Well spring is finally here, and the flowers and trees are starting to bloom with the promise of summer to follow. To date, we have had two MACVPR meetings with excellent speakers, the formation of the Regional Groups, the start of our website improvements, and plans for the Fall Symposium. Thank you to Ginny and Deidre, our Education Co-Chairs, the Education Committee, and our Co-President-Elect, Robert Berry, for great speakers and very pertinent information for both Cardiac and Pulmonary Rehab programs. Thank you to Ann and Lynne for their assistance in working on the website updates and to the Executive Committee and all of you for your continued support and involvement.

The MACVPR wants and needs you for our Executive committee!! We will be voting in October for the 2012 Executive Committee. We are still looking for a Co-President-Elect to serve as Co-President with Robert Berry. This is your opportunity to play a larger role in the MACVPR, assist with the direction of the association, plan for the future and share your expertise. MACVPR benefits all of us and that is in large part due to the Executive Committee, who steers the association in the right direction by sharing information from AACVPR, updating insurance guidelines, providing education, etc. So please take some time and think about how you could play a larger role as a member and serve on the Executive Committee. Please feel free to talk to one of us about your interest in any position on the EC, and we will be happy answer your questions.

The formation of the Regional Groups is well on its way with five groups formed and meeting. Members have asked what they are supposed to be doing in these groups. The purpose of the Regional Groups is whatever the group decides they want to do. This is an opportunity to benefit from each others expertise and experience. Each group should decide on when they meet, where and how they meet, and what the focus will be. The sharing of information, forms, billing issues, and more will benefit all participants. For example, the Northeast group has decided to have a half day meeting at Monadnock Community Hospital in New Hampshire. They will visit their program, lunch together, and meet for half a day. We encourage each group to try to meet within the next few months and report back to us about your experience.

We are looking to revise our website to make it more user friendly and pertinent. Lynne and Ann have been working on this project, and we plan to have the revisions completed by 2012. If you have any comments or suggestions, please let us know.

AACVPR Update:

- Annual Meeting September 7-10, 2011 in Anaheim, CA. The AACVPR labels this meeting as “the premier event for those of us specializing in the fields of Cardiac and Pulmonary Rehabilitation. There is no other multi-disciplinary meeting devoted solely to what we do.” If you plan to attend, please let us know so we can connect in CA.

- AACVPR cites a new study which states that “Cardiac Rehabilitation has been shown to reduce mortality and cardiovascular events after MI, and participation in CR after PCI was associated with a significant reduction in all-cause and cardiovascular mortality.” You can find the complete article by Kashish Goel, MBBS in Circulation 2011:DOI:10:1161/ CirculationAHA.110.983536.

- AACVPR is also offering a PLINE webcast series on Program Leadership with best practices for running a successful rehabilitation program. There will be seven webcasts offered on-demand for $225.00. You don’t have to travel or pay for a room and can watch the webcasts at your leisure. Education credits are available. Call AACVPR for more info and to register.

Other webcasts being offered are:

- August 23, 2011 – Fats and Cholesterol – The Good, the Bad and the Ugly!

- November 8, 2011 - Cardiac Rehabilitation Research

- December 15, 2011 – Pulmonary Rehabilitation Research
Are you a member of AACVPR – if not why? They offer the most up to date information on reimbursement for Cardiac and Pulmonary programs, newest research results, a forum to ask questions and get answers and continuing education. You also receive an online copy of The Journal of Cardiac & Pulmonary Rehabilitation. If you are not a member you should think about joining AACVPR.

MACVPR Update-
- If you have not submitted your program information to be listed in our directory, please contact Ann ASAP to do so. The MACVPR Directory is a valuable resource not only for patients but for your program growth.
- Remember the forum is available for you anytime to ask questions, share information, and problem solve together.
- **Remember:** October 21, 2011 Annual Symposium Ayer, MA at Devens Commons

Watch for details on our annual symposium in October. Ginny and Deidre and the Education Committee have been working diligently on putting together another outstanding program. The symposium will feature national speakers from AACVPR on both Cardiac and Pulmonary Rehab topics. This symposium promises to be an outstanding educational offering for our members and Cardiac and Pulmonary clinicians. Stay tuned for more information and registration details.

