

## MACVPR MEETING MINUTES

Wed., September 13, 2006

Attendees: Preeti Benjamin, MACVPR President, Pam Peitz, MACVPR Vice President, Kristen Fletcher, MACVPR Secretary, Marybeth Daniels MACVPR Treasurer, Cecily Ludka, Jo Ann Kim, Tina Milman, Sara Stees, Nancy Kaylor, Melissa Eigenbrode

- I. President Preeti Benjamin opened the meeting.
- II. Fall Dinner meeting will be held Thursday, November 9, 2006. 6:00 PM  
Topic – **Pulmonary Hypertension**  
Location - Chiapparelli's  
237 High Street  
Baltimore, MD 21202  
Phone# 410-837-0309  
[www.chiapparellis.com](http://www.chiapparellis.com)
- III. Jo Ann Kim presented her research on the various outcomes tools that are available for use in the clinical setting for both for cardiac and pulmonary rehab. It was suggested that we vote on and agree on using the same measurement tool to use in our individual programs in order to benchmark success of our programs. All members present agreed to pick one tool from each outcome area suggested by AACVPR for program certification. Health, Clinical, Behavioral Domains.

**A. Health Domain:** We have chosen one assessment category for this domain: **QOL**. MACVPR decided on the SF-12v2™ to measure quality of life (Mental Health and Physical Functioning). We will administer to patient pre- and post program. It is a quick and easy tool used to measure 2 areas of quality of life. It is free with one time fee of \$25.00. This also a well respected tool and well known within clinical field. The SF-12v2™ Health Survey is a 12-item subset of the SF-36v2™ that measures the same eight domains of health. As a brief, reliable measure of overall health status, the SF-12v2 is the instrument of choice in large population health surveys and has been used extensively as a screening tool. Because of its brevity, it is frequently embedded in longer, condition-specific surveys.

Adapted for use in more than 36 countries and yielding physical and mental component summary measure scores that are comparable to those from the SF-36v2 in both general and disease-specific populations, the SF-12v2 Health Survey was developed by QualityMetric to improve on the SF-12® in scoring, item construction, and survey layout. Of particular note, SF-12v2 Health Survey offers:

Scoring algorithms for each of the eight health domains  
Integration of norm-based scoring  
Scales that cover a much wider range

The SF-12v2 can be self-administered or given by a trained interviewer in person or by telephone to persons ages 14 and older and usually takes two to three minutes to complete. Most of the items in the survey ask respondents to consider a specific period of time, or recall period, when responding. The SF-12v2 is available in a standard form that uses a four-week recall period, and an acute form that uses a one-week recall period.

For more information:

<http://www.qualitymetric.com/products/sf12v2.aspx>

- i. Other tools discussed but voted against were:
  - a. SF – 36 – lengthy and software needed to score
  - b. Dartmouth COOP
  - c. Duke
  - d. Minnesota Living with Heart Failure

B. **Clinical Domain:** We have chosen three assessment categories for this domain: **BMI, Functional Capacity, and Depression.**

1. **BMI-** It was decided to calculate BMI on the patients first session and their last session.
2. **Functional Capacity:** It was decided upon to use the highest MET level the patient can achieve in Rehab on the 2<sup>nd</sup> and last sessions (a minimum of 12 sessions attended is required for this assessment)
3. **Depression:** The CES-D (Center for Epidemiologic Studies Depression Scale) was agreed upon for use at is FREE easy complete, is self scored and there is a recommended score when it's necessary to refer. It has also been validated and proved reliable.

For more information:

<http://www.chcr.brown.edu/pcoc/cesdscale.pdf>

4. Tools voted against for measuring depression:
  - a. The ZUNG
  - b. Beck Depression Inventory.

C. **Behavioral Domain:** We have chosen one assessment category for this domain: **Nutrition**. The nutritional assessment tool we have chosen to use is the MEDIFICTS (Meat, Eggs, Dairy, Fried Foods, In baked goods, Convenience Foods, Table Fats, Snacks) it is very easy to use and for learning levels. We noticed many program we using their own made up tools and at least this tool was validated and reliable.

1. Tools that were voted against for measuring behavior a Physical Activity questionnaire was also discussed an option. But, no reliable ones were out there.

For more information:

<http://www.limcpc.com/Medical%20Info/cholest/medficts.htm>

D. **Collection of Data:** A reference sheet to collection of information and ability for programs to access the tools and score them will most likely be on the website, but will be further discussed at next meeting.

IV. **Reimbursement:** The time has come to try to get support for Senate Bill 1440 and House Bill 4824. AACVPR is looking for 51 Senators and 218 House of Representatives to Co-sponsor the Bills. Right now, Senator Mikulski is a co-sponsor but there are no Representatives from Maryland that are co-sponsoring the bills. If you write to Senator Mikulski, please thank her for her support. The bills are to amend title XVIII of the Social Security Act to provide coverage for cardiac rehabilitation and pulmonary rehabilitation services. Currently, cardiac and pulmonary rehabilitation is covered under “incident to” physician services. There is always a threat that CMS will stop paying for both services. In some parts of the country, pulmonary rehabilitation is not paid for by Medicare. Please have everyone on your staff, Medical Directors and Hospital Administrators send letters.

Currently, AACVPR doesn't want patients to write letters. Remember, **use fax or e-mail** but do not send letters through US Mail. Please put the letters on Hospital Letterhead.

