

SUMMER NEWSLETTER



ISCVPR

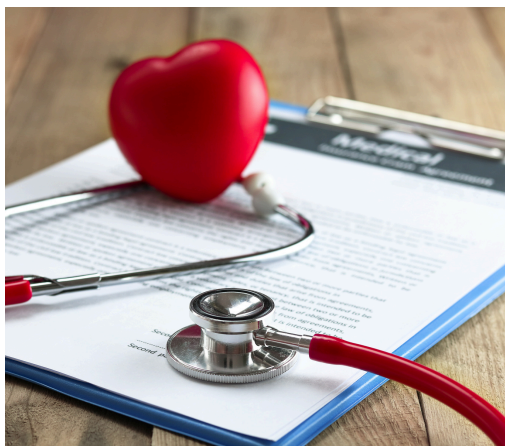
August 2025

Welcome to the Summer Edition of ISCVPR Newsletter

With summer in full swing, we are excited to share fresh updates, celebrate our community's work, and keep the momentum going in the cardiopulmonary rehabilitation community. In this issue, you'll find information on upcoming events, educational opportunities, and ways to get involved in our society. Included is a directory for all AACVPR Certified Programs in Indiana.

Inhaler Education in PR

Pulmonary rehab offers ample opportunity to educate patients on proper use of inhalers and nebulizers. Effective education can ensure adequate medication delivery, symptom management, and reduced exacerbations. Taking the time to educate on inhalers can lead to improved PR outcomes.



Reimbursement Update

No reimbursement changes have been reported, but AACVPR continues advocacy efforts with CMS on key policy issues, including non-physician practitioner order acceptance, implementation of virtual services, and off-campus payment disparities. We encourage you to continue to reach out to your legislators about the SOS Act **HR955, S1949** and the Cardiopulmonary Rehabilitation Services in the Home Act **HR1406, S3021**.

Honoring Dr. Leonard Kaminsky

Dr. Leonard Kaminsky of Ball State University was awarded the prestigious L. Kent Smith Award for Excellence for his groundbreaking contributions to cardiac and pulmonary rehabilitation. Dr. Kaminsky's work has shaped the gold standard of care and continues to influence generations of clinicians and researchers. Read ahead for an article co-authored by Dr. Kaminsky about maximizing the impact of aerobic exercise in cardiac rehabilitation.





Importance of inhaler education in Pulmonary Rehab

Why educate?



The average time spent with a patient during a doctor visit is 17 minutes. Most patients aren't educated on how to use the inhaler prescribed.



We see patients for 2-3 hours a week. Plenty of time to educate on proper use of their inhaled medications.



Educating patients on their inhalers will ensure effective medication delivery, help control their symptoms more effectively, and reduce exacerbations.



Effective education can include checking flow using in-check dial, have patients bring in their inhalers, instruct using teach back method, share instructive videos, address barriers.



In-check dial: This device helps assess whether patients are able to generate proper flow to actuate their specific inhaler delivery device. It helps to identify training needs, optimize medication delivery, reduce medication waste, identify when a new delivery device is indicated and improve the patient's confidence in using their inhaler.



In-check dial

Reimbursement Update 7/2025

Susan Bauman, BSN, CCPR
ISCVPR Reimbursement Co-Chair

We have no changes to report in the area of reimbursement.

AACVPR is re-imagining the Government Affairs Committee (GAC). A couple years ago Hart Health Strategies became our legislative lobby group after the retirement of our long-time strategist.

In February the GAC engaged in a face-to-face conversation with CMS for the following topics:

1. goal for NPP (non-physician practitioner) order acceptance
2. implementation of virtual services
3. permanence for virtual direct supervision policies
4. remove disparities in payment for services furnished off campus (non- excepted programs)
5. clarification of PR lifetime session limit

AACVPR found CMS engaged and interested, currently no response has been received. AACVPR is hoping some of these policies will be addressed as the 2026 CMS regulations are released later this year.

We continue to ask for your interaction with your legislators for the following legislation, which can be accomplished on AACVPR's advocacy page:

1. SOS Act. HR955, S1949. Address the disparity in payment for programs that located off campus after 2010
2. Sustainable CP Rehab Services in the Home Act. HR 1406. S3021.
Provides for permanence of services via virtual telecommunications at home

AACVPR is working hard at the above topics. In addition, they have future initiatives- HF diagnosis qualification revision; criteria to meet physician/NPP supervision; exercise oncology, NCD; addition diagnosis- Afib, cardiac arrest, ILD, PF.

Please reach out with reimbursement questions to Susan Bauman at susan.bauman@nwhealthin.com or Debbie Koehl at dkoehl@iuhealth.com.

FROM THE DESK OF THE VICE – PRESIDENT

KATRINA RIGGIN, M.S

SPECIAL RECOGNITION: HONORING DR. LEONARD KAMISKY, BALL STATE UNIVERSITY



It is with deep admiration and pride that we recognize Dr. Leonard Kaminsky, the distinguished recipient of the L. Kent Smith Award of Excellence, AACVPR's highest honor for lifetime achievement and contribution to the field of cardiovascular and pulmonary rehabilitation. Dr. Kaminsky's legacy spans decades of groundbreaking work, pioneering leadership, and tireless advocacy for evidence-based practice in cardiac rehabilitation. From his early research on the value of cardiorespiratory fitness as a prognostic marker to his most recent co-authorship of AACVPR's official statement on exercise volume optimization, Dr. Kaminsky has continuously shaped the gold standard of care in our field.

He has served in numerous leadership roles within AACVPR and contributed prolifically to scholarly literature, setting a clear benchmark for academic excellence, scientific rigor, and mentorship. His efforts have empowered countless clinicians and researchers to elevate their practice, always guided by data, compassion, and the conviction that physical activity saves lives.

On a personal note, I am honored to call Dr. Kaminsky not only a professional mentor but also a trusted friend. His guidance over the past 30 years has shaped my path in ways that words cannot fully express. His steady encouragement, wisdom, and generous spirit are as impactful as his published work.

Please join me—and all of us in ISCVPR and AACVPR—in celebrating Dr. Kaminsky for his remarkable career, his steadfast leadership, and his unwavering dedication to improving patient outcomes. His influence will ripple for generations to come.

Congratulations, Dr. Kaminsky. This recognition is both well-earned and deeply deserved.

Maximizing the Impact of Aerobic Exercise in Cardiac Rehabilitation

The recently published official statement from AACVPR, "Volume of Aerobic Exercise to Optimize Outcomes in Cardiac Rehabilitation", authored by Savage, Beckie, Kaminsky, Lavie, and Ozemek, delivers a timely and evidence-based roadmap for clinicians aiming to elevate patient outcomes through structured aerobic training.

This consensus paper answers a fundamental question many of us face in practice: What is the right dose of aerobic exercise in CR to meaningfully reduce morbidity, improve fitness, and enhance quality of life?