Wishing you all a happy and safe summer. Enjoy the sunshine and don’t forget to stop and smell the flowers.

MACVPR Co-presidents,

**president@macvpr.org**

Esther Burchinal, MS, CES, RCEP

Judy Flannery, RN, BSN

Emerson Hospital Cardiac Rehab

Harrington Hospital

Cardiac Rehab

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**Congratulations**

The MACVPR Executive Committee would like to congratulate Wayne Reynolds, RN Coordinator-Cardiac/ Pulmonary Rehabilitation of Signature Healthcare in Brockton on his appointment as a **Fellow of the AACVPR.**

Fellowship of the AACVPR recognizes high standards of professional development and commitment to the goals and long range plans of the AACVPR as well as outstanding performance in one or all of the areas: clinical practice, professional education, and/or research. An applicant must also have been a member for at least 3 years and attended at least 2 annual meetings. An additional requirement is that they must receive recommendations in writing from two current Fellows of the Association. In order to be considered for advancement to Fellow status, at a minimum you must possess the above noted qualifications, complete an application and receive approval by the Leadership Committee.

In speaking with Wayne on his accomplishments Wayne said…”Well, it’s an honor to be given the status of Fellowship by AACVPR. For me, it’s real recognition of my efforts with the MAC Committee (J-14 is a very strong group), Day on the Hill, the Health & Public Policy Committee and with MACVPR as well. I’m actually more proud to put RN, FAACVPR after my name than any advanced degree that I could earn simply because of the significance it holds as far as my involvement in our profession.”

Wayne now joins other Fellows from our state including Gary Balady and Robert Berry. Wayne is currently serving on the Health & Public Policy committee.

Congratulations **Wayne Reynolds, RN, FAACVPR**

We are all very proud of you and are glad to have you as an esteemed member of the MACVPR.

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**Congratulations!!**

Kate Traynor, RN, MS

on her appointment to the

AACVPR Clinical Applications Committee (CAC)
Reimbursement Update

PULMONARY REHAB

The AACVPR has sent out reminders that effective October 2010 certain procedure codes have been bundled into HCPCS G0237-0239. These are the codes that are used for NON-COPD patients that are participating in pulmonary rehabilitation. These codes include all necessary therapeutic procedures and monitoring. Many of the various components of rehab that were previously billed separately are now bundled into the G0237-0239 codes. We strongly suggest that you contact your billing/compliance department to review these changes as they affect your practice. The policy -version 16.3 can be found in the NCCI Policy Manual for Medicare Services.

CARDIAC REHAB

If any programs are billing for more than 1 CR session per day, you must use the Modifier 59 code or risk rejection of the charge. Be sure to check with your billing or financial dept if this applies to your program.

GENERAL UPDATES

We are still awaiting word about the next step in our efforts to allow Non Physician Practitioners (NPs or PAs) to fulfill certain MD supervision requirements for cardiac and pulmonary rehab programs as we have been reporting. Will let you know as soon as we hear about next steps.

J14MAC Committee Update: In September, Murray Low will become chair of the AACVPR Health and Public Policy and Reimbursement Committee (replacing Karen Lui). There is a plan for our MAC (J14) to merge with the J13 MAC (NY) in the future… this won’t happen for awhile but we will keep you posted on that front as well.

Kate Traynor has recently been appointed to the AACVPR Clinical Applications Committee (CAC). This committee focuses on clinical issues relevant to CR and PR. Recently the committee previewed a soon to be released Pulmonary Rehab Outcome Toolkit (looks very good and comprehensive-stay tuned). The CAC also has a Certification Task Force that annually reviews the certification process for content review. “Word on the street” about this year’s application process is that applicants seem to struggle a bit with the “Outcome Tab” and resulting Quality Improvement efforts. The CAC is revamping the Outcomes page in the members only section of the AACVPR website and a recommendation was made to step up efforts to help programs with preparation for applying for certification (that is more education about the process and a “mentoring” program of some sort).

