

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

Co-Presidents:

Robert Berry, MS, RCEP, FAACVPR

Dennis O'Brien, BS, RN

Presidents Elect:

Vacant

Immediate Past Presidents:

Esther Burchinal, MS, CES, RCEP

Judy Flannery, RN, BSN

Treasurer:

Vacant

Newsletter Editor:

Lynne MacDonald, PT

Education:

Ginny Dow, RN, BSN, BC

Deirdre Proudman, RN, BSN, CCRN

Membership:

Melessa Ashworth, RN, BSN

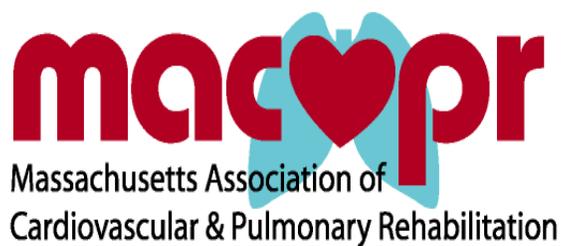
Administrative Assistant:

Ann Stone, BS

A Publication of the
Massachusetts Association of
Cardiovascular and Pulmonary
Rehabilitation

Table of Contents

Letter from the Editor	2
Reimbursement Update	3
Clinical Article: Metabolic Syndrome	4-6
Tales From the Trenches	6
Membership News	7
Treasurer's Report	7
MACVPR Forum Update	7
Education Update	8
Connections: Mind/Body/	9
AACVPR Updates	10
Certification	10
Membership Form	11



News

Winter 2012

Co-President's Message

Hello all MACVPR members! Even though January is past, it is worth remembering that the month is named after the two-faced Roman god Janus, who had a face looking both to the past and also to the future. In this spirit, we celebrate MACVPR's accomplishments of 2011 and look forward to the promises of 2012.

2011 was a year of change for MACVPR. We would like to offer many, many thanks to both Ann Stone and Lynn MacDonald for their tireless work on updating the look of the MACVPR website and forum; creating a contemporary look and feel to both applications. Please be sure to check both out to stay up to date with the latest happenings in cardiac and pulmonary rehab. 2011 also saw us bid a reluctant farewell to long-time MACVPR Treasurer, Susan Carrigan, who will be focusing her considerable talents on other projects. Susan's departure leaves the Treasurer's position vacant on the MACVPR Executive Committee along with both Co-President elect positions. Please contact the MACVPR Executive Committee if you are interested in learning more about these positions. Remember, experience is NOT required! What IS required is a passion for our patients, the work we do every day, and a desire to give back to the profession that has given each of us jobs we love. Remember too, the Nike slogan from a few years back: "Just Do It!" You'll be glad you did.

One thing that did not change in 2011 was the quality of the educational symposiums provided by MACVPR. 2011 saw MACVPR offer programming that rivaled what is typically available at the National Meetings of other organizations, including AACVPR and ACSM. The highlight of the year was undoubtedly the October Symposium at the Devens Common Center where nationally known speakers, Philip Ades, MD and Gayla Oakley, RN shared their respective expertise with the audience. The event was so well received that MACVPR has already made plans to return there for the 2012 October Symposium.

Looking to 2012, MACVPR remains as committed as ever to our mission statement:

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

This mission statement is operationalized by the following Strategic Goals:

