Hope this update finds you all enjoying what is left of a beautiful autumn season in New England. It was really great to see so many of you at our Fall New England Regional Symposium in October. The feedback from many who attended was very positive and we hoped that you enjoyed the new, more convenient location at the Hampton Inn in Natick this year. The Executive Committee will be regrouping in December to review the program evaluations. As always when we try something new, there will be opportunities to improve for next year. In general, I thought the slate of speakers this year were very informative and the topics were varied enough to provide new learning for all of our colleagues. Kudos to our Education Chair, Deirdre Proudman, for all of the work that she has been doing behind the scenes to organize the speakers. It was nice to see colleagues from our neighboring New England states as well. Hope you had a chance to network and discuss new ideas and best practices.

As I continue in the leadership role for my second year as President of MACVPR, I wanted to update you on some of the exciting ideas, offerings and announcements from the Executive Committee members.

CCRP: We have once again applied to AACVPR Professional Certification Committee to host the CCRP exam as a regional site in Massachusetts. We are hoping to be accepted as a Regional Site for a date in late April (I have submitted the application with a tentative date of April 28). More to come on this once I have officially heard back from the AACVPR Professional Certification Committee. As a hosting site, we need to have at least 10 persons registered to take the exam at our site. If you are interested in this potential offering, please let me know as I would like to get an estimate number from our local region. You can send me an email at karen_lafond@sshosp.org.

As many of you know, the CCRP exam is for any qualified cardiac rehab professional who is interested in taking their current practice up to the next level. I encourage any of you who would like to consider taking advantage of this great opportunity for professional certification in your specialized field in our local regional area. Having had the experience of taking the CCRP exam in the Fall of 2013 in Denver, I can recommend that the resources that are available through the AACVPR were very helpful as part of my preparatory process. As of today, there are many of our colleagues both in Massachusetts as well as nationwide who have become CCRP certified either at the National AACVPR conference or at their local regional location. That is a great tribute to the commitment and dedication to enhancing our current practice.

Executive Committee and/or committee work opportunities: On Thursday, December 10 from 9-11AM we will be having an open Executive Committee meeting. The meeting will take place at the American Cancer Society building at 30 Speen St. in Framingham. We would like to invite any of our colleagues to attend this meeting to learn about how to get more involved in our organization. Please reach out to anyone on the Executive Committee or email me directly if you are interested in attending the meeting. If you are unable to attend but would like to become more involved, let me know.
Finding the N: By now, you should have received an email re: “Finding the N” – phase 2. I am a current member of the AACVPR Membership Committee and we are looking to know how many of us and under what disciplines are out there working in both cardiac and pulmonary rehab programs across the country. The AACVPR membership committee is overseeing this project and I have been asked to send out the Survey Monkey for all programs to complete. This short survey was part of the email message that was sent out to all of you in mid-November. Your response to the survey will go directly to the AACVPR Membership committee chairperson. Hoping to have all of the surveys back in early December. Please let me know if you had not received this email and we will get it out to you.

Administrative Assistant change: After many years of committing time and energy towards keeping our organization running smoothly, our administrative assistant, Ann Stone, is stepping down from her current role with the organization. In the short term, Ann will be available to manage our current website until we are able to hire a replacement for her. We will be posting this position and in the interim, if you know of anyone who may be interested in this role, please contact either myself or Lynne MacDonald (our President-elect for 2016) at lynne.macdonald12@gmail.com.

I hope to see many of you at our next educational meeting in January. We have some great speakers lined up as well as time for networking with others. Let’s hope for some good weather, too. We have secured the American Cancer Society building in Framingham again for our educational half-day meetings for 2016. Look forward to your continued feedback with the Executive Committee so that we can better meet your needs. As always, looking for more of you to get involved in the organization and please reach out to any of our EC members to learn more about the different roles that are available to you.

Best Regards,
Karen

Karen LaFond, MSN, RN, CCRP
President MACVPR
karen_lafond@sshosp.org

“The way to get started is to quit talking and begin doing.”
— Walt Disney

This quote describes how I hope to get started as your new President for 2016. I am anticipating an exciting year with some new faces on the Executive Committee! It will also be challenging as we have big shoes to fill in the Administrative Assistant role since Ann Stone is stepping down this year. She will certainly be missed.

I am hoping that someone will step up to take on my role as Newsletter Editor for 2016. It really is a fun position. If you have good computer skills with Word and can copy and paste, you will have no problem putting together the newsletter! Please consider getting involved.

I have been trying to make the newsletter as helpful to you as practitioners as possible. Unfortunately, we never get much feedback about the newsletter. I had thought that having more patient education material already written would be helpful to me. It’s nice to get some information here in this newsletter, but who has time to translate that into patient education? Therefore I had asked the contributors to the newsletter to provide information that can be just printed off and used in your practices. You can find these documents in Word format on the website under the newsletter section. Did you find this helpful to you at all? I know I printed off the documents from the last newsletter and now use them in my department.