That’s it for this month! Please contact Priscilla Perruzzi (PPerruzzi@partners.org), or Kate Traynor (ktraynor@partners.org), if you have any questions.

Kate, Ann, and Judy at Senator Brown’s office

Kate, Wayne, and Judy at Senator Brown’s office
The U.S. Department of Agriculture (USDA) issues and updates the Dietary Guidelines for Americans (DGA) every 5 years. The DGA are based on recommendations from the Dietary Guidelines Advisory Committee and are intended to be guidelines for all Americans 2 years and older. These guidelines are the overarching principles on which the food pyramid and other governmentally sponsored programs base their nutritional recommendations.

Thirty years ago, after extensive research and debate the first Dietary Guidelines for Americans (DGA) were released to a tremendous amount of controversy and criticism. In 2010, the most recent DGA were released to a similar response. Surprisingly, the recommendations are not significantly different thirty years later, but the waistlines of Americans are. The most current data tells us that 72% of men and 64% of women are overweight or obese, with about one-third of adults being obese. Unfortunately, this obesity epidemic is not limited to adults, currently 32% of children (age 2-19) are overweight and obese with 17% classifying as obese (2). Conversely, there are 15% of Americans who are financially unable to obtain adequate food to meet their nutritional needs (3).

Overweight, obesity, and poor diet have been linked to the development of many chronic diseases including cardiovascular disease, hypertension, diabetes mellitus, and some forms of cancer. Considering these nutrition based health challenges, the 2010 DGA have been updated to reflect two overarching goals (4):

1. Maintaining calorie balance over time to achieve and sustain a healthy weight.
2. Focusing on consuming nutrient-dense foods and beverages.

While these goals seem simple, many Americans find them challenging to achieve. Figure 5-1 compares the average American intake with the recommendations made by the DGA (4).

The 2010 DGA provide clear and straightforward guidelines to achieving these goals by focusing on two simple concepts: foods to increase and foods/food components to reduce. This allows for all Americans to adapt these guidelines to their individual age, diet preferences and caloric needs.
The updated guidelines get more specific on how to apply these recommendations in a separate chapter on “building healthy eating patterns”. Building healthy eating patterns offers several principles of healthy eating and meal patterns including: Dietary Approach to Stopping Hypertension (DASH), Mediterranean Diet and various vegetarian options that allow Americans to practically implement the new recommendations in their own lives. Centered around an appropriate amount of calories, each pattern encourages individuals to take into account how each food and beverage they consume will fit into their daily intake. Each pattern focuses on including nutrient dense foods and physical activity because even in the absence of being overweight, increased consumption of sodium, saturated/trans fats, cholesterol, added sugar, alcohol and a sedentary lifestyle are associated with increased risk for chronic disease and related mortality. Fig 5-2 illustrates the nutrient density of common foods in the American diet, and the number of added calories we consume in the form of added sugars and fat.
Components that Speak Directly to the Prevention of Cardiovascular Disease:

**Cholesterol and Fat:** Emphasis has been placed on the use of liquid fats such as monounsaturated and polyunsaturated fats that have been coined “good” or “heart healthy” fats and the avoidance of solid fats including saturated and trans fats, that have been coined as “bad” fats. The 2010 DGA recommend reducing trans and solid fat “as much as possible” by replacing them with monounsaturated fats. This replacement of solid sources of fat with liquid sources will reduce all Americans risk for coronary heart disease. The American Heart Association (AHA) feels this recommendation was too vague. They suggest that trans fats should not make up more than 1% of energy, which is approximately 3 grams per day based on a 2,000 calorie diet. In addition they strongly encouraged further limitations on saturated fat consumption for all Americans from 10% to 7% to further reduce risk for cardiovascular diseases.