1. Ensure that MACVPR remains the preeminent professional organization for Cardiac and Pulmonary Rehabilitation in the New England Area. This goal will be accomplished by retaining the current membership, increasing the membership base 10%, and widening the professional distribution both geographically and across professional disciplines. We all know and work with professionals everyday who share our enthusiasm and passion for patient education and maximizing outcomes; why not invite them to join MACVPR?
2. Encourage and support increasing the quality of Cardiac and Pulmonary Rehabilitation in Massachusetts. MACVPR will continue to provide the highest quality symposiums, networking opportunities and newsletter available. We will continue to encourage all MACVPR members to share their expertise (we ALL have some to offer, you know!) with each other via the Regional groups and the MACVPR Discussion Forum. AACVPR Program Certification remains the benchmark by which quality programs are judged, and we will continue to support programs in achieving this distinction.
3. Improve the utilization of Cardiac and Pulmonary Rehabilitation in Massachusetts. One of the reasons for re-designing the MACVPR website was to increase visibility of our profession to both other professionals, and also to the public. Diversifying our membership base into other disciplines; nurse practitioners, physician assistants, etc. also increases our visibility. The Regional groups will be useful in identifying barriers to delivering our services that can be unique to particular areas. Coming together to discuss these types of issues at regular meetings greatly increases the chance of finding innovative solutions.

Co-President's Address Cont.

Key dates to remember for 2012

February 29	AACVPR Program Certification Applications due
February 29 – March 1	AACVPR "Day on the Hill" Massachusetts will be represented by the more than capable Kate Traynor, RN
March 11 – 17	Pulmonary Rehabilitation Week
May 10	MACVPR General Meeting. Watch the website for more details!
September 6 – 8	AACVPR Annual Meeting, Orlando, FL
October 26	MACVPR Regional Symposium Devens Common Center, Devens, MA

Submitted by Dennis O'Brien, RN and Robert Berry, MS RCEP

president@macvpr.org

As an ongoing incentive to get members involved we would like to offer free CE's for your contribution to the newsletter!!! Anyone who contributes an article for Tales from the Trenches or a Clinical Article can receive this.....a \$20 value !

Our aim is to spotlight anything unique, innovative or creative that you are doing in your programs and share your ideas with our membership. We can all learn a lot from what each other is doing on a daily basis!! Maybe you know of a program that is doing something unique that you would like to find out more info on....well feel free to interview them and submit the findings to share in our newsletter!! If you don't want to do the interview, pass the idea along to me and I would be happy to do it. Also feel free to write an article on anything your program is doing that you would like to share!!

Ideas for Tales might be:

- Highlighting an exceptional patient that has done very well despite difficult obstacles
- Transitioning patients to aftercare programs
- Interesting ideas for Process Improvement
- How does your program deliver education?

For more information please contact Lynne MacDonald at newslettereditor@macvpr.org

Letter From the Editor

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

Deirdre Proudman BSN, RN-C, CCRN has provided us with a comprehensive literature review of Metabolic Syndrome.

Once again, Pamela Katz Ressler, MS, RN, HN-BC of Stress Resources has contributed another installment of our feature: **Connections: Mind/ Body/Spirit**. She has provided us with a more in depth understanding of Emotional Intelligence and ways to strengthen it to improve our social interactions with the outside world.

Our "Tales from the Trenches" column was written by a recent EP graduate on transitioning from a student to an employee. Many thanks to Corey Cazeault for his contribution.

The new and improved MACVPR website was launched on October 21, 2011!!! We have tried to make it more user friendly and informative to our members, especially the Member Forum. Hopefully more people will begin to utilize this great resource.

I am begging for more input from our members in submitting clinical articles or Tales from the Trenches articles. It is very frustrating that all of the ideas/input comes from the EC members. We have 123 members and I am sure many of you have ideas to contribute. It would certainly make the NL more vibrant and fresh if we got input from as many people as possible. Please feel free to e-mail me and share your ideas—maybe we can brainstorm together!

Lynne MacDonald, PT

Milton Hospital Cardiac Rehab

Newsletter Editor newslettereditor@macvpr.org

"I am begging for more input from our members"

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

Metabolic Syndrome and the Influence of a Cardiac Rehabilitation Program for Cardiometabolic Risk as Primary Prevention

Deirdre Proudman, BSN, RN-C, CCRN
Lowell General Hospital Cardiac Rehab

Introduction

An estimated 81,100,000 American adults (more than one in three) have one or more types of cardiovascular disease. Cardiovascular disease (CVD) has remained the number one cause of death and disability in both men and women (American Heart Association, 2010). Heart disease, a chronic multistage inflammatory disease is influenced by environmental exposures, lifestyle factors, and genetic determinants that are reflected in traditional risk factors, inflammatory markers, and metabolic status. According to the American Heart Association Heart Disease and Stroke Statistics – 2010 Update, statistics reveal an astonishing 50 to 75 million Americans having metabolic syndrome.