Now that we are a Joint Affiliate and we all are also members of AACVPR and receive AACVPR’s News & Views, I am wondering if we should change the MACVR newsletter in any way? I guess I will leave that up to the new Newsletter Editor for 2016 and the EC but we would welcome any input from all of you. We always want to meet the needs of the members of the organization….but you need to voice your opinion.

Feel free to email me at lynne.macdonald12@gmail.com with your ideas or contributions. Thanks!

Lynne MacDonald, PT
Beth Israel Deaconess Hospital-Milton Cardiac Rehab
MACVPR Newsletter Editor

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.
As new joint affiliate members we have full access to the AACVPR website and the reimbursement updates [https://www.aacvpr.org/Advocacy/Reimbursement-Updates](https://www.aacvpr.org/Advocacy/Reimbursement-Updates) which provides a wealth of information. I invite you all to review this information and note the specific changes that affect your programs. The proposed CMS 2016 Hospital Outpatient Prospective Payment System (HOPPS) are listed and show a modest bump in payment for Pulmonary Rehabilitation and a significant bump for Intensive Cardiac Rehabilitation. Traditional Cardiac Rehabilitation reimbursement has remained basically unchanged. Phil Porte, BA and Karen Lui, RN, MS, AACVPR participated in a recent Webcast entitled Medicare Rules and Important Regulatory Issues for 2016 which I highly recommend that you view. This 60 minute presentation is available to you as joint affiliate member.

Hopefully the transition from ICD-9 codes to ICD-10 diagnosis codes has been smooth for you. If not I once again refer you to the AACVPR website for a multitude of resources and encourage you to post questions on the forum. If you are having issues please let us know so your learning needs are identified and can be addressed by the MACVPR and AACVPR Education Committees. [https://www.aacvpr.org/Portals/0/Advocacy/Reimbursement%20Updates/2015/September%204,%202015%20Reimbursement%20Update-%20Transition%20to%20ICD-I%20%20Diagnosis%20Codes-Preparation%20Continues.pdf](https://www.aacvpr.org/Portals/0/Advocacy/Reimbursement%20Updates/2015/September%204,%202015%20Reimbursement%20Update-%20Transition%20to%20ICD-I%20%20Diagnosis%20Codes-Preparation%20Continues.pdf)

The AACVPR continues to lobby in Washington to address the issues related to supervision of cardiac and pulmonary rehabilitation programs. I like to think that we are getting closer to a solution that will allow non physician providers (NPs, PAs and CNs) to supervise the day to day operations of programs and remove the restrictions imposed by requiring a physician to be immediately available. Stay tuned for the legislative updates to H.R 355 and considers participating in the Day on the Hill festivities (March 3 & 4, 2016 in Washington DC). This will provide opportunities for you to speak directly with your legislators and their staff.

These are exciting yet challenging times for our profession in the health care arena. The work we do is significant in the lives of many. We must continue to stay active within our professional organizations for the recognition our programs deserve.

Thank you for the opportunity to serve as your Immediate Past President.

Deborah Sullivan, MS, APRN-BC, CCRP
Immediate Past President
Temperature, Pulse, Respirations, Blood Pressure, Pain, and Health Literacy: The Newest Vital Sign

Deirdre Proudman MSN RN-BC, CCRN
Cardiac and Pulmonary Rehabilitation Lowell General Hospital

The Centers for Medicare and Medicaid Services and the Joint Commission (2010) estimate that up to half of all readmissions are preventable. Nonadherence to medication regimens, failure to adhere to a reduced sodium diet, and delays in seeking medical attention in a COPD exacerbation are among the primary reasons related to rehospitalization.

Research shows that patients with low health literacy are less likely to comply with prescribed treatment and medical instructions from their providers. Providing patient-centered care and patient assessment are core competencies for cardiac and pulmonary rehabilitation/secondary prevention professionals. Identifying patients who are at risk for low health literacy allows health care providers to apply specific clear health communication techniques that may enhance understanding.

Literacy is defined by the International Adult Literacy Survey (IALS) as the understanding and application of words (prose), numbers (numeracy), and forms, etc. (document). Health literacy has been defined as the “degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” (Institute of Medicine, 2004). The importance of health literacy in chronic disease care and self-management has been addressed in publications by the Institute of Medicine (2004), the Agency for Healthcare Research and Policy (2004), and the Joint Commission (2007).

Health care literacy includes reading and visual communication, oral communication, numeracy skills, knowledge of health, and cultural competence.

Self-management refers to behaviors and strategies that individuals take to maintain or improve their health status. During the evolution of a chronic illness such as coronary artery disease (CAD), congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), or diabetes (DM), patients and their families are constantly learning new behaviors required for appropriate disease management skills. Self-management’s aim is to increase patient involvement and control in their treatment and its effect on their lives.