**Sodium:** One of the most noted changes in the 2010 DGA is the emphasis of the Institute of Medicine’s (IOM) stated adequate intake of 1500mg for sodium which now applies to African Americans, individuals with hypertension, diabetes, or chronic kidney disease, and individuals 51 years and older. These groups consist of 50% of the U.S. population (4). This recommendation was based off of the well known DASH diet which provides meal planning guidelines that can help reduce the health implication of hypertension. The IOM states that the tolerable upper limit of sodium for the remaining 50% of Americans remains 2300mg. Many groups including the AHA would like to see all Americans consuming less than these recommended amounts, but reducing sodium intake has been a significant challenge for Americans. The IOM reported in 2010 that the average American takes in 3400mg of sodium daily (6). A majority of this comes from our culture’s extensive industry of processed foods and pre-prepared meals. It remains to be seen if increasingly stringent sodium recommendations will have an impact on our food industry.

**Dietary Fiber:** Fiber is a type carbohydrate that the body can’t fully digest and is found in whole grains, fruits and vegetables. Fiber has many health benefits including improved blood sugar control, increased satiety in weight management, support of digestive health and reduced risk for heart disease. There are two forms of fiber, soluble and insoluble. Soluble fiber found primarily in oats, beans, fruits and vegetables helps to reduce LDL-cholesterol. As soluble fiber moves through the intestines during digestion, it binds to bile acids (bile) in our gut and it is excreted. Bile is made in the liver from cholesterol to aid in the digestion and absorption of dietary fat. As bile is excreted from our body, we use our blood cholesterol to replenish this lost bile. This mechanism allows for patients with dyslipidemia or those at risk for heart disease to reduce their LDL-cholesterol naturally, thus reducing their risk for heart disease.

**B12 Supplementation:** Vitamin B12 is a water-soluble vitamin found in animal products such as meats, dairy and eggs. However as Americans age, their consumption of these foods can decrease related to appetite or dentition. This decreased intake coupled with multi factorial decreased absorption commonly leads to vitamin B12 deficiencies in elderly Americans. Vitamin B12 plays a role in preventing elevated serum homocysteine levels which has been associated with an increased risk of cardiovascular diseases (7).

**Implications for practice:** The DGA and all of the nutrition education materials that are based on its recommendations are evidence-based, peer-reviewed, free and accessible resources for use in your cardiac or pulmonary rehab practices. www.mypyramid.gov contains meal planning, diet analysis, and print materials that you and your patients may find useful. Keep in mind that these recommendations are made for a general healthy population. Specific nutrition recommendations for cardiac and pulmonary patients can be found at www.heart.org or www.lungusa.org.
Education Committee

Our committee is currently busy planning the 2011 New England Cardiovascular and Pulmonary Rehabilitation Symposium to be held on October 21, 2011 at Devens Common Center in Devens, MA.

Gayla Oakley, RN, FAACVPR is one of our featured speakers and will offer information on program and practice priorities as well as an AACVPR update. Phil Ades MD, recently published in the JCPR, will present *Treatment of Obesity in Cardiac Rehabilitation*. For the second year, our October 21, 2011 agenda will also include a poster presentation session. Individuals are welcome to submit an abstract. The purpose of the poster session is to provide a forum to share original research findings, showcase successful approaches to patient care and highlight your innovative ideas and/or quality improvement projects. We again look forward to providing this unique networking opportunity to you and your colleagues.

Please send any ideas for educational topics or speakers to the education co-chairs Ginny Dow or Deirdre Proudman. We welcome any members to help with program planning.

**Education Committee Co-Chairs**
Ginny Dow RN, BSN, BC
Deirdre Proudman, RN-C, BSN, CCRN
education_chair@macvpr.org

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May Half Day Meeting Update

The May half day meeting opened with a warm welcome from our co-presidents Esther Burchinal MS, CES, RCEP and Judith Flannery RN, BSN. Their opening address highlighted a team approach to recommit and contribute. Each of the EC members provided updates to the group.

Arlene Schiro, MA, NP, RN-CS, Clinical Manager Pulmonary and Critical Care Medicine Brigham and Women’s Hospital, provided a dynamic presentation on Pulmonary Hypertension and Exercise Rehabilitation. She provided members with a comprehensive program on pulmonary arterial hypertension as a progressive and deadly disease with no cure and a focus on treatment to improve quality and length of life. She emphasized the role of exercise training in PAH in improving exercise endurance and increasing performance, enhancing ability to perform ADLs and therefore quality of life, reducing hospitalizations, and decreasing symptoms, especially dyspnea. Included was the pathophysiology, classifications of PAH, and review of medications. Arlene’s teaching style was very effective in helping the group understand this complex disease and the great passion she has for her patients was clearly conveyed.

