Fall has arrived and the clocks have turned back but the MACVPR continues to move ahead!! It has been a busy month both on the national and local fronts and here is a synopsis of what has been going on.

NATIONALLY:
The New England area was well represented at the 25th AACVPR meeting in Milwaukee. It was a wonderful opportunity to network and to hear experts in the field. We are proud to announce that Wayne Reynolds past president of the MACVPR and current chair of the J14 MAC Committee has been appointed to the AACVPR Health Policy and Reimbursement Committee. This is certainly an honor for Wayne as well as our state and professional organization.

The AACVPR has announced that it is reinstating the state Certification Chair/Liaison position. The individual in this position at the state level will serve as a liaison between the national organization and the local affiliates with issues pertaining to the certification process. More on this position below in the “Local” portion of our update. Information and news pertinent to AACVPR certification is in the “Certification Update” of this newsletter and is provided by our President Elect.

HR6376 – this is a very important bill that would allow physician extenders (PA’s, NP’s) to act in the supervising role in cardiac and pulmonary rehab programs. This is especially important for critical access hospitals that may not have a physician on site at all times. Without this legislation there is the potential for programs to close. The push is to have the bill attached to the Physician Fee legislation that will be voted on before the end of the session. It is critical that we all contact our representatives to ask them to sign on as co sponsors of this bill. If you have not done so already, please contact your local US representative requesting their support and co sponsorship of this bill. There are sample letter templates available on the AACVPR website if you need help drafting a letter.

Locally:
Congratulations to all programs that have achieved certification / recertification this year!!! This brings the total of certified programs in our state to 34, 25 cardiac and 9 pulmonary! (please see page 7)

Deb Sullivan and her education committee out did themselves once again—the New England Symposium was a huge success. It was a great turnout on a sunny fall day with attendees from seven states—the word is out about the quality of our meetings. Our national speakers updated us on the issues that we are all struggling with as we try to comply with the new regulations. A unique experience was the cooking demonstration using healthy recipes that those in attendance were then able to sample at lunch—very tasty!! Our first poster presentation was equally exciting developments!

We are pleased to introduce our 2011 executive committee that was voted on at the meeting, as well as announce that we have filled the vacancy in the President Elect position!!!

Co-Presidents: Esther Burchinal and Judy Flannery
Past President: Priscilla Perruzzi and Kate Traynor
Treasurer: Susan Carrigan
Education Chair: Ginny Dow
Newsletter Editor: Lynne MacDonald
Bylaw Revisions

The members present voted on revisions in the MACVPR by laws. Please refer to the bylaws online in the members only section to view in entirety.

Membership Fees

After careful deliberation by the EC, the membership fees will be increasing to $100 (for 2yrs) effective January 2011. We understand that this increase comes at a time that is financially challenging to many but as is evident in managing our CR and PR programs the cost of maintaining a quality product is increasing. There has not been an increase in membership fees in many, many years and this increase remains considerably less than those of other organizations in the health field. The additional funds will allow us to continue to provide high quality of educational sessions that meet the needs of our members as well as improve our website. The executive committee continues to work towards innovative ways to keep our members up to date in this fast changing health care environment.

Distinguished Service Award

Congratulations to Wayne Reynolds, Coordinator of CR and PR at Signature Healthcare- Brockton Hospital, the recipient of the 2011 MACVPR Distinguished Service Award. Please see the details of his well deserved selection in this newsletter.

In closing we would like to wish all our members a very HAPPY THANKSGIVING. We are thankful for the opportunity to work with such professional, knowledgeable and caring individuals. And a special thanks to our friends on the Executive Committee who have been superb and made our load lighter: Esther, Judy, Deb, Ginny, Lynne, Stephanie, Susan and Melessa and to Ann Stone, our Administrative Assistant, without whom this entire organization could not function!

Letter From the Editor

This edition of MACVPR News is chock full of valuable information.

We were fortunate to have a clinical article submitted by Judith Ciampa Wright OTR/L, CHT on overuse Injuries of the Upper Extremity in response to many clinicians reporting overuse injuries related to repetitive blood pressure taking in rehab. I am sure you will find this information helpful in avoiding injuries in the future.

Once again, Pamela Katz Ressler, RN, BSN, HN-BC of Stress Resources has contributed another installment of our feature: Connections: Mind/Body/Spirit. She has written a terrific article on how to facilitate safe and comfortable care to an individual with symptoms or a diagnosis of PTSD in your program. She gives us plenty of resources and hands on advice in dealing with these patients.

In our “Tales from the Trenches” column I have included information from a recent JCAHO survey to help outline some points that have been focused on in rehab.

Please read about our recent Distinguished Service Award Winner, Wayne Reynolds, who is very deserving of this prestigious MACVPR award.

Finally, please enjoy reading the recap of our phenomenal 2010 New England Cardiovascular and Pulmonary Rehab Symposium. It was a tremendous success, including our addition of the Poster Presentations — what a wealth of information!!