Key Findings and Practical Applications:

Evidence-Based Volume Matters

The authors propose a target aerobic exercise volume of 1000–1500 MET-minutes per week, with a minimum threshold of at least 500 MET-min/week to begin achieving clinically significant benefits. This recommendation is anchored in robust studies showing direct associations between exercise dose and improvements in cardiorespiratory fitness (CRF), a powerful predictor of mortality.

Frequency and Duration: More is More

While the traditional 36-session model is beneficial, programs that offer higher-frequency and longer-duration exercise sessions lead to superior gains. The paper encourages us to customize the exercise prescription to help patients reach the higher MET-min targets safely and progressively.

CRF as the Clinical Goalpost

The statement reinforces CRF ($\text{VO}_{2\text{peak}}$) as a measurable and modifiable outcome. Programs are urged to track changes in CRF to assess the effectiveness of training and to support value-based care models.

Barriers and Solutions

Authors acknowledge the practical barriers to achieving higher training volumes—patient adherence, time constraints, transportation, and insurance coverage. Creative solutions, such as hybrid models, home-based sessions, and incorporating step count or wearable tech, are recommended to close this gap.

Team-Based Optimization

A recurring theme in the paper is the interdisciplinary effort needed to achieve these higher training goals. Exercise physiologists, nurses, and physicians must collaborate to reassess intensity, progress workloads, and motivate patients consistently.

As we reflect on our collective practice in Indiana and surrounding regions, this guidance challenges us to look beyond session counts and zero in on exercise dose. It may prompt us to:

- Review how we calculate and document MET-minutes/week
- Advocate for extended CR beyond 36 sessions or more structured Supervised Maintenance
- Incorporate wearable activity monitors more deliberately
- Use VO_2 peak changes as a clinical outcome in program evaluations

This statement doesn't just reinforce what we already know—it raises the bar. For ISCVPR members, it is both a call to action and a toolkit for making a measurable impact on our patients' lives through exercise volume optimization.

Let us continue to learn and lead with evidence, compassion, and innovation.

*For a full review of the AACVPR statement, visit [Volume of Aerobic Exercise to Optimize Outcomes in Cardiac Rehabilitation An Official Statement From the American Association of Cardiovascular and Pulmonary Rehabilitation](#) Savage, Patrick D. MS, FAACVPR; Beckie, Theresa M. PhD; Kaminsky, Leonard A. PhD, MAACVPR; Lavie, Carl J. MD; Ozemek, Cemal PhD, FAACVPR

Cardiopulmonary Rehabilitation Competency Series

With Joni B

Curated by:

S. Joni Bertsch MSN, RN, CCRP, Certificate in Pulmonary
Rehabilitation AARC/AACVPR

IU Health Ball Memorial Cardiopulmonary Rehabilitation

This series of educational tools and articles has been thoughtfully put together to support continued growth and excellence in cardiopulmonary rehabilitation. These materials can be used to strengthen patient education efforts, enhance clinical knowledge, and promote best practices across the state.

Please feel free to explore and implement these materials to further empower your staff and elevate the care you provide.

Summer 2025

Tobacco Cessation

Fall 2025

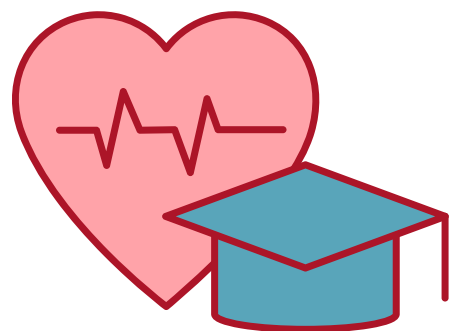
Patient Assessment

Winter 2025

Blood Lipid Management

Spring 2026

Non-COPD Respiratory Diseases



CHAPTER 7

TOBACCO CESSATION

ANDREA BON-WILSON, MA, LPC, CAC II, FAACVPR

INTRODUCTION

Smoking tobacco continues to be the leading cause of preventable death in the United States today.¹ One in five deaths from cardiovascular disease (CVD) is attributable to smoking. Smoking is associated with an increased risk of CVD events in patients with established disease, including recurrent myocardial infarction (MI), sudden death, and restenosis after percutaneous coronary intervention (PCI). In individuals with coronary heart disease (CHD), smoking cessation is associated with a 36% reduction in the risk of all-cause mortality, making it an important secondary prevention intervention.²

The way tobacco is grown, mixed, and processed today has made cigarettes more addictive than ever before. Because of this, the majority of smokers who try to quit on their own typically require many attempts. There is no safe level of exposure to tobacco smoke. Sustained use and long-term exposure to tobacco smoke are due to the powerfully addicting effects of tobacco products, which are mediated by diverse actions of nicotine and perhaps other compounds, at multiple types of nicotinic receptors in the brain.³

As a result of the high rates of relapse to smoking weeks, months, and even years after quitting, the US Public Health Service Clinical Practice Guideline on Treating Tobacco Use and Dependence suggest that tobacco dependence must now be considered a chronic condition that requires repeated intervention.⁴

Tobacco use is the one risk factor for cardiovascular disease that can negate all the positive effects of a cardiac rehabilitation program and yet it is one of the most difficult behaviors to change. It is therefore important for all Cardiac Rehabilitation Professionals (CRPs) to have the knowledge and skills to create a partnership

with their tobacco dependent patients that promotes, not hinders, successful control of this addiction.

This chapter will address the following:

1. The US DHHS clinical practice guideline as it relates to cardiac rehabilitation.
2. Physiologic and biochemical consequences of tobacco use including its mechanism of addiction
3. Impact of environmental tobacco smoke (ETS) on CV risk
4. Assessing your tobacco user in a manner that promotes a therapeutic alliance
5. The central role of pharmacotherapy in treating tobacco dependence
6. Behavior change strategies that encourage a quit attempt and prevent relapse
7. Support services available outside of the cardiac rehabilitation program

THE US DHHS CLINICAL PRACTICE GUIDELINE AS IT RELATES TO CARDIAC REHABILITATION

The 2008 update to Treating Tobacco Use and Dependence, Clinical Practice Guideline from the US Department of Health and Human Services, Public Health Service⁵ established that counseling and medications for tobacco dependence do work. Their key recommendations address the importance of offering advice and help to all tobacco users. The Guideline addresses tobacco treatment in all health care settings but several key recommendations should be a clear “take home” message for cardiac rehab programs. Those key recommendations include:

- Tobacco dependence is a chronic disease that often requires repeated intervention and multiple attempts to quit. Effective treatments

exist, however, that can significantly increase rates of long-term abstinence.

A cornerstone to chronic disease management is stepped care improvement. Cardiac rehabilitation programs, with their frequent encounters, allow the CRP to intervene up to 36 times, guiding their patient through the process of quitting and offering varied treatment options until the most effective treatment for this patient is identified.