Regional Networking was provided by a breakout session into the Southeast Regional Group, Northeast Regional Group, Central Regional Group, West Regional Group, and Boston Regional Group. Members formed small groups to share and discuss issues, expertise, and experience in a free forum.

The program ended with Robert Berry, MS, RCEP, FAACVPR, President-Elect and our liaison to the AACVPR providing an excellent and instructional Program Certification Update. Highlights from Robert’s presentation included the application timeline, the cardiac and pulmonary certification and recertification tabs, and an overview of common problem areas. Content areas specifically reviewed were the ITP, staff competency skills documentation, AACVPR vs. CMS emergency equipment requirements, exercise prescription, medical emergencies, and physician feedback. Certification resources were also provided. Robert’s PowerPoint outline is an excellent resource for all members.

The strength of our organization and benefit of being an MACVPR member was clearly evident in this program. Thank you to all for making our May 10th meeting a success.

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Poster Presentation Session

The MACVPR cordially invites cardiovascular and pulmonary professionals to participate in our second poster presentation session which will be held during the

**MACVPR 2011 New England Cardiovascular and Pulmonary Rehabilitation Symposium**
Devens Common Center
October 21, 2011

The purpose is to provide a forum to share original research findings, showcase successful approaches to patient care, and highlight innovative ideas and projects. This session will also provide an opportunity to disseminate important practice strategies, network with colleagues, and receive feedback from your peers on your work.

To participate in the poster session you must be registered for the conference and submit an abstract online at [http://www.macvpr.org/upcoming-meetings-Abstracts.htm](http://www.macvpr.org/upcoming-meetings-Abstracts.htm).

Direct any questions you may have to education_chair@macvpr.org
Welcome New Members

Marcelo Castro RN, BSN, RRT-NPS, MBA
Holy Family Hospital
Methuen, MA

Kathleen Harrington RN, MSN
Winchester Hospital
Winchester, MA

Mary Walsh RN
Berkshire Health Systems
Pittsfield, MA

Incentive

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

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

Ideas for Tales might be:

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

For more information please contact Lynne MacDonald at newslettereditor@macvpr

Save the Date

Full Day Meeting
Friday October 21, 2011

MACVPR 2011 New England Cardiovascular & Pulmonary Rehabilitation Symposium

Featuring:

Gayla Oakley, RN, FAACVPR
Outcome Measures

Philip A. Ades, MD, FAACVPR
Treatment of Obesity

…the full agenda of topics and speakers will be finalized soon

- Keep your programs current
- Visit our poster presentation session highlighting innovative approaches to patient care
- Network with clinicians throughout New England

Devens Commons
31 Andrews Parkway
Devens, MA 01434
(located on Route 2, convenient to I-95 and 495)

Watch your emails for the on-line registration link to this important meeting coming soon
Greeting MACVPR members:

We are currently at 118 members with 1 student from Becker College. I am encouraged by the possibility of two new programs starting in Massachusetts. A reminder to those of you about to renew your membership, as of January 2011 dues are $100 dollars for 2 years. I am preparing to send letters to nursing and exercise physiology programs at local colleges and universities to attempt to increase our student membership. If you attended a local program email me at capemda@gmail.com and let me know of your program. Students can gain many benefits from a MACVPR student membership such as keeping current on trends in risk factor management, helping patients understand how best to manage heart disease and begin networking with other professionals in your field.