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
Reimbursement Update

Reimbursement of Cardiac and Pulmonary Rehabilitation services continues to be a “hot topic” and summaries of key issues were presented recently at both the AACVPR National Meeting and the MACVPR Regional Symposium. Hopefully many of you took advantage of these very informative opportunities. Key points are summarized below:

**Pulmonary Rehabilitation:**
- Qualifying diagnoses must be Moderate, Severe or Very Severe COPD (GOLD II, III, and IV) to use Procedure Code GO424 and Revenue Code 0948.
- Other diagnoses fall under “Respiratory Care Services”, GO237 – 239
- Patients are permitted a maximum “LIFETIME” benefit of 72 sessions (NOT tied to a “new event” like cardiac rehabilitation). Up to 36 initial sessions, then can do additional 36 with KX Modifier, only if you have MEDICAL NECESSITY and DOCUMENTATION to prove it. Billing departments utilize a “common working file” (CWF) to track cumulative sessions. You will need to check with them to clarify total number of pulmonary rehab sessions your patient may have previously been billed for.
- Each “session” MUST include some exercise. If you are billing for two sessions in one day, patient must exercise during EACH of those two sessions.
- Medical Director must review and sign ITP every 30 days AND have direct patient contact (this is different from cardiac rehabilitation)
- NPP’s (Non-physician Practitioners) cannot satisfy the physician supervision requirement- must be an MD or DO (hence the push for support of HR6376, see below)

**Cardiac Rehabilitation:**
- “hottest topic” at this point: an opportunity for INCREASED reimbursement in CY2012! Have you spoken to your billing office regarding submitting cost reports to CMS using a “non-standard cost center” for cardiac rehab services? If not, please visit aacvpr.org (you do NOT need to be a member) and click on the Health and Public Policy Tab. Under Regulatory and Legislative resources, all background information is posted there and there is a “printable version” for distribution. This will require follow-up on your part but the outcome could potentially be very positive! How can we not all benefit from increased reimbursement…
- aerobic exercise every day, but not every session (unlike Pulmonary Rehabilitation)
- NPP’s (Non-physician Practitioners) cannot satisfy the physician supervision requirement- must be an MD or DO (hence the push for support of HR6376, see below)

**HR6376:**
AACVPR is urging you to ACT in support of HR6376. You do NOT need to be an AACVPR member to take action. This bill is part of the physician fee fix legislation and will address the role of NPP’s in Cardiac and Pulmonary Rehabilitation. If you did not receive the special emailing from AACVPR and/or MACVPR, please contact either myself or Ann Stone at admin@macvpr.org and we can forward it to you. It is a US House of Representatives bill only at this point and we are being asked to contact our Congressional Representatives to urge them to sign-on as a co-sponsor to HR6376.

In closing, I urge you to join AACVPR as monthly Reimbursement Updates are emailed as part of your membership benefits. These are extremely informative and timely. Should you have any specific questions regarding reimbursement, please contact Wayne Reynolds RN, who is currently Chairman of the J14MAC A/B Committee at wreynolds@signature-healthcare.org.

Stephanie DiCenso MS, RCEP, CES
MACVPR Immediate Past-President
Member J14 MAC Committee
dicenso3@comcast.net

MACVPR Forum Update

Have you used the MACVPR On-Line Forum yet? If you haven’t its time you did. The forum is for you and all MACVPR members. This is the place for you to ask questions, get answers, share ideas and so much more. I recently took over monitoring the forum and I find it can be a great source of information, and it is greatly under utilized.

Recently someone asked about a product to clean their equipment with that doesn’t require wearing gloves. I was able to find out from our Infection Control agent that CaviWipes do not require gloves. I also found out that they come in packets with strips that stick to equipment. I also posted a question that I would like some responses to: I am looking for info from hospital based programs that have a maintenance program. I would like info on your fees, hours, unique programs etc.

I challenge our members to checkout the Forum, answer my questions, ask a question, share an idea or just become familiar with the site. First sign in to MACVPR then you also must sign-in to the Forum. When in the Forum you can either select “Active Topics” in the top right or go into “Testing Forums” to see older topics. Lets see if we can get 25 people to visit the Forum in the next 2 weeks!!

Judy Flannery RN BSN
Coordinator Cardiac Rehab
Harrington Hospital

“This is the place for you to ask questions, get answers, share ideas and so much more.”
Anatomy and Physiology of Tendinosis

Diagnosis and treatment of upper extremity overuse injuries pose some of the most significant challenges in a rehabilitation clinic. In the past few decades, as participation in sports and other types of demanding physical activities have become more common factors accompanying the demands of work, overuse disorders of the upper extremity are becoming an increasing cause of disability. As a result, cumulative trauma disorders are becoming one of the most commonly occurring conditions treated by hand therapists. (7)

Traditionally, diagnoses such as lateral epicondylitis or DeQuervain’s disease have been referred to as “tendinitis”. However, they and similar diagnoses are more accurately described as tendinopathies. Understanding the difference between tendinitis and tendinopathy (or tendinosis) assists in management and general understanding of the complex nature of these problems. Tendinitis is an acute inflammatory response to an injured tendon. Recent studies have shown that in the presence of tendinosis, a non-inflammatory process is present, and degeneration of the connective tissue of the tendon from aging, microtrauma, or vascular compromise is the source of pathology. True tendinitis is now thought to be rare, with the degenerative changes of tendinosis occurring most frequently. (2)

Tendinopathy has an increased incidence with age, the male gender, obesity, and hormonal changes associated with hormone replacement therapy and oral contraceptive use in women (4). Excessive loading of tendons during vigorous physical activity is considered to be the main cause of degeneration of the tendon. (3)

Tendons connect muscle to bone and transmit the forces generated by the muscle to create joint movement. Every muscle has a tendinous origin and insertion. The origin is an anchor point, usually fixed, and the insertion is where the movement of the specific muscle occurs. In the forearm, wrist, and hand, there are two types of muscles: intrinsic and extrinsic. Intrinsic muscles begin and end within the hand, and the extrinsic muscles begin above or at the elbow and insert on the hand, controlling movements of the wrist and fingers.