- The effectiveness of individual, group, and telephone counseling increases with treatment intensity. Two components of counseling are especially effective, and clinicians should use these when counseling patients making a quit attempt:

- Practical counseling (problem solving/skills training)
- Social support delivered as part of treatment

Cardiac rehab programs can not only provide the problem solving and skills training that are helpful but can deliver it in a time sensitive manner. As in all adult learning, if a skill is immediately usable it is more likely to be tried. Patients often share their current difficulty with cravings giving the CRP an opportunity to explore a targeted skill set. Also once a relationship with your patient is established the CRP can become their strongest ally in this journey.

- Numerous effective medications are available for tobacco dependence, and clinicians should encourage their use by all patients attempting to quit smoking-except when medically contraindicated or with specific populations for which there is insufficient evidence of effectiveness.

Seven first-line medications (5 nicotine and 2 non-nicotine) reliably increase long-term smoking abstinence rates: nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, nicotine patch, bupropion SR, and varenicline.

Medication use and adherence is one of the biggest challenges for cardiac patients to master. Often feeling overwhelmed with all the new medications they have to take, they may want to reject medication use and medications for tobacco dependence are often the first one they try to eliminate. The CRP can play a critical role in helping the patient choose and use these medications

in an effective manner to achieve their goal.

- Counseling and medication are effective when used by themselves for treating tobacco dependence. The combination of counseling and medication, however, is more effective than either alone. Thus, clinicians should encourage all individuals making a quit attempt to use both counseling and medication.

This key recommendation should be a cornerstone for the ITP. The CRP is in the unique position to not only make recommendations but provide the follow through and revisions of the plan when necessary.

PHYSIOLOGIC AND BIOCHEMICAL CONSEQUENCES OF TOBACCO USE INCLUDING ITS MECHANISM OF ADDICTION

Smoking causes numerous problems within the cardiovascular system with increased risk in those with vascular disease including coronary heart disease (CHD), peripheral arterial disease, abdominal aortic aneurysm, and stroke. The major components in cigarette smoke that increases this risk are nicotine, carbon monoxide, and oxidant gases.

Nicotine promotes catecholamine release, increasing heart rate and blood pressure and thus increasing myocardial oxygen demand. Nicotine constricts peripheral arteries, interfering with blood flow to tissues. The strength of this hemodynamic effect is related to its rate of delivery. Smoking results in a rapid rise in nicotine levels. Carbon monoxide, a byproduct of smoking (any smoke, not just smoking nicotine), injures vascular endothelium, interferes with the ability of red blood cells to carry oxygen, and contributes to hypercoagulation thus reducing the amount of oxygen delivered to the heart muscle. Oxidant gases induce inflammation, augment platelet aggregability, promoting adherence of platelets to damaged endothelium.^{6,7}

The interplay of these constituents contributes to ventricular dysfunction and lowers ventricular fibrillation threshold. It influences other risk factors like decreasing HDL levels. Also through oxidative stress it can make LDL more atherogenic. The improved outcome associated with smoking cessation in those with CVD is apparent soon after quitting and in people of all age groups, including the elderly. For example, the risk of MI decreases by 50% within two years of cessation

and rate of restenosis following bypass surgery are decreased after cessation.⁷

Most patients understand that cigarette smoking can impact their lung health but do not have the same appreciation of its impact on their cardiovascular system. It is important that cardiac rehabilitation professionals know the risks and have the information available for their patients. It is equally important to understand the addictive quality of nicotine and how patients may struggle with quitting even if they know the damage it is causing to their heart health.

Within 10 seconds of smoking nicotine, powerful neurochemicals are released in the brain including:⁸

- a. Dopamine: associated with pleasure and appetite suppression
- b. Serotonin: works as an antidepressant, calms smokers and regulates anger and mood, and suppresses appetite
- c. Norepinephrine: stimulates and helps with mental focus, increases metabolism, and suppresses appetite
- d. Gaba: reduces anxiety and tension
- e. Glutamate: effects learning and enhances memory
- f. B-endorphin: an opioid neuropeptide that reduces anxiety and tension⁹

After one hour, these neurochemicals all decline as the body metabolizes the nicotine. Nicotine is one of the most addictive drugs known to mankind. Tobacco alters a person's central nervous system clearly making it not just a bad habit. It takes time, often several months, for these nicotinic receptor binding sites to down regulate to normal levels. Until that occurs your patient will be susceptible to withdrawal.

When not smoking, a smoker experiences nicotine withdrawal symptoms very quickly including:

- Dysphoric or depressed mood
- Insomnia
- Irritability, frustration, or anger
- Anxiety symptoms

- Difficulty concentrating
- Restlessness
- Increased appetite or weight gain
- Decreased heart rate
- Cough, chest tightness, constipation, gas
- Fatigue
- Mental cravings for a cigarette¹⁰

This rapid occurrence of withdrawal and cravings has earned Tobacco Use Disorder a DSM 5 diagnostic classification.

IMPACT OF ENVIRONMENTAL TOBACCO SMOKE (ETS) ON CV RISK

Secondhand smoke, also known as environmental tobacco smoke (ETS), is a mixture of smoke given off by the burning end of a cigarette, pipe, or cigar and smoke exhaled from the lungs of smokers. It is involuntarily inhaled by nonsmokers, lingers in the air hours after cigarettes have been extinguished and can cause or exacerbate a wide range of adverse health effects including CVD, cancer, respiratory infections, and asthma.

ETS causes 41,000 deaths in adult nonsmokers in the United States each year, including 34,000 deaths from heart disease.¹¹

The current Surgeon General's Report concluded that scientific evidence indicates that there is no risk-free level of exposure to ETS. Eliminating smoking indoors protects nonsmokers but ventilation and/or separation do not. According to the Surgeon General, short exposures can cause blood platelets to become stickier, damage the lining of blood vessels, decrease coronary flow velocity reserves, and reduce heart rate variability.

The impact can be as significant as those seen in one pack per day smokers.¹² One study found that nearly 88% of children and adult nonsmokers had detectable levels of nicotine in their systems, simply because they lived or worked with smokers.¹³

The implementation of smoke-free ordinances was associated with 33% decrease in MI and 17% decrease in sudden cardiac death.¹⁴ It is therefore equally

important during the assessment process to determine for all patients if they live with smokers or are exposed to ETS.

ASSESSING YOUR TOBACCO USER IN A MANNER THAT PROMOTES A THERAPEUTIC ALLIANCE

Empathy for patients is the most important component of all counseling skills. Smokers are very sensitive to feeling judged about their behavior. Motivational Interviewing is a counseling style in which empathy is a cornerstone and is helpful when counseling your patients on any behavior change.

The essential skills of MI are open ended questions, reflective listening, affirmations, and summary statements with all encounters, when helping patients with behavior change, especially when there is ambivalence. MI promotes intrinsic motivation to change and encourages self-efficacy.