The Newest Vital Sign is a new tool designed to quickly and simply assess a patient’s health literacy skills. It can be administered in only 3 minutes and is available in English and Spanish. The patient is given a specially designed ice cream nutrition label to review and is asked a series of questions about it. Based on the number of correct answers, health care providers can assess the patient’s health literacy level and adjust the way they communicate to ensure patient understanding.

The Newest Vital Sign is available to medical and public health providers at no cost at www.pfizerhealthliteracy.com. The information below is taken directly from their downloadable flip book. In addition to assessing health literacy, it can also be used in nutritional counseling and education on label reading.

Why Does an Ice Cream Label Work as a Predictor of the Ability To Understand Medical Instructions?

A patient’s ability to read and analyze any kind of nutrition label requires the same analytical and conceptual skills that are needed to understand and follow a provider’s medical instructions. The skills, defined as the understanding and application of words (prose), numbers (numeracy), and forms (documents).

The use of an ice cream label is especially relevant as recent research in the American Journal of Preventive Medicine (November 2006) has shown that poor comprehension of food labels correlated highly with low-level literacy and numeracy skills. However, the study found that even patients with better reading skills could have difficulties interpreting the labels.

Whether reading a food label or following medical instructions, patients need to:

- remember numbers and make mathematical calculations.
- identify and be mindful of different ingredients that could be potentially harmful to them.
- make decisions about their actions based on the given information.

PROSE LITERACY:

Clinical example: The patient has scheduled some blood tests and is instructed in writing to fast the night before the tests. The skill needed to follow this instruction is **Prose Literacy**.

Ice cream label example: The patient needs this skill to read the label and determine if he can eat the ice cream if he is allergic to peanuts.

NUMERACY:

Clinical example: A patient is given a prescription for a new medication that needs to be taken at a certain dosage twice a day. The skill needed to take the medication properly is **Numeracy**.

Ice cream label example: The patient needs this same skill to calculate how many calories are in a serving of ice cream.
**DOCUMENT LITERACY:**
Clinical example: The patient is told to buy a glucose meter and use it 30 minutes before each meal and before going to bed. If the number is higher than 200, he should call the office. The skill needed to follow this instruction is **Document Literacy.**

Ice cream label example: The patient needs this skill to identify the amount of saturated fat in a serving of ice cream and how it will affect his daily diet if he doesn’t eat it.

**Best Practices for Implementation:**
A nurse (or other trained clinic staff) is the preferred administrator of the Newest Vital Sign.
Administer the NVS at the same time that the patient’s other vital signs are being taken during the initial assessment.

Show the patient the ice cream label and read each question to your patient.

**Score by giving 1 point for each correct answer (maximum 6 points).**
Score of 0-1 suggests high likelihood (50% or more) of limited literacy.
Score of 2-3 indicates the possibility of limited literacy.
Score of 4-6 almost always indicates adequate literacy.

Record the NVS score in the patient’s medical record, preferably near other vital sign measures.
Record the NVS score in the patient’s chart, preferably near other vital sign measures.
Tailor communication to ensure patient understanding and utilize teach back as a method to evaluate understanding.

![Ice Cream Label Example](image)
Score Sheet for the Newest Vital Sign Questions and Answers

**READ TO SUBJECT:** This information is on the back of a container of a pint of ice cream.

1. If you eat the entire container, how many calories will you eat?
   
   **Answer:** 1,000 is the only correct answer

2. If you are allowed to eat 60 grams of carbohydrates as a snack, how much ice cream could you have?
   
   **Answer:** Any of the following is correct: 1 cup (or any amount up to 1 cup), Half the container. Note: If patient answers “two servings,” ask “How much ice cream would that be if you were to measure it into a bowl.”

3. Your doctor advises you to reduce the amount of saturated fat in your diet. You usually have 42 g of saturated fat each day, which includes one serving of ice cream. If you stop eating ice cream, how many grams of saturated fat would you be consuming each day?
   
   **Answer:** 33 is the only correct answer

4. If you usually eat 2500 calories in a day, what percentage of your daily value of calories will you be eating if you eat one serving?
   
   **Answer:** 10% is the only correct answer

**READ TO SUBJECT:** Pretend that you are allergic to the following substances: Penicillin, peanuts, latex gloves, and bee stings.

5. Is it safe for you to eat this ice cream?
   
   **Answer:** No

6. (Ask only if the patient responds “no” to question 5): Why not?
   
