
High-Dose Nicotine Patch (> 25mg)	2.3 (1.7-3.0)	N/A
Nicotine Inhaler	2.1 (1.5-2.9)	1.1 (0.8-1.5)
Nicotine Patch	1.9 (1.7-2.2)	1.0 (reference)
Nicotine Gum	1.5 (1.2-1.7)	0.8 (0.6-1.0)
	Combination therapies	Combination therapies
Patch (> 14 weeks) + <i>ad lib</i> NRT (gum or spray)	3.6 (2.5-5.2)	1.9 (1.3-2.7)
Patch + Bupropion SR	2.5 (1.9-3.4)	1.3 (1.0-1.8)
Patch + Inhaler	2.2 (1.3-3.6)	N/A

Update on Smoking Cessation...continued



Another major contributor to relapse is living with a smoker. Access is everything. Using anecdotes can be helpful. So I ask my patients: When you go on a diet, would you sit in a bakery? In other words, remove the temptation. It is important to help your patient with a strategy to approach a loved one about making their home smoke-free, not smoking around them, and to not leave cigarettes out and visible. Be clear that it does not require them to ask the person to quit but to just be supportive of the patient's attempt to quit.

But of all the challenges to staying quit, it is letting go of the emotional attachment to smoking that is the most difficult. Patients wonder why they ever started smoking again after they had quit for so many years. The reason, I believe, is that they never said goodbye to their cigarettes. After all, how do you say good bye to your best friend? For the patient to succeed in the long term, he needs to understand that he is divorcing his cigarettes. This is not a separation, it is a divorce. Patients seem to relate well to this metaphor; because it is an acknowledgement that smoking was not always a negative for them. There were good times. But the relationship has gone sour, and it is time to form a new relationship. Healthy living can be that new relationship.

Resources

There are ample free or low cost resources available to help you help your patients quit smoking for life! The AHA has a No-Smoking Confidence Assessment and Tips Sheet and other handouts offering specific strategies for quitting. You can obtain free booklets to guide quitting through the Mass Clearinghouse. The cost of stop-smoking medications is no longer a deterrent for Mass Health patients as all are covered for a small copay of \$1-\$3. Quitworks, a state sponsored free phone counseling service, can be used as an ongoing support for your patients who are struggling.

It would also be good to have a smoking cessation champion in your program. This staff member can help your program stay up to date on new information for smoking cessation and formulate a protocol for counseling your active smokers and support recent quitters. This person can start by taking a basic online training available through U Mass Center for Tobacco Treatment. Please go to www.macvpr.org for links to this and the above resources.

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“For the patient to succeed in the long term, he needs to understand that he is divorcing his cigarettes.”

How do you currently assess a smoker's tobacco use?

Smokerlyzer®



The brand that treatment professionals use

A Smokerlyzer® measures carbon monoxide (CO) through a quick breath sample and provides bio-marker feedback about the smoker's personal smoking habit. It is the same type of feedback you get from a cholesterol or blood pressure test.

Could you imagine counseling a person about their cholesterol or blood pressure without an assessment test? Why should tobacco treatment be any different?

1. **Assess smoking level and personalize the dangerous effects of smoking**
2. **Monitor the smoker's progress and keep them coming back**
3. **Show the smoker positive test results immediately after quitting smoking**

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Membership News

Greeting MACVPR members.

Our current membership stands at 125 members. Although it remains steady, MACVPR is always looking for methods to attract new members. Some incentives we are considering:

- Our best recruiting tool is our meetings. I would like to be able to offer the opportunity to invite a non-member to a half day meeting to see what we are about. *Stay tuned.*
- Another project initiative to increase membership may be to offer an "Incentive Special." I would like to see more than 1 member of the same institution join. *Stay tuned.*
- Letters to Nursing Programs and Exercise Physiology Programs may also be beneficial to market new students. Although this has been done be-

fore, it has been a number of years. I will be distributing MACVPR membership applications to students at area hospitals.

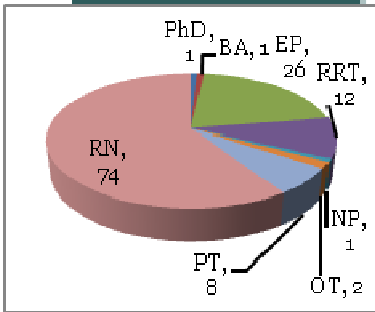
- Lastly, those of you with hospital intern programs; I am looking for a current member willing to interact directly with an intern to recruit for MACVPR.

I'm gathering a list of target programs that I can send letters out to market MACVPR. I will also be making myself more visible at the upcoming meetings to let those attending see just what MACVPR membership entails. As always I welcome any new ideas.