Tendons are comprised of collagen bundles, tenocytes (tendon cells), and ground substance. Collagen provides tensile strength and the ground substance provides structural support. The tenocytes are involved in the synthesis of the ground substance and the collagen. Collagen fibers (primary bundles) are grouped into fascicles (secondary bundles), fiber bundles (tertiary bundles), and finally, the tendon itself. The epitenon is a sheath containing the vascular, lymphatic, and nerve supply for the tendon and is surrounded by the paratenon, which is comprised of collagen, elastin, and synovial cells. The osteotendinous junction is where the tendon transmits force to rigid bone, and the myotendinous junction is where the muscle transmits force into the tendon. Tendinopathy usually involves the osteotendinous junction. (2)

With increasing age, energy production in the tendon shifts from an aerobic process to a more anaerobic process with a low metabolic rate. This assists tendons in carrying loads and maintaining tension for long periods of time, and helps to reduce the risk of ischemia and resulting necrosis. However, once the tendon is injured, the low metabolic rate and poor vascularity contribute to a slow rate of healing. (1, 3) Tendons have a supply of blood from three sources: intrinsic sources at the myotendinous and osteotendinous junctions, and extrinsically through the tendon sheath. The myotendinous junction has a better blood supply because it receives some blood directly from the muscle, while the supply at the osteotendinous junction is relatively sparse. Tendon vascularity can be compromised at sites of compression, torsion, and friction as well as the myotendinous and osteotendinous junctions. In addition to decreasing with age, vascularity also decreases with mechanical loading of the tendon, which can also effect healing of the tendon. (3)

In addition to the relatively poor vascularity of the tendon tissue, a current theory of how tendon damage occurs pertains to ischemia and reperfusion of tendon tissue. Ischemia can be the result of a tendon being used under maximal tensile load, and when the tendon reperfuases after ischemia, oxygen free radicals can be generated, causing tendon damage through oxidative stress. Hypoxia alone, through ischemia, can also result in damage of the tendon. (3)

Under normal circumstances, tendons are able to transmit forces from muscle to bone and also protect muscles from damage by acting as a shock absorber for the muscle. They have a high level of mechanical strength, and are elastic in nature, allowing them to stretch and sustain forces from their associated muscle. (3) Tendon damage can occur with repetitive movement, with and without force, and with stretching over bony surfaces. (1) The extrinsic muscle-tendon units, which act on the wrist and hand but originate as high as the humerus, are subject to high levels of force and movement over bony surfaces because of their length and position over single or multiple joints.

The damage from mechanical stress occurs with collagen degeneration, fiber disorientation, and increased ground substance production, with an absence of inflammatory cells. (5) Tendons have a high level of elasticity to allow them to perform optimally, and can sustain strain <4%. Microscopic failure can occur when the strain exceeds 4%. Beyond 8-10% strain, macroscopic damage can occur with tears to the tendon. Frequent cumulative microtrauma, occurring from stresses within physiological limits can cause tendon damage if there is not enough time for the tendon to heal. (3)

Healing in the case of tendinosis is found to be disordered, with an imbalance between cell synthesis and...
Overuse Injuries of the Upper Extremity ...continued

degeneration. (3) It occurs by cellular proliferation either intrinsically, from within the tendon, or extrinsically, from the
tendon sheath and synovium. In the event of intrinsic healing, a relatively normal gliding of the tendon surface is maintained.
The increased scar production and adhesion development found in extrinsic healing can disrupt the gliding and mechanics of
the tendon, contributing to the pathology of the tendon. (3) In addition to cellular disorganization, the attempts at healing

Rehabilitation and Management of Tendinosis

Understanding tendinosis as a condition is essential in its management because of the chronic nature of the problem. (5)
Many patients come into the clinic expecting near or complete relief of their symptoms within a handful of visits. Education
on the meaning of degeneration of tendon tissue and the healing process, which will likely take months, is essential in
establishing a successful course of management. (2) However, despite extensive research on tendinosis, much is still
unknown, and the optimal treatment strategies have not been determined. (6,8) Physical rehabilitation from an occupational
or physical therapist is often the treatment of choice, and within treatment protocols there is some research showing
positive evidence of the efficacy of rehabilitation interventions, but more research is needed to determine the optimal
treatment programs. (6,7,8). Therapists need to create a treatment plan based on what is currently known about the
histology of tendinopathy, research on effective treatment interventions, and clinical experience.

Therapeutic modalities, such as iontophoresis and ultrasound, stretching/strengthening exercises, and splinting are all
routinely included in a rehabilitation program for tendinosis. (1,2,6,7,8,9) Recent paradigm shifts have changed from thinking
of these problems as inflammatory, with treatments aimed at reducing inflammation, to the current understanding of soft
tissue degeneration with treatments aimed at facilitating soft tissue healing. (1,2) Although there are some findings supporting
the use of these types of interventions in the management of tendinosis, and clinical experience lends itself toward
supporting these current forms of treatment, the general consensus is that there needs to be more research done to fully
support the use of these protocols in a successful rehabilitation program.