   **Answer:** Because it has peanut oil.

**Interpretation**

<table>
<thead>
<tr>
<th>Number of correct answers:</th>
</tr>
</thead>
</table>

Score of 0-1 suggests high likelihood (50% or more) of limited literacy
Score of 2-3 indicates the possibility of limited literacy.
Score of 4-6 almost always indicates adequate literacy.
Carolyn Come, MD, Brigham and Woman’s Hospital Pulmonary and Critical Care Medicine, Instructor at Harvard Medical School, and Director of BWH Faulkner Pulmonary Rehabilitation program, opened the symposium with her presentation on Pre-and Postoperative Pulmonary Rehabilitation for a Patient Undergoing Lung Transplant. Dr. Come’s knowledge of her subject matter was evident as she illustrated the history of human lung transplant beginning in 1963 to the first transplant at BWH in 1990. The transplant roadmap reviewed disease specific indications and contraindications, patient evaluation, and the wait if selected. Her passion for her practice and her patients was evident in the personal stories intertwined throughout her presentation. The role of pulmonary rehabilitation was discussed pre and post transplantation. “PREHAB” optimized cardiac output and muscle strength pretransplant. It is an opportunity to assess oxygen needs, optimize lung function, and is an environment for patient education and support. It provides an opportunity to introduce exercise as an activity of daily living transitioning to immediate rehabilitation post transplant. Patients are subject to a rigorous schedule of exercise, 4-5 times per day alternating with periods of rest and education before discharge and transitioning to an outpatient program. The message and role of pulmonary rehabilitation programs: Keep moving – before, during, and after transplant!

Novel Devices for Stroke Reduction in Atrial Fibrillation followed our pulmonary topic presented by Bruce G Hook MD, Cardiology/Electrophysiology Lahey Hospital & Medical Center. Dr. Hook immediately engaged the audience opening with the role of atrial fibrillation (AF) in stroke. The impact of atrial fibrillation on stroke risk was further illustrated with the CHADS2 and CHA2DS2-VASc Score Stroke Risk Assessments for annual stroke risk and anticoagulation. Warfarin is effective in limiting stroke in atrial fibrillation, but only about 50% of patients indicated for warfarin are actually prescribed the drug and up to 14-40% of patients may be contraindicated for warfarin. The structure of the left atrial appendage anatomy has been identified as the source of thrombus formation in 90% of patients with stroke and AF. The risks and benefits of the Lariat Procedure, Watchman Device, Amplatzer Cardiac Plug Device, and Atriclip were presented as interventional options for the LAA. Left Atrial Appendage Closure as an Alternative to Warfarin for Stroke Prevention in Atrial Fibrillation with the Watchman Device was a multicenter study in patients ineligible for warfarin with a 94.7% success rate and a procedure time of 52 minutes. A highlight of the presentation included the Lahey Watchman clinical trial experience in PREVAIL AND CAP-2 studies with the first implant: 5/17/11 as part of PREVAIL, final implant: 10/29/13 in CAP-2 trial. March 2015 Watchman received FDA approval for stroke prevention and May 2015 Watchman implants began at Lahey.

Mary McGowan, Chief Executive Officer WomenHeart: The National Coalition for Women with Heart Disease spoke on WomenHeart National Hospital Alliance: A Partnership to Advance Women’s Heart Health and Improve Patient Outcomes as the first and still only national organization solely devoted to women’s heart health and providing patient support services to women living with heart disease. Comprised of hospitals committed to advancing women’s heart health, the partnership seeks to ensure that women heart disease patients in every community have access to information, education, and patient support services. 42 million American women are living with or at risk of heart disease which remains the #1 cause of death of women in this country. WomanHeart Support Networks provide peer to peer patient support for women living with heart disease by another female heart patient who has been trained to provide patient support. Support for women is crucial to recovery for wellbeing and maintaining the lifestyle changes and medication regimen for enhanced quality of life.

Kate Traynor, RN, MS, FAACVPR, Director, Cardiovascular Disease Prevention Center Massachusetts General Hospital, delivered the first of a two part presentation beginning with The Role of Cardiac Rehabilitation in Heart Failure Patients. Kate opened her lecture with a history lesson and a reference to Paul Dudley White and his prescription for a healthy way of life. The central component of his philosophy was its emphasis on the value of regular physical activity. He also emphasized the value of physical effort as an antidote to anxiety and emotional stress. If we bear in mind that in his structure for a healthy life he included the control of hypertension and obesity, the opposition to cigarette smoking, and the moderate use of alcohol, we realize that he was a pioneer in the promotion of prevention and rehabilitation of heart patients, and the core components of cardic rehabilitation. Exercise training in addition to psychosocial, risk factor management and/or educational interventions is considered Class I indication (useful and effective) in CAD pts with CAD. Pathophysiological mechanisms of exercise intolerance in heart failure suggest that in addition to the usual assessment, individualized treatment plan, and core components, the standard exercise recommendation of 30 minutes/day, 5 or more days a week with parameters for intensity, duration, and frequency could be modified to include interval vs. continuous
exercise and strength and resistance training as a modality. Outcomes from the MGH program echoing study conclusions that exercise training and cardiac rehabilitation was associated with significant improvement in overall quality of life and self management.