Thanks and stay warm!

Melessa

membership@macvpr.org



Membership Graph

Treasurer's Report

Current balances as of February 1, 2011:

Citizen's Bank checking:	\$8,437.36
Citizen's Bank Money Market fund	\$2,629.32
Total	\$11,066.68

- Directors and Officers Insurance premium of \$494.00 paid 1/20/11
- Putting together information and bank statements to give to accountant before May tax filing deadline.

Susan Carrigan, BSN, RN C

UMass Memorial Med Center Cardiac Rehab

treasurer@macvpr.org



The MACVPR Forum remains sorely underutilized!!!!

MACVPR Forum Update

Well, I don't want to "beat a dead horse" but..... The MACVPR forum remains sorely underutilized!!!!

Some recent topics posted:

- Do you have pulmonary Rehab support groups? What is the structure and response?
- What relaxation/stress management tools do you commonly use with your pulmonary rehab groups
- Do you close your programs due to snow?
- Does anyone have a telemetry monitoring system that interfaces with Meditech?
- Info on Cr Maintenance program: Days/Times of operation, patient charges, education??

Contact Ann Stone at admin@macvpr.org if you have any difficulty signing on. She is happy to help :)

Please sign on to the forum to check out the responses or post one of your own!!!

Tales from the Trenches

From Cardiac Rehab Coordinator to Running a Golf Tournament.....

As coordinator of Cardiac Rehab at Harrington Hospital for over 25 years I have worn many hats; person in charge, educator, counselor, function planner, hostess, cook, etc., but the strangest is co-chair of a golf tournament. Since I do not golf this is probably the most bizarre and farfetched. Like most of my roles over the years chairing a golf tournament is one I acquired without realizing how I really got involved-- it just happened. Being a person who can never say no – once I was asked to be co-chair I said OK and just went along with the flow. If I had only known what I was really getting into I should have run for the hills! I had been a member of the golf committee for many years but I had never had a major role and was mainly there for support since it was a fund raiser for our Cardiac Rehab program.

The Cardiac Rehab golf tournament had begun in 1983 after our current CEO had told me and our Cardiac Rehab maintenance members that funding for the program was in jeopardy and we should start looking for alternate funding. One of my co-workers was head of the EKG Dept. and an avid golfer along with many of our patients. He decided that a golf tournament would be a good fund raiser for the program and asked for my blessing. It sounded like a good idea and since he was going to be in charge of it I said it was a good start to raising some money for the program. The first tournament was held at a local golf course with 20-25 golfers, mostly cardiac rehab members and guests. I don't even remember how much money they raised but the Cardiac Rehab golf tournament was born. Over the years the tournament evolved into a major fund raising event every fall. It was usually sold out and raised \$5000-\$6000. It was now known as the Dr. Van Vooren Memorial Golf Tournament with many loyal followers. Dr. Van Vooren was the founder of Cardiac Rehab at Harrington Hospital and had passed away. Out of our love and respect for him we named the tournament in his memory.

In 2004 my co-worker, who had chaired it all these years, decided it was time for he and his wife to move to a warmer climate, Arizona. It was then he turned the whole golf tournament over to me! He also gave me all his paperwork, templates, list of golfers, list of supported and donors, etc. etc. It was now a major, well respected golf tournament; how was I and committee of seven going to run the whole tournament! The first thing I realized I could not do this alone I needed help and lots of it. I decided to look for a local service organization to co-sponsor the event with the hospital. Lucky for me one of my co-workers belonged to the local Rotary Club. He was a golfer, many of their members were golfers and they were looking for a fund raiser for their scholarship fund. So the partnership of Harrington Hospital and the Southbridge Rotary Club was born to co-sponsor the Dr. VanVooren Memorial Golf Tournament. So since 2005 I have co-chaired the golf tournament with 3 other co-chairs. My responsibilities are varied. I organize, book and plan all the meetings which start in April and end with the tournament the second week of September. I plan the agenda, book the meeting room, invite the attendees etc. I also send solicitation letters to local businesses and industries asking for donations. I then keep track of all donations and write the thank you letters. Any questions pertaining to golf specifically I defer to my co-chairs and committee. The whole event; pre-planning, invites, day of the tournament etc., is like planning a wedding and reception for 144 people!