Literature review

The metabolic syndrome (MetS) is a complex of interrelated risk factors for cardiovascular disease (CVD) and diabetes. Various diagnostic criteria have been proposed by different organizations over the past decade. In 2001, the National Cholesterol Education Program (NCEP) Adult Treatment Panel III (ATP III) proposed a simple set of diagnostic criteria based on common clinical measures including waist circumference, triglycerides, HDL-C, blood pressure, and fasting glucose level. The presence of defined abnormalities in any 3 of these 5 measures constitutes a diagnosis of the metabolic syndrome (Grundy, et al., 2005, e285). The primary purpose for identifying the MetS was to identify individuals at higher risk of CVD that extended beyond LDL-C and was obesity-related.

Cornier, et al., (2008) and Grundy et al., (2005) described the purpose of identifying these patients was to emphasize further the importance of a healthy lifestyle in reducing risk. One of the primary observations regarding the clustering of metabolic disorders was the association of these features with increased CVD risk. It is well accepted and established that multiple risk factors confer greater risk than a single risk factor. In fact, the findings that led to the development of the Framingham Risk Score (FRS) are based on this observation.

Most recently, diagnostic criteria have come from the

International Diabetes Federation and the American Heart Association/National Heart, Lung, and Blood Institute (Alberti, Zimmet, & Shaw, 2006; Grundy, et al., 2009). The main difference between the two concerns the measure for central obesity, with this being an obligatory component in the International Diabetes Federation definition, lower than in the American Heart Association/National Heart, Lung, and Blood Institute criteria, and ethnic specific.

The primary goal of clinical management of the metabolic syndrome is to reduce risk for clinical atherosclerotic disease. A closely related goal is to decrease the risk for type 2 diabetes mellitus in those patients who do not yet manifest clinical diabetes. Most studies show that the MetS is associated with an approximate doubling of cardiovascular disease risk and a 7-fold increased risk for incident type 2 diabetes mellitus (Wilson, D'Agostino, Parise, & Meigs (2005).

Management of the metabolic syndrome should be carried out in the context of global cardiovascular disease prevention efforts. The burden of coronary heart disease (CHD) is enormous, even though associated mortality rates fell by more than 40% between 1980 and 2000. The annual direct and indirect costs for coronary heart disease were \$142.5 billion in 2006, and they continue to rise (Ford, et al., 2007, p.2389). Determining the respective contributions of prevention and therapy to the declines in mortality from coronary heart disease is therefore becoming increasingly important, for the purposes of both understanding past trends and planning future strategies. According to the U.S IMPACT Model and data sources from the U.S., the largest reductions in deaths came from the use of secondary-prevention medications, risk factor modification, or cardiac rehabilitation after acute myocardial infarction or after revascularization (Ford, et al, 2007). In contrast, the increase in the body-mass index of 2.6%, and the 2.9% increase in the prevalence of diabetes resulted in approximately 25, 905 and 33,465 additional deaths overall, respectively (Table 2). According to the CDC (2008) and Church, et al.,(2009), the public health importance is great, considering that individuals

“The literature demonstrates that nurse-led primary and secondary care programs would be an effective adjunct for patients with cardiometabolic risk to supplement practitioner advice.”

Metabolic Syndrome...continued

with diabetes have more than twice the risk for premature death, heart disease and stroke combined compared with individuals without insulin resistance.