The second presentation was the **AACVPR Update** presented by Kate as a member of the Board of Directors at the National level. Key strategic initiatives of AACVPR for the coming year include the headings of education, innovation, viability & quality, and membership. Accomplishments to date include the launch of the Certified Cardiac Rehabilitation Professional (CCRP), the only certification aligned with the published CR competencies, “Finding the N” – Phase 1 identifying the number of cardiac and pulmonary rehabilitation programs in the US and Phase 2 collecting program staff information. In February, a new eLearning Center was launched on the AACVPR website as part of our efforts to provide innovative new learning opportunities. Kate also outlined:

- Benefits of AACVPR membership including practice guidelines, resources, and publications.
- How AACVPR is aligned with changes in health care policy and reimbursement
- Certification of programs
- AACVPR Registry and Outcomes
- Joint Affiliation
- Advocacy and A Call to Action- Day of the Hill DOTH March 23 & 24 2016 Washington DC

The final presentation of the day was **Clinical Features of Spontaneous Coronary Artery Dissection (SCAD)** delivered by Malissa Wood MD, Co-Director of the MGH Heart Center Corrigan Women's Heart Health Program and lead investigator of the MGH Spontaneous Coronary Artery Dissection (SCAD) Registry. Dr. Wood opened with a case study of a 40 year old female and her catheterization films and brought us through her clinical course. Illustrated throughout the presentation were the gender differences in symptoms experienced by women with acute coronary syndrome (ACS) and the unlikelihood of these symptoms being recognized as caused by ACS. The proportion of MI patients who presented without chest pain was significantly higher for women than men with young women less likely to have chest pain than older women (Canto, JAMA 2012). Also, in women ages 30-55, abundant competing and conflicting priorities influenced decisions about seeking acute care. Spontaneous coronary artery dissection is an uncommon occurrence, but because it occurs spontaneously, it’s important to recognize the symptoms and get treatment immediately. The artery wall has three layers and when a tear occurs, blood is able to pass through the innermost layer and become trapped and bulge inward. This narrows or blocks the artery and can cause a heart attack because blood flow cannot reach the heart muscle. Patients are often young women who are otherwise healthy, with few or no risk factors for heart disease. Some studies have pointed to a hormonal link, showing a greater incidence among post-partum women and women who are experiencing or close to a menstrual cycle. In men, SCAD may occur after extreme exertion, such as isometric exercises. Treatment for SCAD patients differs from other heart attack patients, who may require angioplasty to open the artery or bypass surgery. For SCAD patients, more conservative therapy that emphasizes blood pressure control, rest, and medication was analogized to a pregnancy. First trimester is rest allowing the artery to heal, second trimester is cardiac rehabilitation, and third trimester is reentry into work, and family roles. Young women can present with typical and atypical symptoms in the setting of coronary artery disease. Further research is required to better understand the risk factors for and pathophysiology of coronary artery dissection in order to develop possible preventive therapies.

We also had one **Poster Presentation**: **Benefits of High Intensity Interval Training (HIIT) on Heart Disease Patients** By Jacqueline Flaherty

**Fitchburg State University Exercise Physiology Student** (please see full article in the Winter 2015 newsletter on our website)

**SUMMARY:** Sixty signed evaluations were returned from seventy-one registrants. All speakers were scored with a “1” which was the best score except on two evaluations. Contact hours were **American Association of Critical Care Nurses (AACN) for 5.50 Contact Hours Synergy CERP Category A, File Number 00019344.**

**Positive feedback:** Great location, great speakers! Education committee great job!

**Room for improvement:** Room temperature. Too cold. Lunch was poorly rated by most. Great pulmonary speaker but rest of program was good but was all cardiac. PowerPoint Presentations should be available for all speakers.

**Topics for upcoming meetings:** Clinical competencies on LVADs, MET Minutes, vary topics to include all professions.
MACVPR 2016 January Half Day Meeting
January 28, 2016     9:00-12:45
American Cancer Society
30 Speen Street, Framingham, MA 01701

Determining Oxygen Need and Delivery Systems
Donna Hawk RRT, AE-C
Respiratory Therapist, Pulmonary Rehabilitation Clinician; Baystate Medical Center

Tipping the Balance toward Better Outcomes:
A review of fall risk assessment and neuromotor training recommendations
Esther Burchinal CCRP, RCEP, CEP
Clinical Exercise Physiologist Emerson Hospital

And

Monica Maldari CEP, RCEP
Assistant Professor Fitchburg State University; Clinical Exercise Physiologist Emerson Hospital

There will also be plenty of time for networking!

Watch your emails for the on-line registration link
Beta Blockers

This is the first in series of brief articles on the side effects of medications commonly used in patients with cardiovascular disease. We will also mention ways in which patients can address or lessen the side effects.

Beta blockers can be used in conditions including heart attack, high blood pressure, heart failure, angina, atrial fibrillation, and non-cardiovascular diseases. To understand the side effects of beta blockers, we should first understand their general mechanism. In a normal stress response, heart rate and blood pressure increase, lungs expand for easier breathing, blood flow to muscles increase, and blood sugar and fats increase to fuel higher energy needs. Beta blockers inhibit stress hormones from activating beta receptors, therefore decreasing stress response.