The golfers golf for four hours then come off the course to a three course meal with raffles, prizes, and announcement of winners. Each golfer gets a goody bag at the beginning of the tournament filled with a variety of gifts; golf towel, hat, pen, golf balls, etc. During the meal each golfer gets a gift from the gift table of 144 prizes which includes gift certificates, golf clubs, golf balls, umbrellas, etc., etc. The best part of the tournament day for me is riding around the golf course to smooze and thank all the golfers for golfing and supporting our causes. Since the golf teams are made up of hospital board members, business CEO's, local business owners, hospital vendors, bank presidents, and Cardiac Rehab members, it is very important to thank all of them.

At the end of the day we have had a great day of golf, food and camaraderie and have raised over \$20,000!! The \$10,000 Cardiac Rehab receives allows me to purchase new equipment for our program, give scholarships to maintenance patients who can't afford the program, give a gas card for transportation to Cardiac Rehab, provide a \$1000 scholarship to a hospital employee & a variety of other things that support our Cardiac Rehab program.

There it is "From the Trenches" Cardiac Rehab coordinator to Golf Tournament Co-chairman.....

Judy Flannery RN, BSN

president@macvpr.org



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

M I N D F U L N E S S

Connections: Mind/Body/Spirit

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

Mindfulness...Mindfulness...Mindfulness. It seems that this word has been in the news constantly over the past few months. What is driving this new found interest in this ancient philosophy of being aware and attentive in the present moment as it is unfolding? Neuroimaging research. Evidence-based biomedical research has finally caught up to our observational, and albeit anecdotal, research that has long suggested a positive psychosocial and physical benefit to mindfulness training. In the June 2009 **Connections: Mind, Body and Spirit** column, I highlighted some mindfulness research looking at the cardiovascular and pulmonary benefits of mindfulness as a clinical intervention. In this column, I will focus on brain changes that are related to mindfulness training, as well as sharing tips for bringing mindfulness into our lives as caregivers.

Researchers at the Massachusetts General Hospital have suggested that there are not only cognitive changes in the brain through training in mindfulness, but also structural changes in the brain anatomy through mindfulness training. Changes in structure are important new insights into the role mindfulness may play in many health and rehabilitation interventions. Recent studies conducted by Dr. Sara Lazar and colleagues, based on MRI scans of participants' brains pre and post an 8-week Mindfulness Based Stress Reduction Program (**MBSR**), revealed structural changes, an increase of 1-3%, in the gray matter of the brain. These changes were most significant in the areas responsible for learning, memory and emotional regulation. Interestingly, some changes were also associated with a decrease in size of brain structure, most notably the amygdala. The amygdala plays a large role in the regulation of fear and hyper-vigilance. Research with mindfulness meditators has found that the structure of the amygdala is smaller in meditators than in non-meditators. Further research is needed to determine the causal relationship of these findings. Earlier studies have suggested an increase in brain activity/function in areas of the brain associated with positive emotion, optimism and focus.

This powerful scientific evidence suggests that we have much more control than we imagined in growing and changing our brain and emotions; so where do we start? I have included some simple tips for bringing mindfulness into your life. My suggestion for caregivers is try to incorporate at least one or two tips of mindfulness into your life on a daily basis before you suggest them to your patients. As caregivers, we need to understand and role model the difficulties and the benefits we can all receive in making simple but profound changes in our brains.

Simple Tips for Daily Mindfulness

1. Take 5 minutes before you leave the house in the morning to release any tension by doing gentle stretching.
2. When you get into your car, or are walking to your train or bus, concentrate on slowing your breath, and breathing from your belly.
3. Use red lights and stop signs as reminders to loosen your grip on the steering wheel and slow your breathing down. Allow your breath to settle in the belly, expanding the belly like a balloon on the inhale and allowing it to deflate on the exhale.
4. When you arrive at work, take a few moments to notice any tension in your muscles. Allow yourself time to stretch and deep breath as you walk into your workplace.
5. Use your breaks to truly relax rather than simply getting coffee or a snack. Try using your break to be by yourself, perhaps releasing muscle tension, taking a short walk, or simply closing your eyes for a few moments.
6. Choose to **S.T.O.P.** (**S**-stop; **T**-take a breath; **O**-observe your mind and body; **P**-proceed with your day) for 1-3 minutes every hour of the workday. Become aware of your breathing, allow your mind to settle and re-group.
7. Use everyday cues in your work environment as reminders to "center" yourself (e.g. entering a room, opening an e-mail message, sitting down at your desk, answering the phone, performing tasks).
8. At the end of the workday, try retracing today's activities, acknowledging and congratulating yourself for what you **have** accomplished. Make a list for tomorrow...you've done enough for today.
9. Pay attention to your walk to your car or other transportation. Practice mindfulness by noticing the environment, the air, any sounds, and concentrate on your breath. Spend a few moments in your car before you begin your commute home to deepen your breathing, and release any neck or shoulder tension. Take a moment to simply "BE". Like most of us, you are heading to your next full-time job...home.
10. When you arrive home, change out of work clothes. This simple act helps you make a smoother transition into your next role. If possible, make time to be by yourself for 5-10 minutes to be quiet and still.