According to the Heart disease and stroke statistics 2010 update (p. e 48), on the basis of NHANES 2003–2006 data, the age-adjusted prevalence of metabolic syndrome, is 34% (35.1% among men and 32.6% among women).

Diagnoses and management of the metabolic syndrome (Grundty, et al., 2005; Alberti, et al., 2006; Blaha, et al., 2008) involves individual attention with the aim of reducing the risk for CVD and Type 2 diabetes. Primary management of MetS consists of the promotion of a healthy lifestyle. Mirroring the recommendations for healthy lifestyle promotion, Blaha et al (2008), assembled a comprehensive management plan utilizing an “ABCDE” approach: “A” for assessment of cardiovascular risk and aspirin therapy, “B” for blood pressure control, “C” for cholesterol management, “D” for diabetes prevention and diet therapy, and “E” for exercise therapy. This ABCDE approach summarizes the recommendations and provides a practical and systematic framework for encouraging metabolic syndrome recognition and for implementing a comprehensive, evidence-based management plan for the reduction of cardiovascular risk.

Comprehensive cardiac rehabilitation (CR) is probably the most effective approach for cardiovascular risk reduction and long-term care of cardiac patients as well as of subjects with multiple coronary risk factors. There are considerable published data strongly supporting the benefits of cardiac rehabilitation as a means of risk stratification to decrease the mortality and morbidity of CVD in adults. Beyond the benefits of evidence-based medications, a 12 week cardiac rehabilitation program leads to the reduction in the components of metabolic syndrome. Such data are presented in such statements from the American Heart Association (AHA) and other sources. Notable statements and studies include Thomas et al., (2010), Smith et al., (2006), and Leon et al., (2005) and Giannuzzi, et al., (2003) AHA statements on performance measures on cardiac rehabilitation for referral to and delivery of cardiac rehabilitation/secondary prevention services and the AHA/ACC guidelines for secondary prevention for patients with

coronary and other atherosclerotic vascular disease.

Thompson, et al., (2003) and Marcus et al., (2006) published scientific statements addressing physical activity and intervention studies in the prevention and treatment of CVD. Haskell et al., (2007) and Yassine et al (2009) addressed physical activity and public health on cardiometabolic risk, while Lichtenstein et al., (2006) advise dietary guidelines and lifestyle modifications. Mosca, et al., (2007) redefined guidelines specific to women and prioritized interventions towards prevention.

Cardiovascular risk factors and the constellation of risk factors that compile the metabolic syndrome can be combated and controlled by adherence to current lifestyle recommendations irrelevant of implementation as primary or secondary prevention. Compared with single session interventions, the evidence suggests that cardiac rehabilitation programs as a core component of therapeutic lifestyle modification are generally more effective. Artinian et al., (2010) and Lloyd-Jones et al., (2010) articulated the AHA’s 2020 goals to include a new concept of cardiovascular health that directly incorporates metrics of lifestyle behavior. These modifiable well-known risk factors offer great potential for preventive interventions and nonmedical treatment. Nurses in nurse-led programs, as part of a multidisciplinary team, can provide these preventive interventions.

Despite the well-established benefits of exercise combined with nutritional counseling, Ades(2001), Balady et al.,(2007) and Capwell, et al.,(2010) , physicians are generally not well trained and do not have the time to provide effective nutritional advice, guidance about weight management, and a prescription for exercise. Myers, Hebert, Ribisl, & Franklin (2008), Lavie, Thomas, Squires, Allison, & Millani, (2009), and Blaha et al., (2008), suggest that a large treatment gap exists between the recommended therapies and the care that patients actually receive. This gap has been particularly apparent in the area of primary prevention of cardiovascular disease.