In the heart, beta blockers decrease heart rate and the force of each heartbeat. Because the heart is not working as hard to circulate blood, you may notice some exercise intolerance and fatigue. It is important to continue your exercise regimen, so keep in mind that these side effects should lessen over time as the body adjusts to the medication. Other tips include taking beta blockers in the evening after the day is done, splitting the dose into morning and evening doses, or taking a different beta blocker.

You may also experience cold hands, feet, ears and nose which can be due to decreased blood flow to your extremities. This side effect can be managed by exercise, warming devices, and avoiding triggers (cold environments and stress). You might already be on other medications (calcium channel blockers, ACE inhibitors, “statins”) that can help moderate this side effect as well. If this side effect is very severe, please talk to your physician as this might be a sign of Raynaud’s Disease.

Another side effect of beta blockers is airway constriction in the lungs. You may experience some shortness of breath, which can be especially problematic if you have asthma, COPD, or other respiratory conditions. The best recommendation if you must use beta blockers is to use with caution certain beta blockers that have minimal effects on the lungs. This side effect can be serious, so talk to your physician about what options you have since there are many beta blockers on the market.

If you have diabetes, you should be cautious when using beta blockers, since these medications can increase blood sugar and fats, they can mask the signs of hypoglycemia. Hypoglycemia signs such as tremor and palpitations may be masked, but you can still be aware of blood sugar status. In this situation, it is recommended to monitor blood sugar more closely and look for alternative signs like sweating or poor concentration. Again switching to a different beta blocker may decrease these side effects.

Because beta blockers can affect the brain, you may experience sleep disturbances such as insomnia and vivid dreams. Taking these medications in the morning or taking a different beta blocker may help decrease these effects.

Lastly, do not stop beta blockers suddenly. Any dose reduction or stopping of treatment should be discussed with your physician first.

There are many other side effects including headache, diarrhea, depression, and sexual dysfunction that have been associated with beta blockers. Because this is not an exhaustive review, concerns about your medication side effects should be address with your physician.
MACVPR Administrative Assistant Position

Our Administrative Assistant Ann Stone, has resigned her position. She is a very busy lady with many endeavors and did not feel she could continue to devote her full attention to the MACVPR as she had done so wonderfully for so many years. She will be missed.

We are currently looking to fill the Administrative position effective immediately. This is a part-time position

Job Responsibilities:

Under the supervision of the President/Co-Presidents and the Executive Committee, the Administrative Assistant performs all clerical and administrative functions of the MACVPR organization. Knowledge of Cardiac and Pulmonary Rehab is an asset. Computer knowledge of Microsoft Word, Outlook email and Access is highly recommended.

Assist with Coordination of Full and Half Day Meetings (3)
- Create web/ email announcement
- Maintain roster for the meetings
- Order food for meeting
- Book meeting room
- Attend meeting, assist with set up and registration, and take minutes at business meeting

Support Executive Committee
- Type and send agenda prior to meeting
- Take and distribute minutes
- Maintain EC contact list
- Other duties as needed by committees

Newsletter
- Responsible for posting on website
- Assist Newsletter Editor as needed.

Web Site (this part of the position is optional)
- Update membership information (on Wordpress)
- Update program directory information (on website intranet)
- Upload documents, newsletters, and meeting agendas

Deposits and Reimbursement of expenses:
- Deposits checks received from membership, program development meeting, sponsorship, advertising, and program directory
- Submit to treasurer a deposit summary and expense report

Other duties as assigned by the MACVPR executive committee.

Description of Administrative Assistant Fee and Hours:
- The Administrative Assistant will be reimbursed $21/hour plus reimbursable expenses.
- The position requires approximately an average of 15-20 hours per month (Keep a detailed log of hours and description of tasks worked on.

Please forward your letter of interest and resume via email to:
Lynne.MacDonald12@gmail.com and/or Karen_LaFond@sshosp.org
Processed Meat Scare—Weighing in on What This Means to the Consumer

The Boston Globe recently featured an article about the danger of processed meat causing cancer and a linkage of red meat to increasing cancer risk. According to the World Health Organization international agency processed meat is referred to as “meat that has been salted, cured, fermented, smoked, or undergone other processes to enhance flavor or to improve preservation.” These foods include sausage, hot dogs, corned beef, canned meat, meat based sauces, beef jerky and anything smoked. Red meat is any meat that comes from a mammal including (beef and veal), pigs (pork), sheep (lamb and mutton), horses, goats and bison all count as red meat. (World Health Organization definition) Based on the article, there was an 18 percent increased risk of colorectal cancer found between a 50-gram portion (1.5 oz or 1 ½ slices) of processed meat.