Activity Modification for Prevention and Management

A key element in a rehabilitation program is education regarding activity modification to reduce exposure to aggravating
activity. (1) Based on current research on the histology of tendinosis, preventing or reducing ischemia and mechanical stress
from stressful use should directly affect both the rate of degradation and the healing of tendon tissue. Functional demands
which are consistently reported as contributors to the development of tendinosis are repetitive or sustained gripping,
excessive use of force, direct pressure, vibration, and awkward or static positioning. (7, 8, 9). In addition to these functional
demands, sedentary lifestyle and ergonomic factors are considered to be risk factors. (9) It is important to understand that
these types of functional demands can be a factor in home, self-care/sleep, and leisure activities as well as work-related tasks.

Activity modification can include the following elements: pacing to reduce exposure, ergonomic changes, reducing the
required force of muscle/tendon use, and postural correction. Understanding the elements of activity which can initiate or
provoke symptoms is essential to knowing which activities to change. In addition to the characteristics noted above, activity
which requires the use of force in a way that produces pain (either during or after), which is sustained over time, and which
is repeated multiple times a day are all examples of activities which are attributed to symptom exacerbation. Successful
implementation of activity modification can include:

- Performing sustained or repetitive activity in shorter periods of time (i.e.: weed 15 min a day instead of two hours on
  a weekend) or taking mini breaks every 20-30 min of sustained activity for general movement and/or stretching
  exercises. (See www.workrave.org or similar website for free downloadable pop-ups for exercise/stretch break
  reminders when using the computer.)

- Alternating demanding activity with less demanding activity. (i.e.: instead of dusting every room and then vacuuming
  every room, alternate dusting with vacuuming for each room.)

- Avoiding repeated or sustained gripping with the elbow straight and the hand in a palm-down position (i.e.: reaching
  into cupboards or washing machine). When possible, try to keep the elbow closer to the body and position the
  hand palm-up.

- During repeated gripping tasks (such as taking blood pressure), try to keep the wrist as straight as possible and the
  thumb positioned close to the palm. Alternating hands is also beneficial.

- Choose tools and implements that fill comfortably in the hand, and that are optimal for use during a specific activity
  (i.e.: electric vs. manual can opener / stapler, automatic blood pressure cuff or one with a smaller bulb requiring
  less force, spring loaded scissors, enlarged handled cooking implements).

- When driving, alternate hand position on the steering wheel intermittently to change muscle groups used, and take
  intermittent rest breaks.

- Using adaptive devices when possible (i.e.: electric can openers, food processors, electric staplers, enlarged-barrel
Overuse Injuries of the Upper Extremity ...continued

• Reducing forces when possible (i.e.: making grocery bags lighter, lifting weighted objects with both arms).

• Avoid sustained pinch or grip (i.e.: computer mouse, steering wheel, book, magazine, dog’s leash).

• Assessing computer workstation setup (OSHA at www.osha.gov has an excellent e-tool for ergonomic self-assessment and adjustment).

• Become aware of tolerance for demanding activity and do not exceed it. Symptoms are often delayed in onset following a provoking activity, and an understanding and respect for general tolerance can prevent or minimize symptom exacerbation.

• Be aware of the big picture – the demands of a week and not just a day. For example, spreading activity over several days can be beneficial, but also consider the impact of multiple demanding activities occurring within several days on the ability for soft tissue healing to take place.

Symptom Management and When to Get Help

Prevention of the onset of symptoms is generally considered to be the best course of action. However, early management of symptoms once they do develop can also be key in preventing the degradation of tendon tissue and can facilitate healing. Many patients come into the clinic after months of symptoms which makes management more difficult. Symptom management generally advocated by therapists includes steps thought to effect blood flow: massage, ice, heat, and rest of the involved area. Overall wellness is also generally considered to assist in the prevention and management of tendinosis, including nutrition, cessation of smoking, limitation of caffeine intake, stress management, cardiovascular exercise, and good quality of sleep. In the presence of symptoms lasting greater than a week or more which cannot be modulated through symptom management, assessment and diagnosis by a physician is indicated.

References


It was so wonderful to see all of you who could attend our MACVPR October 23rd Symposium. As noted during the presidential address, several programs have notified us that they recently received AACVPR Program Certification and Recertification. Congratulations to these programs!!! (see below)

For those interested in certification or in need of recertification, please go to AACVPR’s website, www.aacvpr.org/certification and follow the prompts. Program certification and recertification applications are being accepted from Dec. 1, 2010 until Feb 28, 2011 for data collected in 2010. The process is done online and should be easier with the dashboard format. Several recommendations that were reviewed at the October 2010 AACVPR National Conference include:
1) Carefully read the instructions and submit only what is requested,
2) Use the help button if any questions arise and you should receive a response within 24-72 hours
3) Remember to label the ITP
4) Keep a 3 ring binder containing your application and the requested information in your department in case of an audit
5) Even though the 4th edition Pulmonary Rehab Guidelines is now available, this year’s application is still using the 3rd edition.

Program excellence and recognition and link to insurance coverage are among the many reasons to consider national certification. More information about certification, the application process, and a listing of certified programs is available on the national website above. We also plan to offer educational updates within the next year. In addition, please note that AACVPR has decided to reinstate a state liaison to facilitate communication between state and national. Per MACVPR’s general membership vote on 10/23/10, MACVPR’s contact person will be our president elect. In the meantime, if you need further assistance, please contact MACVPR through our website, admin@macvpr.org.

Congratulations again to all the programs recently and currently certified and best wishes to those considering this process towards program excellence and distinction.