The content areas that can be addressed with MI are expressed in the 5 Rs:

1. **Relevance:** Personalize why quitting is relevant. Relevance is not only limited to their heart problem
2. **Risks:** What have been the consequences of their tobacco use. These can be both short term like shortness of breath or long term like recurrent heart disease risk
3. **Rewards:** Eliciting what the patient may have to gain by quitting is helpful.
4. **Roadblocks:** Often the patient sees barriers before they see rewards. Ask the patient what worries or concerns them about quitting.
5. **Repetition:** Changes, new experiences and insights can occur in all of the above areas over time so it is worth re-exploring topics raised in earlier conversations.

A starting point for your patient's attitudes and beliefs of their risks, relevance, rewards, and roadblocks is collected during the initial assessment.

The goal of counseling is to increase self-efficacy so that the smoker is willing to commit to a quit attempt and that recent quitters are able to stay quit. Collecting assessment data is important, but equally important is taking the time

to listen to "their story"; eg, what has smoking meant to them, and what has the struggle with quitting been like for them personally? By listening you will gain better insight into what strengths and barriers they bring to the table and how you will direct the conversation so that the patient finds what their own inner motivation is to make a change in their smoking behavior.

Providing the patient with a paper form to collect basic information and then filling in the gaps by using open ended questions that encourage a dialogue will start to help build a rapport and create the alliance needed to move forward.

Basic Assessment Factors

- Smoking history assessment should include age started, years smoked, and average number of packs smoked per day.
- Assess for current use of tobacco products. Frequently smokers believe they quit while in the hospital but picked up an "occasional" cigarette, or pipe, cigar or even smokeless tobacco thinking that these products do not carry the risk of cigarette smoking. If smoking, assess time to first cigarette and number smoked per day. Lighting up within 30 minutes of waking is a key marker of addiction. It is worth checking to see if the patient is up in the middle of the night to smoke and/or has been trying to delay that first cigarette. Keep in mind too that number smoked per day can have caveats. The patient may be struggling to keep the number smoked down, or may be relighting the same cigarette several times. Always remind yourself that not smoking does not mean not craving. If the patient has remained quit since hospitalization a key question to ask is "how have you been doing with not smoking?"
- Quitting history should include (and emphasize) any and all successes no matter how brief. It helps to explore the longest and most recent quit attempts. If there was a long quit in their past then they experienced life as a nonsmoker. What was that like for them? The most recent quit will give insight into current roadblocks to quitting. Was any pharmacotherapy used to help with quitting? Check if used correctly and for a long enough time.

- Social and environmental factors may promote or hinder quitting or staying quit. Access to cigarettes and living with smokers are two major reasons for lapses which turn into relapse. What is the current home and work smoking policy? How supported do they feel in their attempt to quit or stay quit?
- What other psychosocial issues exist? Depression is a major reason cardiac patients relapse following hospitalization. This could be a pre-existing condition, the result of the event, or withdrawal symptoms which often mimic depressive symptoms during the first two weeks after quitting. Anxiety can also interfere with ability to quit, especially if the patient feels smoking helps manage this emotion—and anxiety and depression often co-exist.
- Does the patient have other substance use disorders? Alcohol often goes hand in hand with smoking. The patient may or may not perceive this as a problem. The CAGE questionnaire is the most common screening tool for potential alcohol abuse and should be a part of your initial assessment packet.¹⁵ If you perceive there is alcohol dependence, it is worth discussing your concern with the PCP since this problem may have been addressed in the past. If the patient is in recovery, it may identify strategies that will help with successfully quitting smoking as well.

Importance/Confidence of Quitting

The importance/confidence scales are commonly used in motivational interviewing. These scales can help determine self-efficacy and can be a starting point of conversation. Keep in mind that by the time the patient enters cardiac rehab he has received clear messages about importance of quitting. To form an alliance with your patient you cannot take the expert role by delineating all the medical reasons they should not smoke. What helps to build rapport is to first ask what they like about smoking or if they say they want to quit what makes it hard for them to not smoke. Next, ask how important they feel it is for them to quit (or stay quit) on a scale of 1 to 10 then following with, for instance, why is it a 7 and not a 4? By doing this the patient has to think of reasons it is important to them to quit. The

follow up question then is what would it take to move from a 7 to a 9, for example. Keep in mind importance is not always related to health but can be something as simple as saving money; this will identify what you may need to emphasize in future discussions. The same steps can be followed to determine confidence level.

One tool that can help with identifying the benefits of quitting is a carbon monoxide (CO) analyzer. It has been referred to as “the stethoscope” of smoking cessation. Carbon monoxide levels provide tangible evidence of the impact of smoking for the patient. It also allows you to measure progress as they cut down or quit making it a strong motivational tool. All programs should consider having this available. (Please see Bittoun reference in list at end of chapter.)

THE CENTRAL ROLE OF PHARMACOTHERAPY IN TREATING TOBACCO DEPENDENCE

According to the most current research and the US Surgeon General, the best way to quit is to combine a smoking cessation medication with a behavioral program. CRPs should be able to advise and monitor use of pharmacotherapies for smoking cessation to maximize their effectiveness. We know that using medication can double and sometimes triple success rate compared to placebo or no medication. Tobacco dependence is an addiction and chronic disease, and like all addictions and chronic disease, control is improved with medication use. A table illustrating the medications licensed for in the US as aids in smoking cessation (as of 2018), including efficacy rates, adverse effects, and dosage can be found at the end of the chapter.¹⁶

There is a continued myth surrounding NRT use that it can precipitate a cardiac event. This often makes patients afraid to use NRT thinking that if they smoke on the patch they might precipitate an MI. Several studies and reviews have shown that use of NRT in the cardiac patient including those with recent ACS is safe, even if the patient smokes while on the patch, and improves quit rates. Reality is that patients will be more likely to stay quit if treatment starts in the hospital. Exposure to smoke and its CO and many oxidants is the real risk and the CRP needs to be able to communicate this to the patient.

A major reason patients relapse to smoking following a cardiac event is that they experience severe cravings. This is often due to under dosing with NRT.

You should encourage your patients to “stay the course” when it comes to using NRT. If the patient is just using the patch and is experiencing “breakthrough” cravings, suggest adding short acting nicotine like gum or lozenge. An example of a time when cravings can be difficult is first thing in the morning. Using a nicotine lozenge when awakening and applying the patch ASAP can help with this. This also gives them something pro-active to try rather than feeling powerless over the addiction.

Varenicline and bupropion are also options for your patients. The drawback is that they require a prescription where NRT does not (unless covered by insurance). Also patients tend to want to avoid adding more medications to their list. However, these medications can be very effective and are safe in cardiac patients and should be considered, especially in patients who do not tolerate NRT.¹⁷ If patients are willing to try these medications but are fearful of side effects, suggest titrating up more slowly than manufacturer’s suggested rate. To help minimize chance of insomnia, neither of these medications should not be taken close to bedtime. Taking them with breakfast and dinner is one strategy.

