**NCCRA Exercise Discipline Meeting Minutes**

 **March 23, 2018**

Our group email list was updated. Fifty-three people were in attendance for our discipline meeting.

Prior to the symposium, group and/or round table discussions were requested concerning ideas of interest from the exercise discipline group. Due to the nature of the ideas contributed, the group discussed topics as one large group.

Discussion began concerning a prior question from Dr. King’s PAD lecture. Only those patients with symptomatic PAD will be covered for PAD SET classes. A diagnosis of PAD alone does not qualify them for classes. Only 20% of patients diagnosed with PAD will experience pain and will be eligible for classes. Training for the PAD patients should be labor intensive interval training. Most hospitals who already offer PAD classes use a one to one patient to staff ratio for classes. Some hospital programs have started by incorporating PAD patients into their already established cardiac classes, still with a one to one ratio. Some programs are utilizing interns to help guide PAD patients during classes. Dr. King stated that ICD is more important than VO2 and that TM walking vs ground walking is the best exercise. He also stated that coaching is very important with these patients. Patients really need to understand the pain scale and know how to use it correctly.

A second discussion focused on mental health care for patients. What can front line staff do, in addition to licensed counselors, that will help our patients with mental health issues (specifically depression) throughout their time in cardiac/pulmonary rehab? A recent AACVPR News and Reviews article entitled “Promoting Quality of Life in Individuals with Pulmonary Disease: The Psychosocial Role of Pulmonary Rehabilitation” suggested the following: regular exercise, enhancing social support through group meetings, discussing sexual health, encouraging hobbies and Interests and providing breathing education and retraining. Another idea suggested was to get spouses involved with patient care so that they may understand better what the patient is going through. Have a space for patient spouses or family to be near patients when they exercise, ask family members to join in education or relaxation with patient. Dr. King mentioned having current FT CPR staff members obtain an LPC certification so they may help counsel consistently during patient tenure. If you are interested in the AACVPR article, here is the link <http://newsandviews.aacvpr.org/blogs/emma-frey/2018/03/15/promoting-quality-of-life-in-individuals-with-pulm?CommunityKey=584f5af2-cbc2-40da-9fe8-2a059787af7d&tab>=

The third discussion was centered on prescription and titration of exercise in patients with heart attack due to spontaneous coronary artery dissection (SCAD). One hospital discussed 3 patients that attended their cardiac rehab with SCAD, two female and one male. Patients completed TM tests to their age predicted max and all had normal BMIs. Two of the three were asymptomatic. One of these patients did experience angina but are being treated with meds. The program based exercise progression on how the patient felt and not patient THR. SCAD patient’s progression of exercise was the same as patients with typical cardiac diagnosis. The question remaining is how much should SCAD patients push themselves? “How much is too much?” If you are interested in this CEPA SCAD webinar, here is the link <https://www.acsm-cepa.org/i4a/pages/index.cfm?pageid=3279>

A fourth discussion focused on progression of exercise in cardiac patients vs pulmonary patients. Various programs in attendance use incentives, prizes, awards, competitions and wellness challenges to help motivate cardiac and pulmonary patients to exercise longer and at higher intensities during classes. Other programs suggest using HIIT to progresses pulmonary and/or cardiac patients. Patients are encouraged to exercise at higher than normal intensities until they need to stop and catch their breath or until they desat. Exercise resumes again at this higher pace once the patient feels better and their SpO2 is above 90%. Dr. King recommended that the use of HIIT with patients should be used safely and should be effective. Safety first is recommended and progression should be efficient and effective. If other disciplines within your program are hesitant to encourage this type of exercise progression, it was suggested that more education is needed to help them understand that HIIT may be safely accomplished if performed correctly. Provide them with research and more education on this topic during PCC’s or staff meetings.

The final topic of discussion, led by Mr. Dave Verill, was regarding the combination ACSMs RCEP and CEP exams. The ACSM CCRB will develop and maintain a single clinical exercise physiologist examination – ACSM Certified Clinical Exercise Physiologist (ACSM-CEP). ACSM will no longer offer the Registered Clinical Exercise Physiologist Certification (RCEP) exam, and will develop and maintain a campaign that promotes the ACSM-CEP credential and the professionals who have it. ACSM and the Clinical Exercise Physiology Association (CEPA) will co-develop a Registry of Clinical Exercise Physiologists. The aim of the Registry will be to emphasize the value that ACSM-CEPs bring to healthcare. All current RCEPs will automatically qualify for the Registry and additional details about the new Registry and information about how current CEP’s may be added to the Registry are currently being discussed. ACSM does not recognize the CCRP as an ACSM certification equivalent. The CCRP is designed to test all disciplines of CPR, whereas the new ACSM exam will combine all aspects of the current RCEP and CEP exams. Most CPR Programs currently accept either the ACSM-CEP and/or ACSM-RCEP for employment. Current CEP certified professionals will not need to take the new ACSM-CEP certification to remain certified.

Thanks to all who attended the meeting and to all who volunteered ideas for discussion. Please remember to use this network of colleagues! If you have questions at any time, or would like to discuss a topic with the group, you may email me and I will send it out to everyone. angela.lanier@iredellhealth.org