Esther Burchinal, MS, CES, RCEP  
Emerson Hospital Cardiac Rehab  
esther@macvpr.org

Despite the current economic environment, financially as an organization we have continued to do well. 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. If you have any ideas for sponsors please forward the information to Ann at admin@macvpr.org.

Current balances as of November 2, 2010:
Citizen’s Bank checking: $8,973.65
Citizen’s Bank Money Market fund $2,628.44
Total $11,602.09

Annual report sent in to Secretary of Commonwealth as required for 11/1/10.

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

Congratulations!!

Certification:
- Baystate Medical Center’s Cardiac Rehab
- Cooley Dickinson’s Pulmonary Rehab
- Lahey Clinic’s Cardiac Rehab
- Lowell General’s Cardiac Rehab

Recertification:
- Brigham and Women’s Pulmonary Rehab
- South Shore Hospital’s Cardiac and Pulmonary Rehab

(These are the programs that informed us of their recent certifications. If we missed you please let us know)
I wanted to share some information from our recent JCAHO survey last Spring. First of all, there was an overall general focus on the facility and cleanliness, especially when it came to patient care. Here are a few points that were asked of our department:

- How do you clean your equipment? How long do you wait for it to dry?
- Where do you store your patient files and are they locked?
- Is your emergency equipment on a dedicated outlet with battery backup? ... and of course they checked.
- The code cart/defibrillator log was checked.
- What is your staff to patient ratio?
- Do you assess for abuse?
- Do you assess for fall risk? What would you do if they were at risk for fall? (how would you follow up)

Of note, when they asked me about assessing for abuse I told them I had just updated our forms to include this because it wasn’t in the chart that she was screening. She acknowledged me but I wasn’t sure if she believed me so I retrieved the new document to prove it and then she responded that she would not give us a deficiency because we had it. If I hadn’t shown it to her she would have — food for thought.

Good luck to anyone awaiting their survey!!!

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

Welcome New Members

Darcy Bussiere, RN
Nashoba Valley Medical Center

Colleen Geary, BS, CES
Caritas Holy Family Hospital

Pat Gonda RRT, CPFT
Caritas Holy Family Hospital

Jessica Mason, RN, MPH, AE-C
Baystate Medical Center

Benjamin Mattson, BS
Caritas Good Samaritan

Jennifer Morin, MS, RCEP
Total fitness Club

Loren Stabile, MS
The Center for Cardiac Fitness / Miriam Hospital

Virginia Verge, RN, BSN
Melrose Wakefield Hospital Hallmark Health

Barbara Yee
Mt. Auburn Hospital
The Distinguished Service Award is given to a member who has made outstanding contributions to the field of cardiac or pulmonary rehabilitation, the MACVPR/AACVPR, and/or has demonstrated commendable efforts toward clinical advancement in primary and secondary prevention of people with cardiovascular and/or pulmonary disease. This award is given on a biannual basis at our October Program Development Meeting.

The Executive Committee of the MACVPR would like to congratulate Wayne Reynolds as the recipient of the MACVPR Distinguished Service Award for 2010.

In her nomination letter Stephanie Dicenso, MS, RCEP, CES states.....

Wayne has worked in critical care, coronary care, and volunteered at Brockton Hosp/Brockton YMCA Cardiac rehab Program since 1982.

He was part of a team that developed phase II cardiac program at BH which opened in 1987 and on the team that developed the BH pulmonary program, opening in 1988.

He has been active with MACVPR since early 90's and on EC from 2002-2008.

Wayne has served as President of the MACVPR in 2006 and again as Co-president with Karen Gates MS, RCEP, CES in 2007.

He volunteered to Chair the J14MAC Committee in 2009 to ensure that Massachusetts had adequate representation on this committee due to the pending changes in the Medicare rules and regs.

He took the initiative in establishing the first face-to-face meeting with our MAC Medical Director, again demonstrating not only his intent to participate, but his actual participation and “will-do” attitude.

He is an active AACVPR member, frequently attends AACVPR annual meetings.

Just recently in October 2010 became a member of the AACVPR Health Policy and Reimbursement Committee.

He has been employed as the Coordinator of Cardiac/Pulmonary Rehabilitation Program with Signature Healthcare/Brockton Hospital in Brockton, MA since 1986.

Avid runner since teens, also biking, lifting, Yoga and for past 3 years have been a student and competitor in ballroom dancing

Above all, Wayne is a terrific person who through his actions repeatedly demonstrates his commitment to the MACVPR and the fields of cardiac and pulmonary rehabilitation

Wayne’s Response…….. Thank You

What an honor it is to be recognized by all of you and to be mentioned in the same way as the past recipients of the Distinguished Service Award. I know all of them, and they all have influenced me in my work both with the MACVPR and in my rehab programs. Though many past recipients have been helpful and inspiring throughout my career in cardiac and pulmonary rehab, there are three who deserve special mention for their mentorship, assistance and the example they have set for me to follow.

Our first honoree, Elizabeth Egan-Bengston was the first person to invite me to join the Executive Committee; recognizing that I not only had a penchant for speaking my mind, but offered solutions to problems that I spoke of. Her graciousness and expertise also inspired me to continue in the leadership arena.

Another DSA recipient, Karen Gates helped to solidify my commitment to the MACVPR and was a superb mentor while I was president-elect. She truly set the standard as a leader and was my partner as co-president after my first term as president, making that a truly remarkable year for both myself and the MACVPR.