Electronic cigarettes are also worth addressing here. Although this is not a proven method for quitting smoking, your patients may perceive it as such. You can clearly state that if they wish to use it to quit smoking there are more effective proven methods available. You can also advise them that they are not harmless regardless of what they have heard or read in their advertising. Since it is so new to the market the long term effects are not known. It has not been adequately studied to be able to speak to its safety or effectiveness at this time. That said if a patient enters the program already using the e-cigarette, is not smoking, and feels it is helping them there is no clear reason in the short term to suggest that they stop. It can be helpful in that they are avoiding carbon monoxide and other oxidants in cigarettes. Ask if their intentions are to only use this or are they willing to explore other alternatives to quitting. Most likely they are wedded to the act of smoking and e-cigarettes closely mimics this for them. Over time you may be able to help them see that they perhaps are “not letting go” of their smoking by using the e-cigarette. All CRP’s should read the American Heart Association’s Policy Statement on electronic cigarettes to fully understand their implications for cardiac patients.¹⁸

BEHAVIOR CHANGE STRATEGIES THAT ENCOURAGE A QUIT ATTEMPT AND PREVENT RELAPSE

Quitting smoking can be thought of as a three step process: preparation, quitting, and maintenance. As part of the preparation it might help your patient to explore the pros and cons of smoking and quitting. This “decisional balance” is a way for them to find their own internal arguments for choosing to not smoke.

A Tobacco Use log, like food records, may help your patient identify activities or situations that trigger tobacco use and can be used to develop more targeted coping strategies to help with not smoking. There are many apps available now to assist with this and other aspects of quitting smoking.

It is important to keep in mind that even in patients who want to quit, ambivalence can still be present. So the first step needs to be to choose to not smoke vs. quit. They do not need to embrace being a nonsmoker to choose to not smoke. Maybe they will choose to not smoke in one place, or choose to smoke only in one place. This will isolate smoking from daily activities and bring the act of smoking into their consciousness which can increase their insight into why they are smoking and also raise awareness of what they don’t like about it. It also can lead to gradual reduction in nicotine which can make quitting easier and pharmacotherapy more effective.

Once the patient expresses readiness to quit, it is best to set a quit date within the next two weeks. If ambivalence remains a stumbling block it might be worth suggesting a “trial” quit date for 24 hours. This can identify possible barriers to success but also may actually catapult them into an actual quit.

The pharmacotherapy they choose to use needs to be purchased and in hand prior to quit date and they should have a clear understanding on how to use it effectively.

Patients who are ready to quit smoking have better success with a quit plan. Part of the plan is to employ strategies they have chosen to use to help manage cravings. Strategies should include how to manage withdrawal symptoms and cognitive and behavioral strategies. Some ideas include:

- Coping with withdrawal: the most effective way to deal with withdrawal is using

pharmacotherapy but withdrawal will still occur. Help the patient determine the withdrawal symptoms they are most concerned about and then come up with a few strategies to get through it. For instance, if constipation is a concern, introduce remedies prior to quitting, like high fiber cereals and hydration.

- Caffeine intake: one important point to highlight is the possible need to cut back on caffeine as smoking increases caffeine metabolism so quitting may lead to higher levels of caffeine. This may be important if the patient is experiencing insomnia, for instance.
- Behavioral strategies: some of the common behavioral strategies include exercise, breathing and relaxation techniques, changing routines, staying busy, using healthy oral substitutes (gum, tooth picks, etc.), controlling the physical environment (removing ash trays and other cues to tobacco use, tobacco free home and vehicle), and planning personal rewards for success. It is often helpful for the patient to make a list of 5 minute tasks to help wait out the urge to smoke. Examples are sorting through photos, organizing a closet, or calling a support person. All of the ideas, like rewards, should hold a personal meaning for the patient.
- Basic strategies: two common ways to remember some of the basic strategies are to use the reference the 4 D's (deep breathing, delay, distract, do something else) and ACE (avoid, change, escape the situation)
- Cognitive strategies: remember the relevance and the personal reasons the patient would like to quit smoking should be written down and referred to daily, particularly in the morning, as this will help reaffirm their decision to not smoke. Mental cravings and irrational thoughts can be dealt with using thought stopping techniques. Thinking about cigarettes doesn't mean having to smoke one. When having a craving, be mindful that the urge to smoke dissipates if you can redirect your thoughts. Combining cognitive with behavioral strategies are more effective than using just one or the other.

If the patient is struggling with identifying trigger situations and coping strategies, the AHA has a useful form on their website called No Smoking Confidence Assessment and Tips that the patient can fill out. This will provide them with a list of strategy options for the most common triggers to smoke.

Maintenance and preventing relapse should be addressed in your ITP for all patients who have quit in the past year. . Discuss the concept of a slip or lapse versus relapse. You can learn from a slip and gain knowledge for what to do differently next time. Keeping it to a lapse and not letting it progress to a full blown relapse is key. Let the patient know that most smokers have six to seven slips before they eventually quit completely.

Situations that can lead to lapses or relapse include:

- Drinking alcohol in social situations around other smokers. These situations may need to be avoided completely in the beginning. At the very least they should have an escape plan or practice some strategies ahead of time like saying "no thanks, I quit."
- Negative affect states like stress or conflict with family members, anxiety, hostility, and depression.
- Joyous times like vacations or celebrations.

Be mindful that tobacco use is a chronic disease that requires ongoing management. Situations and attitudes can change suddenly. Regular "check-ins" with patients who are quit is important. Just asking how are you doing with not smoking, how's your confidence, or have you experienced any difficult times since I last saw you, are some of the ways you can explore this. Affirmations of success are key. And expressing empathy when they are struggling will keep the door open to continued efforts to stay quit.

Access to cigarettes and/or living with smokers greatly increases the chance of a lapse or full blown relapse to smoke. This is a situation that may require more direct help from you to work out strategies. The patient may need to role play an assertive way to request friends or family support for not smoking. It is important to make this a team effort including the physician who can deliver a clear message to the family regarding the impact of ETS

on cardiac risk. A critical part of success is dependent on that social support the patient receives. The patient needs to know how to get the support they need.

SUPPORT SERVICES AVAILABLE OUTSIDE OF THE CARDIAC REHABILITATION PROGRAM

Patients who have untreated depression, anxiety, or other mental health disorders may continue to struggle with quitting. Referral to a mental health professional should be initiated as soon as possible. You can then hopefully work along with the mental health professional to move them along in the process of quitting.

If the patient continues to smoke at program completion ask them to consider accessing online resources, the Quitline, or local programs for continued assistance and support. Such resources include:

- 1-800-Quit Now. This number connects patients to their state quit line.
- Local hospitals, wellness centers or health clubs may have group programs available. Have a list available.