Nurses, in tandem with exercise physiologists, physical therapists, and dieticians, have a great deal to offer in the management of patients with MetS and cardiometabolic risk. Burke (2003), Jiang, Sit, and Wong (2007) and JBI (2005)

Metabolic Syndrome....continued

recognize the evidence base for the care and treatment of patients in nurse-led programs. Page, Lockwood & Conroy-Hiller (2005) suggest that nurse-led clinics can be distinguished by certain characteristics or features related to structure and/or function. These are reported to include a focus on health rather than illness, and an emphasis on life management rather than diagnosis and intervention. There were no negative aspects for nurse-led clinics reported by any of the studies. Although not all outcomes were statistically significant, many of the studies reported improved clinical outcomes. The importance of clinically effective outcomes for a debilitating disease process such as MetS should not be undervalued.

The literature demonstrates that nurse-led primary and secondary care programs would be an effective adjunct for patients with cardiometabolic risk to supplement practitioner advice. The first line clinical intervention for the metabolic syndrome is lifestyle change. The clinical evidence for the efficacy of cardiac rehabilitation has been summarized in multiple systematic reviews and through the development of guidelines. Staffing with experienced cardiovascular nurses is suggested as the preferred model. Clinical effectiveness is contingent upon primary research demonstrating the statistical significant improvements in outcomes.

Evidence-based practice

It is believed that the benefits of a nurse-led cardiac rehabilitation intervention for metabolic syndrome may be suggestive of the development of evidence-based practice in preventive nursing care as well as for future research. In addition, much of the effort of health care is placed on acute care. The importance of cardiac rehabilitation in enhancing cardiac recovery is evidence based and also can be utilized to prevent subsequent morbidity, mortality and disability and the associated cost of metabolic syndrome.

In today's clinical environment, providers have limited time to spend with patients. Further, because of health care management, often new diagnoses are needed to justify treatments at earlier stages of a disease that will prevent further progression of that disease. Nurses can use diagnoses such as metabolic syndrome and insulin resistance to better manage screening and treatment of their patients.

Editor's Note: There were 33 references for this article. In the interest of space, the references will be furnished upon request.

Tales from the Trenches

Transitioning from Student to Employee

by **Korey Cazeault, 2011 Graduate
with BS in Exercise Science**

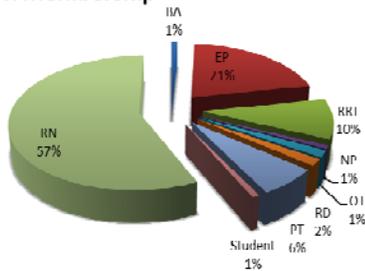
My journey to becoming a professional in cardiac rehab began with my parents. From a young age, my parents taught me the importance of being active, eating well, and maintaining a healthy lifestyle. Before graduating high school, I knew I wanted a career that involved helping people. I enrolled in the Exercise Science program at Becker College and I could not wait to start. Throughout my college years I took classes, such as Anatomy and Physiology, Kinesiology, Nutrition, Strength and Conditioning, and Advanced Personal Trainer. Through these classes I gained a better understanding of how the body works and what we can do to improve it. Although I loved the program, I encountered one major problem; I was not certain what I wanted to do with my degree. The Becker College website has a list of potential employment opportunities, including personal trainer, fitness consultant, and strength and conditioning coach. Eventually senior year came and I had to find an internship. A friend of the family suggested I try getting an internship in cardiac rehab at Harrington Hospital. I promptly met with Judy Flannery and started my internship. Leal Eaton and Judy taught me everything I needed to know about heart conditions, medications, monitoring the patients, and more. I was responsible for one patient's entire exercise routine from start to finish. Now that I am an employee, I have combined what I learned in school with what I learned during my internship. When it comes to making exercise routines for the patients, I find myself using the skills I learned in my personal training class the most. Every patient has different needs and goals they wish to accomplish. I am able to make personalized workouts for patients that provide the most benefit for their needs taking into consideration their cardiac status. I am responsible for teaching the patients the significance of resistance training and weight training exercises, so that they will continue to do them once they have graduated from the program.

