AACVPR Wrap-Up
By: Poppy Patterson, TACVPR President

Our national AACVPR conference was held in Long Beach, California this year. The state of Texas was represented well. Six of the eleven board members were present. There were clinical lectures, best-practice informational lectures, as well as the reimbursement workshops that were well received.

Twyla and I attended the President’s Leadership Luncheon on Saturday. It was a good networking experience. However, the highlight of the luncheon was the recognition of the Affiliate Program Grants.

The AACVPR Board of Directors and Affiliate Society Committee awarded TACVPR an Affiliate Grant in the amount of $750.00. The grant will assist us in pursuing our 2004-2005 goals! We are in the process of creating a new “members only” section on our website. We will also begin working on a statewide outcome database this year. We hope to see all of the TACVPR members participate in the compilation of outcomes. This is an exciting year to be a member!

As the president of TACVPR, I was invited to the “Reimbursement Committee Update-Grassroots Legislative Workshop”. Phil Porte, our legislative analyst for AACVPR, was the featured speaker. Most of the national reimbursement committee members were also present. Here are the highlights of that workshop along with other reimbursement meetings...

The long awaited final OIG national report to CMS is due this fall!

Stay current on all reimbursement issues. Is your program getting reimbursed? Contact your state (Poppy) or national representative if any reimbursement or compliance issues arise.

Remember...
- Cardiac Rehab is considered to be a covered physician service.
- "Incident to" requires physician evaluation, direct supervision, & monitoring of treatment by the physician
- OIG is looking for documentation of physician visits during the cardiac rehab session (1-36 sessions)
- Physician supervision: Physician must be immediately available to furnish assistance & direction

Two issues: 1. Proximity 2. Availability for emergencies
- OIG leaves determination of adequacy to contractor (Trailblazer & Mutual of Omaha)

OIG: Does your program meet these requirements?
- Is the service rendered “incident to”?
- Is the requirement for direct supervision met?
- Does the patient have a covered diagnosis?

Please visit our website at www.tacvpr.org for new updates!!!

TACVPR Membership Expires on December 31st, 2004!!!
To join or renew your TACVPR membership you may sign up online or download a printable membership application at www.tacvpr.org
Annual dues are $35/person OR $25/person if registered by February 14th, 2005
TACVPR Awarded Grant in
Long Beach, CA

In September 2004, TACVPR applied for grant monies from the AACVPR to begin a state-wide outcomes program. We are thrilled to announce that we have been awarded $750.00 to begin this project.

The first step in this project was to create a “Members Only” section on our website. With this step completed we are prepared to move forward.

During the month of November, the TACVPR Board of Directors will be contacting other state organizations who have experience in developing and managing large-scale, multi-site outcomes projects to discuss their projects and experiences. In addition, we will be forming an outcomes committee at our November 4th Board of Directors Meeting.

In the months of December and January, the TACVPR Outcome Committee Members will be contacting programs in Texas to determine the following information:

- What are programs currently doing to collect, measure, document, and evaluate outcomes at the patient and program level?
- What are the major barriers to outcomes measurement?
- What are the expectations of outcomes measurement from programs administration, medical directors, and/or payers?
- Are any programs using the same outcome measurements as other programs?
- Are there any collaborative efforts in outcomes measurements among programs?
- Is there an interest in collaborative outcomes measurement?

Stay tuned for an update on our progress in the Spring Issue of the TACVPR newsletter!!!
Is Your Program AACVPR Certified?

As of 2004, Texas has 27 Cardiac and Pulmonary Rehabilitation programs that have been certified by the American Association of Cardiovascular and Pulmonary Rehabilitation. The goal of program certification is to assure meeting the essential standards of care described in the 4th Edition Guidelines for Cardiac Rehabilitation and Secondary Prevention Programs and/or the standards of care for Pulmonary Rehabilitation. To learn more about AACVPR certification please visit their website at [www.aacvpr.org](http://www.aacvpr.org) and click on the “Certification” link.

Below is a list of states along with the total number of certified programs. GO TEXAS!!!