Online resources at the time of publication include:

- www.becomeanex.org – a website designed to help you re-learn life without cigarettes based on the experiences of successful quitters.
- www.smokefree.gov – a website to help you or someone you care about quit.
- www.lung.org – the American Lung Association's website, which includes information to help people interested in quitting.

SUMMARY

Tobacco cessation is one of the most important lifestyle changes cardiac patients who use tobacco products can accomplish for their health. The US DPHS makes it clear that tobacco use needs to be treated as a chronic disease with a stepped care approach and repeated attempts to achieve success. Low self-efficacy and uncontrolled cravings are often the stumbling blocks.

Promoting the use of nicotine replacement therapy and tobacco cessation medications, along with a behavioral program, can greatly increase the probability of a patient being able to quit. Cardiac rehab programs are an ideal setting to accomplish this. All team members, including the patient's physicians, need to be supportive of the process. Follow up and social support by the cardiac rehabilitation team promotes long-term abstinence.

You cannot expect to succeed with every smoking patient that enters your program. Often just keeping them engaged and attending rehab without dropping out prematurely is a success. One thing that may help programs is to identify a team member who goes beyond the management strategies outlined in this chapter. There are online training programs, webinars, and full tobacco treatment specialist certification available. Quitting smoking will reduce recurrent cardiac events by 50%, more than any medical treatment available including statins. Cardiac rehab programs should position themselves to be able to provide state-of-the-art treatment taking this chronic disease model approach.

TABLE 1. PHARMACOLOGIC PRODUCT GUIDE: FDA-APPROVED MEDICATIONS FOR SMOKING CESSATION

PRODUCT	NICOTINE REPLACEMENT THERAPY (NRT) FORMULATIONS					BUPROPION SR	VARENICLINE
	GUM	LOZENGE	TRANSDERMAL PATCH	NASAL SPRAY	ORAL INHALER		
Nicorette ¹ , Generic OTC 2 mg, 4 mg original, cinnamon, fruit, mint	Nicorette ¹ , Generic Nicorette ¹ Mini OTC 2 mg, 4 mg: cherry, mint	NicoDerm CQ ¹ , Generic OTC (NicoDerm CQ, generic) Rx (generic) 7 mg, 14 mg, 21 mg (24-hr release)	Nicotrol NS ² Rx Metered spray 10 mg/mL nicotine solution	Nicotrol Inhaler ² Rx 10 mg cartridge delivers 4 mg inhaled vapor	Zyban ¹ , Generic Rx 150 mg sustained-release tablet	Chantix ² Rx 0.5 mg, 1 mg tablet	
PRECAUTIONS	- Recent (≤ 2 weeks) myocardial infarction - Serious underlying arrhythmias - Serious or worsening angina pectoris - Temporomandibular joint disease - Pregnancy³ and breastfeeding - Adolescents (<18 years)	- Recent (≤ 2 weeks) myocardial infarction - Serious underlying arrhythmias - Serious or worsening angina pectoris - Pregnancy³ and breastfeeding - Adolescents (<18 years)	- Recent (≤ 2 weeks) myocardial infarction - Serious underlying arrhythmias - Serious or worsening angina pectoris - Underlying chronic nasal disorders (rhinitis, nasal polyps, sinusitis) - Severe reactive airway disease - Pregnancy³ and breastfeeding - Adolescents (<18 years)	- Recent (≤ 2 weeks) myocardial infarction - Serious underlying arrhythmias - Serious or worsening angina pectoris - Bronchospastic disease - Pregnancy³ and breastfeeding - Adolescents (<18 years)	- Concomitant therapy with medications/conditions known to lower the seizure threshold - Hepatic impairment - Pregnancy³ and breastfeeding - Adolescents (<18 years) - Treatment-emergent neuropsychiatric symptoms⁴ - BOXED WARNING REMOVED 12/2016 Contraindications: - Seizure disorder - Concomitant bupropion (eg, Wellbutrin) therapy - Current or prior diagnosis of bulimia or anorexia nervosa - Simultaneous abrupt discontinuation of alcohol or sedatives/benzodiazepines - MAO inhibitors in preceding 14 days; concurrent use of reversible MAO inhibitors	- Severe renal impairment (dosage adjustment is necessary) - Pregnancy³ and breastfeeding - Adolescents (<18 years) - Treatment-emergent neuropsychiatric symptoms⁴ - BOXED WARNING REMOVED 12/2016	

TABLE 1. PHARMACOLOGIC PRODUCT GUIDE: FDA-APPROVED MEDICATIONS FOR SMOKING CESSATION (CONTINUED)

NICOTINE REPLACEMENT THERAPY (NRT) FORMULATIONS					BUPROPION SR	VARENICLINE
GUM	LOZENGE	TRANSDERMAL PATCH	NASAL SPRAY	ORAL INHALER		
1st cigarette ≤30 minutes after waking: 4 mg 1st cigarette >30 minutes after waking: 2 mg Weeks 1–6: 1 piece q 1–2 hours Weeks 7–9: 1 piece q 2–4 hours Weeks 10–12: 1 piece q 4–8 hours - Maximum, 24 pieces/day - Chew each piece slowly - Park between cheek and gum when peppery or tingling sensation appears (~15–30 chews) - Resume chewing when tingle fades - Repeat chew/park steps until most of the nicotine is gone (tingle does not return; generally 30 min) - Park in different areas of mouth - No food or beverages 15 minutes before or during use - Duration: up to 12 weeks	1st cigarette ≤30 minutes after waking: 4 mg 1st cigarette >30 minutes after waking: 2 mg Weeks 1–6: 1 lozenge q 1–2 hours Weeks 7–9: 1 lozenge q 2–4 hours Weeks 10–12: 1 lozenge q 4–8 hours - Maximum, 20 lozenges/day - Allow to dissolve slowly (20–30 minutes for standard; 10 minutes for mini) - Nicotine release may cause a warm, tingling sensation - Do not chew or swallow - Occasionally rotate to different areas of the mouth - No food or beverages 15 minutes before or during use - Duration: up to 12 weeks	>10 cigarettes/day: 21 mg/day x 4–6 weeks 14 mg/day x 2 weeks 7 mg/day x 2 weeks >10 cigarettes/day: 14 mg/day x 6 weeks 7 mg/day x 2 weeks - Rotate patch application site daily; do not apply a new patch to the same skin site for at least one week - May wear patch for 16 hours if patient experiences sleep disturbances (remove at bedtime) - Duration: 8–10 weeks	1–2 doses/hour (8–40 doses/day) One dose = 2 sprays (one in each nostril); each spray delivers 0.5 mg of nicotine to the nasal mucosa - Maximum -5 doses/hour or -40 doses/day - For best results, initially use at least 8 doses/day - Do not sniff, swallow, or inhale through the nose as the spray is being administered - Duration: 3–6 months	6–16 cartridges/day Individualize dosing; initially use 1 cartridge q 1–2 hours - Best effects with continuous puffing for 20 minutes - Initially use at least 6 cartridges/day - Nicotine in cartridge is depleted after 20 minutes of active puffing - Inhale into back of throat or puff in short breaths - Do NOT inhale into the lungs (like a cigarette) but “puff” as if lighting a pipe - Open cartridge retains potency for 24 hours - No food or beverages 15 minutes before or during use - Duration: 3–6 months	150 mg po q AM x 3 days, then 150 mg po bid - Do not exceed 300 mg/day - Begin therapy 1–2 weeks prior to quit date - Allow at least 8 hours between doses - Avoid bedtime dosing to minimize insomnia - Dose tapering is not necessary - Duration: 7–12 weeks, with maintenance up to 6 months in selected patients	Days 1–3: 0.5 mg po q AM Days 4–7: 0.5 mg po bid Weeks 2–12: 1 mg po bid - Begin therapy 1 week prior to quit date - Take dose after eating and with a full glass of water - Dose tapering is not necessary - Dosing adjustment is necessary for patients with severe renal impairment - Duration: 12 weeks; an additional 12-week course may be used in selected patients - May initiate up to 35 days before target quit date OR may reduce smoking over a 12-week period of treatment prior to quitting and continue treatment for an additional 12 weeks