Kory Cazeault

Exercise Specialist Cardiac Rehab
Harrington Hospital

Membership News

MACVPR Membership



What does "Membership" mean to you? Affiliation, Participation, Involvement, Connection, Belonging. Those were words that came to me as I prepared this for the newsletter.

The MACVPR is a valuable organization for professionals in the field of cardiac and pulmonary rehabilitation. The organization works to fulfill the mission of promoting the practice of high standards of care in cardiac and pulmonary settings.

Our current membership stands at 123 members which includes participation from 1 student. In February 2010 we had 123 members so we remain steady. This in a time of closing programs and economic insecurity. Our new website is informative. Members can access the newest information on legislation, reimbursement and certification. They can participate in the on line forum and connect with other members throughout the state. Please remember to renew your membership. All of these benefits for \$100 dollars for a 2 year membership.

Renew, Get involved, Stay Connected, Belong

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

BA	1
EP	26
RRT	12
NP	1
OT	2
RD	2
PT	8
Student	1
RN	70
Total members	123

Treasurer's Report

The Executive Committee is still looking for someone to take over Susan's position as Treasurer for 2012. Please get involved!

Current balances as of February 8, 2012:

Citizen's Bank checking:	\$7,872.74
Citizen's Bank Money Market fund	\$2,630.64
Total	\$10,503.38



Tax returns are being prepared.



Check out the new MACVPR Forum!!

MACVPR Forum Update

Check out the new Forum....it is a lot more user friendly. We created various categories to organize the posts and make it easier to participate. Currently we have posts on these topics:

- Which codes are the correct ones to use for PR with replies from Robert and Wayne.
- Acceptable locations for emergency equipment
- Use of PHQ-9 and appropriate cut off for referral for psychosocial support
- Post asking for ideas for other profitable programs to that are a good fit for Cardiac Rehab i.e. PVD, weight loss, Risk Reduction etc.
- Post re: internship opportunities at Harrington Hospital

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

Try to make it a habit to check out the Forum at least once a week. This is a great but underutilized resource...so please start to take advantage of it. Sharing our thoughts and experiences with one another helps all of our programs improve the care we provide to our patients.

Education Updates



Torrin P. Fitton, MD

The January 19, 2012 MACVPR meeting had approximately 20 in attendance. Two excellent lectures were provided. Dr. Fitton, a cardiothoracic surgeon from Lahey Clinic Medical Center gave an informative lecture on Current Trends in Valve Surgery. The participants wrote in their evaluations:

- "I learned about how decisions are made on which type of valve to use and why
- that more bioprosthetic valves are used than mechanical valves
- that we need to continue antibiotic therapy for prophylaxis after a valve replacement if the patient has any invasive procedures such as dental work
- learned all about the different types of valve designs and which needs Coumadin (mechanical)
- enjoyed his discussion of the financial issues of interventions and the aging population"

There was overwhelming positive feedback that Dr. Fitton was an excellent speaker, related to audience, funny and pertinent to programs."

The second lecture was given by Wayne Reynolds, RN, Director of Cardiac and Pulmonary Rehab at Signature Healthcare Brockton Hospital. The topic was "Program Survival in an Increasingly Hostile Environment". The participants felt they learned about:

- Flexibility in programs
- about coding for insurance
- how to work with the patient to keep them in your program
- no one model is perfect
- learning to adapt
- there are programs with less resources than us

Some gave feedback that they would like more specifics ideas and to hear about how others are adapting to the changes in the environment. This may be a great idea for a follow up session on this topic at a future meeting!

GINNY DOW RN, BSN, BC

DEIRDRE PROUDMAN, RN, BSN, CCRN

Education Co-Chairs

Additional Educational Opportunities:

March 2, 2012 **Webinar: The Role of Clinical Exercise Physiology in LVAD Patients: Turning Failure into Success**

Presented by Dennis Kerrigan Ph.D,
Henry Ford Hospital

For more information visit:

<http://www.acsm-cepa.org>

March 31, 2012 **Exercise is Medicine: Primary Prevention to Chronic Disease Management**

MACEP 2012 Annual Meeting

For more information visit:

<https://sites.google.com/site/macep11/home>

Calling All Regional Groups!!!