<table>
<thead>
<tr>
<th>State</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ohio</td>
<td>72</td>
</tr>
<tr>
<td>New York</td>
<td>54</td>
</tr>
<tr>
<td>Indiana</td>
<td>42</td>
</tr>
<tr>
<td>Louisiana</td>
<td>38</td>
</tr>
<tr>
<td>Virginia</td>
<td>33</td>
</tr>
<tr>
<td>California</td>
<td>29</td>
</tr>
<tr>
<td>Tennessee</td>
<td>27</td>
</tr>
<tr>
<td>New Jersey</td>
<td>23</td>
</tr>
<tr>
<td>South Carolina</td>
<td>18</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>16</td>
</tr>
<tr>
<td>South Dakota</td>
<td>15</td>
</tr>
<tr>
<td>Washington</td>
<td>8</td>
</tr>
<tr>
<td>Delaware</td>
<td>5</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>4</td>
</tr>
<tr>
<td>Utah</td>
<td>3</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>2</td>
</tr>
<tr>
<td>Nevada</td>
<td>1</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>67</td>
</tr>
<tr>
<td>Illinois</td>
<td>53</td>
</tr>
<tr>
<td>Michigan</td>
<td>42</td>
</tr>
<tr>
<td>Missouri</td>
<td>33</td>
</tr>
<tr>
<td>West Virginia</td>
<td>32</td>
</tr>
<tr>
<td>Kentucky</td>
<td>27</td>
</tr>
<tr>
<td>Minnesota</td>
<td>22</td>
</tr>
<tr>
<td>Nebraska</td>
<td>17</td>
</tr>
<tr>
<td>Alabama</td>
<td>15</td>
</tr>
<tr>
<td>Colorado</td>
<td>9</td>
</tr>
<tr>
<td>Idaho</td>
<td>6</td>
</tr>
<tr>
<td>Arkansas</td>
<td>4</td>
</tr>
<tr>
<td>Wyoming</td>
<td>4</td>
</tr>
<tr>
<td>Vermont</td>
<td>3</td>
</tr>
<tr>
<td>Alaska</td>
<td>1</td>
</tr>
<tr>
<td>Hawaii</td>
<td>0</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>62</td>
</tr>
<tr>
<td>Florida</td>
<td>45</td>
</tr>
<tr>
<td>Iowa</td>
<td>38</td>
</tr>
<tr>
<td>North Carolina</td>
<td>33</td>
</tr>
<tr>
<td>Maryland</td>
<td>30</td>
</tr>
<tr>
<td>Mississippi</td>
<td>27</td>
</tr>
<tr>
<td>Connecticut</td>
<td>25</td>
</tr>
<tr>
<td>Georgia</td>
<td>20</td>
</tr>
<tr>
<td>Maine</td>
<td>16</td>
</tr>
<tr>
<td>Oregon</td>
<td>15</td>
</tr>
<tr>
<td>North Dakota</td>
<td>8</td>
</tr>
<tr>
<td>Montana</td>
<td>6</td>
</tr>
<tr>
<td>Arizona</td>
<td>4</td>
</tr>
<tr>
<td>Kansas</td>
<td>3</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>2</td>
</tr>
<tr>
<td>Washington D.C.</td>
<td>1</td>
</tr>
<tr>
<td>New Mexico</td>
<td>0</td>
</tr>
</tbody>
</table>

ICAA/AAFP Join Forces

Recently, The International Council for Active Aging (ICAA) and The American Academy of Family Physicians (AAFP) have joined forces in an effort to boost physical activity among adults ages 50 and older. This newly formed partnership consists of 2 main goals:

1. To offer access to the first national, age-appropriate fitness and wellness facility patient referral program, by giving participating family physicians a locator of ICAA age-friendly fitness and wellness facilities.

2. To increase the number of family physician referrals to ICAA member facilities.

This program recognizes organizations that have made a commitment to creating age-friendly facilities and have gone above and beyond in their design, staffing, programming, marketing, and operations. If you are interested in listing your facility on this website please visit [www.icaa.cc/facilitylocator.htm](http://www.icaa.cc/facilitylocator.htm)

Interested in serving on the TACVPR Board of Directors? E-mail us at [info@tacvpr.org](mailto:info@tacvpr.org)
Spicy Grilled Chicken
(serves 5 -6)

Marinade:
1 small onion, finely chopped (3/8 cup)
2 - 3 tablespoons fresh lime juice (1-2 medium limes)
2 tablespoons olive oil
1 - 2 tablespoons finely chopped fresh cilantro
1 small clove garlic, crushed, or 1/2 teaspoon bottled minced garlic
1/2 teaspoon chili powder
Pepper to taste
7 boneless, skinless chicken breast halves (about 4 ounces each), all visible fat removed

Directions:
In an airtight plastic bag, combine marinade ingredients.

Rinse chicken and pat dry with paper towels. Add to marinade and turn to coat. Seal and refrigerate for 2 - 3 hours, turning occasionally.

Preheat grill to medium - high or preheat broiler.

Grill chicken or broil it about 6 inches from heat for 6 - 7 minutes on each side, or until no longer pink in center.