DOSING

TABLE 1. PHARMACOLOGIC PRODUCT GUIDE: FDA-APPROVED MEDICATIONS FOR SMOKING CESSATION (CONTINUED)

NICOTINE REPLACEMENT THERAPY (NRT) FORMULATIONS						VARENICLINE
GUM	LOZENGE	TRANSDERMAL PATCH	NASAL SPRAY	ORAL INHALER	BUPROPION SR	
ADVERSE EFFECTS • Mouth/jaw soreness • Hiccups • Dyspepsia • Hypersalivation • Effects associated with incorrect chewing technique (due to rapid nicotine release): - Lightheadedness - Nausea/vomiting - Throat and mouth irritation	• Mouth irritation • Nausea • Hiccups • Heartburn • Headache • Sore throat • Dizziness	• Local skin reactions (erythema, pruritus, burning) • Headache • Sleep disturbances (abnormal or vivid dreams, insomnia); associated with nocturnal nicotine absorption	• Nasal and/or throat irritation (hot, peppery, or burning sensation) • Rhinitis • Ocular irritation/tearing • Sneezing • Cough • Headache	• Mouth and/or throat irritation • Cough • Headache • Rhinitis • Dyspepsia • Hiccups	• Insomnia • Dry mouth • Nervousness/difficulty concentrating • Nausea • Dizziness • Constipation • Rash • Seizures (risk is 0.1%) • Neuropsychiatric symptoms (rare; see PRECAUTIONS)	• Nausea • Sleep disturbances (insomnia, abnormal/vivid dreams) • Constipation • Flatulence • Vomiting • Neuropsychiatric symptoms (rare; see PRECAUTIONS)
ADVANTAGES • Might serve as an oral substitute for tobacco • Might delay weight gain • Can be titrated to manage withdrawal symptoms • Can be used in combination with other agents to manage situational urges • Relatively inexpensive	• Might serve as an oral substitute for tobacco • Might delay weight gain • Can be titrated to manage withdrawal symptoms • Can be used in combination with other agents to manage situational urges • Relatively inexpensive	• Once-daily dosing associated with fewer adherence problems • Of all NRT products, its use is least obvious to others • Can be used in combination with other agents; delivers consistent nicotine levels over 24 hours • Relatively inexpensive	• Can be titrated to rapidly manage withdrawal symptoms • Can be used in combination with other agents to manage situational urges	• Might serve as an oral substitute for tobacco • Can be titrated to manage withdrawal symptoms • Mimics hand-to-mouth ritual of smoking • Can be used in combination with other agents to manage situational urges	• Twice-daily oral dosing is simple and associated with fewer adherence problems • Might delay weight gain • Might be beneficial in patients with depression • Can be used in combination with NRT agents • Relatively inexpensive (generic formulations)	• Twice-daily oral dosing is simple and associated with fewer adherence problems • Offers a different mechanism of action for patients who have failed other agents

TABLE 1. PHARMACOLOGIC PRODUCT GUIDE: FDA-APPROVED MEDICATIONS FOR SMOKING CESSATION (CONTINUED)

	NICOTINE REPLACEMENT THERAPY (NRT) FORMULATIONS					BUPROPION SR	VARENICLINE
	GUM	LOZENGE	TRANSDERMAL PATCH	NASAL SPRAY	ORAL INHALER		
DISADVANTAGES	• Need for frequent dosing can compromise adherence • Might be problematic for patients with significant dental work • Proper chewing technique is necessary for effectiveness and to minimize adverse effects • Gum chewing might not be acceptable or desirable for some patients	• Need for frequent dosing can compromise adherence • Gastrointestinal side effects (nausea, hiccups, heartburn) might be bothersome	• When used as monotherapy, cannot be titrated to acutely manage withdrawal symptoms • Not recommended for use by patients with dermatologic conditions (eg, psoriasis, eczema, atopic dermatitis)	• Need for frequent dosing can compromise adherence • Nasal administration might not be acceptable or desirable for some patients; nasal irritation often problematic • Not recommended for use by patients with chronic nasal disorders or severe reactive airway disease	• Need for frequent dosing can compromise adherence • Cost of treatment • Cartridges might be less effective in cold environments ($\leq 60^{\circ}\text{F}$)	• Seizure risk is increased • Several contraindications and precautions preclude use in some patients (see PRECAUTIONS) • Patients should be monitored for potential neuropsychiatric symptoms⁴ (see PRECAUTIONS)	• Cost of treatment • Patients should be monitored for potential neuropsychiatric symptoms⁴ (see PRECAUTIONS)
COST/DAY ⁵	2 mg or 4 mg: \$1.90–\$3.60 (9 pieces)	2 mg or 4 mg: \$3.33–\$3.60 (9 pieces)	\$1.52–\$2.90 (1 patch)	\$8.72 (8 doses)	\$14.88 (6 cartridges)	\$2.58–\$8.25 (2 tablets)	\$15.14 (2 tablets)

1 Marketed by GlaxoSmithKline.

2 Marketed by Pfizer.

3 The U.S. Clinical Practice Guideline states that pregnant smokers should be encouraged to quit without medication based on insufficient evidence of effectiveness and theoretical concerns with safety. Pregnant smokers should be offered behavioral counseling interventions that exceed minimal advice to quit.

4 In July 2009, the FDA mandated that the prescribing information for all bupropion- and varenicline-containing products include a black-boxed warning highlighting the risk of serious neuropsychiatric symptoms, including changes in behavior, hostility, agitation, depressed mood, suicidal thoughts and behavior, and attempted suicide. Clinicians should advise patients to stop taking varenicline or bupropion SR and contact a health care provider immediately if they experience agitation, depressed mood, or any changes in behavior that are not typical of nicotine withdrawal, or if they experience suicidal thoughts or behavior. If treatment is stopped due to neuropsychiatric symptoms, patients should be monitored until the symptoms resolve. Based on results of a mandated clinical trial, the FDA removed this boxed warning in December 2016.