The Executive Committee is encouraging all Regional Groups to meet and discuss issues/problems pertinent to their areas prior to the May General Meeting. We are hoping that each group can meet and report on their progress at the meeting.

Save the Dates

May 10, 2012

General Meeting

American Heart Association

October 26, 2012

MACVPR Fall Symposium

Devens Commons Center



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

“Higher levels of emotional intelligence help one to navigate conflict.”

Connections: Mind/Body/Spirit

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

5 Competencies of Emotional Intelligence

In a previous **Connections: Mind/Body/Spirit (Spring 2011)** column I introduced the concept of Emotional Intelligence as defined by Daniel Goleman. Emotional Intelligence (EI) is built on the framework of empathy, awareness, and mindfulness. Higher levels of emotional intelligence help us to navigate the social interactions between our inner selves and the outside world. The good news is that emotional intelligence can be strengthened by building upon 5 core competencies. Let's take a look at how we can strengthen these competencies or skill sets.

1. Quickly Reduce Stress

Recognition of stress is key. Identify your stress triggers, without necessarily trying to change them. Use these triggers to remind you to practice quick tools of relaxation, such as dropping into a few diaphragmatic breaths, or releasing muscle tension.

2. Recognize and Manage Your Emotions

Without checking into your emotions you cannot effectively address motivations and needs. Tools such as mindfulness and meditation teach us to observe our emotions in healthy ways. Learning to connect with your emotions without being paralyzed by them is an important component to building higher levels of emotional intelligence.

3. Connect with Others with Non-Verbal Communication

We often neglect the power of non-verbal communication skills. It has been suggested that up to 93% of our communication is non-verbal. Developing skills of non-verbal communication is essential for high levels of emotional intelligence. Recognition of cultural differences in personal space and touch should be included in building culturally sensitive non-verbal communication. Non-verbal communication involves numerous factors, including eye contact, facial expressions, body position and gesturing. Our increasing use of electronic communication decreases our skill in practicing non-verbal communication. Seek out opportunities to use non-verbal communication skills to increase your ability to build your emotional intelligence.

4. Use of Humor and Play to Deal with Challenges

Appropriate use of humor or play can defuse difficult situations or workplace challenges. A key skill of emotional intelligence is recognition of a situation in which humor or play may be beneficial and when it would be inappropriate or destructive. Learning about proper use of tools of therapeutic humor, which can be categorized into three basic types: hoping humor, coping humor, gallows humor, can help build emotional intelligence.

5. Resolve Conflict Positively and Confidently

Higher levels of emotional intelligence help one to navigate conflict. Again, developing attention to the present moment or mindfulness is essential for mastery of this competency. Some tips to consider on using emotional intelligence in areas of conflict include:

- Keeping focus on present (not past or future events)
- Define the conflict
- Choose your battles
- Practice forgiveness
- Choose to agree to disagree

Focus on strengthening one or two of the competencies identified as components of emotional intelligence this month and notice if you feel a bit more centered, productive and less stressed.

To read more about Emotional Intelligence, here are some resources:

<http://podcast.mwmclaughlin.com/podcasts/daniel-goleman/>

Goleman, D. (1995). Emotional Intelligence. New York: Bantam

Goleman, D. (2006). Social Intelligence. New York: Bantam

http://www.youtube.com/watch?v=-hoo_dIOP8k

Pamela Katz Ressler, MS, RN, 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 Tufts University School of Medicine and the University of Massachusetts Boston, College of Nursing and Health Sciences, serves on the board of directors of the Integrative Medicine Alliance and is a founding member of the Society for Participatory Medicine. 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 Updates

AACVPR Day on the Hill! February 29- March 1, 2012

DOTH 2012 will focus on asking your US Congressional Members in the House and Senate to support Senate bill #S.2057 to allow non-physician practitioners to provide supervision in CR and PR programs.