Third, one of my first influences in the field, Burton J. Polansky, who is now Chief Emeritus of Medicine and Cardiology at Signature Healthcare- Brockton Hospital and in my eyes, Cardiac Rehab Medical Director “Emeritus” though no longer active with the program. He is one of the earliest pioneers in the field and has remained “current” these days with my help on CR issues, including reimbursement.

Lastly, all of you in the MACVPR who come to meetings with your questions on all matters and bring information back to your programs. Your passion and enthusiasm for what you do is what makes me happy to do whatever I can to be of service, whether on a local or national level, to ensure our patients receive the care they deserve.

Thank you all again.

Now let’s get back to work before CMS comes out with a new regulation!!!
Greetings fellow MACVPR members, I am excited to report that we had a very successful Fall Symposium! Once again we reached out to our members from across Massachusetts as well as professionals from our neighboring New England states to provide a timely and informative conference. The two national speakers, Randal Thomas, MD, MS, FAACVPR and Pat Comoss, RN, BS, FAACVPR, who are considered strong leaders in the field of Cardiovascular and Pulmonary Rehabilitation, provided motivation and direction keeping us on course providing the best possible care to our patients. The agenda also included an early morning yoga session, lead by Esther Burchinal, MS, CES, RCEP; nutrition lecture and cooking demonstration entitled Marrying Health and Healing with Cooking Local Foods delivered by Julia Elliott RD, LDN and husband Chef Ben Elliott; as well as a talk on Pulmonary Hypertension: an Introduction for the Cardiovascular and Pulmonary Rehabilitation Professional with Leslie Mitchell Pharm.D. at the podium. The conference was well attended with over 70 participants.

I must say it was most rewarding to have the privilege to review the evaluations from the conference. Excellent! Excellent! Excellent! I can’t tell you how many times I read this statement. For all the hard work and dedication the planning committee contributes this definitely provides the essential reward. Just knowing that so many benefitted from the expertise of our speakers provides us with the motivation to begin planning once again. You will find highlights from the conference on the next several pages.

The Education committee will be meeting on Friday November 19, 2010 at 10 AM to wrap up loose ends from our New England Symposium as well as establish a plan for our 2011 agenda. Make a difference! Please consider attending to find out how you too can contribute to our state organization.

Performing with Performance Measures was the talk delivered by AACVPR President Randal J. Thomas MD, MS, FAACVPR. In answering the question “why” he began his explanation with a quote from Thomas S. Monson which states “Where performance is measured, performance improves. Where performance is measured and reported, the rate of improvement accelerates.” This motivational presentation highlighted many key facts which included the following:

- Performance measures examine structure, for example is emergency response equipment in place?
- Performance measures look at process as in the number of patients screened for diabetes.
- Performance measures look at the outcomes such as re-hospitalization rate for Myocardial infarction.
- Performance measures are being implemented to bridge the gaps between ideal care and actual care.
- Cardiac and Pulmonary Rehabilitation are vastly underutilized which can only improve with the implementation of performance measures.

Documenting Program Success: Who Expects What from Who? was another exceptional talk delivered by Pat Comoss RN, BS, FAACVPR. She talked about program success form an external perspective and included ways to document and achieve this success. Included in this were compliance measures according to the CMS/Medicare guidelines, the Joint Commission/Department of Health and AACVPR standards. Internal perspectives were also addressed and included the patients as well as other customers such as the physicians, administrators and your own rehabilitation staff.

Pat Comoss shared her expertise, knowledge and strategies to help us navigate an intricate health care system. Her handouts were both helpful and numerous (15 in all) and provided participants with a strong take home message. The time provided gave attendees ample opportunity to ask questions.

Yoga of the Heart was an early morning Yoga session lead by Esther Burchinal, MS, CES, RCEP. Those who participated were able to appreciate a calming start to their day.
The MACVPR Inaugural Poster Presentation Session was held during the MACVPR 2010 New England Cardiovascular and Pulmonary Rehabilitation Symposium at Lahey Clinic, Burlington, MA on Saturday, October 23, 2010. Posters were displayed throughout the conference in the Southeast Lobby and provided a forum to share original research findings, showcase successful approaches to patient care, and highlight innovative ideas and projects. This session also provided an opportunity to disseminate important practice strategies and network with colleagues.

Included in the poster presentation were:

**Brief Motivational Interviewing**  
Patrick Schilling, BS, CEP – Cooley-Dickinson Hospital  
Brief Motivational Interviewing is a skill and technique used to enhance client motivation to change and comply with their Individual Treatment Plan (ITP), improving quality of care and patient outcomes.

**Cardiac Rehabilitation: Predictors of Heart Healthy Behaviors**  
Virginia Dow RN, BSN, BC – Emerson Hospital  
This study was conducted to determine to what degree learned behavior changes that accompany a 12-18 week cardiac rehabilitation program remain with attendees one year after successful completion. Age, diet and exercise self-efficacy, and total exercise were significantly related to compliance 1 year after completion of a cardiac rehabilitation program.

**The Social Support and the Continuum of Care for the Cardiovascular Rehabilitation Patient**  
Deborah Sullivan MS, APRN, BC – Lahey Clinic  
Findings from this qualitative research study suggest that perceived support led to a more active role in terms of health seeking/promoting behaviors versus a more passive/helpless role in the recovery process. In applying the theoretical framework of social support, perceived support leads to healthier identities for the new roles the cardiovascular rehabilitation patient must navigate.