The New American Heart Association Cookbook 25th Anniversary Edition

Calories 122
Protein 23g
Carbohydrates 0g
Cholesterol 63mg
Total Fat 3g
  Saturated 1g
  Polyunsaturated 1g
  Monounsaturated 1g
Fiber 0g
Sodium 57mg

Exciting News from T.A.C.V.P.R

TACVPR has recently strengthened its bond with the AACVPR by completing the “AACVPR - Affiliate Agreement” indicating our participation in the “Affiliate Link Program” (ALP). According to the AACVPR, “Recent legal counsel has advised that this type of formal agreement is in the best interest of both the state/regional organizations and the national organization. Based on the previous structure (or lack thereof), there was potential for liability through the activities of each organization. This agreement provides mutual protection from that potential liability.”

In addition, this formal agreement will help identify those affiliate organizations that desire to maintain a close working relationship with AACVPR for the benefit of both AACVPR and the Affiliate.

Signing this agreement does not change the structure of the Affiliate organization or minimize the autonomy of the Affiliate organization.

For further questions regarding this issue, please e-mail Poppy Patterson at Ppatterson@hillcrest.net

Flu Shot Locator
Visit the following websites
www.texaslung.org
OR
www.lungusa.org
Cardiac Rehab: Where are We Headed?

By: Tim Cleveland

Over the next 3-5 years, cardiac rehabilitation as we know it will cease to exist. When cardiac rehab first made its appearance in the 1970’s, it was based on the fact that patients were in the hospital for at least 1 week. My, how time has changed. Heart attacks are being aborted with new pharmacologic and surgical advances, by-pass and valve patients are in and out of the hospital in 5 days, and need I remind everyone of the major obstacle to cardiac rehab: Medicare. These are the three risk factors that are putting the future of cardiac rehab in jeopardy. So what do we do about it? Should we change the efficiency in which we do surgeries? Should we ignore new pharmacologic and surgical advances? Or should we write our congressman about the injustices set forth by Medicare? Here is my opinion: we need to change the way that we provide cardiac rehab. If medicine is ongoing and ever-changing, shouldn’t rehab do the same? We need to break the mold from which cardiac rehab was created. What would happen if we tried to use the same building techniques that the ancient Egyptians used to build their pyramids? Can you imagine the chaos in this modern world? The point is, we have learned more efficient ways to do things, if we do not keep moving forward; we stagnate and become obsolete. So how does cardiac rehab move forward? The answer is a Disease Management Center. These disease management centers will be the wave of the future. We need to develop programs that focus on hypertension, obesity, hyperlipidemia, diabetes, smoking cessation, stress management, etc (not just heart disease as a whole). It makes perfect sense, address risk factors one at a time instead of all at once. What do we tell our patients about setting goals? Pick one and work at it until it is completed, then choose the next one. Why can’t we develop disease management centers that do just that? We need to focus more on cardiac rehab being a means of primary prevention rather than a secondary prevention. By offering individual risk factor programs, you can reach both the post event patient and the at-risk patient. Take a look at our society, heart disease is not going anywhere. Just think of all of the patients that can be affected by a complete disease management center. So how do you do it? The first thing that you must do is have a proactive medical director. Without one, your program will stagnate. Secondly: develop a disease management center that will reach your cardiovascular community. Treat the patients with heart disease as well as the patients who are at-risk for heart disease. Third: marketing, marketing, marketing!!! If every cardiologist in your community knows about your program as one that he can send all of his heart patients to, regardless of diagnosis, the referrals will come in by the truckload. What about reimbursement? What if this was a monthly out of pocket fee? That would surely take care of the insurance hassle.

The secret to success is: Expand your horizons!!! Think outside of the box. Get creative. If the treatment of heart disease is changing, so should the prevention and rehabilitation.

A common cold is an illness caused by a viral infection located in the nose. Colds involve the sinuses, ears, and bronchial tubes and last for an average of one week. Mild colds may last only 2 or 3 days while more severe colds may last for up to 2 weeks. Adults average 2 to 3 colds per year while children average 6 to 10, depending on their age and exposure. Children’s noses are the major source of cold viruses. There are over 100 cold viruses. Rhinoviruses cause at least one half of colds. Cold symptoms usually develop anywhere from 1 to 3 days after the virus enters your body.

Cold viruses infect only a relatively small proportion of the cells lining the nose and can only multiply when they are inside a living cell. When on an environmental surface, cold viruses cannot multiply. However, they are still infectious if they are transported from an environmental site into the nose.

Cold symptoms are mainly due to the body's response to the infection. A stuffy or runny nose, sore or scratchy throat, sneezing and coughing are usually signs of a cold. More rare symptoms associated with a cold are fever, headache, general aches and pains, fatigue, and weakness. Complications are sinus congestion or infection, or earache.

Treatment is mainly temporary relief of the symptoms. Nasal decongestants to unclog a stuffy nose. Cough suppressants to quiet a cough. Expectorants to loosen mucus so you can cough it up. Antihistamines to stop a runny nose and sneezing. Pain relievers to ease fever, headaches, minor aches and pains.