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

Some recent topics posted:

- Tufts reimbursement denials due to incorrect coding
- Has anyone else seen an increase insurance denial since the start of 2011?!
- How do you handle patients taking extended vacations while in rehab? Does it cause a problem with insurers?
- AACVPR certification cycle..when to recertify

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

As our work lives and home lives have become increasingly blurred with unprecedented levels of connectivity and expectation for multitasking environments, it is impossible to separate “work stress” from “life stress”. When we speak of stress in the workplace, however, there is usually a perception of high demands of a job and a low amount of control over the situation. Dr. Suzanne Kobasa, in her studies in the 1970-80’s, described the incongruity between responsibility and authority as one of the primary drivers of a perception of workplace stress. Stress, in general and in the workplace in particular, takes its toll both physically and economically on individuals and organizations. It has been estimated that three out of four workers in the United States describe their work as stressful. Workplace stress is not limited to the United States. The United Nations’ International Labor Organization has declared occupational stress a “global epidemic”. While the physical toll of stress is evident in healthcare, with widely reported estimates that 60-90% of all primary care visits include a stress related component (Mass General Hospital/Benson-Henry Mind-Body Institute); the economic toll of stress is equally as troubling. Workplace stress costs the U.S. economy an estimated $300 billion per year (American Institute of Stress) in measures such as: absenteeism, staff turnover, worker’s compensation, lower productivity as other related expenses.

What can you do to decrease or manage your workplace stress more effectively, as an employee or as a manager? Here are a few suggestions to get you started on creating a workplace culture that may assist in decreasing stress:

- **Take short breaks every hour** These can be as short as 1-3 minutes, but are essential for optimal productivity and effectiveness. Some suggestions would be gentle stretching of large muscle groups, eat a healthy snack, or simply close your eyes and breathe deeply. There are various high-tech ways to remind you to take a break, some sounding a chime or displaying an image on your computer screen at set intervals. One to try is a new application called Awareness available for both Mac and Windows which will remind you to take a break hourly with the gentle tone of a Tibetan singing bowl [http://iamfutureproof.com/tools/awareness/](http://iamfutureproof.com/tools/awareness/)

- **Practice effective time management** This doesn’t mean squeezing in more “stuff” in less time, but essentially reprioritizing tasks into four categories of Important/Urgent; Important/Not Urgent; Urgent/Not Important; and Not Urgent/Not Important. Our tendency is to put the majority of tasks into the Important/Urgent category and this contributes to a perception of overwhelming stress. In reality, we cannot physically or mentally attend to all tasks in this way. Try to include only 3 tasks at any one time in the category of Important/Urgent. Next, examine the categories of Important/Not Urgent and Urgent/Not Important. As your tasks are completed in your top priority category of Important/Urgent, you may begin to move items from either Important/Not Urgent or Urgent/Not Important categories into this top prioritization. Note that items in the Urgent/Not Important category are items that are generally being driven by someone else’s priority and not your own. To counteract the tendency of feeling increased responsibility and decreased control, make sure you are also including at least one item from your Important/Not Urgent category to prioritize. The final category of Not Important/Not Urgent deserves much less attention than the other categories and you may want to identify tasks that are listed in this category to delegate or delete, after all if they are both not important and not urgent, why are they still on your list?

- **Build Skills of Emotional Intelligence** Emotional Intelligence or EI is a concept coined by Daniel Goleman. It is based on principles of empathy, awareness, and mindfulness. Unlike intellectual intelligence, Emotional Intelligence is focused on the social context of our interactions with ourselves and the outside world. We can build skills of Emotional Intelligence through recognition and practice. There are 5 key skills of Emotional Intelligence which can be learned and practiced in the workplace environment:
  1. Quickly reduce stress.
  2. Recognize and manage your emotions.
  3. Connect with others using nonverbal communication.
  4. Use humor and play to deal with challenges.
  5. Resolve conflicts positively and with confidence

In a future column, I will suggest ways to build each of these 5 key skill sets of Emotional Intelligence. In the meantime, you may want to investigate some of the resources available on the concept of Emotional Intelligence through some of sources listed below:

- [http://danielgoleman.info/topics/emotional-intelligence](http://danielgoleman.info/topics/emotional-intelligence)
- [http://www.6seconds.org/](http://www.6seconds.org/)
- [http://www.youtube.com/watch?v=hoo_dIOP8k](http://www.youtube.com/watch?v=hoo_dIOP8k)
Stress does not disappear overnight. We need to bring awareness to the issue and actively work to build a culture where we feel a greater synergy between level of responsibility and level of authority or control in the workplace. Each workplace is unique in its challenges and accomplishments, but all are similar in their need to recognize that employees are their most important assets and without addressing stress these assets will become depleted. I would love to hear your tips on how you have integrated tools of managing stress into your workplace.