Many consumers may be very alarmed by this information and unsure as to what they should be consuming on a daily basis. Recommendations have not been made by the WHO organization as to how much red meat or processed meat can be safely consumed. One thing that we know for sure is that red meats and processed meats tend to be higher in calories and saturated fats. These are the fats that may raise cholesterol, increase our risk for diabetes and lastly but surely add to our waistlines. Processed meats and red meat is something that we should all be careful of on a day to day basis regardless of the recent information from the World Health Organization. We need to be mindful of moderation daily. WHAT IS MODERATION? How can we quantify this? I thought it would be a good idea to visit the recommendations made by the American Cancer Society and American Heart Association to gain some insight as these are held as standard recommendations for all.

The American Cancer Society recommends that an individual should limit the amount of processed meat and red meat consumed in a day. The American Heart Association recommends that we choose poultry and fish without skin and prepare in healthy ways. If choosing red meat, choose lean cuts and prepare in healthy ways. Also, they recommend choosing foods prepared with little or no salt. Reducing daily sodium intake to 1500 mg is desirable because it can lower blood pressure. Processed meats tend to be high in sodium which will definitely put a person over the edge of their daily limit. For example, 2 oz or 2 slices of Boars Head Golden Classic oven roasted chicken breast contains 350 mg of salt per serving which is 42% less than the leading turkey. It is important to choose wisely when making dietary choices. Increasing fruits and vegetables is an excellent way to feel full without taking in extra saturated fats and salt. Limiting protein to the “palm of hand” for portion control will also help to stay within portion guidelines. Some individuals could aim to have a vegetarian meal once or twice a week to eliminate animal proteins, increase fiber and reduce sodium. For some individuals, cutting back on animal proteins and adding in extra legumes is a manageable compromise.

In conclusion, it is recommended to try and make these recommendations as part of your daily routine. It is not stated that one has to 100% eliminate processed meat and red meat from the American Diet but to be more mindful of food choices and portions. Keep a food log and track the amount of food items within your typical day that include red meats and processed meats. Then, try to cut these portions in half on the days that you have them. Next, try to cut down the amount of days per week that you have these foods. Once this becomes comfortable, aim to have these foods every other week and replace with higher fiber lower fat food options such as fish, chicken, legumes, fruits, vegetables, low fat dairy and whole grains. Remember, eating healthy takes time and can at times be a balancing act. Look forward to trying new foods and modify foods when necessary.
Membership News

I enjoyed seeing all of you at the October Symposium. As you know MACVPR is now an AACVPR Affiliate. This continues your access to:

The macvpr.org website “Members Only” section which includes:
- Tri-annual MACVPR News” Newsletters
- Reimbursement Updates
- On-line Networking Forum
- Two Half-day complimentary Membership Meetings
- Reduced registration fee at the Fall Full-day Membership meeting.

Also as an AACVPR State Affiliate with your Joint Affiliate Membership, you will pay yearly dues and receive all of the benefits that Education Advantage and Professional Memberships offer. You are automatically enrolled as a member of your state society, gaining you access to your local network and resources.

If you recently joined AACVPR and qualify for the reimbursement please reach out to me at capemds@gmail.com and I will be sure our Treasurer- Donna Hawk disperses your $50 check.

I will be stepping down as Membership Chair at the end of this year. I have appreciated meeting and working with all of you and will continue to see you at meetings.

Melessa Fox, RN, BSN
Falmouth Hospital Cardiac Rehab
MACVPR Membership Chair

Treasurer’s Report

Current balances as of November 13, 2015:

<table>
<thead>
<tr>
<th>Account</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citizen’s Bank checking</td>
<td>$15,063.61</td>
</tr>
<tr>
<td>Citizen’s Bank Money Market fund</td>
<td>$2,634.86</td>
</tr>
<tr>
<td>Total</td>
<td>$17,698.47</td>
</tr>
</tbody>
</table>

Payment to Hampton Inn is pending leaving a balance of $14,840.23

As a reminder PAYPAL is available for all payments to MACVPR or if you prefer you can still mail in your payment.

Donna Hawk, RRT, AE-C
Baystate Medical Center Pulmonary Rehab
MACVPR Treasurer
Sally D. is currently a patient attending cardiac rehabilitation due to her congestive heart failure, she has been attending these sessions for the past 3 months since being told her heart failure has progressed to stage C. Sally’s son is the primary care taker and makes sure that she takes all of her medications as prescribed, as well as providing healthy meals for his mother. Today while walking into cardiac rehab, Sally admits to feeling fatigue, as well as experiencing symptoms of nausea, and blurred vision. The son reports some mild confusion while driving the patient in but resolved after re-orienting Sally. Sally chalks it up to being symptoms of her CHF. As the nurse or member of the rehabilitation team you may be thinking of differential diagnosis that may support some of these symptoms. Your team assesses Sally’s vital signs, current medication list and places her on the telemetry monitor.