5 Approximate cost based on the recommended initial dosing for each agent and the wholesale acquisition cost from Red Book Online. Thomson Reuters, January 2018.

Abbreviations: MAO, monoamine oxidase; NRT, nicotine replacement therapy; OTC, over-the-counter (nonprescription product); Rx, prescription product.

For complete prescribing information and a comprehensive listing of warnings and precautions, please refer to the manufacturers' package inserts.

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TOBACCO CESSATION - QUIZ

McKool, K RN, MSN, CTTS-M. (Ed.). (2018). Tobacco Cessation. CR Best practice resource: A CCRP study guide. (pp. 128-144). The American Association of Cardiovascular and Pulmonary Rehabilitation.

NAME _____ DATE _____

1. "Smoking tobacco continues to be the leading cause of preventable death in the United States" and "Tobacco dependence is a chronic disease that often requires repeated intervention and multiple attempts to quit." Cardiopulmonary Rehabilitation Programs can be instrumental in smoking cessation because: (select all correct answers)

- a. They have the opportunity to intervene up to 36 times
- b. Can deliver social support
- c. Can provide problem solving skills
- d. Can dispense tobacco dependence medications
- e. Cardiopulmonary Rehab staff can be a strong ally for patients

2. Studies show that smoking causes numerous problems within the cardiovascular disease. The major components in cigarette smoke that increase these risks are:

- a. Nicotine, carbon monoxide, and oxidant gases
- b. Nicotine, tar, and carbon dioxide
- c. Nicotine, menthol, and tar

3. Most patients do not realize the effect that smoking has on their cardiovascular system. Studies show that the risk of a myocardial infarction decreases by _____% within two years of smoking cessation.

- a. 10%
- b. 25%
- c. 50%
- d. 75%

4. A smoker will experience nicotine withdrawal symptoms very quickly when not smoking. These include: (select all correct answers)

- a. Depressed mood
- b. Insomnia
- c. Irritability
- d. Anxiety
- e. Hallucinations
- f. Increased energy
- g. Numbness
- h. Restlessness
- i. Difficulty concentrating
- j. Increased appetite
- k. Decreased heart rate
- l. Cough
- m. Fatigue
- n. Cravings

5. Secondhand smoke, also known as environmental tobacco smoke (ETS) lingers in the air and studies support that it causes adverse health effects. To prevent exposure and negative effects of ETS:

- a. Smoking needs to be eliminated from the home
- b. Smoking needs to be behind closed door with an adequate ventilation system
- c. Smoking needs to be confined to the car of garage

6. “_____ for patients is the most important component of all counseling skills”

- a. Sympathy
- b. Professionalism
- c. Empathy
- d. Judgement

7. It is helpful to remember the 5 “R’s” when helping patients with behavior change. These are: (select the correct 5)

- a. Relentless
- b. Relevance
- c. Risks
- d. Rewards
- e. Ridicule
- f. Roadblocks
- g. Repetition

8. Smoking cessation can be thought of as a three-step process:

- a. Realization, Reparation, Restoration
- b. Denial, Refusal, Acceptance
- c. Preparation, Quitting, Maintenance

9. It is important to remember that tobacco use is a chronic disease that requires ongoing management, therefore maintenance and preventing relapse should addressed in the ITP for patients who have quit within the past year.

- a. True
- b. False

10. It is important to remember that tobacco cessation is one of the most important lifestyle changes patients can accomplish for their health. “Quitting smoking will reduce recurrent cardiac events by 50%, more than any medical treatment available including statins.”

- a. True
- b. False

TOBACCO CESSATION - ANSWER KEY

McKool, K RN, MSN, CTTS-M. (Ed.). (2018). Tobacco Cessation. CR Best practice resource: A CCRP study guide. (pp. 128-144). The American Association of Cardiovascular and Pulmonary Rehabilitation.

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- a. **True**
- b. False

ISCVPR Program Highlights

Summer 2025

Board of Directors meeting: August 7th, 2025, 10am-2pm

Fall 2025

Board of Directors meeting: November 6th, 2025, 10am-2pm

All meetings are at Irsay YMCA at City Way (430 S Alabama Street, Indianapolis).

All Members are welcome to attend, just contact any board member for more information.

Regional Meetings – TBA

Central

We will meet virtually sometime this winter

Northwest

We will meet in-person sometime this fall

www.iscvpr.org



www.aacvpr.org

Summer Zucchini & Garbanzo Salad



Ingredients

- 2 zucchini, diced
- 1 red onion, diced
- 1 red pepper, diced
- 3 oz cherry tomatoes, diced
- 1 carrot, peeled and diced
- 2 lemons, juiced
- ½ cup chopped fresh dill
- 1 tbs paprika
- ¼ tsp of black pepper
- ½ c. water
- 1 can of garbanzo beans, cooked and cooled.

RECIPE BY: PRITIKIN.COM

SERVINGS: 6

Directions

1. Mix zucchini, onion, pepper, tomatoes, carrot, lemon juice, dill, paprika, black pepper, and water together in a mixing bowl.
2. Cover and let marinate in the fridge for at least one hour.
3. Serve and top with desired amount of garbanzo beans.



MENTAL HEALTH FIRST AID

presented by

MSCVPR

Michigan Society for Cardiovascular
and Pulmonary Rehabilitation



OCTOBER 18th | 8a - 4p

- At Oakland University or virtually.
- 7 CEU credits for RT, AACVPR, ACSM, and RN. \$100 to attend.
- Register at www.mentalhealthfirstaid.org
- Reach out to Miranda Umbras, PhD, ACSM-CEP, MSCVPR President at mirandaumbras@gmail.com with questions.

**Registration opens
August 1, 2025**



HELP WANTED!



ISCVPR is looking for someone to help manage our social media and grow our online presence. If you love creating content and connecting people with information online, we'd love to hear from you.

**Are you great with Facebook, Instagram, or X?
You might be a great fit!**

- Build your portfolio
- Gain experience in digital healthcare communications
- Make a positive impact on cardiopulmonary rehabilitation professionals across Indiana

If you or someone you know is interested in helping us with our social media presence, please email us!

EMAIL@email.com





American Heart Association®

Heart Walk

2025 INDIANAPOLIS HEART WALK

Saturday, September 20th, 2025

REGISTER TODAY!

Victory Field

501 West Maryland Street | Indianapolis, IN 46225

Gates open at 8:00am, opening ceremony is at 9:45pm, and the walk begins at 10:00am. The route has a 5k and 1 Mile option.

The Heart Walk is a fun, family-friendly event that brings our community together to get active, raise life-saving funds, and support the mission of the American Heart Association.

www2.heart.org