Pamela Katz Ressler, MS, RN, HN-BC is the founder and president of Stress Resources (www.StressResources.com) located in Concord, MA. Stress Resources specializes in stress management, holistic healthcare education, and health communication for healthcare providers, organizations, and individuals. Pam is a frequent speaker to local, national, and international audiences on topics relating to stress management, mindfulness, resiliency strategies, therapeutic communication, patient advocacy through social media, and holistic healthcare. She is an adjunct faculty member at the Tufts University School of Medicine and the University of Massachusetts Boston, College of Nursing and Health Sciences, 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

Upcoming Webcasts

August 23, 2011  Nutritional Strategies for Prevention and Treatment of Coronary Heart Disease
Presented by: Dr. Michael Shapiro

November 8, 2011  Cardiac Rehabilitation Research: Year in Review 2010-2011
Presented by: Dr. Murray Low

December 15, 2011  Pulmonary Rehabilitation Research: Translating the Research into Clinical Practice
Presented by: Dr. Brian Carlin

Moving Forward in a Decade of Change

INSPIRE YOURSELF.
INSPIRE YOUR PATIENTS.

26th Annual Meeting  •  September 8–10, 2011  •  Anaheim Marriott Hotel  •  Anaheim, CA
Medication Reconciliation Matters

Ray, an 83 year old man with a history of CABG, multiple stenting, and a history of heart failure with implantation of a biventricular pacer/ICD presents to cardiac rehabilitation with profound weakness. Because of his present status, his wife drove him to rehab today. He is a 10+year veteran of cardiac rehab. BP 76/46 HR 66. Recent med changes to Zestoretic, the brand name for the combination of Zestril and Hydrochlorothiazide. Ray’s physician gave him samples until his prescription from his mail away pharmacy would arrive. He added the new medication to his medication list carried in his wallet and his weekly prefilled medications. Cardiac rehab staff was able to determine from his medication list that he added the Zestoretic to his lisinopril and hydrochlorothiazide. Because he did not understand or was not instructed otherwise, he added the new prescriptions to his home medications.

John, a 47 year old male s/p MI/PCI with presentation as cardiac arrest in the hospital parking lot presents to cardiac rehabilitation for his initial visit. Review of his medication list reveals no antiplatelet drug therapy despite Effient being listed as a discharge medication. He is positive he has been compliant with all medications prescribed to him through his regular pharmacy. John’s brother picked him up at discharge and brought John’s prescription to a different pharmacy where his Effient was still waiting for him.

Medication reconciliation is defined as the formal process of collecting and maintaining a complete and accurate list of a patient’s medications and comparing that list to the physician’s orders at admission, transfer, or discharge from care. Medication reconciliation is included in the Joint Commission’s National Patient Safety Goals. Goal 8 “Accurately and completely reconciles medications across the continuum of care” has been expanded by adding requirements specific to ambulatory care and outpatient settings. http://www.jointcommission.org/assets/1/6/2011_NPSGs_AHC.pdf

Medication reconciliation is a hospital wide initiative to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions. As part of the continuum of care, it is imperative for outpatient cardiac and pulmonary rehabilitation settings to maintain medication reconciliation among patients for the proper treatment and standard of care.

The Joint Commission’s Goal 8 can be described in four steps:
1. Document a complete list of home medications upon admission.
2. Compare the list of home medications to those ordered while the patient was hospitalized or from the physician’s office and reconcile any discrepancies.
3. Update the medication list and repeat the comparison and reconciliation process at transition points during the patient’s rehabilitation.
4. Communicate the reconciled list of medications to the next provider of care and provide the patient with a copy upon discharge.