Influenza is commonly called "the flu". It is caused by the influenza virus, which infects the respiratory tract, (nose, throat, lungs). The flu is spread easily from person to person when an infected person coughs, sneezes, or talks and the virus is expelled into the air. The virus is then inhaled by someone else, and the flu begins.

The influenza virus thrives during the winter months when most of the population is indoors in close proximity. This allows for the virus to be easily spread. The incubation period after exposure is 1 to 4 days with an average of 2 days. A person is considered contagious from 1 day before the symptoms begin until approximately 5 days after illness onset.

Flu symptoms are the same as a cold, however, there is also a characteristic high fever that lasts 3 to 4 days, a prominent headache, usually often severe aches and pains, early and prominent extreme exhaustion and usually chest discomfort. Flu can lead to bronchitis and pneumonia which may be life threatening.

Treatment is the same as for a cold with the exception of the availability of some antiviral medicines. One of the main things that can be done is to get the annual flu vaccine. The vaccine protects against the projected types of virus causing the flu for the current flu season. Any one over the age of 65, any one who has a decreased immune system (or persons working with these people), and/or any one with a chronic disease process (lung, kidney, heart, diabetes, etc.) should get a flu shot each year. Flu vaccines cannot give you the flu. Most people have little or no reaction to the vaccine. 1 in 4 might have a swollen, red, tender area at the injection site. A much smaller number of people may develop a slight fever, chills or a headache within the first 24 hours. Adverse reactions are seen in people with allergies to eggs.

Whether it's the flu or a cold, here are some general guidelines for keeping it away:

♥ Wash your hands often. Remember, cold viruses are picked up from objects and can be passed to the eyes and nose easily.
♥ Keep at least 3 feet away from coughers and sneezers. If you are in an enclosed space (such as an elevator) with a cougher, turn your back or get off and get on another elevator.
♥ Beware of closed in spaces. Poor air circulation and low humidity in homes and office buildings in the winter harbor viruses.
♥ Drink plenty of fluids and eat a healthy diet.
♥ Keep active. Walking, dancing, or cycling 3 times a week is all it takes to enhance your resistance to upper respiratory tract infections.
♥ Get plenty of sleep.
♥ Treat only the symptoms you have. (Cough - cough suppressant, etc)
♥ Get your flu shot each year
♥ Be sure you are getting enough vitamins. A multivitamin daily is usually sufficient.
News from The American Heart Association

The American Heart Association’s Get With the Guidelines-Coronary Artery Disease (GWTG-CAD) program is gearing up for another eventful year across Texas. The GWTG-CAD program is a hospital based quality improvement program assisting hospitals to ensure that patients are treated to the secondary prevention guidelines throughout their hospitalization and at discharge. This includes receiving the appropriate medications and risk factor counseling in hopes of reducing chances for another event.

Cardiac rehabilitation plays an important role in the implementation of GWTG-CAD especially given the focus of secondary prevention. Some of the more successful hospitals that have implemented GWTG-CAD have relied heavily on the involvement of their cardiac rehabilitation departments. This is a great chance to show your hospital the value and impact that cardiac rehabilitation has on patient care and outcomes.

There will be several CME accredited workshops throughout the state this fall and next spring. Keep your eyes and ears open for workshops in your area.

For more information about GWTG-CAD go to http://www.americanheart.org/getwiththeguidelines or contact Alan Baronoskie, American Heart Association, Quality Improvement Director at (512) 433-7193 or alan.baronoskie@heart.org

Job Postings

Clinical Overread Specialist
Frontera Strategies, LP
Dallas, TX
Seeking qualified candidates that have experience in cardiopulmonary metabolic exercise testing.
Contact: Ches Williams
214-680-1184
cwilliams@frontstrat.com

Cardiopulmonary Technologist
Frontera Strategies, LP
Houston, TX
Looking for MS in exercise physiology with minimum 1 year cardiac stress testing.
Contact: Nate Nelson
832-338-7772
nnelson@frontstrat.com

Registered Nurse
Richardson Regional Medical Center
Richardson, TX
Looking for a full-time RN to work in Outpatient Cardiac Rehab
Contact: Janet Suhr, MBA
972-498-4570
janets@richardsonhealth.com

If you have a job posting that you would like to include in our February newsletter, please contact Janet Suhr at janets@richardsonhealth.com.
Are You a Part of Your Regional Chapter?

SETACVPR
Contact: President Laney Liscum
laney_liscum@mhhs.org

NTACVPR
Contact: President Tim Cleveland
TimCleveland@texashealth.org

T.A.C.V.P.R. 2004
Fall Newsletter
Janet Suhr
403 West Campbell Road Ste 100
Richardson, TX  75080