**The Existential Dilemma of Coronary Artery Disease: Nurse as Agent of Change in the Emerging Field of Behavioral Cardiology**  
Patricia Baum RN, BSN – Lahey Clinic  
“To Be or Not to Be?” The Nurse and Behavioral Cardiology are prepared to diagnose the internal struggle persons face when they discover the way they live their life may be in direct conflict with their cardiovascular health.

**Enhanced External Counterpulsation for the Cardiac Rehabilitation Patient**  
Deirdre Proudman RN-C, BSN, CCRN – Lowell General Hospital  
EECP is a cutting-edge therapy and treatment option for patients with angina refractory to medical management. EECP has been shown to improve the patient’s quality of life by decreasing ischemic symptoms and permitting increased activity by stimulating the formation of collaterals to create a natural bypass around narrowed or blocked arteries that cause angina.

**Animal Assisted Activity for Stress Management**  
Donna Lind RN - Lowell General Hospital  
Animal Assisted Activity (AAA) is visitation performed with a volunteer handler and animal in a setting promoting emotional wellness. The primary purpose in visitation is to expand the stress management component of our cardiac rehabilitation program.

**Influenza Immunization as Secondary Prevention for Cardiovascular Disease**  
Deirdre Proudman RN-C, BSN, CCRN – Lowell General Hospital  
The American Heart Association and American College of Cardiology recommend influenza immunization with inactivated vaccine as part of comprehensive secondary prevention in persons with coronary and other atherosclerotic vascular disease (Class I, Level B). Health promotion is now being geared toward specific caring based interventions which can be designed for specific populations.

Summaries submitted by Deirdre Proudman RN-C, BSN, CCRN – Lowell General Hospital
Comments from Attendees….

- Speakers excellent - up to date info, cooking demo was fun - lunch and recipes fantastic!
- Enjoyed yoga early pre-conference
- Wonderful! I came from Maine and am so glad I made the trip! Very relevant, helpful information!
- Another excellent program! Great topics and speakers
- Varied topics - great presentations - great refreshments and lunch!
- All speakers' very knowledgeable, good info, very pertinent info, very helpful to our practices with info that can be implemented and practiced.
- Online registration, etc. was superb and efficient.
### Squash Soup

- 2 tbsp canola oil
- 1 large onion, finely chopped
- 4 large garlic cloves, chopped
- 3 14 1/2-ounce cans low-salt chicken broth
- 4 cups 1-inch pieces peeled butternut squash (about 1 1/2 pounds)
- 4 cups 1-inch pieces peeled acorn squash (about 1 1/2 pounds)
- 1 1/4 teaspoons minced fresh thyme
- 1 1/4 teaspoons minced fresh sage
- 1/4 cup non fat greek plain yogurt or low fat sour cream

**Preparation:**
Heat oil over medium heat. Add onion and garlic and sauté until tender, about 10 minutes. Add broth, all squash and herbs; bring to boil. Reduce heat, cover and simmer until squash is very tender, about 20 minutes. Working in batches, puree soup in blender. Return soup to same pot. Stir in yogurt or sour cream. Season with salt and pepper. (Can be made 1 day ahead. Chill. Re-warm over medium heat before serving.)

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### Chicken Waldorf

- Vegetable-oil cooking spray
- 3 boneless, skinless chicken breasts (about 4 oz each)
- 4 large celery stalks, chopped
- 2 Granny Smith apples, peeled, cored and cut into 1/2 inch cubes
- 1 red bell pepper, cored, seeded, and diced
- 3/4 cup reduced-fat sour cream
- 1/2 cup lowfat plain yogurt
- 1/4 cup golden raisins
- 1/4 cup chopped walnuts
- 1 tbsp honey
- 2 tsp fresh lemon juice

**Preparation**
Coat a medium pan with cooking spray. Heat over medium heat; sear chicken 8 to 10 minutes per side. When chicken reaches 155°F, remove from pan. Let cool; dice. Mix remaining ingredients except greens in a bowl with chicken. Add salt and pepper. Refrigerate 1 hour.

Chicken could be on top of a salad or in a wrap sandwich.

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### Apple Crisp

- 1/2 cup dried cranberries (available at specialty foods shops)
- 1 cinnamon stick
- 1 cup water
- 2/3 cup all-purpose flour
- 1/2 cup firmly packed light brown sugar
- 1/4 teaspoon salt (optional)
- 4 tablespoons smart balance, cut into bits
- 9 McIntosh apples (about 3 pounds)

**Preparation:**
In a small saucepan simmer the cranberries, the cinnamon stick, and the water for 10 minutes. Drain the cranberries and remove the cinnamon stick. In a small bowl blend the flour, the brown sugar, the salt, and the smart balance until the mixture resembles coarse meal and toss the mixture well. Peel, core, and slice the apples thin and in a buttered 9- by 13-inch glass dish toss them with the cranberries. Sprinkle the brown sugar mixture over the fruit and bake the crisp in a preheated 400°F. oven for 25 minutes, or until the apples are tender and the topping is golden.
PTSD

“Treatment for PTSD should be multidisciplinary and is often focused on teaching or relearning practical coping tools along with cognitive behavioral strategies, ..”