These are the findings:

| BP: 92/48 | Current Medications: |
| HR: 50 | Lasix 40 mg BID |
| POx: 93% RA | Lisinopril 20 mg Daily |
| Temp: 98.6 | Imdur 60 mg Daily |
| Rhythm Strip: | Hydralazine 100 mg BID |

**What rhythm is seen above?**

A) 2nd degree Type I AV Block  
B) 2nd degree Type II AV Block  
C) Third degree heart block  
D) Sick Sinus Syndrome

**What may be the cause of this rhythm?**

What would be your initial action prior to sending patient to the ED? (chose all the apply)

A) Give atropine  
B) Monitor for deterioration  
C) Set patient up for transcutaneous pacing  
D) Place IV and apply oxygen

**Answers:**

B: 2nd degree Type II AV block: Also known as Mobitz Type II. This type of block occurs below the AV node, either at the bundle of His or, more commonly, at the level of the bundle branches. Type II heart block occurs when the SA node (“pacemaker” of the heart, generates the electrical impulse of the heart which is responsible for the initiation of the heartbeat) fails to conduct to the ventricles. The type of heart block can impair cardiac output as well as progress to third-degree AV block.

Digoxin may be the culprit in this case. Cardiac glycosides slow conduction and increase the refractory period in specialized cardiac conducting tissue by stimulating vagal tone. Digitalis has parasympathetic properties, which include hypersensitization of carotid sinus baroreceptors and also increased vagal efferent activity to the heart.

Alterations in cardiac rate and rhythm from digitalis toxicity may simulate almost every known type of dysrhythmia. Although no dysrhythmia is pathognomonic for digoxin toxicity, toxicity should be suspected when evidence of increased automaticity and depressed conduction is noted. Further education should be provided to patients in regards to toxicity signs and symptoms.

B, C, D: Atropine is unlikely to be effective in someone with AV block. This drug could further increase the rate of discharge in the SA node, which could trigger a situation in which even fewer impulses are conducted through the ventricles and the ventricular rate is further slowed.

Monitor the patient for deterioration as they could potentially progress to a complete heart block. Set the patient up for transcutaneous pacing, follow your programs established emergency protocols which may include activation of the MET team, obtaining a 12 lead EKG, notification of referring physician/medical director, administration of supplemental oxygen, establishing IV access and arranging transport to your emergency department for further evaluation and management.

Please see page 16 for references
"Tell me what I need to know about who you are". Have you ever asked patients to share their story or narrative as part of their healthcare, not what we need to know about their diagnosis, but who they are as people? In healthcare we are charged with collecting data and information about a disease condition, but do we also listen to the stories that give the data context? A growing number of healthcare professionals are recognizing that stories matter when it comes to healthcare, not just in relationship between the provider and patient but in overall healthcare costs and satisfaction.

We often use the terms "story" and "narrative" interchangeably. In fact, story is but one strand of the overall narrative. A patient’s narrative is made up of multiple stories and is evolving and changing as one attempts to make sense or meaning from a diagnosis or illness. When we incorporate narrative into our clinical care we can form understanding, empathy and achieve a care plan that has a higher likelihood of long-term adherence and success. Recently, I was honored to be one of thirty thought leaders from the fields of health care, policy, education and the arts that the Robert Wood Johnson Foundation brought together to imagine and co-create a Narrative Playbook for Healthcare. The intention of this project was to break down methods, information and strategies in the field of narrative into easy and effective “plays” or interventions for clinicians, patients, families and caregivers to use in health care. Using the analogy of a sports playbook, we designed a way for all members of the patient’s team (with patient and family as central to the team) to harness the power of narrative in healing. The result of our work is now available to be freely used and shared as the Narrative Playbook: Strategic Use of Story to Improve Care, Healing and Health.

How do you use the Narrative Playbook? First, take a few minutes to watch the 5 minute introduction video clip to the Robert Wood Johnson Foundation Narrative Playbook. Next, I suggest you simply browse through the contents page and the introduction -- see how and why narrative is important in healthcare. Finally, select a specific need for narrative in your life or work and examine the methods, worksheets and resources recommended. I am especially interested in hearing your experiences and suggestions for future revisions to the Narrative Playbook -- share your story!

As always, I love comments 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

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

Pamela Katz Ressler, MS, RN, HNB-BC is the founder of Stress Resources (StressResources.com) located in Concord, MA. Stress Resources specializes in providing individuals and organizations with strategic, sustainable tools to build resilience and mindfulness. 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 a faculty member at the Tufts University School of Medicine teaching courses in pain research, education and policy, as well as stress management, palliative care, and mindfulness for healthcare providers. Pam serves on the Consumer Health Council of the Massachusetts Health Quality Partners (MHQP) and on the board of directors of the Integrative Medicine Alliance.
REFERENCES


AACVPR Updates

Save the Date for the AACVPR 31st Annual Meeting

September 7-10, 2016
Hilton New Orleans Riverside, New Orleans, LA
*Pre-Meeting Workshops & Opening Reception: September 7*