Connections: Mind, body, Spiritcont'd

Some links to read more about research on mindfulness and the brain:

- Research Study: [Mindfulness practice leads to increases in regional brain gray matter density](http://www.nmr.mgh.harvard.edu/~lazar/Holzel_Pre.Post_MBSR.2010.pdf)
http://www.nmr.mgh.harvard.edu/~lazar/Holzel_Pre.Post_MBSR.2010.pdf
- Boston Globe – Brain Gain
http://www.boston.com/lifestyle/health/articles/2011/01/31/mindfulness_therapy_puts_the_focus_on_improving_the_quality_of_body_and_spirit/
- Newsweek – Can You Build a Better Brain?
<http://www.newsweek.com/2011/01/03/can-you-build-a-better-brain.html>
- New York Times – How Meditation May Change Your Brain
<http://well.blogs.nytimes.com/2011/01/28/how-meditation-may-change-the-brain/?src=me&ref=general>

As always, I love to hear comment and feedback from readers. What topics of mind/body/spirit would you be interested in exploring in future columns? Let me know at pressler@StressResources.com

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, holistic healthcare education, and health communication for healthcare providers, organizations, and individuals. Pam is a frequent speaker to local, national, and international audiences on topics relating to stress management, mindfulness, resiliency strategies, therapeutic communication, patient advocacy through social media, and holistic healthcare. She is an adjunct faculty member at the University of Massachusetts Boston, College of Nursing and Health Sciences, teaching courses in stress management for healthcare providers and serves on the board of directors of the Integrative Medicine Alliance. Pam's CD, *Opening the Door to Meditation*, featuring tools of relaxation and meditation is available on www.StressResources.com and www.amazon.com.

AACVPR Upcoming Webcasts

April 7, 2011 ***Trigger of Acute Cardiac Events***
Presented by Dr. Barry Franklin and Dr. Carl Lavie, Jr.

May 26, 2011 ***New Approaches to the Patient with Restrictive of Hypertensive Lung Disease***
Presented by Dr. Edwin Neil Schachter and Angela Binns-Lindsey

April/June 2011 ***Anti-Platelet Therapy***
Presented by Dr. Jeffrey Berger

How Did You Celebrate??

I would love to hear how your programs celebrated Cardiac & Pulmonary Rehab Weeks!!!! Please share photos and/or a short write up of your celebration and we will include it in the next newsletter. Send any information and pictures to me at newslettereditor@macvpr



Certification



To all who submitted applications for the 2011 cycle, congratulations on striving to achieve program excellence!!!!

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.

The 2010 AACVPR Program Certification cycle closed on February 28, 2011. If you are submitting an application for this cycle, please remember to check your AACVPR Program Certification Dashboard frequently to see if your application reviewer has requested additional information. Requests from the reviewer must be responded to within 48 hours. It is a good idea to make a binder of all the additional documentation that AACVPR might request to speed the response process. Questions regarding content of applications should be directed to members of the National Certification Committee who can be reached through the AACVPR office.

Key dates to remember:

- February 28, 2011 AACVPR Program Certifications were due
- March 1, 2011 Review of applications begins
- May 31, 2011 Review of applications completed
- August 31, 2011 Program notification

If you are planning on applying for AACVPR Program Certification during the 2011 cycle, NOW is the time to get started! Visit the AACVPR website to access valuable resources to assist you in this process. Can't find what you're looking for? Contact MACVPR Program Certification liaison, Robert Berry (robert.berry@bhs.org) or the AACVPR Program Certification National Call Center (312-321-5146 option 1) for additional assistance.

Robert Berry, MS, RCEP
Baystate Medical Center

Letter From the Editor

We have another informative edition of **MACVPR NEWS**. Many thanks to all that have contributed.

Kathleen McKool RN, MSN, CTTS-M has provided us with an extensive update on treatment approaches for smoking cessation, including much needed practical advice and strategies to motivate your patients to successfully quit smoking and stay quit!!

Once again, Pamela Katz Ressler, RN, BSN, HN-BC of Stress Resources has contributed another installment of our feature: **Connections: Mind/ Body/Spirit**. She is keeping us all updated on current research by writing a fabulous article on mindfulness including simple tips for daily mindfulness to practice ourselves before advising patients to utilize the techniques. I want to thank Pam for her continued support of MACVPR, by providing us with informative articles for each newsletter.