Connections: Mind/Body/Spirit

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

Question: I have been reading about Post Traumatic Stress Disorder (PTSD) in the news lately and also have had several patients who had difficulty undergoing medical testing, procedures, and rehabilitation due to symptoms of PTSD. Are there any mind-body interventions that may be helpful for use with PTSD?

Answer: While the disorder PTSD (or Post Traumatic Stress Disorder) has been around as long as humans have been traumatized, it has only recently become acknowledged, recognized and treated in our society. In fact, PTSD was first recognized as a distinct diagnosis in 1980. Recently the military has become much more aware of the condition and has begun to create initiatives to address PTSD both pre and post deployment of our troops. But PTSD is not solely a manifestation of wartime combat, exposure to traumatic, life altering events may trigger PTSD to develop in anyone: men, women, children, teens, adults and seniors. Health care professionals, first responders, and disaster relief workers may also be diagnosed with the disorder at some point in their lives.

Post Traumatic Stress Disorder (PTSD) develops as a result of witnessing or experiencing a very frightening, life threatening, emotionally or physically traumatic event(s). The symptoms of PTSD manifest themselves as avoidance, anxiety, hyperarousal, hypervigilance or dissociation to normal life experiences. Statistics regarding this illness indicate that approximately 7%-8% of people in the United States will likely develop PTSD in their lifetime. Approximately 7.7 million American adults 18 years or older suffer with PTSD each year. Prevalence of PTSD in combat veterans and abuse victims range from 10%-30% with higher rates among African-Americans than in Caucasians, and women suffering from PTSD twice as frequently as men. What is very important to recognize is that not everyone exposed to traumatic events will develop PTSD – it is not clear what mechanism triggers Post Traumatic Stress Disorder in some individuals and not others exposed to the same trauma.

Frequently PTSD manifests itself with several of the following symptoms:
- Recurrent re-experiencing of a trauma or dissociative re-living of the trauma
- Avoidance to the point of phobia, places, people, experiences that may remind the individual of the trauma
- Chronic physical signs of hyper arousal, sleep problems, increased startle response, hyper vigilance, poor concentration, irritability, anger, anxiety

Treatment for PTSD should be multidisciplinary and is often focused on teaching or relearning practical coping tools along with cognitive behavioral strategies, as well as the use of medication in some cases. Coping tools include mind/body skills such as relaxation techniques, mindfulness, increasing communication skills, reframing techniques, and educating the individual about connection of thoughts and feelings with physical symptoms. Some preliminary studies using a technique called Eye Movement Desensitization and Reprocessing or EMDR has shown positive results in a several small studies, but it is inconclusive whether this technique is more effective than other cognitive approaches. Acupuncture has also been used as an adjunctive treatment with PTSD with benefit to some individuals. The military has undertaken several studies to evaluate the effectiveness of mindfulness based approaches (specifically Mindfulness Based Stress Reduction or MBSR) for Post Traumatic Stress Disorder and the preliminary results are promising.

As a health care practitioner what can you do to facilitate safe and comfortable care to an individual with a symptom or a diagnosis of PTSD in your department or facility? Here are some suggestions:
- Acknowledge and recognize that PTSD occurs in many people, all ages and all genders. Often people with PTSD have not been properly diagnosed and may benefit from a referral for a consultation. Educate your patients and families that this is not only a condition of combat veterans and treatment is often very effective. Have educational resources and referral information available – including trusted websites (remember, currently most individuals seek out health information on the Internet)
- Some websites to consider:
  - http://www.ptsd.va.gov/
  - http://psychcentral.com/disorders/ptsd/
- Inform and explain in detail what to expect during a treatment, exam, or medical testing. Include a description of any sounds or sensations that may occur. Allow time for questions and be flexible whenever possible with modifications to allow a patient a sense of control in a situation that is unknown or potentially a stress trigger.
- Modify the treatment environment to decrease stimulation and increase control by the individual. An exam-
Connections: Mind, body, Spirit …..cont”d

- Encourage distraction and relaxation activities during periods of waiting, isolation or preparation. Do you have handheld games or puzzles available for patients? How about CDs or MP3 players with music, guided relaxation exercises or recorded books? Decreased concentration is an issue for many with PTSD, so short, focused activities are most effective.
- Proactively teach quick relaxation tools such as focused breathing (diaphragmatic breathing) or gentle chair yoga stretches to mitigate an over-activated stress response. Reinforce this teaching in subsequent visits.
- Incorporate tools of mindfulness into rehabilitation plans.

Acknowledging, recognizing and responding to manifestations of PTSD in your patients by incorporating mind/body interventions will assure a more successful rehabilitation and quality of life for your patient and their family.

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

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1 http://www.medicinenet.com/posttraumatic_stress_disorder/article.htm
4 http://www.medicinenet.com/posttraumatic_stress_disorder/article.htm
6 http://clinicaltrials.gov/ct2/show/NCT00880152

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.

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Remember to Celebrate!

February 13-19, 2011
March 13-19, 2011

CARDIAC REHABILITATION
Take Your Recovery To Heart

PULMONARY REHABILITATION
Our Aim Is To Inspire You
**PLEASE RENEW YOUR MEMBERSHIP**

The following individual memberships have either expired since November 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.

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**Reminder:**

The Executive Committee is still trying to fill the **Co-Presidents 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!!

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**MEMBERSHIP APPLICATION**

Or

Download application from [www.macvpr.org](http://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

Two year membership
- [ ] $75 through December 31, 2010
- [ ] $100 January 2011
  (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 Rehabilitation (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