Upcoming Webcasts

- March 6, 2012 **Enhancing the Delivery of Cardiac and Pulmonary Rehabilitation through Internships**
Presented by: Annie Bennett, M.Ed.
Laura Raymond, BS, RN, FAACVPR
- May 22, 2012 **Motivational Interviewing to Promote Health Behavior Change**
Presented by: Lola A. Coke, PhD, ACNS-BC, RN-BC, FAHA
- Ongoing **Program Leadership in the New Era (PLINE) Virtual Conference**
8 Great speakers, 7 Relevant Topics, 1 Power-Packed program!

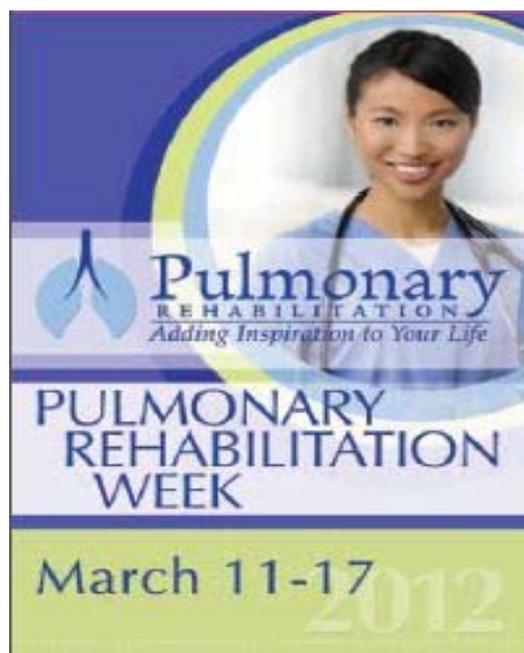


Certification

The 2012 AACVPR certification cycle closes on February 29, 2012.

Believe it or not, now is the time to start preparing certification and re-certification applications for the 2013 certification cycle!! Give yourselves plenty of time and avoid being rushed at the last minute!

If anyone is experiencing problems with your certification application during the review process, feel free to contact Robert Berry at president@macvpr.org. He is happy to assist.

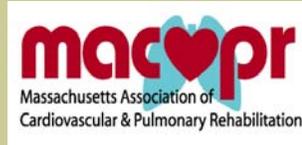


PLEASE RENEW YOUR MEMBERSHIP

The following individual memberships have either expired since January 2012 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.

Joyce	Grusmark	10/1/2011
Beth	Marzelli	11/1/2011
Cara	Whittum	11/1/2011
Brenda	Ferguson	12/1/2011
Christine	Leger	12/1/2011
Kristen	Almechatt	1/1/2012
Sherri-Lee	Bentley	1/1/2012
Dawn	Sweerus	1/1/2012
Rose	Deskavich	1/1/2012
Joyce	Arel	1/1/2012
Andrea	Hazelton	1/1/2012
Michelle	Kobbs	1/1/2012
Teresa	LeBlanc	1/1/2012
Donna	Lind	1/1/2012
Richard	Parian	1/1/2012
Charles	Fezzie	1/1/2012
Jane	Schweizer	1/1/2012
Margaret	Copithorne	1/1/2012
Janet	Taylor	2/1/2012
Claire	Rindenello	2/1/2012
Heather	Chelak	3/1/2012
Stephanie	DiCenso	3/1/2012
Doreen	Cleary	3/1/2012
Kory	Cazeault	3/1/2012
Monica	Maldari	4/1/2012
Susan	Bernas	4/1/2012
Kathleen	McKool	4/1/2012
Deborah	Sullivan	4/1/2012
Gisele	Bousquet	4/1/2012



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