In our "Tales from the Trenches" column one of our new co-president's, Judy Flannery, has written a great summary on how she got started

and has continued to run an annual golf tournament to help support the Harrington Hospital Cardiac Rehab department.

Please feel free to e-mail me as I am always interested in ideas for clinical articles or developing a new regular feature in the newsletter. I need feedback and ideas in order to keep this newsletter vibrant and continue to be a helpful tool to you and your individual programs.

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



"...thank Pam for her continued support of MACVPR, by providing us with informative articles for each newsletter."

Education Committee

Co-Chairs:

Ginny Dow, RN, BSN, BC

Deirdre Proudman, RN,BSN,CCRN

Hello to MACVPR members!!

The 2011 year began with an exciting January General meeting planned which unfortunately, like many other events, had to be cancelled due to inclement weather. We were able to reschedule the speakers and the facility for March 31st, so hopefully the snowstorms will be behind us by then (but this is New England, so keep your fingers crossed!). The program planned for March 31st includes a speaker on Stress and the Workplace, a subject which is affecting many of our patients in these turbulent economic times. We also have a speaker on the new AHA CPR and resuscitation guidelines to give us some background on the changes and what to expect in your next CPR/ renewal. We also will leave time for networking which many members feel is a valuable part of our meetings. Some other good news is Deirdre Proudman RN, CCRN, from Lowell General Cardiac Rehab, has agreed to co-chair the education committee with me, so thank you Deirdre for agreeing to help the MACVPR. Deirdre has experience in planning seminars for Lowell General and has been on the education committee for MACVPR. Please send any ideas you may have for educational topics or speakers to the education co-chairs Ginny Dow or Deirdre Proudman. We welcome any members to join the education committee to help with program planning.

education_chair@macvpr.org

SAVE THE DATES

May 10, 2011
Half Day Meeting

◇
October 21,
2011

Fall N.E.
Symposium

Half Day Meeting Thursday, March 31st, 2011 Agenda

8:00 am - 8:30am

Registration

Coffee, tea and light breakfast refreshments

8:30 am - 9:00am

Welcome

Priscilla Perruzzi, BA, RRT & Kate Traynor, RN, MS
Immediate Co- Past Presidents

Co - President's Address

Esther Burchinal, MS, CES, RCEP
Judith Flannery, RN, BSN

9:00 am - 10:15am

Work, Stress, and Health: Patient Risk Identification and Implications for Patient Education

Nicky Champagne, Ed.D

University of Massachusetts Lowell

Department of Community Health and Sustainability

10:15am - 10:30am

Break - Please visit our sponsor-Cardiac Science

10:30am - 11:15am

Regional Networking:

ITP implementation to date ... or so far....."

MACVPR Co-Presidents

11:15am - 11:45am

Review of the new AHA 2010 Guidelines for CPR and ECC

Darlene Bourgeois, RN, CCRN, MSN

Lahey Clinic Medical Center

11:45am-12:00 Noon

Wrap- Up

American Heart Association

20 Speen Street - Framingham, MA 01701

Complimentary
meeting for MACVPR
members...
go to macvpr.org to
register

Congratulations!!

Deborah Sullivan MS, APRN, BC

(our former MACVPR Education Chair for many years)

on becoming a member of the

AACVPR Education Committee

PLEASE RENEW YOUR MEMBERSHIP

The following individual memberships have either expired since February 2011 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.

Jackie	Kilrain	2/1/2011
Kathy	Pietras	2/1/2011
Michael	Sawtelle	2/1/2011
Kathleen	Waldron	2/1/2011
Jean	Williamson	2/1/2011
Susan	Crider	3/1/2011
Dyan	Dal Pozzo	3/1/2011
Carolyn	Donovan	3/1/2011
Lisa	Eckhardt	3/1/2011
Melinda	Grieco	3/1/2011
Ann	Grimes-Jenkins	3/1/2011
Meredith	Jefski	3/1/2011
Julie	Jones	3/1/2011
Nancy	McDade	3/1/2011
Sue	Nordstrom	3/1/2011
Rosemary	Walus	3/1/2011

Reminder:

The Executive Committee is still trying to fill the **Co- President Elect** position for 2011. Robert Berry has agreed to take the position but would prefer to share it with someone else. It is a great opportunity for you to get involved with your organization. Remember we always work together as a team.

**Consider joining the EC...
you won't regret it!!**



_____ Date
 Check# _____
 Cash
 Database
 Intranet
 Email
 Receipt

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

\$100 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