Please let Deb Lund know how many letters have been sent and to which Representatives have been sent letters. Remember, if you live in one area and work in another area, the areas may have different Representatives. If you do not know your Representative, go to [www.house.gov](http://www.house.gov) and put in your zip code. Hopefully, we can get letters sent to all Representatives in the 8 districts. AACVPR wanted the letters to go out in early Sept. Let's do them ASAP. If you have any questions regarding this issue, please feel free to contact Deb Lund at 410-553-2932.

## MARYLAND

District	Representative	Party	Hometown
01	<b>Wayne T. Gilchrest</b> Maryland-1st, Republican 2245 Rayburn HOB Washington, DC 20515-2001 Phone: (202) 225-5311 Fax: 202-225-0254 e-mail: <a href="http://www.house.gov/gilchrest">www.house.gov/gilchrest</a>	R	Kennedyville
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03	<b>Benjamin L. Cardin</b> Maryland-3rd, Democrat 2207 Rayburn HOB Washington, DC 20515-2003 Phone: (202) 225-4016 Fax: 202-225-9219 e-mail: <a href="mailto:www.rep.cardin@mail.house.gov">www.rep.cardin@mail.house.gov</a>	D	Baltimore
04	<b>Albert Russell Wynn</b> Maryland-4th, Democrat 434 Cannon HOB Washington, DC 20515-2004 Phone: (202) 225-8699 Fax: 202-225-8714 e-mail: <a href="http://www.wynn.house.gov">www.wynn.house.gov</a>	D	Mitchellville
05	<b>Steny H. Hoyer</b> Maryland-5th, Democrat 1705 Longworth HOB Washington, DC 20515-2005 Phone: (202) 225-4131 Fax: 202-225-4300 e-mail: <a href="mailto:rep.hoyer@mail.house.gov">rep.hoyer@mail.house.gov</a>	D	Mechanicsville

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SAMPLE LETTER TO YOUR **HOUSE OF REPRESENTATIVE MEMBER:**

Dear \_\_\_\_\_:

I am writing to ask for your support of HR 4824 to establish pulmonary and cardiac rehabilitation as a specific Medicare benefit category. This House legislation is sponsored by Republican Chip Pickering (R-MS) and Democrat John Lewis (D-GA). Both pulmonary and cardiac rehabilitation have been covered services under the Medicare statute, authorized under Section 1861(s)(2)(B) which authorizes outpatient services that are “incident to” physician services. The proposed legislation would create specific legislative language within Title XVIII authorizing payment for pulmonary and cardiac rehabilitation services.

*Cardiac rehabilitation* is a set of physician ordered patient services that include initial evaluation and goal setting, monitored therapeutic exercise, education, psycho-social support and on going assessment of patient progress. Scientific studies have shown that patients with heart failure and other cardiac diseases benefit (reduced health care costs, morbidity and mortality) from cardiac rehabilitation.

*Pulmonary rehabilitation* is a set of physician ordered services that include initial evaluation and goal setting, therapeutic exercise, education, psycho-social support and on going assessment of patient progress. Scientific studies have shown that patients with COPD and other respiratory diseases significantly benefit (reduced health care costs, morbidity and mortality) from pulmonary rehabilitation.

**This legislation is necessary for the following reasons:**

*Cardiac rehabilitation* has had coverage under Medicare since the late 1980’s. However, the status of cardiac rehabilitation as an “incident to” physician service has created regulatory uncertainty and confusion about its physician supervision level and compliance with Medicare regulation. In fact, in some regions, cardiac rehabilitation programs **have been closed** due to this confusion. This legislation would remove cardiac rehabilitation from the confusing regulatory environment of “incident to” services and clearly create it as a specific Medicare benefit with specific physician involvement delineated.

*Pulmonary rehabilitation* also is a covered service by Medicare, most notably stated in a 1981 letter addressing that specific question. However, there is no national coverage policy for pulmonary rehabilitation services even though virtually all Medicare contractors (fiscal intermediaries) have released their own coverage policies. These policies vary widely and **coverage is extremely inconsistent to nonexistent throughout the country**, depending on the local coverage determination policy (LCD). CMS/NIH included pulmonary rehabilitation as the standard of care in their National Emphysema Treat Trial (NETT). Having no national coverage policy for pulmonary rehabilitation means that beneficiaries in some regions have no access to this important therapeutic benefit. This legislation would establish pulmonary rehabilitation in its own unique

benefit category and lead CMS to promulgate a national coverage policy that ensures access to this scientifically proven medical therapy for Medicare beneficiaries suffering from COPD and other respiratory disorders.

I appreciate your consideration of this critical issue for your cardiac and pulmonary constituents in (**IN OUR STATE**). I hope I can count on your support as a co-sponsor of HR 4824.

Sincerely,

V. 2006 Spring Conference

- a. Suggested Topics were requested by Conference Committee
- b. Pam Peitz reported problems with coming up with a mailing list from the last conference. She created a list from MHA, AACVPR, VACVPR, DC Metro CVPR, and MACVPR. It was suggested that she look into the Tri-State association (contact Pat Comoss) and the ACSM Northeast Chapter for mailing lists.

VI. **Treasurer's Report** – Marybeth Daniels

- a. Pre-AACVPR conference - \$22, 886.03.

VII. Meeting Adjourned.