National Patient Safety Goal 8 (NPSG 8), the medication reconciliation standard http://www.jointcommission.org/npsg_reconciling_medication/

Deirdre Proudman RN-C, BSN, CCRN

Call to Action

The Executive Committee is still trying to fill the Co-President Elect position for 2012. Robert Berry has agreed to take the position but would prefer to share the responsibility with someone else.

Additionally, we will have vacancies in the positions of President Elect and Treasurer, as Susan Carri-gan has decided to step down after serving on the board for seven years. The Executive Committee would like to thank her for her dedicated service and invite other members to get involved with your organization. It is a great opportunity for professional growth in a supportive environment. The Executive Committee always works together as a team. Elections for these positions will be held at the October full day meeting. If interested or you just want more information please contact president@macvpr.org

Consider joining the EC... you won’t regret it!!
To all who submitted applications for the 2011 cycle, congratulations on striving to achieve program excellence!!!!

We should have been able to report that the Review of Applications was completed May 31, 2011. However, some programs have received notification that “Your application is still in phase 1 of the review process. Please continue to check your dashboard regularly for additional information requested by your reviewer.” This has been a bit disconcerting for the applicants who thought they could stop their daily checks of their dashboard on May 31, 2011. Apparently they were unable to complete the process on time.

The official timeline to receive notification of the disposition of the applications is August 31, 2011. Considering that the review process has taken longer than expected and the fact that last year some programs did not receive notification until late September, it may be safe to say that some notifications may be delayed this year as well. I guess we will all have to be patient :) If you are planning on applying for AACVPR Program Certification during the 2012 cycle, NOW is the time to get started! Visit the AACVPR website to access valuable resources to assist you in this process. Can’t find what you’re looking for? Contact MACVPR Program Certification liaison, Robert Berry (robert.berry@bhs.org) or the AACVPR Program Certification National Call Center (312-321-5146 option 1) for additional assistance.

Please remember when you receive your successful notifications (and we are confident you will), please notify Ann Stone admin@macvpr.org or Lynne MacDonald newslettereditor@macvpr so that we may include you in the Fall newsletter. Good Luck to all!!!

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

The following individual memberships have either expired since April 2011 or will expire before the next newsletter.

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Expired</th>
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<tbody>
<tr>
<td>Heidi Szalai</td>
<td>4/1/2011</td>
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<td>Barbara Bing</td>
<td>4/1/2011</td>
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<td>Kathleen Congdon</td>
<td>4/1/2011</td>
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<tr>
<td>Diane Koczat</td>
<td>4/1/2011</td>
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<tr>
<td>Patricia Toye</td>
<td>5/1/2011</td>
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<td>Karen LaFond</td>
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<td>Heather Nestor</td>
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<td>Jeanne Colbath</td>
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<td>Allayne Mendys</td>
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<tr>
<td>Patricia Belliveau</td>
<td>6/1/2011</td>
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<tr>
<td>Clare LaMorte</td>
<td>8/1/2011</td>
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<tr>
<td>Amy Yankowski</td>
<td>9/1/2011</td>
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<tr>
<td>Lauren Healey</td>
<td>9/1/2011</td>
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MEMBERSHIP APPLICATION

Or
Download application from www.macvpr.org

Name (with Credentials):

____________________________________________________

____________________________________________________

Mailing Address you want the card sent:
Home/Work (Please circle)

____________________________________________________

____________________________________________________

Work #:

Home #:

E mail: _____________________________

Profession: ____________________________

Institution: ____________________________

☐ Cardiac  ☐ Pulmonary
☐ New or ☐ Renewing Membership

☐ $100 Two year membership (Begins on the first day of the month joined and ends two years from that date)

☐ $25 for a One Year student membership (Students must be enrolled in a minimal of 12 credits per quarter and provide copy of schedule with membership application.)

How did you learn about the MACVPR?

____________________________________________________

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

☐ Yes  ☐ No

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

Mail check or money order to:

MACVPR
C/O Ann Stone
PO Box 426 Woods Hole, MA 02543
admin@macvpr.org

aes 02/2011